Technical Meeting on
Building Linkages across Health Systems Strengthening (HSS) Activities at Country Level
REPORT AND ACTION POINTS

Organized by the **EU-WHO Policy Dialogue Programme**
Tuesday 17 April 2012 & Wednesday 18 April 2012
EB Room, WHO, Geneva

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I. Background and context

WHO through the Health Systems Policies and Workforce Department (HPW) entered into a collaborative agreement with the European Union (EU) in October 2011 to *'support policy dialogue on national health policies, strategies, and plans (NHPSP) in selected countries*'. This collaboration, hereafter called the 'EU-WHO Policy Dialogue Programme', aims at building country capacities for the development, negotiation, implementation, monitoring and evaluation of robust and comprehensive national health policies, strategies and plans, with a view of promoting universal coverage, people-centred primary care, and health in all policies. It aims at strengthening country processes, as well as, where appropriate, aid effectiveness in line with the principles of the International Health Partnership (IHP+). By building synergies between WHO's response and the EU's aid, *the overall objective is to ultimately improve health sector results in concerned countries*.

The EU-WHO Policy Dialogue Agreement, comes with a 5 183 000 EUR budget envelope, covering 7 countries, namely Liberia, Moldova, Sierra Leone, Sudan, Togo, Tunisia, and Vietnam, over a 3-year period. The inception phase, whose objective was to formulate a Programme Road Map in all 7 target countries, ended in March 2012. Several topics requiring technical backstopping were highlighted in the Road Maps such as monitoring & evaluation, harmonization of aid, health financing, essential medicines, and human resources for health. These topics are covered in different departments and clusters across WHO headquarters, who themselves also carry out joint programmes with the EU.

Following the end of the inception phase, this meeting *Building Linkages across Health Systems Strengthening (HSS) Activities at Country Level* was called to provide a platform for constructive exchange on how best to address the Road Map technical areas and achieve clarity on where HQ-RO-CO cooperation would be most feasible in the 7 target countries. The meeting also aimed to provide an opportunity to strengthen collaboration between the various WHO-EU joint programmes.

Participants included the WHO country staff from the 7 target countries, corresponding regional counterparts, and those HQ departments who are in collaboration with the EU on joint programmes and/or covering technical Road Maps areas requiring backstopping (see annex).

II. Objectives

1. Share and discuss amongst peers the 7 Programme Road Maps, including lessons learned and obstacles encountered in the inception phase
2. Decide on ways to organize specific HSS technical support across WHO (HQ-RO-WCO) on Road Map technical areas
3. Bring clarity on the specifics of different existing WHO-EU joint programmes

III. Expected Outcomes

1. Road Maps peer-reviewed in a constructive manner with more clarity on challenges and lessons learnt during the inception phase

2. Concrete collaboration for Road Map activities at country level planned with relevant WHO technical departments
3. Information exchanged on different existing WHO-EU joint programmes

IV. Summary of discussions

The *Technical Meeting on Building Linkages across Health Systems Strengthening (HSS) Activities at Country Level* consisted of a half-day introductory session, a one-day session focused on country presentations of the EU-WHO Policy Dialogue Programme Road Maps and the local health sector context, and a half-day interactive question-and-answer session with a representative from the EU in Brussels.

The introductory session introduced the concept of the EU-WHO Policy Dialogue Programme as well as the objectives of the meeting. The different WHO-EU joint programmes managed by the Health Systems and Services (HSS) Cluster were presented and discussed (see annex 3)

The one-day session on the Programme Road Maps aimed to fulfill the core objectives of the meeting (see above). The resultant discussions focused both on country contextual issues as well as the thematic areas addressed in the Road Map.

Significant recurring themes during the presentations and discussions are summarized below:

1. WHO has tremendous convening power in the health sector in countries and should use this role to ensure its lead on health. EU funds can be a crucial catalyst.

A recent European Court of Auditors study found that the European Commission does not demonstrate enough competence in matters of international public health[1]. A resultant EU Global Health Communication advocates for the central role of WHO in global health architecture. The EU is looking to WHO for leadership in this area, even in middle-income countries such as Moldova or Vietnam where the EU is targeting specific support to ensure that available resources are better utilized, even if the EU contribution is small vis à vis overall health sector resources.

The EU takes into account the specific mandate of an organization when choosing its partners. The EU sees WHO in a strong leadership and convening role for health. However, it is clear that in some countries, WHO Country Offices (WCOs) are not adequately fulfilling that role. Often WHO is bypassed as the preferred partner of EU in countries due to low WCO capacity, or the perception of such, and the strong local presence of other agencies.

Many of the WHO Representatives (WRs) present regretted the limited absorption capacity of their WCOs due to lack of staff and funds. The call for strengthening the WCOs was unmistakable across countries. The EU-WHO Policy Dialogue Programme funds thus come at an opportune moment; however, WHO recruitment procedures are too cumbersome and politically charged, hampering a rapid

[1] Special Report No 2/2009 (2009/C201/07) — *The European Union's Public Health Programme (2003–07): an effective way to improve health?*. (http://ec.europa.eu/health/programme/docs/php2003-2007_an_effective_way_to_improve_health.pdf).

deployment of EU-funded Technical Officers or even consultants to countries and leading to considerable missed opportunities (Liberia, Sudan, Togo, Tunisia).

