# 2ND MEETING OF THE INDEPENDENT ADVISORY GROUP

Johannesburg, Republic of South Africa,
3-4 October 2016

World Health Organization
REGIONAL OFFICE FOR Africa

# 2nd Meeting of the Independent Advisory Group (IAG)

## Johannesburg, Republic of South Africa, 3-4 October 2016

First row: Prof RGF Leke, Dr N A Romisch-Diouf, Dr Moeti, Mrs S Branchi,
Second row: Dr M Belocine, Dr R.N.Kamwi, Dr R Z N Ming-Huie
Absent from photo: Dame S Davies, Dr F Omaswa

2nd Meeting of the Independent Advisory Group (IAG) to the Regional Director for Africa – Johannesburg, Republic of South Africa, 3- 4 October 2016

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# Abbreviations

| | |
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| Africa CDC | Africa Centres for Disease Control |
| AICS | Accountability and Internal Control Strengthening |
| AMR | Antimicrobial resistance |
| AUC | African Union Commission |
| CCS | Country Cooperation Strategy |
| DALYs | Disability Adjusted Life Years |
| DFID | Department for International Development (UK) |
| DOH | Department of Health |
| ECA | United Nations Economic Commission for Africa |
| ECOWAS | Economic Community of West African States |
| FENSA | Framework of Engagement with Non-State Actors |
| GAVI | Global Alliance for Vaccines and Immunizations |
| HHA | Harmonization for Health in Africa |
| HR | Human resources |
| HSE | Health Security and Emergencies |
| IAG | Independent Advisory Group |
| IAS | International AIDS Society |
| IDSR | Integrated disease surveillance and response |
| IHR | International Health Regulations |
| ISTs | Intercountry Support Teams |
| KPI | Key Performance Indicator |
| MDGs | Millennium Development Goals |
| MOU | Memorandum of Understanding |
| NCDs | Noncommunicable Diseases |
| NHPSPs | National Health Policies, Strategies and Plans |
| PHC | Primary Health Care |
| RC | Regional Committee |
| RO | Regional Office |
| RECs | Regional Economic Communities |
| SDGs | Sustainable Development Goals |
| TB | Tuberculosis |
| UHC | Universal Health Coverage |
| UK | United Kingdom |
| US | United States |
| USD | United States dollar |
| WCO | WHO Country Office |

WHO/AFRO WHO Regional Office for Africa

# EXECUTIVE SUMMARY

Executive Summary

The WHO Regional Director for Africa constituted an Independent Advisory Group (IAG) in May 2015 to provide her with strategic and policy advice on how to orient and strengthen WHO's work in the African Region. Their advice at the first meeting was to embark on a transformation programme, strengthen WHO's leadership, strengthen its capacity to deliver at country level and on priority technical areas, enhance external communication, and mobilize resources to expand the financial resource base.

The second IAG meeting, in October 2016 was an opportunity to give feedback on progress and achievements made since the last meeting. This included the development and launch of the Transformation Programme, reorganization of the Regional Office (RO) and Intercountry Support Teams (ISTs), improved staff selection processes, the implementation of an Accountability and Internal Control Strengthening (AICS) project, the use of managerial key performance indicators (KPIs) for improved administrative and financial performance in country offices, new and improved partnerships, and the development of a regional communication strategy.

AFRO's executive management presented information on the human resources reform and the functional review of country offices. A session on taking forward the Sustainable Development Goals (SDGs) focused on the critical role of health systems in service delivery, progress on Universal Health Coverage (UHC), the health of adolescents, women and children as flagship programmes, and health security and preparedness. Perspectives on positioning AFRO for health leadership and effective action were discussed, taking into consideration the crowded health development landscape. The participants also discussed emerging global health issues including the changing demographic profile of Africa, antimicrobial resistance (AMR), new vectors and climate change. The feedback from the IAG was very positive on these initiatives and developments.

The Regional Director recognized the valuable support and inputs from the IAG and the need to continue its work of supporting the health and welfare of the people in the WHO African Region. The IAG members agreed to a three-year term, with chairing of the group to be rotated among members, and to meet when necessary with more frequent communication between meetings. The IAG concluded with the following broad recommendations:

**Maximize use of WHO's convening power**

WHO should adopt a 'first among equals' approach to partnership and facilitation, starting with the 2017 Africa Health Forum. Partnerships have to come first.

**Fully exercise leadership role**

The Regional Director should use every opportunity to meet Heads of State, political, academic, and civil leaders to provide evidence in support of sound policies that affect health.

**Invest in communications infrastructure**

The WHO Secretariat should invest in communications infrastructure to communicate more effectively both within and outside the Secretariat. WRs should be supported through training, and country offices should have appropriate infrastructure such as video-conferencing facilities;

**Build on the strength of the polio legacy**

WHO should build on the strengths of the polio network in expanding its capacities to respond to outbreaks and emergencies.

**Strengthen capacities in emerging challenges and medicines regulation**

The Secretariat needs to systematically consider emerging challenges in its programmes and human resource capacities. Specifically, the Secretariat should increase its capacities to spearhead improvements in medicine regulation.

**Invest in research to inform policies and programmes across all programmes of work**

The WHO Secretariat should engage more actively with academia throughout the Region and invest in research across all programmes.

**Continue with implementation of the Transformation Agenda, including the human resources reforms**

The Regional Office should, following the good progress made, continue with the Transformation Agenda and human resources improvements.

## 1. INTRODUCTION

The 2nd meeting of the Independent Advisory Group (IAG) to the WHO Regional Director for Africa took place in October 2016, 18 months after the inaugural meeting in May 2015, after a period of intense activity in the Regional Office for Africa. This period saw AFRO's significant contribution in bringing the West African Ebola virus disease outbreak to a close; curbing yellow fever outbreaks in Angola and the Democratic Republic of the Congo by launching the largest emergency vaccination campaign ever attempted in Africa; and the purposeful overhaul of the management and human resources of AFRO.

The IAG's overarching advice at the previous meeting was for the Regional Director to transform the Organization into a more transparent, responsive and results-driven one. Other recommendations included strengthening WHO's leadership in the African Region and its ability to deliver at country level and on priority technical areas; enhancing external communications; and expanding its resource base through innovative financing mechanisms.

The Regional Director has adopted a progressive, ambitious Transformation Agenda to realize the IAG's recommendations. This has included strengthening human resources capacity through reorganization and improved recruitment processes, enaging in dialogue with the African Union Commission on enhancing investments in health security and emergencies, accelerating implementation of the 2005 International Health Regulations, and embarking on a decisive and busy outreach programme to enhance relationships with key global partners. A number of significant milestones were reached, and more will be in the coming year.

This meeting was an opportunity to provide feedback to the IAG on progress to date, and solicit its members' advice on the way forward on the Transformation Agenda, AFRO's positioning amidst the crowded health development landscape and the Sustainable Development Goals agenda, partnerships and emerging health issues, among others.

1. Introduction

> "I congratulate the Regional Director for her leadership which shows she trusted her people. I personally saw the change in the field with regard to the emergency response in Guinea Conakry, how collectively we can deliver. If we can deliver there, we can deliver in easier contexts."
>
> **Mohammed Belhocine: Consultant, Algeria**

# 2. Proceedings

## 2.1 SESSION 1: OPENING AND OVERVIEW

The WHO Regional Director for Africa, Dr Matshidiso Moeti, welcomed delegates to the 2nd meeting of the IAG and thanked the IAG members for providing support in their individual capacities for the work of the WHO Regional Office for Africa.

In the absence of the Chair and Co-Chair, the members endorsed the Regional Director's proposal that Dr Mohammed Belhocine chair the meeting until the arrival of Professor Francis Omaswa, the Chair. Dr Moeti recalled the IAG's recommendations from the previous meeting which included the need to look beyond the Ebola outbreak and rebuild health systems in the affected areas, to promote transparency in the Region, and to create a transformation programme. While she welcomed the engagements she had with individual members, she promised to be more engaged with them in different spheres of public health and advocacy. The past year had been very stressful and she thanked colleagues for their perseverance and support.

The Regional Office made a significant contribution in bringing the West Africa Ebola Outbreak to a close, deploying a large contingent of staff who knew the Region well, which added value to their technical expertise. The unique contribution of these AFRO colleagues was acknowledged across all levels of WHO. These included investigations, laboratory work, community engagement, national coordination efforts as well as supporting the African Union Commission (AUC) deployment teams and mobilizing resources. The Regional Office also participated in WHO's global reform and reorganization of its emergency response effort.

The Regional Director provided **feedback on major action points and recommendations** of the 1st IAG meeting. Some key achievements were:

- Development and launch of the Transformation Agenda (TA), which was shared with Ministers of Health at the Sixty-fifth Regional Committee, who were very supportive
- Purposeful reorganization of management and human resources at the RO/ISTs, including improved selection processes
- Initiation of a functional review of WHO Country Offices
- Implementation of the Accountability and Internal Control Strengthening (AICS) project leading to improvements in compliance and accountability
- Use of managerial key performance indicators in WCOs resulting in improved administrative and financial performance
- Intense efforts to improve relations with key partners, including the AUC, UK DoH and DFID, the United States Government and the Chinese Government, among others.
- Development of a Regional Communication Strategy

She urged IAG members to be open and candid in giving advice and feedback. She welcomed their perceptions of how the Secretariat was faring to allow her to reflect and adjust accordingly. The Regional Director thanked the members for their support, and looked forward to fruitful discussions on how to consolidate the work underway.

The IAG commended the Regional Director and her team for the progress made and urged them not to be distracted from their vision but to continue on the path of transforming WHO in the African Region into an effective, efficient and transparent organization.

> "Regarding your progress made since the previous IAG meeting, you made us proud, you really responded to the advice. Congratulations!"
>
> Richard Kamwi: RBM Board Member and former minister of health and social services, Namibia, 2005 – 2015.

## 2.2 SESSION 2: IMPLEMENTING THE TRANSFORMATION AGENDA

**Human resources reforms at the Regional Office**

The four areas of progress highlighted were (see Annex 3):

- Restructuring of the Regional Office, ISTs and Country Offices to make the African Region "fit for purpose"
- Ensuring that recruitment and selection processes are effective and transparent
- Ensuring that staff are well equipped for working in the Organization and performance is appropriately recognized
- Enhancing staff well-being and welfare

Under the human resources reforms, six clusters were restructured, and unmatched staff were being reassigned or separating from the Organization, which was a very challenging process. Improved recruitment and selection processes are underway. A major action for ensuring staff were well equipped for working in the Organization was the establishment of an induction programme, which had been completed by 98% of newly recruited staff since January. A welcome guide was produced and the gymnasium was refurbished.

The IAG welcomed the achievements made and highlighted the courage and determination shown in the difficult work done around the human resources reforms. They commended the involvement of an external consultancy group and experts to promote objectivity and transparency, suggesting that the evidence-based and objective approach adopted could be used as a solid argument to advocate for additional resources for the Region. Greater transparency would encourage more applications and vacancies should be communicated more broadly.

**Delivering better at country level – Functional review of WCOs and staff re-profiling**

AFRO requires the right mix of skills and competencies, especially at country level, for WHO to provide the necessary support to Member States to scale up interventions to attain the SDGs. A functional review of the country offices was initiated through an independent consultancy firm, Dalberg (See Annex 4).

> "Countries believe in WHO. Take advantage of that. We see WHO giving technical support with the Global Fund – let them acknowledge WHO's support."
>
> Rose Leke: Emeritus Professor and Board Chair, National Medical Research Institute, University of Yaounde, Cameroon

The outputs of the functional review were:

- A staff allocation tool comprising a database and a dashboard for assessing individual country offices, using proxy indicators such as DALYs, number of health workers per capita and number of outbreaks between 1970 and 2014.
- An implementation plan for taking forward the functional review at country level, which offered two scenarios for change (in 2 or 3 years), with financial implications for each scenario.

The key observation made by the consultants was that there was very little correlation between country needs and the actual staffing level in WHO country offices. The IAG heard comments on the process and responses from countries. The Regional Office has established a steering group to oversee and support this work, while WRs will lead the process at country level.

The IAG members welcomed the work done so far and urged that countries be treated individually as each had unique health, economic and political contexts.

They recommended that AFRO improve its communication strategy and engage more broadly with partners, civil society, the media and academia. The IAG called for increased visibility of WHO's work at country level as partners did not always see or recognize WHO's contribution. In this regard, the Heads of Office should be well equipped/trained to take up this challenge.

In addition, they called for continued progress in ensuring that the right and appropriate human resources were available in WHO particularly in countries, to be able to deliver on the priorities of the Region and Member States.

The IAG urged AFRO to better anticipate and more effectively manage the challenges that would certainly be associated with the change management process, including internal resistance from staff members.

**Advice on Human Resources Reforms:**

- Regarding the human resources reforms, the Regional Office should continue to deepen progress and incorporate recognition of performance, the use of incentives, and staff well-being and welfare programmes. At country level, career development opportunities and pathways should be systematically developed for national professional officers (NPOs), including utilizing the skills of NPOs for missions to other countries to broaden their perspectives and learning and including them in a regional resource pool.
- The AFRO Secretariat should consider providing training to unmatched staff after the matching exercise so they could compete for other positions. It should work on attracting staff not only from within the Organization but also from external sources, through broader communication, transparency in recruitment processes, and the use of independent recruitment agencies. WHO should encourage the use of persons with expertise in non-medical disciplines such as anthropology and sociology to broaden its work, and strengthen its links with academia.
- For the implementation of the country functional reviews at country level, the RO support team should work in partnership with WRs to use all existing tools to identify priorities and manage their financial and human resources. Since the tool has been developed but not tested, the WRs could initiate the process of analysis and design of the functional review, with the recognition that each country must be assessed individually. The WHO country offices should be supported to develop Country Cooperation Strategies under a broad consultation, and indicators can be developed to measure CCS implementation.
- In terms of communication, the Secretariat should consider upskilling WRs to engage with multisectoral partnerships and empowering them to deal with non-health ministries. It should reassess the communications capacity of WCOs with regard to the use of health promotion NPOs, who are not necessarily best placed to provide good communication support for country offices. To monitor progress on cross-border communication efforts, it could consider a Key Performance Indicator which measures cross-sectoral work and communications.

> "Congratulations on the paper on Human Resources Reforms at the Regional Office. I am impressed – this was a short period of time, from diagnosis to effective action. Practically, at country level, it takes courage to do this. You will get support as long as you keep showing courage and determination to achieve results. Don't lose the big picture, you are already on the right path."
>
> Marie-Andrée Romisch Diouf, Senior Consultant: Development Cooperation and Global Health, France

## 2.3 SESSION 3: TAKING THE SDGS FORWARD

Three background documents were introduced to highlight the critical role that strong health systems play in the delivery of services for achieving the health-related SDGs (see Annex 4).

**Strengthening UHC in the context of SDGs**

AFRO is accelerating its support to countries for achieving UHC and will convene a forum in December 2016 to assemble technical expertise in countries. This will continue on a biennial basis to build a network on UHC expertise in countries. A set of indicators was developed as a baseline to monitor UHC in an effort to deliver better than on the MDGs. From this, a framework categorizing actions for countries will be developed to assess contexts in a more nuanced way. Work is underway to redesign service delivery, and AFRO hopes to have a clearer profile of access to blood transfusion services and medicines in the Region by the end of the year. AFRO has just concluded a meeting which assessed learning materials for countries and ministries of health to facilitate the policy dialogue to lead to the national strategic plans and discussions.

> "In the overcrowded landscape of global health, WHO's guidance is crucial. WHO needs to be visionary and publish its work.
>
> Saran Branchi, Regional Advisor for Global Health, French Embassy, Côte d'Ivoire"

**Health of adolescents, women and children as flagship indicators for UHC progress**

The SDGs have even more ambitious targets for women's and children's health than the MDGs. The Global Strategy for Women's, Children's and Adolescents' Health 2016 -2030 gives prominence to adolescents, with adolescent girls at increased risk of dying from complications of pregnancy, contracting Sexually Transmitted Infections (STIs) and HIV infection. Many of the drivers lie outside the health sector, such as education, water and sanitation, access to roads and motivation of health workers. The improvement in indicators for women's health will reflect progress on UHC.

**Health security and preparedness in the context of health systems strengthening**

Antimicrobial resistance is the next emerging threat for health security. WHO is undertaking major reforms. These include regional risk mapping to better understand the types of risks being faced for more evidence-based preparedness; the high level conference on health security beyond Ebola; and the development of a regional health security and emergency strategy to guide Member States. There are still major challenges in striving to make health security a priority in the African Region.

While observing that this was a very challenging session, the IAG members indicated that the SDGs presented a good opportunity for WHO to work with other non-health sectors, civil society and academia. WHO could assist countries to identify inequities and focus on implementing PHC for these populations to ensure no one is left behind. WHO could also act as a catalyst to incorporate NCDs at primary health care level, and strengthen National Health Agendas, and link with health security and preparedness work.

WHO, through its convening power, could lead dialogue with Member States and partners on how to work on the health-related SDGs. The transformed Regional Office should be known for its clear leadership. AFRO should develop a programme on political engagement with Heads of State and their spouses, possibly through working with the Organisation of African First Ladies Against HIV/AIDS, which was important to move work on the health-oriented SDGs beyond the health sector.
Health-related SDGs should be made more understandable to those outside the health sector.

The IAG members observed that, in most cases, ministers of finance needed to be convinced on the potential return on investment in health within the context of UHC and health security issues (such as antimicrobial resistance), which was viewed more favourably than mere requests for additional funding. In this regard AFRO needed to invest in human resource capacity to develop investment cases for ministers of finance to better articulate this position.

The IAG also underscored the importance of WHO's role in drug regulation which was seen as weak in Africa. Research was required to identify what worked in one location and why, such as in South Africa and Europe. Viral forecasting in Cameroon showed the need for basic research on risk mapping and vector surveillance. In relation to IDSR, the polio programme could potentially be used for improving broader health outcomes, as seen with recent immunization programmes, including those in response to the yellow fever outbreaks in Angola and the DRC, which had successfully utilized the polio networks for delivery.

The IAG reiterated that the Region's emergency response needed to be supported by existing health systems and should be integrated with all existing systems rather than creating another vertical system. The most critical component was early detection and response, linked to strengthened health systems. IDSR tools, which were developed jointly with partners, could be revisited using the investment in the polio network, as seen with Nigeria's proper outbreak response on Ebola. This could also be used as matched funding with donors and governments, to ensure sustainability and continued commitment.

"The SDGs are taking us beyond the MDGs which were about diseases. The SDGs are not about diseases but about health that the world has now embraced as part of the development agenda.

Marie-Andrée Romisch Diouf, Senior Consultant: Development Cooperation and Global Health, France"

**Advice on taking the SDGs forward:**

- The Regional Office Secretariat should use its convening power and support countries in implementing health-related SDGs by, for example, holding dialogue on broad, multisectoral issues and act as a more effective catalyst for action in other sectors, including global health security. New challenges under the SDGs will require integrating NCDs into PHC and UHC strategies. Through operational research, WHO could identify triggers and conditions that will enable programmes to work across different country settings and generate evidence for action relating to the SDGs and health security.
- WHO should maintain its role of supporting countries in surveillance and emergency response in line with the IHR (2005), while collaborating with the Africa CDC in the context of One Health. WHO should provide guidance to countries on integrating emergency response into existing health systems to ensure their readiness, including implementing integrated disease surveillance and response (IDSR). In this respect, AFRO could build capacity for forecasting, early warning and rapid detection of zoonotic diseases.
- To strengthen public health and IDSR, including outbreak response capacities, AFRO should explore the transition of existing resources in the polio network as part of the polio legacy. In terms of investing in health more broadly, the Regional Office could more strongly support planning and financing while strengthening country capacity to improve data collection and analysis, especially in the use of National Health Accounts (NHA).

## 2.4 SESSION 4: POSITIONING WHO AFRO FOR HEALTH LEADERSHIP AND EFFECTIVE ACTION

**Navigating a complex, crowded health development landscape – developing and consolidating our niche and most useful contribution at regional and country levels**

The Regional Office is operating in an increasingly complex and changing health landscape, with many players contributing to health at global, regional and country levels. Global initiatives, philanthropies, bilateral and multilateral partners play a significant role in funding and occasionally implementing programmes. Countries, which are supposed to be leading in accordance with the Paris Declaration, are swayed by the 'loudest voices' and at times it is unclear whose agenda is taking precedence. The Organization is no longer viewed as the only source of health information (See Annex 5).

The IAG members observed that the discussions on the matter were very timely as the Member States prepared to elect a new WHO Director-General. Countries still believe in WHO as a neutral, important partner in the health arena, playing a convening and coordinating role in the overcrowded landscape of global health.

**Advice on positioning AFRO for health leadership and effective action:**

The Regional Director was urged to insist on due acknowledgement for the support provided, and communicate this more effectively in negotiations for technical support. At the same time, the Regional Office was urged to monitor and improve its reporting on financial contributions to partners.

To advance these goals, AFRO was advised to develop case studies from countries which received funding from partners to provide evidence of how funding had been utilized to improve lives, and use this as evidence for potential funders. The Regional Director should consider side meetings during Executive Board meetings and World Health Assemblies to showcase what is happening in the Region, and have a presence at ECOWAS and IAS meetings in 2017. To promote a unified African voice at the financing dialogue, the IAG suggested a meeting before the event to coordinate efforts.

**Partnerships – where are we?**

> "Everyone in WHO has the responsibility to work with partners, including media and social media.
>
> Minhui Ren:
> Assistant Director-General:
> HIV/AIDS, TB, Malaria and NTDs, HQ"

Partnerships constitute one of the focus areas of the Transformation Agenda. Some key developments over the past year included the signing of a Framework for Collaboration between WHO and the AUC; operationalization of the Africa CDC; and signing of memoranda of understanding with the UN Economic Commission for Africa and the Organisation of African First Ladies Against HIV/AIDS; and action plans with the African Leaders Malaria Alliance (ALMA). WHO and the African Union Commission also organized the 1st ministerial meeting on immunization in Africa. Bilateral discussions had also taken place with BMGF, China, UK/DFID, USAID and the US Department of Health and Human Security. The recent Framework of Engagement with Non-State Actors (FENSA) was a good opportunity for WHO to be proactive in engaging new, non-traditional partners.

In relation to resource mobilization, WHO's funding gap is estimated at US$ 500 million, and will feature at the financing dialogue on 31 October 2016. Over 80% of WHO's income is from voluntary contributions, with limited contributions from the African Region. WHO needed to fulfil its leadership role by reaching out, not only to traditional partners, but to the private sector as well. More work with academia and civil society was required to encourage joint actions (See Annex 5).

The IAG welcomed the proposed Africa Health Forum planned for 2017, which is a platform for continuing dialogue and aimed at attracting potential, non-traditional partners. They agreed that countries had high expectations from WHO, but that the Organization was under-resourced. It was suggested that a mindset change was needed. AFRO should also demonstrate how WHO has saved lives in joint efforts with partners. Everyone had the responsibility to work with partners, which included the media and optimizing social media. There was also a need to change the leadership approach from charismatic to facilitative.

**Advice on partnerships:**

> "AFRO is doing well. Challenges exist but are not insurmountable. I particularly like the idea of the 2017 Regional Health Forum, and inviting potential new funding partners including the private sector."
>
> Richard Kamwi: RBM Board Member and former minister of health and social services, Namibia, 2005 – 2015

- AFRO should be more proactive in promoting partnerships and ensure that they are a leading pillar of its work, not an afterthought. FENSA opened new opportunities, and the Regional Office should outline what these could be for potential partners. The IAG reminded AFRO that while partners had their own interests, the way was now open for it to support and engage with any partner, which had the same fundamental values and principles of attaining the highest possible level of health and upholding human rights.

- The IAG unanimously welcomed the proposed Africa Health Forum in 2017, and advised AFRO to broaden participation to include academics, new potential funding partners, regional philanthropists and civil society organizations. Partnerships have to come first. It should explore ways of influencing mayoral networks, First Ladies/spouses and parliaments on health.

## 2.5 SESSION 5: EMERGING PUBLIC HEALTH AND DEVELOPMENT ISSUES

This session dealt with AMR; migration; demographic changes; urbanization and implications for health in the Region. The narrative on health previously focused largely on the burden of disease, but the health situation in Africa is facing rapidly evolving economic, social and demographic changes. This may require a reassessment of how service delivery is currently structured, based on the changing demographics of adolescents and the elderly, to be equipped to respond to emerging future needs. Massive urbanization is underway, and by 2016, half a billion Africans will live in urban centres, with about 40% living in urban areas. The continent is contending with new vectors, a resurgence of old vectors, and the recent experience with Ebola which moved from relatively remote areas into high density areas, highlighting the consequent issue of security. Antimicrobial resistance (AMR) poses a real health and economic threat (See Annex 6).