Another prominent dilemma raised as a constraining factor to WHO's leadership role in countries is the difficulty in finding true health sector generalists – technical experts with the ability to comprehend the big picture of health systems and convene partners and garner country-level resources. Specialists are of course also needed in specific situations and they can also be scarce, depending on the topic at hand.

A problem some WCOs have faced is that WHO does much of the technical work but because the funding comes from elsewhere, other agencies and institutions are perceived to be behind the achievements, leading to more funding channeled to those agencies and not coming to WHO.

2. ***The role of the WHO Country Offices (WCOs) is key; WCOs must be strengthened to provide solid policy advice and guidance to the Ministry of Health (MoH)***

This EU-WHO Policy Dialogue Programme aims at building WCO capacity through its reinforcement of WCO staff. This is because WHO has a definite comparative advantage in health planning, management, and health policy implementation, all areas of major skills gaps in MoHs (Togo, Liberia, Sudan). The WCOs must leverage this comparative advantage and work with EU delegations for more prominence and funds for health issues. An example cited was the WCO work in Ghana to secure 12 million EUR over 5 years for the Ghana MDG Acceleration Fund where the WCO played a central coordinating role.

The ponderous WHO recruitment procedures are currently posing a real danger to WHO's abilities to adequately play a lead role in the current momentum built up in countries for national health policy dialogue. One major detrimental consequence is the perception that the WHO is weak.

3. ***The EU-WHO Policy Dialogue Programme represents a new way of designing a multi-country global programme – it was a bottom-up process with demand coming from WCOs and EU delegations***

A call for expressions of interest was sent to both WCOs and EU delegations; about 30 countries responded positively. The EU sees this Programme as a pilot for integrated collaboration with WHO. Broad health systems activities based on NHPSPs, such as in this Programme, are perceived to be a pivotal way to bring about integration. Moreover, the EU prefers large multi-country funding managed by one organization or pooled funds as opposed to small-scale funding – this type of global programme is seen more favourably compared to local WHO-EU country agreements. However, the process of engaging countries in a bottom-up process is significant in that country contextual issues go into the programme design and content. The EU is also keen on UN agencies working jointly and even pooling funds in-country but acknowledges that in some settings, there is conflict between the various UN agencies.

4. ***The trend in EU funding for health is general and sector budget support – the EU would like to avoid a project approach by moving towards this important modality for development cooperation***

50% of the 10th European Development Fund (EDF) has been allocated through budget support, 33% of which is given to general budget support and 15-20% to sector budget support. In general, health is not

a huge priority for the EU, highlighted by the fact that only 20% of all development cooperation funding is channeled to social sector – health is only one of the several topics coming under this rubric.

The EU is well aware that sector budget support is more efficient if policy dialogue for health is of high quality, underlining the priority given to the EU-WHO Policy Dialogue Programme.

General budget support goes directly to the Ministry of Finance (MoF), even if some of those funds are earmarked for health. In that case, the country must demonstrate that the money has been spent for health, regardless of whether it was disbursed by the MoF or MoH. This is also supposed to encourage a closer working relationship between the MoH and the MoF. Here, WHO can play a vital broker role in pushing for a clear definition of health outputs and outcomes linked to EU budget support – for example, in Togo, the WCO successfully advocated for health indicators (*increase in the national budget for the health sector* and *better access to generic essential medicines*) to be included in monitoring of EU aid to Togo. WHO can also set an example by collaborating with the MoH for better aid coordination mechanisms along the International Health Partnership (IHP+) principles, in line with the leadership role WHO should take on in countries.

5. EU Programme activities should link to other EU-funded activities in country as well as other relevant HSS funding, i.e. GAVI, HSF Platform activities, etc. The overall health policy process should thus be addressed in Road Maps

The EU-WHO Policy Dialogue Programme should be seen as a small part of a greater whole, the whole being the overall policy dialogue process. Hence, as far as possible, it was reiterated during this meeting and agreed upon with country participants that the Road Maps should address all major activities and events in a country's health policy cycle, marking distinctly where the EU-WHO Policy Dialogue Programme activities fit in, through technical support and/or funding. This means that the Road Maps would potentially include other relevant HSS funding and activities such as GAVI HSS or other EU-funded activities such as sector budget support or, for example, the *EU Health Sector Capacity Support Project* in Vietnam which covers policy dialogue activities at provincial level.

Where possible, other agencies in-country should be brought on board the EU-WHO Policy Dialogue work in order to avoid the perception of a purely bilateral project. In addition, other agencies can be as a resource for technical support.

6. EU-WHO Policy Dialogue Programme must link to disease/population programmes as well

It was mentioned that some Road Maps did not show enough inclusion of and consultation with disease and population-based programmes. Programme representatives underlined the need for robust health sector dialogue for any fruitful exchange and impact for disease programmes; however, even though the situation analysis for a national health plan is often solid, the response in countries often ignores the specific disease or population challenges. In the end, health systems must of course deliver on health outcomes. The EU-WHO Policy Dialogue Programme can be an important catalyst to bring more dialogue between the systems experts and the programmatic experts in-country.