If actions are not initiated on emerging issues such as AMR; epidemiological changes including NCDs, rapid urbanization and unplanned migration; rapidly changing demographic parameters; and climate change and its impact on health, health systems may be overwhelmed in the near future.

The IAG members agreed that AMR in Africa, as seen with multi-drug resistant TB, was a real threat which needed to be dealt with through a multisectoral approach, as embodied in the Ottawa Charter and the SDGs. Health care costs due to AMR are escalating at an unsustainable rate, and a radical change is needed in access to and use of antimicrobials.

In relation to the epidemiological changes, the increasing burden of NCDs and AMR, the IAG noted that these would have serious implications on medicines regulation as well as the need for an Essential Drugs List for NCDs. The meeting also noted that one of the key entry points for NCDs in the Region should be enforcement of the provisions of the WHO Framework Convention on Tobacco Control.

The IAG agreed that health promotion needed to be revived, and countries should use the evidence from STEPS Surveys to lobby for increased funding towards NCDs prevention and care. The IAG emphasized WHO's role in assisting countries to develop legislation around alcohol and the food and beverage industry in relation to sugar-sweetened beverages.

**Advice on emerging public health and development issues:**

- WHO was advised to consider how to include emerging public health and development issues in the National Health Strategic Plan, which all partners use to support ministries of health, and monitor implementation. AFRO should monitor health-related emerging issues, but needed to prioritize its interventions to focus on issues that would exert the most pressure on the functioning of health systems such as AMR, the increasing burden of NCDs or road traffic accidents.

- AMR is a real threat which extends beyond the health sector. The IAG urged WHO to raise this issue more vocally at Heads of State level, consider simple targets (such as no sale of antibiotics without prescription), implement systems for monitoring, and document best practices. Medicines regulation in Africa is weak, and the Secretariat needed stronger capacity to support countries to ensure medicine quality and safety to prevent the development of AMR.

- In its efforts to promote health, WHO should fully utilize existing reference documents (such as Health in All Policies, among others) to empower country teams to raise health promotion and prevention in various forums. This includes addressing NCD risk factors such as tobacco, alcohol and sugar-sweetened beverages through legislation, public policy or media advocacy to introduce balanced reporting on issues which affect public health and for which substantial resistance exists from private industry.

- With regard to rapid urbanization, AFRO was advised to collaborate with the WHO Kobe Centre for Health Development on urbanization, healthy cities and urban development initiatives in Africa, and support urbanization and urban planning using existing frameworks.

> "Regarding UHC, political will is essential for real change in a country, and WHO needs to consider how to use its convening power to mobilize countries in UHC. This could be a concrete way for governments to move forward because countries don't know where to begin. It is crucial for WHO to move beyond the health sector."
>
> Saran Branchi, Regional Advisor for Global Health, French Embassy, Côte d'Ivoire

## 2.6 SESSION 6: OPTIMIZING THE ROLE OF IAG MEMBERS IN THE FACE OF CHANGES IN THE GLOBAL HEALTH LANDSCAPE

The Regional Director reiterated her appreciation for the support and input provided by the IAG (See Annex 7). In keeping with the terms of reference, members had advocated for AFRO's work on an ad hoc basis, and had made efforts to keep the Regional Director in touch with networks. She commended the IAG members for their interactions, sound advice, openness and range of input.

The Regional Director proposed that the relationship continue as the IAG members were valuable to AFRO's work. Relations with the IAG could be strengthened through videoconferencing, timely notice of annual/biannual meetings, or a Sharepoint platform for documents or facilitated virtual discussions. She suggested linking individual IAG members with themes, and reiterated the value of their connections with relevant international platforms and partners including philanthropists where AFRO might not be present. The chairing of the group should be rotated among members. The IAG members were invited to share insights on how AFRO could glean information on strategic decisions and issues occurring globally, and optimize these to consolidate its niche.

The IAG members congratulated the Regional Director and stressed that she was on the right path and should not be distracted from the goals set out in the Transformation Agenda. They noted the importance and relevance of their ambassadorial, intelligence-gathering and liaison roles, and reiterated the honour they had to serve the Region in this way. They were impressed with the frank and open brainstorming with AFRO's leadership on how the Regional Office could position itself in the global arena.

They agreed that the relationship could be strengthened through more regular communication and follow-up, and that meetings in person would spark new ideas. Alternatively, members could share agendas to meet the Regional Director on her travels; or communicate more informally by email or telephone calls, rather than a common platform. It was important to keep the IAG meetings informal to encourage frank discussions. They believed there was a need to reassess the Group's usefulness and composition to consider new members with different skills, bearing in mind their advocacy abilities. Potential new members should be independent to preserve the IAG's freedom of speech. They suggested that interns/younger AFRO staff attend as observers to learn from the process, which they felt was most valuable.

They agreed to a term of two to three years, and keeping a core group for continuity. Future meetings should be held as needed and could be structured around general issues on Day 1, and special interest issues on Day 2. Selected WRs could be invited to present to extend the input beyond the Regional Office, although the size of the meeting should not impede free discussion and IAG interactions with WHO staff. It was proposed that a workplan be developed after the next meeting.

Individual members reiterated their support to facilitate linkages during governing bodies meetings in Geneva and with other partners and initiatives such as NGOs, the Africa CDC, the private sector such as the African Development Bank, and African philanthropists/billionaires who should be contacted before the proposed Africa Health Forum. They considered how to involve the Regional Office more deeply in international discussions and strategic dialogue, which included organizing side events during the Executive Board Meeting and the World Health Assembly. They emphasized the importance of working together with the AUC which was undergoing a transition. The Regional Director thanked members of the IAG for their comments and for agreeing to an additional term.

> "WHO's credibility and visibility will be enhanced through providing useful information which is accessible to partners. This requires stronger investment in modern technology and communications. It will allow AFRO to better play its specific role of gathering and making available good practices."
>
> Marie-Andrée Romisch Diouf, Senior Consultant: Development Cooperation and Global Health, France

## 3. CONCLUSION AND RECOMMENDATIONS

The chair commended the Regional Director for the new approach which was visible through the good contributions of staff, and urged her to implement what she believed was right, remembering that the IAG was an advisory group. He congratulated the Secretariat for their contributions and hard work.

The meeting was characterized by candid, inspiring views and was extremely constructive. The Regional Director was very reassured by IAG's emphasis that the Regional Office was proceeding in the right direction. She noted additional elements such as engaging better with academia and making use of their voice, which she promised to do. She undertook to improve contact with the IAG, and thanked the IAG and the Secretariat for their enthusiastic approval of the new direction.

IAG members gave verbal and written suggestions to the draft text. AFRO was reminded that with limited resources, it would need to prioritize its activities.

The report will be reviewed and the draft will be distributed to the IAG members by 30 October 2016.

**Overall recommendations**

The IAG commended the Regional Director and her team for the progress made in such a short time. The meeting concluded with the following broad recommendations:

- **Maximize use of WHO's convening power.** WHO should adopt a 'first among equals' approach to partnership and facilitation, starting with the 2017 Africa Health Forum. It should make concerted efforts to engage with new partners, for example, regional philanthropists, academics, civil society, First Ladies/spouses, parliamentarians, and mayoral networks.
- **Exercise leadership.** The Regional Director should use every opportunity to meet Heads of State, political, social and civil leaders to provide them with evidence in support of sound policies that affect health. High level engagement is particularly important around emerging health issues such as AMR, and drug regulation and development. WHO should assume leadership of AMR using the One Health approach, and also assume leadership of the health-related SDGs. Doing so will require investments in the collection and use of evidence, research and data across all programmes.
- **Invest in communications infrastructure.** The WHO Secretariat should invest in communications infrastructure and human resources to communicate more effectively both within the Secretariat as well as with external partners. Such investments will enable greater visibility on key health issues. The WHO Secretariat needs to make a concerted effort to improve internal communications by ensuring that all country offices have the infrastructure to communicate easily with each other and with the Regional Office, thus enhancing cross-border communications and experience sharing.
- **Build on the strength of the polio legacy.** WHO should build on the strengths of the polio network in expanding its capacities to respond to outbreaks and emergencies.
- **Strengthen capacities in emerging challenges and medicines regulation**. The Secretariat should systematically consider emerging challenges as part of its programming and human resource requirements. Specifically, the IAG recommended that the Secretariat increase it capacities to spearhead improvements in medicine regulation on the continent, as a critical challenge.
- **Continue with implementation of the Transformation Agenda, including human resources reforms.** The Regional Office had shown good progress and should continue with the Transformation Agenda and HR improvements. The Regional Office should work in partnership with the WRs to utilize all available tools and information for country office functional reviews.

3. Conclusion and recommendations

"You need to continue this work and show the competitors there is space for everyone for health in Africa. We are here to deliver, to save lives, not for competition. Let's put hands together. We have this role."

Mohammed Belhocine: Consultant, Algeria

Annexes

## Annex 1: Programme of Work

| | | |
|---|---|---|
| **Day 1: Monday 3 October 2016** | | |
| **Session 1:** | **Opening and overview** | |
| 09:00 -10:00 | Welcome and opening remarks | Dr Matshidiso Moeti; Dr Mohammed Belhocine (co-chair) |
| | Feedback on the major action points from previous IAG meeting | Dr Matshidiso Moeti |
| | Discussion and clarification | All |
| 10:00-10:30 | Coffee Break | |
| **Session 2:** | **Implementing the Transformation Programme** | |
| 10:30-12:30 | HR reforms at Regional Office | Mr Thomas |
| | Delivering better at country level<br>• Functional review of WCOs and staff re-profiling | Dr Cabore |
| | Discussion<br>• Recommendations and action points for moving forward | All |
| 12:30-14:00 | Lunch | |
| **Session 3** | **Taking the SDGs forward** | |
| 14:00-17:30 | What we are doing in the area of SDGs:<br>• Strengthening UHC in the context of SDGs<br>• Health of Adolescents, Women, Children as flagship indicators for UHC progress<br>• Health security and preparedness in the context of health systems strengthening | Dr Dovlo<br>Dr Zawaira<br>Dr Fall |
| | Discussion<br>• Recommendations and action points for moving forward | All |
| 17:30 | Dinner | |
| **Day 2: Tuesday 4 October 2016** | | |
| Session 4: | Positioning WHO AFRO for health leadership and effective action | |
| 08:30-10:00 | Navigating a complex, crowded health development landscape - developing and consolidating our niche and most useful contribution at:<br>• Regional level and<br>• Country level | Dr Zawaira |
| | Partnerships - where are we? | Mrs Drameh- Avognon |
| | Discussion: Recommendations and action points for moving forward | All |
| 10:00-10:30 | Coffee Break | |
| **Session 5:** | **Emerging global issues with public health impact** | |
| 10:30-12:30 | Emerging public health and development issues:<br>• Impact of agriculture on AMR; migration; demographic changes; urbanization among others - implications for health in the region. | Dr Robalo |
| 12:30-14:00 | Lunch | |
| **Session 6** | **Way forward** | |
| 14:00-17:30 | Optimizing the role of IAG members in the face of changes in global health landscape | Dr Moeti |
| **Session 7** | **Closing** | |
| 16:00-17:00 | Summary and action points | Dr Asamoah-Odei |
| | Closing remarks | Dr Moeti and Dr Omaswa |
| | End of meeting | |

## Annex 2: List of participants

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# Annex 3: Implementing the Transformation Agenda

## 3.1 HR Reforms at the Regional Office

The Human Resources-related strategic actions identified in the Transformation Agenda focus on four areas: (a) restructuring and staffing the Regional Office, Intercountry Support Teams and Country Offices to make the African Region "fit for purpose", (b) ensuring that recruitment and selection processes are effective and transparent, (c) ensuring that staff are well equipped for working in the Organization and that performance is appropriately recognized, and (d) enhancing staff well-being and welfare. The actions taken to-date and the status of work in these areas:

### A. Restructuring and staffing the Regional Office, Intercountry Support Teams and Country Offices to make the African Region "fit for purpose"

#### *Regional Office*

The RO restructuring is nearing completion. For each Cluster, the structure and functions were reviewed against WHO mandates, strategies and programmatic priorities and plans. This work was executed by both internal staff and consultant firms.

Position descriptions were then developed for all identified positions and classified by external consultants, who subsequently conducted a "matching exercise" to compare current positions against the new proposed positions (511 positions descriptions have been prepared to-date). Personnel were either assigned to new positions, where appropriate or, for those whose positions did not match, relevant administrative actions were taken (they entered a reassignment process for possible assignment to a position somewhere within WHO globally or were separated from the Organization).

The recruitment process was then undertaken (or to be undertaken) for all vacant funded positions following the conclusion of the above steps.

The above restructuring process began with the professional positions. Analysis, position descriptions and assignment of personnel for the supporting general services positions will be completed by end of 2016. For the Technical Clusters, professional positions:

- Health Systems and Services (HSS) – completed restructuring process in March 2016.
- Health Security and Emergencies (HSE) – completed restructuring process in March 2016. However, subsequent to the exercise, the global WHO Health Emergencies Programme (WHE) was established which replaces HSE. The exercise is being updated to reflect the new positions and functions in the WHE Programme. A harmonized recruitment process is underway globally to fill the positions in this Programme.
- Family and Reproductive Health (FRH) - completed restructuring process in April 2016.

**Transformation Agenda strategic actions**

- Conduct a joint internal and external functional review of the WHO Secretariat in the African Region (including the Regional Office, Intercountry Support Teams and country offices) aimed at making it fit for purpose;
- Restructure the Regional Office to effectively address outbreaks and emergencies in line with the resolution of the Executive Board special session on Ebola;
- Establish and fill the position of a full-time Ombudsperson;
- Enhance regional human resource capacity by developing a robust system for supporting young professionals to work at AFRO as interns or junior professional officers (JPOs),
- Conduct an external operational assessment of the 47 WHO Country Offices aimed at defining human resource needs and taking appropriate actions;
- Implement a policy on mobility and rotation for different categories of staff within the WHO African Region;
- Develop job descriptions, create posts and recruit communication officers for regional communication hubs (e.g. Dakar, Johannesburg, Nairobi, Addis Ababa and Abuja).

- Communicable Diseases (CDS) – completed restructuring process in May 2016.
- Noncommunicable Diseases (NCD) – the analysis of the new structure is nearing completion, after which the rest of the established process will be followed.

The relevant technical components of the Intercountry Support Teams (ISTS) were assessed and realigned in conjunction with the respective technical Clusters.

For the Management and Administrative Clusters/Offices, professional positions:

- The office of the Regional Director (RDO), including Country and Intercountry Support (CIS); Communication (COM); Partnerships, Resource Mobilization and Governing Bodies (EPG); Polio Eradication (PEP); and Ombudsperson (OMB) completed the restructuring process in September 2016.
- The office of the Director of Programme Management (DPM), including Planning, Budgeting, Monitoring & Evaluation (PBM) and Health Promotion and Social Economic Determinants (HPD) completed the restructuring process in September 2016.
- General Management and Coordination - completed analysis and proposed structures in September 2016. One unit, Administrative Support Services (ASU) was reviewed and 117 position descriptions updated in October 2015. Position descriptions for all other offices are under development now, following which the established process will be followed.

Staff impact: Of the 175 professional staff in the RDO, DPM and first four technical Clusters above, 29 were initially not matched against a position. Of these, 9 were separated from WHO, 12 were reassigned to other positions, and 8 are still pending the full administrative process.

Statistics to date (for professional positions):

| | | | Staff not matched to a new position | | | | |
|---|---|---|---|---|---|---|---|
| **Cluster/Office** | Number of positions after restructuring | Number matched with existing staff | Total Staff not Matched | Separated from WHO | Reassigned to another WHO position | Pending (admin. process still active) | Number of completed or in-process recruitments to-date |
| HSS | 59 | 25 | 13 | 7 | 6 | 0 | 25 |
| HSE* | 48 | 17 | 5 | 2 | 2 | 1 | 4 |
| FRH | 71 | 48 | 1 | 0 | 0 | 0 | 0 |
| CDS | 74 | 26 | 5 | 0 | 0 | 2 | 11 |
| RDO | 30 | 22 | 4 | 0 | 0 | 4 | 0 |
| DPM | 12 | 8 | 1 | 0 | 0 | 1 | 0 |
| **TOTAL** | **394** | **146** | **29** | **9** | **12** | **8** | **40** |

*These numbers represent action for HSE; the numbers will change with the new WHE programme structure and implementation.

***Other actions to date:***

- The position of Ombudsperson was established and filled in September 2016.
- A more formal intern programme was established; the first group of interns began in the Regional Office in August 2016. Interns have also been placed in Sierra Leone, Mozambique, Rwanda and Gabon.

***Challenges:***

1. Taking lessons learned from the above restructuring process, it is clear that administrative support, particularly in Human Resources, needs to increase temporarily in order to address the large increase in HR actions. Two UN Volunteers joined the Regional Office in September 2016 for this purpose.
2. There is a risk of appeals from those who have been separated or reassigned. While every measure is being taken to ensure that the delineated process is followed stringently, this risk still exists and cannot be reduced to zero risk. Therefore, some costs may need to be paid at the conclusion of the appeals process, depending on the outcome.

***Country Offices***

Dalberg Global Development Advisors was contracted to conduct an analysis of the 47 country offices and propose a methodology by which AFRO could determine the size, structure and profile of each country office. That analysis was completed in late-August 2016. The results are under review by AFRO management. A project team will be established to begin a restructuring exercise of these 47 offices in early 2017. Lessons learned from the Regional Office realignment process have been factored into the design of this phase of the HR realignment process.

**Ensuring that recruitment and selection processes are effective and transparent**

- Standard, harmonized recruitment processes have been used, in alignment with those used for professional positions throughout WHO.
- Budget centre personnel have been included in the end-to-end process of all recruitments resulting from the restructuring exercise;
- Generic position descriptions have been developed and utilized wherever possible;
- Fast track recruitment processes have been established and utilized to fill the large numbers of recruitments as effectively and efficiently as feasible;
- Recruitment guidelines and checklists were issued to Country Offices and ISTs in June 2015, regarding minimum documentary requirements for recruitments. AFRO will participate in a forthcoming HQ-led development of harmonized recruitment processes for countries.

**Transformation Agenda strategic actions**

- Enhance transparency in the staff recruitment process by involving the relevant budget centres in the end-to-end process;
- Brief selection committee(s), directors and WRs on WHO's recruitment policy and human resource reforms;
- Improve staff recruitment outreach (through the use of headhunting, LinkedIn, etc.) to attract a larger talent pool with a view to addressing gender and language imbalances;
- Set up a recruitment committee at country office level to oversee every step of the recruitment process;
- Develop standard operating procedures for the establishment of recruitment committees at all budget centres.

**Transformation Agenda strategic actions**

- Revamp the staff development learning (SDL) programme in the Region;
- Develop a mandatory induction programme for newly-recruited staff members;
- Enhance transparency in rewarding good performance through intranet publication of criteria for promotion and/or upward position reclassifications and identify and implement innovative ways of recognizing high-performing staff/ teams at all levels (country offices, Inter-country Support Teams and clusters in the Regional Office).

**Transformation Agenda strategic actions**

- Develop and implement staff well-being and welfare programmes at all levels including: training on work-life balance; peer support/ buddy mechanisms for team leaders and managers; and the operation of staff clinics, staff canteens and staff gyms.

**Transformation Agenda strategic actions**

- Conduct an external operational assessment of the 47 WHO Country Offices aimed at defining human resource needs and taking appropriate actions;

### B. Ensuring staff are well equipped for working in the Organization and performance is appropriately recognized.

- Mandatory induction programme has been developed and is in effect for newly recruited staff;
- The awards programme for good performance was revamped globally in 2016 and AFRO is participating in it. The programme calls for recognition and rewards for high-performing teams.
- Roster of selection panel being finalized and a training programme on interviewing techniques and the role of panel members will be rolled out upon finalization of the roster which is scheduled for end October 2016.

### C. Enhancing staff well-being and welfare

- A Staff Welfare Officer position was established and filled. Work to-date has included assisting families getting settled in Brazzaville, planning family events, and issuing a monthly welfare newsletter.
- A detailed "Welcome to Brazzaville" booklet was published in January 2016, with information about the actions necessary to begin work in WHO and how to assimilate into and enjoy Brazzaville life.
- The gymnasium for the Regional Office personnel and families has been upgraded and opened in early September. Revised rules around the use of these facilities have been developed with the staff association to ensure sustainability of the equipment and infrastructure.

## 3.2 Delivering better at country level – functional review of WCOs and staff re-profiling

**Background: Restructuring Country Offices to make the African Region "fit for purpose"**

The overall objective of the functional review of the country offices is to strengthen the technical and the administrative capacity in, and performance of the WHO country offices by designing a tailor-made and demand-driven technical cooperation package with each Member State.

Following a competitive bidding process, Dalberg Global Development Advisors was contracted to conduct an analysis of the 47 country offices and propose a methodology by which AFRO could determine the size, structure and profile of each country office.

The ultimate goal of this evaluation is to prepare Member States for the challenges of scaling up interventions to attain the Sustainable Development Goals (SDGs) but also to build national capacity that can respond more effectively to any emerging disease outbreak or humanitarian crisis.

The focus of the functional evaluation is the development of a coherent organizational structure that enhances the efficiency, effectiveness and the relevance of the WHO country offices to the country needs and priorities elaborated in the Country Cooperation Strategies (CCS).

This functional review builds on the recent evaluation on the realignment of the Regional and the Intercountry Support Teams to the AFRO strategic priorities.

More specifically, the review evaluated:

(a) The current WHO organizational set up in the country offices, the adequacy of its staffing level and skills mix, the budget portfolio and opportunities to mobilize domestic resources for the collaborative programme. It analysed how this input is aligned with the priorities articulated in the WHO Country Cooperation Strategies, the WHO AFRO priorities elaborated in the Transformation Agenda, and the designated roles and responsibilities of WHO country offices.

(b) Identified the key internal and external drivers and conditions influencing the presence and work of the WHO country offices.

(c) Developed a robust analytical framework and method that will facilitate the classification and grouping of countries on the basis of the level of their health, social and economic development indictors. Countries with protracted natural and man-made disasters were factored into this analysis.

(d) Develop a costed implementation plan with a timeline, a realistic budget and key performance indicators.

**Preliminary Outcome/Deliverables:**

(a) It was determined that grouping countries based on a given set of indicators (population, socioeconomic performance, health system strength, etc.) and then applying a model to determine optimal staffing strength and mix would not be possible given the differences between all countries of the Region.

(b) A model has been developed based on WHO categories using the following indicators:

  (i). Communicable, noncommunicable diseases and promoting health through the life course (burden of prevalent communicable and noncommunicable diseases and family and reproductive health issues) – DALYs from IHME;

  (ii). Health systems (Local Capacity, proxied by the number of physicians, nurses and midwives) per 1,000 population from World Bank;

  (iii). Preparedness surveillance and response (Number of disease outbreaks between 1970 and 2014) from WHO/AFRO.

(c) The target staffing for the technical expertise varies depending on country size, which is the basis for the fixed staffing component and needs – needs being determined by the model and representing the variable staffing component.

(d) For category 6 staffing (corporate services and enabling functions), the staffing footprint is determined by the number of technical staff and adequate segregation of duties or outsourcing to accomplish this segregation.

(e) The initial outcome of running the model is that there is very little correlation between "needs" and actual staffing profile in countries.

(f) To implement the "raw" output of the model would imply increasing the number of non-polio staff to 1,632 FTEs – a 27% increase, with the assumption that we are implementing the end game strategy for polio.

### Next Steps

(a) An implementation plan was developed with two possible scenarios:

(i). Scenario 1 would span a period of 3 years starting with 4 pilot countries and then an additional 11 in year 1 – remaining countries split over years 2 and 3 at a cost of approximately US$ 10.0 million;

(ii). Scenario 2 would span a period of 2 years at a cost of USD$ 8.8 million.

(b) Taking on board lessons learned from the Regional Office restructuring, a robust implementation team will be in place to carry out the missions to each of the countries as well as additional HR activities that need to be implemented (recruitment/classification/legal).

(c) A funding proposal was submitted to partners and 50% of the required funds for the project were secured. We expect other partners, who have expressed interest, to fill the gap.

(d) The implementation project is expected to start in November 2016.

### Challenges

WHO is an organization that is dependent on the Assessed Contribution of its Member States and Voluntary Contributions from donors and other stakeholders, the latter being highly earmarked which could make implementing the outcomes of the project difficult.