7. *The EU-WHO Policy Dialogue Programme is seed funding but is a key entry point to leverage more space for policy dialogue in countries*

The Programme is designed to launch long-term processes (ex: Sierra Leone EU funds are being used to ensure adequate implementation of Human Resources for Health plan and its support beyond the health sector) and presents a golden opportunity for WHO to showcase its global convening power. Remarkable examples include the first health forum in 10 years in Moldova which is currently being planned with the support of EU funds; the very first convening of all Director-Generals in the MoH in Sudan to discuss health policy issues; the high level of government appropriation of the National Health Assembly concept in Tunisia, first put forward by WHO, to accompany the reform process. The concept of participatory policy dialogue is also now the government's own position, exceeding WHO's expectations. The MoH Tunisia used to be very verticalist in thinking – now it is transitioning to a broader, horizontal approach to health sector reform.

Key policy dialogue skills*:

- Listening
- Asking right question (expert skills)
- Facilitating consensus-building
- Understanding the broad picture (generalist skills)
- Coordinating across sectors/programmes/levels – be able to manage change

** Adapted from presentation by Stefano Lazzari, WR Tunisia*

EU-WHO Policy Dialogue funds can thus be used to change the way we work in health policy and HSS, despite its small amounts. WHO at all levels of the organization should emphasize that this Programme is not just a micro-project but rather a comprehensive solution. Policy dialogue promotion can be the decisive entry point to launch major processes (such as in the above-mentioned examples) and secure bigger funding in country – this is precisely the added value that WHO, with an able WR and WCO, can provide to EU's seed investment.

8. *Working with EU delegations*

There is little technical capacity for public health issues at most EU delegations and in Brussels as well, reflecting the relatively low priority given to health by the EU compared to other development aid areas. Often, larger sector budget support or other EU programme funds running into the millions of USD take up more of Delegation's attention. In any case, EU delegations should be kept informed of the EU-WHO Policy Dialogue Programme progress at every step of the way as the information does feed back to higher levels of the organization. A 2007 EU-internal survey unfortunately demonstrated that only 10-15% of EU delegations showed good communication with WCOs – this must improve.

Furthermore, if a public health expert is on staff at the local EU delegation, it is much easier to make the case for health issues and this should be adequately leveraged by WCOs. In Togo and Liberia, for example, more funds were allocated for health and more prominence was given for health issues due to the efforts of the local health experts at the Delegation.

EU Delegations determine 2 focus areas of work within their development aid. Even if health is not one of 2 focus areas, WCO can raise the visibility of health issues by advocating for the health sector to monitor EU aid at country level (Togo) with health-specific indicators. WHO may not receive any funds

but health is given more prominence and significant secondary effects can be seen, such as feeding back to Brussels that health should and can be given more priority.

9. HQ-RO-WCO links

It was agreed that more communication and information sharing was clearly necessary to enable more rapid solutions to problems and issues that arise. More interaction between the 3 levels is needed, perhaps in the form of a systematized exchange via teleconferences. A Technical Assistance Plan for each country should be elaborated in advance, in order to better plan and inform all Organizational levels.

It was acknowledged that tension exists between HQ and ROs regarding information exchange. Country representatives repeated that for them, it is of little concern whether a mission or technical support comes from HQ or the ROs but often the ROs feel they are not well-informed by HQ. HQ must thus make a renewed effort to keep the regions informed in a timely manner.

10. Documentation

Agreement among meeting participants prevailed that more of the country efforts within this Programme need to be documented, both the *explicit* and *implicit* objectives of activities. For example, in Moldova, regular 'brown bag lunches' co-organized by WHO within the MoH has the explicit objective of bringing colleagues together and keeping one another informed. The implicit objective, among others, is to create a different dynamic in the MoH.

More collaborative documentation work could be done with the Alliance for Health Policy and Systems Research. More specific discussions are needed as to whether case studies would be more relevant in the Programme context or Policy Dialogue guidelines or perhaps both? In any case, both real-time good stories must be made known as well as conventional research. What has been changing in the modus operandi in the health sector of a country must be established in writing, regardless in the first instance of who is contributing and why. The systematic and coherent documentation of the overall policy process should demonstrate accomplishments without focusing only on the activities undertaken by the EU-WHO Policy Dialogue Programme.

11. Reporting

Reporting in country is linked to documentation needs – it should address not only activities undertaken but also what policy processes the EU-WHO Policy Dialogue Programme has contributed to and what milestones have been achieved.

HQ must submit a first-year Programme report within the 3 months following the end of the 1st year of Programme (October 2012). The EU requires demonstration of their funding's impact at country level. HQ thus requires regular feedback from countries regarding progress made on activities planned under the Programme Road Maps. To this end, missions and teleconferences will be organized by HQ and financial and narrative reports will be expected from WCOs. HQ will develop a reporting template to

assist countries in their reporting and to provide consistency in the type of information coming from all 7 target countries.

WCOs are encouraged to take advantage of reporting obligations to document and raise visibility not only for the EU-WHO Policy Dialogue Programme but for EU-WHO joint collaborations and policy dialogue issues in general.

12. Health financing

Health financing issues featured prominently on 4 countries' Road Maps (Liberia, Moldova, Sierra Leone, Sudan). It was emphasized by the HQ health financing team that service delivery should be the starting point for evaluating health financing approaches in countries. One should examine the activities needed to enable the MoH to engage stakeholders in addressing the changes necessary in health financing to influence primary health care quality and access. The diagnosis of why access is low as well as analysis of the contextual factors will lead to the health financing mechanisms a country needs to make services more available.

Decentralization can be seen as a financing policy instrument itself which could be an enormous opportunity in many target countries to address health financing issues. In Tunisia, the redistribution agenda is another clear opportunity for health financing policy change. WHO should lay out clear lines, which may not necessarily be neutral, to steer the course of the policy dialogue around these issues.

13. Monitoring & Evaluation

The WHO HQ M&E experts introduced their work under the *Commission on Information and Accountability for Women's and Children's Health (CoIA)*, a high-level commission to improve global reporting, oversight and accountability for women's and children's health[2]. Critical support for M&E processes for NHPSPs in the 7 target countries will be provided by co-funding from the CoIA. Although the Commission's focus is on women and children, country technical support and funding for streamlining of M&E frameworks is linked explicitly to a country's NHPSP as a whole. Implementation of CoIA's *Global Strategy for Women's and Children's Health* includes a series of regional and country technical workshops, led by WHO headquarters, to newly formulate or improve the monitoring & evaluation plan for the NHPSP. The EU-WHO Policy Dialogue Programme is working closely with CoIA at both the global and regional/country level to ensure synergies with CoIA's technical support and funding for the paramount Road Map area of M&E.

14. Visibility

Visibility and communication issues were thoroughly reviewed in a session headed by a representative from the WHO HQ Flagship Communications Department. Suggestions were made on different types of communications methods and how to link with local partners for better visibility of the EU-WHO Policy Dialogue Programme.

[2] http://www.who.int/topics/millennium_development_goals/accountability_commission/en/

Salient points which came out of the communications session were:

- Concrete stories about real people often communicate better than technical pieces
- Document real change and any activities linked to it
- Vague ideas such as policy dialogue are not necessarily difficult to communicate when linked to concrete stories
- Audio and visual materials help tremendously to support communication of a message
- High-profile media programme launching events as planned in Togo, Vietnam, and Moldova are a good way of keeping the topic at hand on people's minds
- Flagship Communications will work with the 7 countries individually, depending on each country's visibility needs

15. EU grant management

A training session on EU grant management took place on 19 and 20 April 2012. All countries attended this session as well as people from RO's and HQ departments. The material is available on request.

V. Next steps and action points

HQ

1. Address the issue of difficult recruitment procedures at higher levels of WHO, such as the Director-General's Office and Human Resources Management
2. Discuss with regions the possibility of building up a database of pre-screened generalist and specialist consultants
3. Organize regular teleconferences with 7 target countries according to the schedule of each country
4. Inform ROs regularly of 7 target countries' Programme activities
5. Liaise with Alliance for Health Policy and Systems Research regarding case studies and/or policy dialogue guidelines
6. Liaise with Flagship Communications Department regarding writing up real-time stories on policy dialogue activities and achievements in countries
7. Consider publishing country updates on NHPSP web site

WCOs

8. Ensure better visibility of WHO activities in country, taking into account pointers and tips from the WHO HQ Flagship Communications Department
9. Adapt and revise Road Maps where feasible to include broader health policy process activities, linked with other EU-funded activities, HSS activities, and disease/population programmes
10. Under the leadership of the WR, leverage EU funding at country level to raise prominence for health policy dialogue and raise further funding locally for this area

11. Continue active engagement of EU delegations into EU-WHO Policy Dialogue Programme at country level
12. Put together bi-yearly Technical Assistance Plan in cooperation with HQ and ROs

Annex 1:

EU-WHO Policy Dialogue Programme, Technical Meeting on Building Linkages across Health Systems Strengthening (HSS) Activities at Country Level

List of Participants

1. Pierre Mpele-Kilebou, WR Togo, Chief of Delegation, Regional Office AFRO
2. Nestor Ndayimirije, WR Liberia
3. Wondimagegnehu Alemu, WR Sierra Leone
4. Anshu Banerjee, WR Sudan
5. Jarno Habicht, WR Moldova
6. Stefano Lazzari, WR Tunisia
7. Graham Harrison, Acting WR Vietnam