Staff are generally uneasy about restructuring processes as they see it as a reduction in force – need to address this through enhanced communication strategy.

### Strategic areas for input and advice

- What strategies can we develop to convince donors to finance the outcomes of the study and not stick to their specialty projects/countries of interest?
- What are the IAG's views on a 2 or 3 year implementation period, noting that the longer period allows for greater attention to detail which prevent possible legal cases but exacerbate the upheaval in the work force?
- Are the criteria used in the model sufficiently robust? Is there another way to implement as opposed to dealing with each country separately?
- What thoughts do members have on how we can better manage the change process?

# Annex 4: Taking the SDGs forward

## 4.1 Strengthening UHC in the context of SDGs

### Introduction

Our goal of universal health coverage (UHC) is to ensure that all people obtain the health services they need, of appropriate quality, without suffering financial hardship. This embodies principles of equity of access to use of health services and requires effective primary health care services. It should reflect UHC's three critical dimensions – Who is covered? What services are covered? And how much of the cost is covered?

We shall need our approach to be dynamic and sensitive to countries' contexts and needs, with the three dimensions above being progressively expanded over time to increase their coverage as resources become available and situations evolve.

The results of efforts for UHC will be (**i) improved health sector leadership and governance with informed actions (ii) reduction in the priority causes of morbidity and mortality; (iii) mitigation of emerging health risks, with poverty alleviation, and economic growth.**

Universal Health Coverage (UHC) will be achieved by 2030 only through coherent, comprehensive and sustainable health systems strengthening. Functional health systems will also be essential to ensuring individuals and communities' health security, so that gains made from expanding health services coverage are not disrupted and reversed as was sharply illustrated by recent health emergencies including the Ebola and the yellow fever outbreaks, or by natural disasters and conflict. This will imply systems functioning in a resilient fashion within a variety of institutional, economic, fiscal, and political contexts. Most countries in the African Region are not yet there.

### Key challenges and issues: What will Member States need to do to achieve UHC and the SDGs?

Several resources and process inputs can be identified for developing an effective UHC system:

- Adequate human resources (doctors, nurses, community health workers among others). Thirty three countries in the Region are considered to be in a state of HRH crisis with the situation actually worsening in a few.
- Adequate service delivery facilities fully provided with essential drugs, core equipment, and other basic supplies such as infection prevention and control (IPC) and water supplies to deliver a basic essential package of services to all.
- Adequate and appropriately allocated financial resources so that all people, regardless of wealth, can obtain needed services without experiencing financial hardship.
- A well-governed and managed health sector providing integrated, quality promotive, preventive, curative, palliative and rehabilitative services focused on outcomes.
- A recognition of and engagement with other public health-related services and sectors addressing the social and environmental determinants of health.
- Countries' commitment to UHC that is based on health as a human right.

## Areas AFRO has focused on (using the WHO core functions):

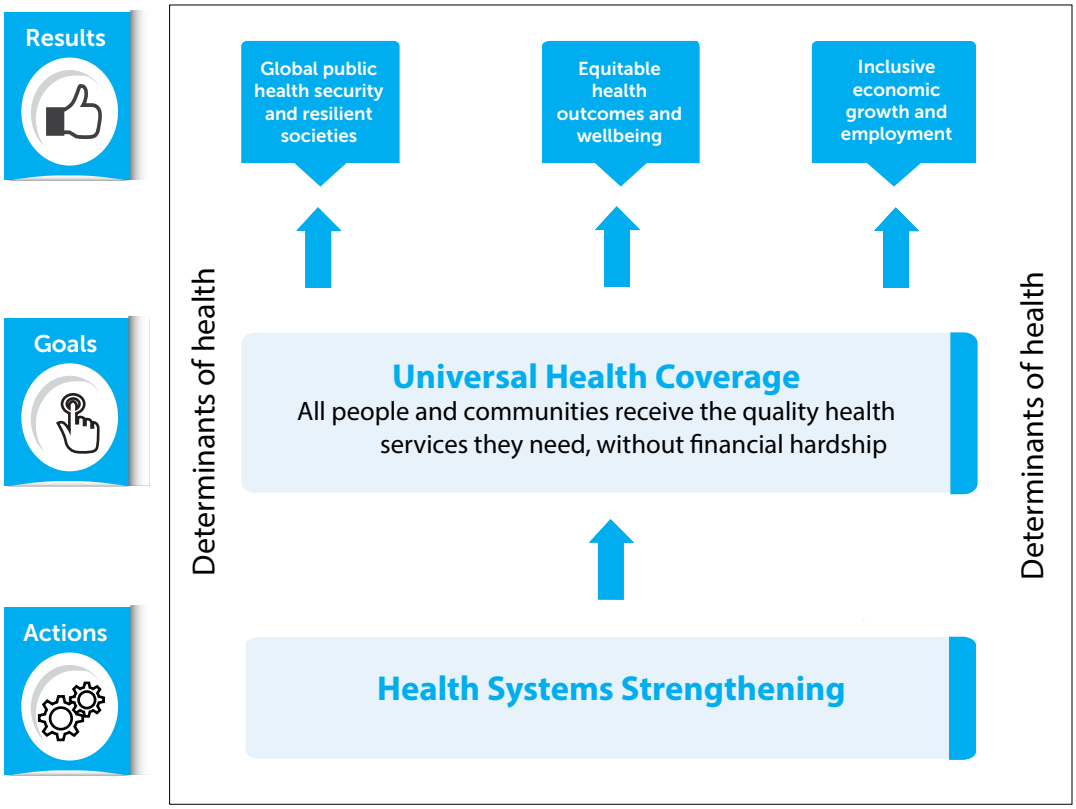
- **Leadership, governance and partnerships for joint action, for example:**
  - Regular UHC/SDG forums (biannual) for MOHs technical leadership, among others
  - Advocacy/facilitation within and across sectors and partnerships, including with UN agencies
- **A research and knowledge dissemination agenda**
  - Identifying new WHO-CCs for research and knowledge generation and sharing
  - Establish expert panels on evidence-based areas of emphasis and work
- **Guidance, norms and standards, and their implementation**
  - Develop a framework of actions towards towards the SDGs and UHC and monitor these based on an established UHC baseline and a system of dashboards and scorecards for reviews
  - Expanding National Health Accounts exercises and number of countries with good health financing strategies
- **Ethical and evidence-based policy options**
  - Facilitation of countries' inclusive policy dialogue and planning processes and their work with other sectors to agree on UHC and SDGs focus of sector policies and plans
  - Develop new integrated protocols for the investment case in health
- **Providing technical support, catalysing change, and building sustainable institutional capacity**
  - Articulate clearly the specific technical efforts countries need to make to achieve UHC and the SDGs with related technical guidance and tools for implementing interventions
  - Tailoring technical support more effectively to the country types in the Region
- **Monitoring the health situation and assessing health trends**
  - Develop/agree on core sets of UHC/HSS indicators based on countries' contexts (and global agreed metrics), with baseline and monitoring systems, dashboards and scorecards
  - Continue production of Atlases of Health Statistics and Health Financing on each country
  - Produce annual thematic and other reports on areas of topical interest

## IAG's advice sought on the following:

- What needs to be done to re-emphasize PHC principles and to improve equity of health outcomes?
- What can AFRO do to improve investments by countries in effective decentralization and improved management and accountability for results at all levels?
- How can we improve regional research and knowledge management capacity around UHC/SDGs and what are the best platforms for sharing practices and experiences more effectively?

| Thematic areas on which AFRO proposes to produce guidance and normative work: | |
|---|---|
| 1. Defining country types, status and contexts | Country assessments; review and analyse upcoming NHPSPs; demographic and diseases burden analysis (double NCD and CD burdens); intersectoral work of MOHs and effect of non-health sector policies and social determinants on health and well-being |
| 2. PHC and district/peripheral health systems | Integrating resilience and preparedness components; focus on vulnerable and marginalized populations (leave no one behind); subnational systems governance, management and accountability |
| 3. Financing health | Extending effective aid/Paris principles to domestic resources allocation and efficient use; cross-programme effectiveness and efficiencies. Tools to prioritize and sequence/phase investments & interventions to ensure effective chain of actions for results |
| 4. Health technologies, medicines & products | Regulatory systems and quality assurance; logistics and supply chain effectiveness and efficiencies; scaling up new interventions/products with analysis of costs and benefits |
| 5. Delivery of services | Hospitals' roles in UHC and SDGs ; mainstreaming NCDs, injuries and health systems foundations; Health security and IHR as integral parts of health services<br>Recognizing urban shift and implications for health needs in peri- and intra urban deprived communities |
| 6. Partnerships and collaborations | Within countries; external partners; inter-regional; intra-region/ RECs etc. |
| 7. Knowledge generation and sharing, research and information | Revamping and reprioritizing and facilitating the Region's WHO-CCs and their focus areas; the AFRO barometer (qualitative components on UHC and SDGs) |
| 8. Health Information Systems and data for monitoring SDG and UHC progress | CRVS expansion (4 to 20 countries @ 25% coverage of deaths); Expanding core HIS capacities in countries through an information and informatics initiative (data collaborative); renewal of regional National Health Observatories objectives and roles |

## A Framework for UHC as part of the SDGs




## SDG 3 - Health

**SDG 3: Ensure healthy lives and promote well-being for all at all ages**

**Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all**

| MDG unfinished and expanded agenda | New SDG 3 targets | | SDG 3 means of Implementation targets | |
|---|---|---|---|---|
| 3.1: Reduce maternal mortality | 3.4: Reduce mortality from NCD and promote mental health | | 3.a: Strengthen implemention of framework convention on tobacco control | |
| 3.2: End preventable newborn and child deaths | 3.5: Strengthen prevention and treatment of substance abuse. | | 3.b: Provide access to medicines and vaccines for all, support R&D of vaccines and medicines for all | |
| 3.3: End the epidemics of HIV, TB, malaria and NTD and combat hepatitis, waterbone and other communicable diseases | 3.6: Halve global deaths and injuries from road traffic accidents | | 3.c: Increase health financing and health workforce in developing countries | |
| 3.7: Ensure universal access to sexual and reproductive health-care services | 3.9: Reduce deaths from hazardous chemicals and air, water and soil pollution and contamination | | 3.d: Strengthen capacity for early warning risk reduction and management of health risks | |

**Interactions with economic, other social and environmental SDGs and SDG 17 on means of implementation**

Source: http://sustainabledevelopment.un.org/sdgs

## 4.2 Health of Adolescents, Women and Children as flagship indicators for UHC progress

### Background

The WHO Africa Region has 11% of the world's population, but has

- **The highest maternal, newborn and child mortality:**
  - 3,062 million under-five children died in Africa (2015)
  - Under-five mortality rate at 85/1000 live births
  - Malaria is still killing an African child every 30 seconds
  - One in 5 African children is not accessing basic life-saving vaccines
  - 60% of the people live with HIV/AIDS,
  - 90% of new HIV infections among children
  - Newborn mortality rate at 32/1000 live births
  - Of the 302 000 maternal deaths worldwide, 66% occurs in Africa
  - Of the 20 countries with the highest maternal mortality ratios worldwide, 18 are in the WHO African Region
  - Child marriage persists in many countries of the Region
- **Low contraceptive uptake ( 19% in 1990 to 27% in 2013)**
- **Double burden of nutrition:**
  - 13,9 million under-five children with severe acute malnutrition in Africa (2015 estimates)
  - Under-five children with overweight increased from 5.4 million to 10.3 million from 1990 to 2015

**Issues and challenges:** We have supported countries to undertake Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) programme reviews to identify the issues preventing countries from progressing as envisaged. Some of the identified issues include:

### Technical/Programmatic:

- Low and uneven coverage of the proven interventions.
- Poor quality of care for mothers and newborns
- Unevenly distributed health workforce which is overworked, unmotivated and in some cases lacks capacity to deal with lifesaving interventions like managing haemorrhage, neonatal resuscitation and caring for the preterm newborns.

Low coverage with Skilled Birth Attendants during labour,

- Very high unmet need for family planning.
- Unavailability of data (including for newborns and still births) to guide planning for appropriate targeting

**External enablers:**

- Other factors are inadequate political will to implement to scale the already agreed initiatives. For example in 2014, only four countries achieved the 2001 Abuja Target of allocating at least 15% of the national budget to the health sector. Yet these funds are especially crucial to cushion those who are needy. According to the confidential enquiries into maternal deaths conducted in many African countries, deaths are likely to occur in women with the lowest level of education, lowest wealth quintile, living in rural or hard-to-reach areas with inadequate socio-physical support (adolescents, single women).