8. Samir Ben Yahmed, WR Libya, (Observer)

9. Eric Johnson, National Professional Officer (NPO) or Technical Officer (TO) in charge, WHO Liberia
10. Teniin Gakuruh, NPO or TO in charge, WHO Sierra Leone
11. Ehsanullah Tarin, NPO or TO in charge, WHO Sudan
12. Minzah Pekele, NPO or TO in charge, WHO Togo
13. Bawara Debati, NPO or TO in charge, WHO Togo
14. Lokombe Elongo, NPO or TO in charge, WHO Togo
15. Abdel El Abassi, NPO or TO in charge, WHO Tunisia
16. Paul Veele, NPO or TO in charge, WHO Vietnam

17. Mawuli Adzodo, Medical Officer, Health Policies and Service Delivery, Inter-country Team, West Africa
18. Babacar Dramé, Medical Officer, Health Policies and Service Delivery, AFRO
19. Omar Sam, Medical Officer, Health Policies and Service Delivery, Inter-country Team, West Africa
20. Mounir Farag, Medical Officer, Health Management Support, EMRO
21. Momin Ahmed, Regional Advisor, Health Policy & Planning, EMRO
22. Juan Tello, Programme Manager, Country Policies, Systems and Services, EURO
23. Momoe Takeuchi, Technical Officer, Health Systems Development, WPRO

24. Christian Collard, Development and Cooperation, EuropeAid, Human and Society Development

25. Stéphane Vandam, External Relations Officer, WHO, Office at the European Union

26. Wim Van Lerberghe, Director, Health Systems Policies and Workforce (HPW), HQ
27. Elizabeth Mason, Director, Maternal, Newborn, Child and Adolescent Health, HQ

28. Ties Boerma, Director, Health Statistics and Informatics, HQ
29. David Evans, Director, Health Systems Financing, HQ
30. Gerard Schmets, Coordinator, HDS, Health System Governance, Policy and Aid Effectiveness (HGS), HQ
31. Mario Dal Poz, Coordinator, Human Resources for Health, HQ
32. Gilles Forte, Coordinator, Medicines Programme Coordination, HQ
33. Joe Kutzin, Coordinator, Health Financing Policy, HQ
34. Inke Mathauer, Health Systems Analyst, Health Financing Policy, HQ
35. Kathy O'Neill, Coordinator, Public Health Mapping and GIS Programme, HQ
36. Tessa Tan-Torres, Coordinator, Costs, Effectiveness, Expenditure and Priority Setting, HQ
37. Mazuwa Banda, Technical Officer, HIV Strategic Information and Planning, HQ
38. Maurice Bucagu, Medical Officer, Maternal Health Policy, Planning and Programmes, HQ
39. Bernadette Daelmans, Coordinator, Maternal Health Policy, Planning and Programmes, HQ
40. Mikael Ostergren, Program Manager, Maternal, Newborn, Child and Adolescent Health, HQ
41. Richard Carr, Technical Officer, Roll Back Malaria Partnership Secretariat, HQ
42. Miloud Kaddar, Health Economist, Expanded Programme on Immunization Plus, HQ
43. Gaya Gamhewage, Coordinator, Flagship Communications, HQ
44. Shambu Acharya, Coordinator, Country Collaboration, HQ
45. Phyllida Travis, Coordinator, Secretariat, International Health Partnership, HQ
46. Denis Porignon, Health Systems Expert, HPW, HGS, HQ
47. Dheepa Rajan, Technical Officer, HPW, HGS, HQ
48. Sowmya Kadandale, Technical Officer, HPW, HGS, HQ
49. Maia Ambegaokar, Health Systems Advisor, HPW, HQ
50. Mohammed Lamine Dramé, Technical Officer, HPW, HQ

Annex 2:

EU-WHO Policy Dialogue Programme, Technical Meeting on Building Linkages across Health Systems Strengthening (HSS) Activities at Country Level

Agenda

Session 1:

EU-WHO Joint Collaborations

17 April 2012

8:30 – 9:00	**Arrival and registration of participants**
9:00 – 9:15	Opening remarks (Wim Van Lerberghe) Introduction of participants
9:15 – 9:45	Presentation: EU-WHO Policy Dialogue Programme and other HSS collaborations with the EU (Wim Van Lerberghe)
9:45 – 10:45	Q&A, Discussion
10:45 – 11:00	**Coffee break**

Session 2:

EU-WHO Policy Dialogue Programme Road Maps and Linkages to HSS Thematic Areas

Facilitators: Denis Porignon, Dheepa Rajan

17 April 2012

11:00 – 11:20	Presentation of Moldova Road Map with emphasis on ***health sector coordination/policy development*** (Jarno Habicht, WR Moldova)
	Panel: Phyllida Travis; Stefano Lazzari; Juan Tello
11:20 – 11:35	Panel comments
11:35 – 12:00	Plenary discussion

12:00 – 13:00	**Lunch break**
13:00 – 13:20	Presentation of Vietnam Road Map with emphasis on ***sub-national planning and budgeting*** (Momoe Takeuchi, WPRO)
	Panel: Mazuwa Banda; Mikael Ostergren; Juan Tello
13:20 – 13:35	Panel comments
13:35 – 14:00	Plenary discussion
14:00 – 14:20	Presentation of the OneHealth costing tool (Tessa Tan-Torres)
14:20 – 14:30	Q&A, Discussion
14:30 – 14:50	Presentation of Togo Road Map with emphasis on ***monitoring & evaluation frameworks*** and ***essential medicines*** (Pierre Mpele-Kilebou, WR Togo)
	Panel: Kathy O'Neill; Mawuli Adzodo; Gilles Forte
14:50 – 15:05	Panel comments
15:05 – 15:30	Plenary discussion
15:30 – 16:00	**Coffee break**
16:00 – 16:20	Presentation of Sierra Leone Road Map with emphasis on ***human resources for health*** (Teniin Gakuruh, Technical Officer, Sierra Leone)
	Panel: Mario Dal Poz; Mawuli Adzodo
16:20 -- 16:35	Panel comments
16:35 -- 17:00	Plenary discussion
17:00 – 17:20	Presentation of Sudan Road Map with emphasis on ***health financing*** (Anshu Banerjee, WR Sudan)
	Panel: Mounir Farag; Momin Ahmed
17:20 – 17:35	Panel comments

17:35 – 18:00	Plenary discussion

18 April 2012

8:30 – 8:50	Presentation of Liberia Road Map (Nestor Ndayimirije, WR Liberia)
	Panel: Kathy O'Neill; Mawuli Adzodo
8:50 – 9:05	Panel comments
9:05 – 9:30	Plenary discussion
9:30 – 9:50	Presentation of Tunisia Road Map with emphasis on ***MoH capacity building*** (Stefano Lazzari, WR Tunisia)
	Panel: Wim Van Lerberghe; Mounir Farag; Momin Ahmed
9:50 – 10:05	Panel comments
10:05 – 10:30	Plenary discussion
10:30 – 10: 45	**Coffee break**

10:45 – 11:00	Introduction to visibility, communications in the context of EU-WHO joint collaborations (Gaya Gamhewage)
11:00 – 12:00	Q&A, Discussion
12:00 – 13:00	**Lunch break**

Session 3:

Finalizing EU-WHO joint work

18 April 2012

13:00 – 14:30	Résumé of Road Map discussions (Wim Van Lerberghe)

	How can we best deal with commonalities and differences across themes? *How can we ensure smooth collaboration with EU delegations?* *What are the next steps for the different levels of the Organization?*

14:30 – 14:40	Introduction to internal reporting for EU-WHO Policy Dialogue Program (HQ-RO-CO) (Denis Porignon)
14:40 – 15:00	Q&A, Discussion
15:00 – 15:15	**Coffee break**

15:15 - 16:00	Concluding remarks, closing (Carissa Etienne)

Annex 3: Summary sheets of other joint EU-WHO Programmes in HSS Cluster

1) *International Health Partnership Plus*

European Union/World Health Organization Programme: Strengthening health systems, improving health services, and supporting capacity of partner countries to confront health challenges

Title: Supporting more effective aid for improved health services in developing countries through the International Health Partnership+
Duration: 2 years 2012/2013
Budget: EUR 3.5 million

Overall objective: To achieve more effective aid and better performing national health systems and improved health services in developing countries, with a focus on IHP+ signatories
Specific objectives:

1. Health aid more effective in 15 countries by end 2013, against deliverables defined at country level. These deliverables will relate to the elements in the IHP+ 'menu' that are appropriate for the specific country in 2012/13
2. Greater harmonization of development partner procedures achieved with reduced transaction costs, especially in financial management; increased knowledge and experience of how to accelerate alignment with country health plans

Target audience: 30 developing countries and 25 development agencies, foundations that have signed the IHP+ Global Compact: Benin, Burkina Faso, Burundi, Cambodia, Cameroon, Cote d'Ivoire, Cape Verde, Chad, Democratic Republic of Congo, Djibouti, El Salvador, Ethiopia, Guinea, Kenya, Madagascar, Mali, Mauritania, Mozambique, Nepal, Niger, Nigeria, Pakistan, Rwanda, Senegal, Sierra Leone, Sudan, Togo, Uganda, Vietnam, Zambia, Australia, Belgium, Canada, Finland, France, Germany, Italy, Norway, Portugal, Spain, Sweden, The Netherlands, the United Kingdom, The Joint United Nations Programme on HIV/AIDS (UNAIDS), The United Nations Children's Fund (UNICEF), the world Bank, United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), World Health Organization (WHO), African Development Bank (AfDB), ILO, The Bill and Melinda Gates Foundation, The European Commission, The GAVI Alliance and The Global Fund to fight AIDS, Tuberculosis and Malaria

Expected results and main activities

These are derived from the IHP+ Phase III work plan which has been endorsed by the IHP+ Executive Team. The EC will co-finance this work plan, along with DFID, Spain, Ausaid, Norway, possibly Germany.

1. Country level: alignment of health aid with one national health plan is consolidated and accelerated.
2. Global level: accelerated health aid effectiveness through harmonized agency procedures
3. Enhanced capacity of civil society to engage in national policy dialogue and performance monitoring processes supported by IHP+
4. Enhanced accountability for results through increased use of reliable and transparent information in joint sector monitoring and review processes, and increased accountability of governments and development partners to each other and the general public

5. Effective coordination of partnership operations and communications by the IHP+ core team

Performance Monitoring An independent consortium, IHP+Results, periodically reviews performance against a standard set of indicators adapted for the health sector from the OECD Paris indicators. Countries are being encouraged to incorporate aid effectiveness indicators into national monitoring processes, to complement their health system performance indicators.