- 11 out of the 18 countries with the highest maternal mortality ratio (MMR) were facing humanitarian, conflict or post-conflict situations that may have caused breakdown of the health system resulting in a dramatic rise in deaths due to complications that would be easily treatable in stable conditions.

With regard to neonatal mortality, 18 countries[1] were estimated to have very high number of neonatal deaths of more than 13,000 neonatal deaths by the close of 2015. Many of the causes associated with high maternal mortality also largely contribute to neonatal deaths. Access to quality care for both mothers and their newborns also remains a challenge especially for the marginalized populations.

Following the launch of the Global Strategy for Women's, Children's and Adolescents' Health, 24 countries have renewed their commitment towards ending preventable maternal, newborn and child deaths. In addition, all the countries attending the Regional Committee meeting in August 2016 adopted the paper that outlined the areas countries needed to focus on to end maternal and newborn deaths and improve their well-being

We shall work with countries to operationalize the strategies that have demonstrated success in maternal and newborn survival. These include addressing inequities, strengthening the health system, supporting and empowering women, families and communities.

**Strategic areas for IAG input and advice:**

- How can we get Member States in African Region to have sustained interest and investment in Women's, Children's and Adolescent's Health?
- The SDGs targets (reducing MMR to 70/100,000, newborn mortality to 12/1000 and U5MR to 25/1000) are even more ambitious than the MDGs; what will it take to galvanise countries to achieve them?
- Many of the drivers/enablers lie outside the health sector: education, water and sanitation, having accessible roads for referral of mothers in labour, motivation and remuneration of health workers. Any suggestions on how we can get ministries of health to become stronger advocates for multisectoral action and sustained financing?

[1] Nigeria, DRC, Ethiopia, Angola, Tanzania, Kenya, Uganda, Côte d'Ivoire, Mozambique, Mali, Niger, Ghana, Chad, Cameroon, Burkina Faso, South Sudan, Malawi, Burundi

## 4.3 Health security and preparedness in the context of health systems strengthening

### Background

The entire Region is at risk of health emergencies emanating from natural and man-made disasters as well as epidemics. Annually, Member States in the WHO African Region report over 100 public health emergencies. Of these, infectious diseases account for 80%. Among the infectious diseases, cholera, measles, and meningitis are the most recurring. Others include Ebola, Chikungunya, typhoid, Dengue, Rift Valley fever, yellow fever, plague, and recently the Zika Virus Disease[2]. Most of the infectious diseases have historically originated from animal health because the health of humans, animals and ecosystems are interconnected.

Emerging and re-emerging pathogens are of particular concern as seen with the yellow fever outbreak in Angola were 4100 suspected and 883 confirmed cases were reported with 121 deaths.[3] The outbreak spread to the Democratic Republic of the Congo with cases being exported to as far as China and Kenya.

Cabo Verde reported an outbreak of Zika virus linked to the South America outbreak. Ebola and Marburg have caused major outbreaks. Recently, West Africa experienced an unprecedented Ebola outbreak with over 28 637 cases including 11 318 deaths, exceeding all past outbreaks combined.

The problem of antimicrobial resistance is also becoming a significant health security risk and threatens the effective prevention and treatment of an ever-increasing range of bacterial, parasitic, viral and fungal infections. Antimicrobial resistance requires action across all government sectors and society. Antimicrobial resistance has been reported from all parts of the world and new resistance mechanisms keep emerging and spreading.

The devastating Ebola outbreak in West Africa has taught us that health security is all about a strong health system that is able to promptly detect, report and adequately respond to public health threats and in so doing limit their adverse socioeconomic consequences.

The African Region's broad vision for strengthening health security is embedded in supporting countries to build strong, integrated and resilient systems. The main area of focus is to accelerate implementation of the International Health Regulations - IHR (2005) under the broader realm of strengthening health systems.

Recently, a Regional Strategy on health security was adopted by the Ministers of Health of our Region. This strategy advocates for building of resilient health systems and services while supporting countries to establish effective decentralized (district) health services with effective liaison community systems as the primary alert system.

### Major challenges

- Gaps in policy and legal frameworks that continue to negatively affect the achievement of the IHR core capacities.
- Insufficient resources (financial, human and logistics) including low domestic investment in health security as a national priority.
- Fragmented health services built around vertical and well-funded programmes.

2. World Health Organization (2016). Mapping the Risk and Distribution of Epidemics in the WHO African Region: A technical report, Brazzaville, World Health Organization, Regional Office for Africa 2016. http://www.afro.who.int/en/clusters-a-programmes/dpc/epidemic-a-pandemic-alert-and-response/epr-publications/4949-mapping-the-risk-and-distribution-of-epidemics-in-the-who-african-region-a-technical-report.html

3. World Health Organization (2016). Yellow fever situation report 16 September 20016

- Limited community engagement and involvement in primary health initiatives.
- Inadequate intercountry collaboration and partnerships.
- Limited availability of national data that are timely, comparable and of good quality for rapid and evidence-based decision-making. These hinder the ability to detect, analyse, plan, allocate resources and make decisions.
- Fragmented health information systems, heavy reporting burdens, and a lack of interoperability in terms of data and information systems.

To improve preparedness and response to health security and emergencies, the Sixty-sixth Regional Committee session of health ministers adopted a regional strategy[4] and a resolution.

Strategic approaches for surveillance, preparedness and systems streng-thening.

Our approach to public health surveillance, preparedness and response relies on the establishment of IHR core capacities to prevent, detect and respond to health emergencies. These include:

- Assessing and mapping countries' health profile, health security risks and vulnerabilities, using the "all-hazards approach".[5]
- Prioritizing disease surveillance and preparedness in national health plans and integrating IDSR into the national health information management system (HMIS).
- Building adequate national and regional surveillance, public health laboratory and emergency response capacities.
- Promoting intersectoral and joint actions, networks and partnerships for surveillance emergency preparedness and response.
- Conducting joint external evaluations for IHR core capacities and supporting implementation of country plans.
- Despite heightened awareness in high-income countries and recognition that antibiotic resistance is a global problem, the issue is still not on the agenda of most countries in the Region. AFRO has initiated a project to foster AMR surveillance in the Region and support countries with comprehensive national plans on AMR, in line with the strategic objective of the global AMR plans. Surveillance for AMR will feed into national information systems.
- Strengthening evidence and knowledge management through improved data collection processes, documentation and operational research in collaboration with WHO collaborating centres and other specialized institutions.
- Establishing a regional multisector partnership forum for "One health" to serve as a platform for coordinated action, mobilizing resources and forging consensus among partners and Member States; to improve preparedness, alert and response and strengthen cross-country and cross-institutional collaboration.

4. World Health Organization (2016). Regional Strategy for Health Security and Emergencies 2016-2020, World Health Organization, Regional Office for Africa 2016 (AFR/RC61/14)

5. " All-hazard approach" is defined as "an integrated management strategy that incorporates planning for and consideration of all potential natural and technological hazards"

- Building district and county health systems that sustain delivery of comprehensive, integrated people-centred services to communities in an equitable way, and can respond effectively to unusual events (for example, natural disasters, insecurity, disease outbreaks).
- Strengthening surveillance, preparedness and response in the African Region by building a resilient health system in which prompt data collection, analyses and dissemination play critical roles as important components of timely detection of public health threats.
- Integrating IHR, IDSR and alert systems into district level and community health services. Access to and confidence in essential basic health services and the removal of costs will enhance interactions between communities and alert systems.

**Strategic areas for IAG input and advice:**

- How can we make health security integral to national development and health plans?
- How should we engage countries to take security and surveillance at sub-national level more seriously?
- What is needed to promote intersectoral collaboration for IHR (2005) implementation?
- How can we best promote cross-border liaisons?
- How do we strengthen WHO's leadership role at regional and sub-regional level?

# Annex 5: Positioning AFRO for health leadership and effective action

## 5.1 Navigating a complex, crowded health development landscape: developing and consolidating our niche and most useful contribution at Regional level and country level

### Background

"The institutional landscape of global health is increasingly complex, and incentives that favour the creation of new organizations, financing channels, and monitoring systems over the reform of those that already exist, risk making the situation worse." (WHO 12th General Programme of Work). The current situation is characterized by low government-controlled or led service delivery, especially in developing countries and the proliferation of nongovernmental, transnational, private and humanitarian organizations. Each organization targets specific needs. The support is geographically and temporally limited, often dictated by country and regional emergencies. As a result regional and country priorities agreed upon between WHO and Member States are missed.

Over the years the public health landscape has changed, with multiple players crowding the health development landscape. Key players include: bilateral funding agencies (USAID, DFID, France, Canada, Sweden), multilateral funding initiatives (RMNCAH Global Financing Facility-GFF, Global Alliance for Vaccines and Immunization-GAVI, Global Fund to fight Aids, Malaria and Tuberculosis-GFATM), UN agencies (UNAIDS, UNFPA, UNICEF, UN Women, WB, WHO), philanthropic foundations (Bill and Melinda Gates Foundation), international nongovernmental organizations (Partnership for Maternal Newborn and Child Health-PMNCH), the private sector, and others.

Uncoordinated actions of the above players pose key challenges for WHO values and mandates as well as national governments to achieving the health needs of their citizens. The key principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action such as ownership, alignment, harmonization, managing for results and mutual accountability are not always put into practice.

### Issues and challenges:

- In most countries in the Region, health spending remains below what is required to provide even the most basic services.
- Disease specific and geographically and time-limited projects do not address health system bottlenecks. Often, there is low and patchy coverage of interventions that are not comprehensive and sustainable long enough to achieve the desired level of impact.
- Prioritization is directly or indirectly driven by resources from partners rather than real regional or country needs.
- Multilateral funding agencies such as the GFF in its support to implementation of the Global Strategy for Women's Children's and Adolescents' Health, requires governments to fix otherwise flexible IDA loan, GFF grant and domestic resources to RMNCAH investment cases with very limited interventions and focusing on limited geographical areas. This is not only compromising decision-making space for governments but also has a potential for promoting inequity.

- Ministries of health through which WHO exercises its mandate are facing a challenge of setting health agenda and coordinating the multiple players of their countries.
- WHO's leadership and directing position is no longer a given but has to be earned.
- Although GAVI has focused on country-led identification of priorities and technical support requirements, the organization is also increasingly getting engaged in implementation at country and regional levels.

### Strategic areas for IAG input and advice

Notwithstanding the above challenges, Member States have a duty to protect and care for the health of their citizens, through the application of modern scientific evidence-based interventions, robust management of health delivery systems, including infrastructure, human resources, financing, equipment and commodities and health information. This includes providing health-care services, preventive medicine, environmental sanitation and protective legislation from exposure to industrial, agricultural or environmental hazards.

WHO has to identify its own niche and define strategies for navigating through this complex environment. The core values of WHO include equity, social justice, universality, people-centredness, community protection, participation, scientific soundness, personal responsibility, self-reliance and self-determination. These core values are critical to building strong and resilient health systems and to propelling the countries of the Region towards universal coverage for better health outcomes.

### Key questions to the IAG

- How does WHO position itself and brand its products based on its core functions to show a clear difference from what the other actors are doing?
- What does WHO need to do internally to optimize its capacity to support Member States?
- What minimum core capacity do we require in countries to give WHO the competitive advantage?
- What mechanisms are required to ensure that WHO continues to ensure its relevance to Member States and partners?
- What needs to be done to better capture WHO's contribution to the overall improvement of health in the Region and communicate this effectively?

## 5.2 Partnerships – where are we?

### Background

Strengthening strategic partnerships is one of the focus areas of The Transformation Agenda (TA). WHO needs strategic partners and partnerships to assume its leadership in health in the African Region and to best position its unique role and comparative advantage in providing support to countries. Currently, its key partners include governments, UN agencies, international organizations, donors, civil society organizations, religious leaders, the private sector, academia, media, global health initiatives, regional economic blocs.

## Updates and achievements

During the last two years a number of important partnership milestones were achieved through AFRO's increased collaboration with the AUC, including which include the Framework for collaboration between the WHO and AUC on the establishment and operationalization of the Africa CDC signed in August 2016, and the development of key AUC health policy instruments including the Africa Health Strategy 2016-2030, which were endorsed at an AUC Health Ministers meeting hosted by WHO on the margins of the WHA. WHO and AUC also organized the first ever Ministerial Conference on Immunization in Africa in February 2016 which resulted in a Declaration signed by Ministers of Health, Finance, Education and Social Affairs.