2) *Human Resources for Health*

'Strengthening health workforce development and tackling the critical shortage of health workers' (SANTE/2008/153-644)

Background

The importance of health workforce for health systems performance, universal access to quality of care and achieving the Millennium Development Goals (MDGs) is widely recognized. The shortage of health workforce is global, but the problem is most acute in Sub-Saharan Africa, where the magnitude of the problem has reached crisis level. The European Commission summarized the situation in its Strategy for Action on the Crisis in Human Resources for Health in Developing Countries (COM(2005)642). The situation is comprehensively described in The World Health Report 2006, which estimates a shortage of 2.3 million doctors, nurses and midwives. These additional health workers are needed to scale up the health workforce to the levels required to strengthen health systems and accelerate progress towards the MDGs. A critical health workforce shortage is experienced in 57 countries, 36 of which are in Africa. Europe has demonstrated its commitment to tackle this crisis in its Communication, European Programme for Action to tackle the critical shortage of health workers in developing countries (2007-2013) (COM(2006)870), which was endorsed by the General Affairs and External Relations Council and the Representatives of the Governments of the Member States meeting within the Council on 14 May 2007.

In addressing the Programme for Action, Contribution Agreement (CA) DCI SANTE/2008/153-644 was signed in order to **strengthen health workforce development and tackling the critical shortage of health workers,** following discussions between the EC and the World Health Organization.

The objective of the CA is to contribute to the improvement of health sector performance and progress in attaining MDGs through the development and implementation of health workforce policies, strategies and plans to tackle critical shortage of health workers.

The specific objectives and activities are:

- To enhance governance and build capacities in the formulation and implementation of policies and plans for health workforce development:
  - Strengthening the capacity of HRH units in the ministries of health;
  - Better understanding and advocacy for improved aid effectiveness for HRH.

- To establish and strengthen mechanisms for collating and sharing information and evidence for the assessment and monitoring of the health workforce at country, regional and global levels;
  - Strengthening the Africa Health Workforce Observatory;
  - Strengthening the Eastern Mediterranean Health Workforce Observatory;
  - Ensuring global coordination of Health Workforce Observatories.
- To support establishing mechanisms for effective management of health workers' migration and retention:
  - Development of a framework for a Code of practice on health workforce migration;
  - Development of policy options and interventions for retention of the health workforce.
- To support scaling up production of the health workforce at regional and national levels:
  - Assessment of investment requirements and development of investment plans on educational infrastructure;
  - Partnerships, volunteering and twinning initiatives between European academic institutions, professional associations and African health profession education institutions;
  - Feasibility study for the establishment of a fund to facilitate access of health profession students to text books, diagnostic equipment and educational resources;
  - Development of innovative learning/training programmes.
- To support countries in addressing their critical Human Resources for Health (HRH) bottlenecks for priority health service.
  - Provision of catalytic funding to support health workforce development in the countries;
  - Support the establishment of an African Platform on HRH.

Contract implementation

The activities have been implemented by the World Health Organization (WHO) and the Global Health Workforce Alliance (GHWA). Implementation by WHO is undertaken by the WHO Regional Offices for Africa, for the Eastern Mediterranean, and WHO Headquarters.

The project has been in effect since 1 January 2009 during which the first 6 months was the inception phase comprising two significant elements: a) initiating the implementation of the activities, and b) further detailing and planning of the activities for the 3-year period of the contract.

The inception report was submitted in the beginning of July, as required in the contract, and elaborated activities to be undertaken at national, regional and global levels by WHO and GHWA.

During the second half of 2009, the implementation was accelerated and a progress report was submitted covering the activities undertaken in the first year of implementation. Following the submission of the report, a face to face meeting was held in Brussels on 4 June 2010 with the participation of EU, WHO and a GHWA and the meeting allowed to discuss the activities undertaken and future directions.

During the submission of the first year progress, report, a request was made for amendment in relation to objective 5 (implemented by GHWA) on the basis of the experience of the first year implementation. In the contract, GHWA had planned to support four (4) countries with catalytic funding. The evaluations and consultations led GHWA to review their approach and showed the possibility of supporting 8 countries with the amount cited in the Commission contract. This request was accepted by EU and the amendment was signed on 4 November 2010. Then GHWA have gradually started to expand its activities to additional 4 countries.