A revised Memorandum of Understanding (MOU) was signed in March 2016 with the UN Economic Commission for Africa (ECA). Areas of collaboration include high-level advocacy for health financing to achieve UHC, health-related research, health information and data generation, processing and use for policy- and decision-making and addressing key determinants of health.

Collaboration was also enhanced with Regional Economic Communities such as the Economic Community of Central African States (ECCAS) whose 7th Ordinary Session of the Council of Ministers of Health was attended by Dr Moeti in February 2016 with technical support provided by WHO staff. The Intercountry Support Team for Central Africa is providing ongoing technical support to ECCAS in the establishment of the Organization of Health for Central Africa and the Community Health Fund for Central Africa.

Furthermore, WHO is in the process of establishing a formal working relationship with the Organisation of African First Ladies Against HIV/AIDS (OAFLA). An MOU was signed in January 2016 and there are plans to hold a joint planning meeting in October in Brazzaville. Areas of collaboration include advocacy on HIV/AIDS and mother and child health (MCH).

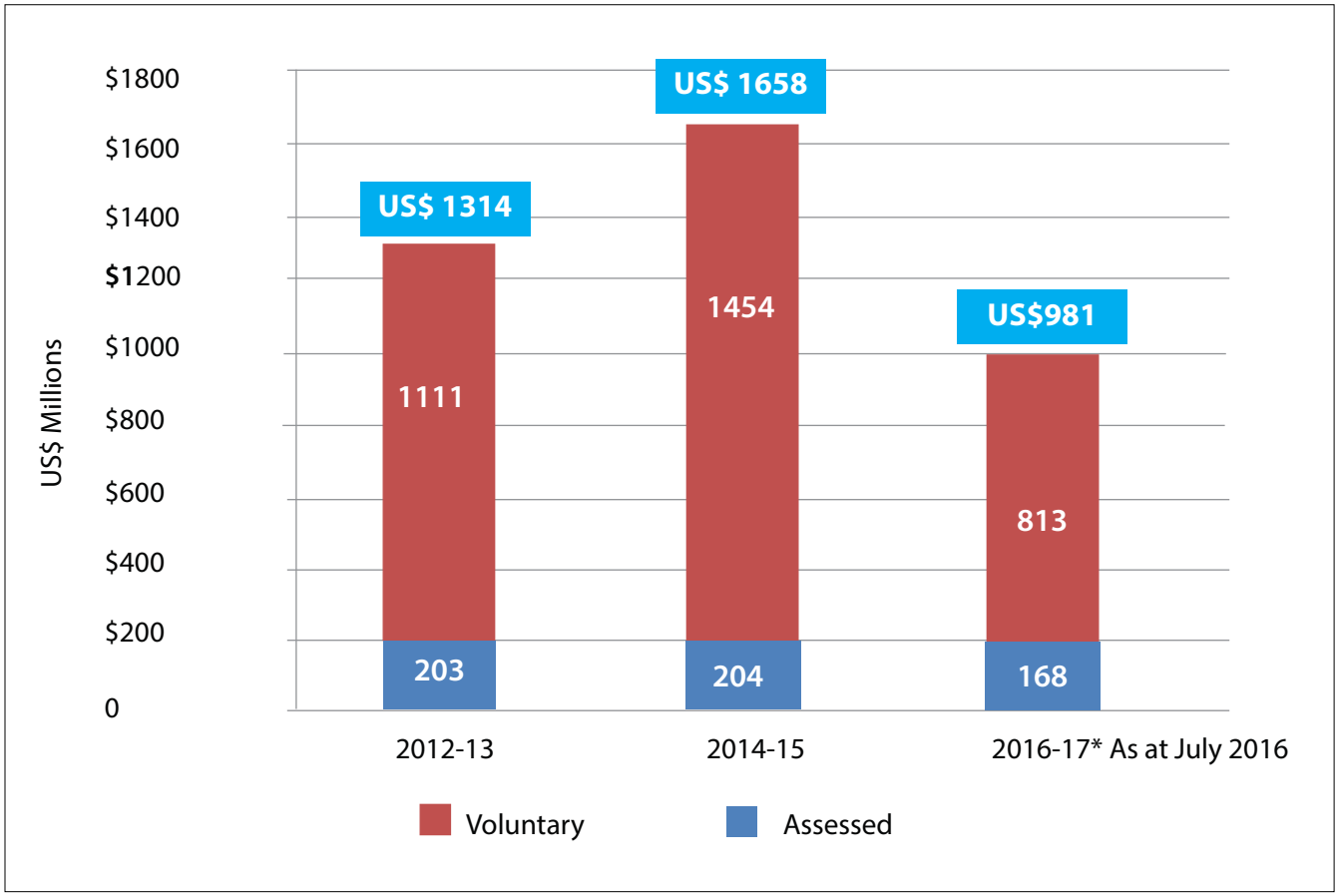
This year marks the 10th anniversary of the Harmonization for Health in Africa mechanism (HHA), which is an instrument of regional leadership in the health sector, and is hosted in AFRO. Membership in HHA had been growing steadily and the collaboration between partners has helped build capacities in countries in developing and budgeting national strategic plans and improving collaboration between ministries of health and finance.

A Framework of Engagement with Non-State Actors (FENSA) was finally adopted in May 2016 by the World Health Assembly (WHA) as a process to guide WHO's engagement with non-state actors. WHO was requested to commence its implementation and to report annually to the Executive Board. One key milestone going forward is the establishment of a Register of non-state actors. Non-State actors are defined as NGOs, private sector entities, philanthropic foundations and academic institutions.

## Issues and challenges

For the biennium 2016-2017 it is projected that, over 80% of WHO's income will come from voluntary contributions, with Assessed Contributions from Member States accounting for less than 20% of the overall financing of the Organization (Figure 1). The issues of alignment, flexibility and predictability in funding should therefore underpin our engagement with donors and partners.

## Figure 1: Contributions to the WHO Regional Office for Africa




The biennium 2014-2015 saw a significant increase in funding to the Region due largely to the Ebola virus disease outbreak. Contributions to the Global Polio Eradication Initiative (GPEI) are also included in these figures and account for over 40% of funds mobilized. As the GPEI Programme ramps down, this will have significant implications on funding to the Region. The table below shows the key contributors to the Region over the last three bienniums.

Donors from the Region for this biennium (accounting for a contribution of around US$ 113 million) include the African Development Bank (US$ 17 million), the Nigerian National Primary Health Care Development Agency (US$ 63 million), Nigerian National Malaria Elimination Programme (US$ 2.2 million), African Field Epidemiological Network (US$ 0.79 million), West African Health Organisation (US$ 0.125 million) and a number of Member States – including Botswana, Cameroon, Gabon, The Gambia, Lesotho, Namibia, Zambia, Angola and others.

The importance of resource mobilization efforts is emphasized and resource mobilization strategies and plans will be developed for the Region in the first quarter of 2017. A mapping exercise of stakeholders will also be undertaken before the end of 2016.

| Key Donors | 2012-2013 | 2014-2015 | 2016-2017 |
|---|---|---|---|
| | | | |
| BMGF | 297 823 242 | 221 341 402 | 135 617 572 |
| UK DFID | 90 214 423 | 153 469 491 | 112 690 665 |
| USAID | 50 800 545 | 103 767 972 | 45 553 190 |
| GAVI ALLIANCE | 69 719 247 | 64 087 122 | 41 622 259 |
| CDC | 36 851 413 | 55 067 477 | 32 121 908 |
| CANADA (CIDA/ACDI) | 69 905 062 | 40 378 524 | 19 079 693 |
| ROTARY INTERNATIONAL | 34 649 983 | 61 786 193 | 25 676 732 |
| NATIONAL PHILANTHROPIC TRUST | 17 116 384 | 81 605 866 | 21 375 977 |
| CERF | 38 643 658 | 24 215 173 | 10 443 128 |
| GERMANY - KfW | 14 234 655 | 42 535 276 | 7 765 841 |
| NIGERIA - NATIONAL PHC AGENCY | | | 63 187 663 |
| UNFPA | 13 801 649 | 23 168 787 | 24 921 293 |
| AfDB | | 32 587 005 | 17 383 701 |
| CANADA - FATD | | 30 596 362 | 18 149 413 |
| UNFIP | 23 705 756 | 19 203 615 | 5 065 150 |
| EC (AIDCO) | 11 442 259 | 14 836 055 | 10 100 385 |
| UNDP - MDTF | | 25 932 699 | |
| AUSTRALIA - (AusAID) | 9 495 399 | 14 364 762 | |
| NORWAY - NORAD | | 14 939 277 | 7 159 814 |
| UNAIDS | 10 765 537 | 9 824 561 | |
| EUROPEAN COMMISSION | 7 584 599 | | 9 157 759 |
| | | | |

To address funding needs (both in countries and at the regional level), new and innovative ways of securing resources need to be pursued while ensuring that traditional methods are not neglected. There have been a number of bilateral discussions and visits to and from partners including Bill and Melinda Gates Foundation, China, UK/DFID, USAID and the US Department of Health and Human Security. The aims of these visits were to further strengthen collaboration and understanding of priorities between AFRO and its development partners.

The growing demand by citizens on how and where their public funds are spent and for what purpose is driving the need for more transparent reporting. A report monitoring system was launched in March 2016 to improve on the provision of timely technical and financial reports to development partners. Since its operationalization the number of overdue reports has decreased. Efforts are now underway to put in place mechanisms to improve the quality of our reports.

Effective implementation of joint workplans with the AUC and ECA requires that activities be also reflected in clusters' biennial workplans and budgeted for. It also requires close follow-up to ensure that all parties involved deliver on their commitments. The second African Ministers of Health meeting jointly convened by the WHO and the AUC could not take place in Tunisia in April 2016 as initially planned due to issues of political sensitivity, and the meeting was postponed *sine die*.

The 2nd Review of the HHA mechanism is currently being undertaken to look at the progress achieved so far in harmonizing partners' interventions and setting the course for the future of HHA mechanism. The report which is expected by the end of September 2016 will be presented to the HHA partners in October 2016 in Brazzaville, Congo.

## Strategic areas for input and advice

- Strengthening engagement with partners and key stakeholders:
    - WHO AFRO will be convening the Africa Health Forum in 2017 – how can we best utilize this opportunity to address resource mobilization and participation of regional philanthropist and organizations in the work of WHO?
    - With the adoption of FENSA by the WHA, how can the IAG play a role in ensuring that WHO African Region actively engage with these organizations?
    - How can we explore other innovative mechanisms for meeting the funding requirements to deliver on commitments made in the Transformation Agenda?

# Annex 6: Emerging public health and development issues

## Emerging public health and development issues: Impact of agriculture on AMR; migration; demographic changes; urbanization among others – implications for health in the Region

### Summary of the situation

A major challenge affecting sustained resolution of Africa's health situation is the complex of rapidly evolving economic, social, and demographic contexts in the Region. The combined demographic and epidemiological transitions challenge the prioritization of interventions in the Region with addressing the existing morbidity and mortality causes. It may require retooling and reconfiguring health sectors, systems and services to meet rapidly emerging future needs.

Despite growing Gross Domestic Product (GDP) and other socioeconomic improvements, both human and financial resources for health are overwhelmed by the volume of current challenges and the important focus on infectious diseases and primary care health services, even as new challenges emerge that may overwhelm health services and leave countries chasing after myriad huge challenges with limited resources if actions are not initiated immediately. The structure and nature of health systems, services and programmes may need to start changing in fundamental ways in order to be able to moderate the effect of these emerging challenges and to avoid undermining the gains made so far in development.

### What are the health implications (positive and negative) of some of these emerging public health and development issues?

In this paper we will focus on the following issues:

1. Antimicrobial resistance (AMR)
2. Epidemiological changes including noncommunicable diseases
3. Urbanization
4. Unplanned migration
5. Rapidly changing demographic parameters and
6. Climate change and its impact on health

## 6.1 Antimicrobial resistance (AMR)

Antimicrobial misuse, its poor regulation, with circulation of fictitious and substandard medicaments in both human and animal health and large-scale use of antimicrobial drugs in animal agriculture are increasingly becoming main drivers of antimicrobial resistance globally. The implications of increased AMR in the African Region will be failure of treatments for common ailments and a rising cost of care. It may also exacerbate the shortage of medicines for certain morbidities that are prevalent in the WHO Africa Region but no longer present good profit margins for manufacturers.

## 6.2 Epidemiological changes including noncommunicable diseases

The performance on the MDGs in Africa clearly shows that while significant progress had been made, the core infectious diseases burden remains very high and the gains could easily be reversed once external funding ceases. Noncommunicable diseases are the next major cause of a health crisis in Africa.

The factors that promote NCDs such as a sedentary lifestyle, high fat diets, alcohol misuse and tobacco, are increasing in Africa especially among the young and the newly affluent population. Hypertension, diabetes and other ailments and conditions considered more prevalent in developed contexts have become major causes of ill health in Africa. The increasing burden of NCDs will over the next decade result in Africa significantly contributing to the overall global burden and cost of health care if preventive measures are not scaled up.

## 6.3 Urbanization

There has been a growing trend around the world of people moving from rural areas to cities, and in general of being far more mobile than ever before (Figure 2). This trend is especially pronounced in Africa, where the percentage of people living in urban areas is expected to increase by 40% by 2050 from a 2014 baseline[6]. Across the African continent, major cities are primed for explosions of population growth (Figure 3), especially in peri-urban areas.

Peri-urban high density settlements have become areas of intense poverty and ill health, even as health sectors have usually focused on rural health systems development. A rapidly enlarging private sector in urban areas often lacks the standards and regulation needed to protect the population and assure healthy outcomes of their interventions. The resulting mismatch between creation of new health facilities and expanding populations will lead to pressure on the limited health resources available in urban areas and in turn contribute to poor health outcomes.

## 6.4 Unplanned migration

Migration and mobility are particularly complex in the African Region. The cross-border mobility dynamics along transport corridors and border communities, particularly those which engage in daily crossings for trade and livelihood purposes (many taking place unmonitored), make the spread of communicable diseases and outbreaks a real threat. The consequence of migration, both internal and external, is a loss of the most qualified contributors to economic growth, and in health it is the loss of qualified health workers to richer countries.

## 6.5 Rapidly changing demographic parameters

The medical advancements and consequent increased human life span pose emergent issues of rising ageing populations and their health and economic challenges. The continuing high population growth in Africa adds to the demographic changes with high number of children and their consequent specific requirements.

The changes here may have implications for higher NCDs based on the increased prevalence of risk factors that are the consequence of behavioural and lifestyle changes. However, there is likely to be increased demand for more sophisticated and sometimes more expensive services. The challenge is that the political clout of an expanded urban middle class may divert scarce resources towards these needs and undermine programmes to tackle the existing burden of disease. The health sectors in such countries also need to become much more sophisticated in terms of well capacitated institutions to govern and manage health, and to better mobilize, allocate and use domestic resources in more cost-effective ways.

## 6.6 Climate change and impact on health

The rapidly changing environmental situation will affect the social determinants and causes of ill health. It may mean new and persistent vectors of diseases, changes in the interaction between animal and human habitats, with major implications for outbreaks and unusual epidemics.

6. "Foresight Africa 2016: Urbanization in the African context". Brookings Institute. 2015.

Environmental degradation may intensify poverty by undermining livelihoods with other implications around nutrition and food security as well as water and sanitation issues.

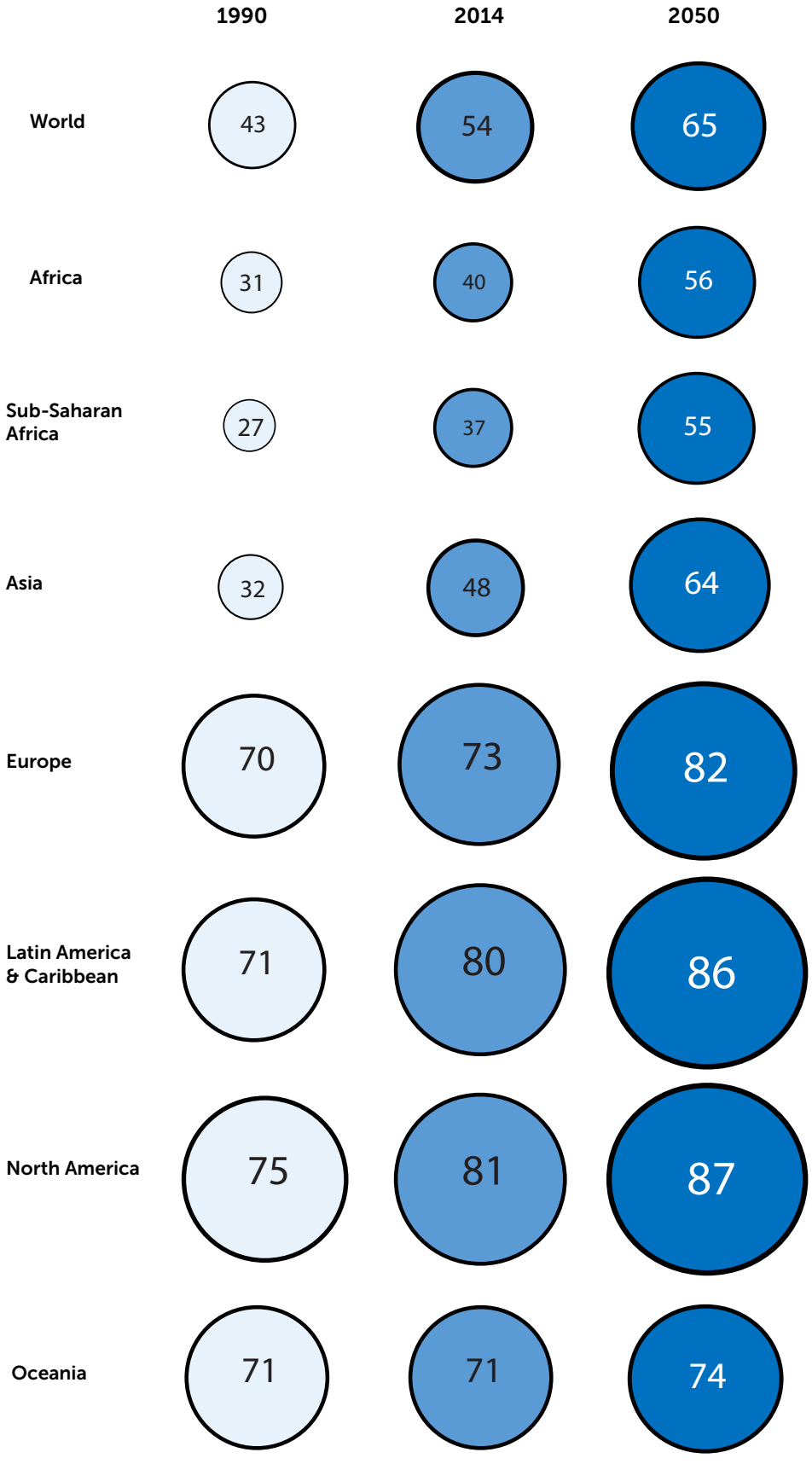
## Issues and Challenges

- The implications of AMR will be the failure of treatments for common ailments and as a consequence rising cost, morbidity and mortality.
- Both governments and external development partners are not adequately prepared to mitigate the challenges of changing epidemiology. Health services will need to be retooled in order to address these emerging needs adequately.
- The rapid increase of people living in cities will require major investment in municipal infrastructure, municipal functions such as water and sanitation, and improved safety and security services.
- The increase in migration and urbanization will also have a major impact on public health systems across the continent. It must be addressed through migration-competent health system looking at the mobility continuum rather than the cross-border movement.
- The health system in Africa is not adequately prepared to deal with the rising ageing population and their health, social and economic needs.
- There is insufficient priority and resources at the governmental level to address environmental impact on health.

## Key questions

1. How can WHO better address these emerging challenges in the short and long terms?
2. The Africa Region still has many major unresolved health challenges. How can AFRO bring advocacy and resources to bear on raising awareness to addressing these emerging challenges?
3. What actions are within the Region's capabilities to undertake and what will require a more global approach?

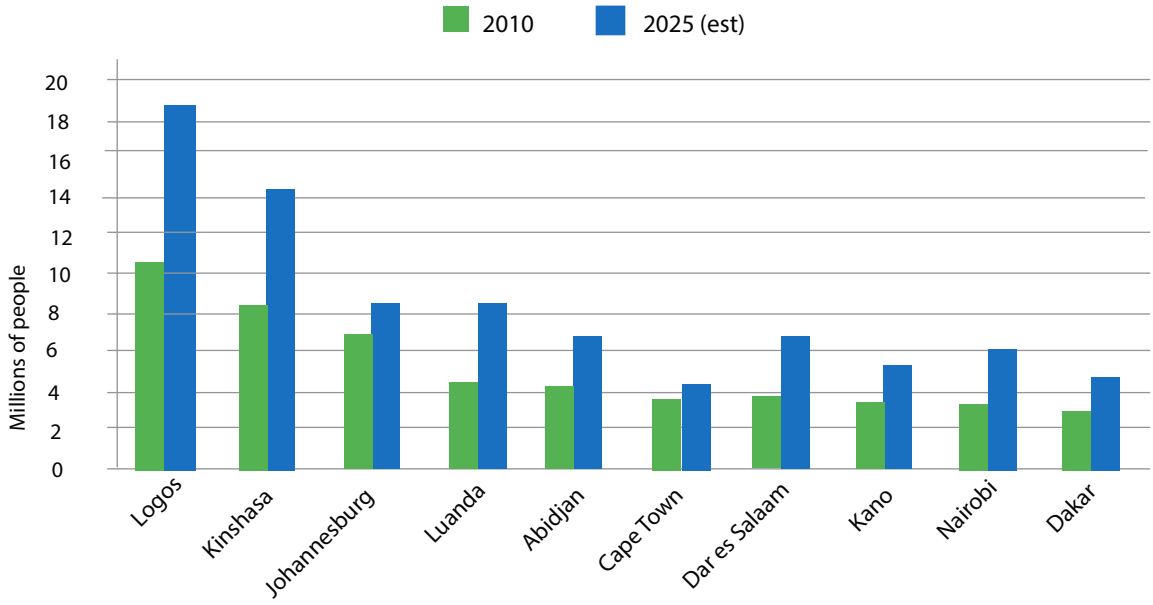
## Figure 2: Percentage of Populations Living in Urban Areas




Source: "Foresight Africa 2016: Urbanization in the African contect". Brookings. 2015.

## Figure 3: African cities primed for extreme growth

### Exhibit 1:




Source: "State of African Cities 2014". UN Habitat.

# Annex 7: Optimizing the role of IAG members in the face of changes in the global health landscape

## Background

The Regional Director constituted an Independent Advisory Group (IAG) to provide her with strategic and policy advice on how to strengthen WHO's work in the African Region towards better delivery, a more results-driven approach and making the best use of internal and external resources and expertise.

The Terms of Reference of the IAG included among others:

- Advise on key milestones which could be the focus of work during the first 12 - 24 months of the Regional Director's five-year term.
- Recommend strategies for mobilizing additional resources for WHO AFRO strategic actions.
- Play the role of advocates and champions for the work and reforms of the Regional Office.
- Contribute to keeping the Regional Director and her Team closely connected to ongoing global discussions and initiatives, using informal networks and global perspectives that would add value to the work of WHO in the African Region.

### Issues and Challenges

Notwithstanding the important strategic role that the IAG members were meant to play, regrettably due to multiple competing regional and global agendas, the Secretariat could not convene a follow-up meeting for over a year and half.

Although individual members of the IAG provided important advice on the ongoing work of WHO in the Region including proposals for a global health diplomacy course for senior government health officials and WHO AFRO senior staff, high level advocacy on the work of WHO AFRO to give global visibility, and suggestions for an "AFRO Fellows" programme, these were not collective IAG actions.

Given the emergence of multiple actors and competing global health actions and agendas, WHO AFRO has to work closely with a wide range of partners and leverage their expansive expertise. It is therefore critical to continue having a participative and inclusive approach in our engagement with the IAG. This entails exploring with the IAG ways of developing a structured working relationship with the IAG.

### Strategic areas for IAG input and advice

- How can the IAG, as a strategic group, continue to provide insights on how WHO AFRO could access "intelligence" on strategic decisions and issues that are happening globally, navigate these, and consolidate its niche?
- How can the role of IAG members be optimized in support of AFRO in the face of changes in the global health landscape?
- Should the IAG be re-organized to operate under defined thematic areas?
- How can IAG members help WHO AFRO build links with relevant international platforms and partners including philanthropists within and outside Africa to expand and support AFRO's capacity?

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