The contribution agreement required a mid-term review. A terms of reference was agreed with EU. In order to bring an external view, it was decided to involve a consultant in the process. A Steering group also contributed and oversaw the process. In consultation with EU, Dr John Martin, was identified to undertake the review and he provided the mid-term progress report, which was submitted to EU On January 19 2011. Major outcomes of the mid-term review included:

- "The project is making a significant contribution to the implementation of the HRH global strategy and plan of action and follow up to Kampala. It has generated impressive momentum at global, regional and particularly country level and has put in place essential elements of the structure and processes necessary to promote decision-making and action at national, regional (AFR and EMR) and global levels. These include evidence and knowledge about HRH problems in specific countries; transfer of knowledge and awareness to other countries resulting in increasing demand for action and WHO support; national networks and forums (observatories) comprising key stakeholders for policy dialogue and decision-making, backed up by regional observatories; common tools and methodologies that ensure comparability of evidence and action; international norms and commitment to action.
- 10 national observatories are reported to be functioning in AFR and a further 13 in process. At the same time 36 country profiles have been prepared, of which 10 have been validated and edited and a further 15 are awaiting validation by national technical committees. Currently 4 national observatories are functioning in EMR.
- The principal roles and functions of AHWO and national observatories have been clarified, particularly their network roles in bringing together key stakeholders, including partners
- Practical lessons are emerging from country experiences with national observatories with regard to ensuring their credibility and sustainability. These include the critical value of policy dialogue and networking between stakeholders; their potential as mechanisms to oversee and foster action in other project activities; and the need to allow due time both in creating ownership amongst stakeholders as well as in obtaining data beyond the public sector for credible country profiles.
- The project has contributed to widespread awareness about key HRH challenges and consensus about necessary corrective action as an outcome of country-specific analyses and inter-country and regional dialogue between stakeholders. A resolution by the 50th ECSA health ministers' conference (Feb 2010) calling for strengthening HRH units is an example of active political interest and support.
- Important HRH products have been produced at global and regional levels. These include the Code of Practice on International Recruitment of Health Personnel, methodologies including the

GHWA/CCF process for engaging stakeholders, as well as various guidelines and advocacy materials derived from country experiences.

- Valuable new information is emerging from country case studies. An important example is a four-country study which reveals that current international consensus on improving aid effectiveness has not been translated into action that responds to HRH needs in countries.
- GHWA engagement has increased the number of countries receiving support and promoted stakeholder engagement."

The progress in the second year of the implementation and the planned activities in the third year of implementation were outlined in the progress report submitted in early 2011 and it was followed with a face to face meeting in Brussels in May 2011.

Due to capacity challenges in countries and some delays arising from political changes or slow decision making processes, a no-cost extension for 6 months was requested and it was approved by the Commission.

As the contribution agreement is to be completed on 30 June 2012, the end of programme evaluation is to be embarked on.

3) *Human Resources for Health – Portuguese-speaking countries*

Support for the development of the human resources for health in PALOP
(Project 9.ACP.MTR.04)

1. Summary and context of the action

This revised report is submitted in line with the agreement with EC (Project 9.ACP.MTR.04) as the progress report reflecting the activities in the year 3 of the implementation, therefore, covering the activities undertaken from 1st September 2010 to 31st August 2011.

The importance of Human Resources for Health (HRH) is widely recognized as a cornerstone for the achievement of health systems development and Millennium Development Goals (MDG). The crisis in HRH is global, but particularly acute in sub-Saharan Africa, where the magnitude of the problem has reached critical levels. The situation was widely described in the *World Health Report 2006*, which estimates that there is a global deficit of approximately 4.3 million health workers in the world, mainly medical doctors, nurses, and midwives. Taking into account the global analysis set out in the Report, the European Commission (EC) General Affairs and External Relations Council (GAERC) adopted the EU Strategy for Action. The Council called on the EC and its Member States to develop a coordinated EU response in support of country level efforts to address the HRH crisis. The Council adopted an **EU Consensus Statement on the Crisis in Human Resources for Health**, stating that: "*Europe is committed to supporting international action to address the global shortage of health workers and the crisis in human resources for health in developing countries*".

Of the 57 countries that suffer from a critical deficit of HRH, 36 are in Africa, of which three are Portuguese-speaking countries (PALOP): Angola, Guinea-Bissau and Mozambique. Two additional Portuguese-speaking countries in the African Region also face serious HRH challenges. Although all these countries have committed to addressing the HRH problem, and almost all have developed plans and strategies for HRH development, they face tremendous challenges to implement them. In order to

implement these plans, some of them need to be updated, revised, and adjusted to align them with financial, political, and technical capacities.

The general objective of the EC project is the improvement of the population health conditions in the PALOPs by improving access and quality of health services. A strategy to achieve this objective is to improve the national and regional capacity for HRH development. The project aims at meeting the needs for HRH development identified through an extensive process of analysis of the HRH situation in the five PALOPs. This approach expresses the countries' and partners' willingness to undertake these interventions, ensuring the creation of a network among PALOPs, promoting dialogue and synergy among them together with regional and other appropriate platforms.

The project has been in effect since August 2008. A Year 1 report was submitted at the end of 2009 covering the activities. This was followed by an interim report submitted in April 2010 and a second report in August 2010, both accompanied by a financial report. This report presented covers the achievements and challenges from September 2010 to August 2011.

In November 2010, the period of implementation of the agreement was extended to 49 months, including an approval the work plan until September 2012.

1.1 Objectives

The overall objective of the intervention shall be the improvement of health conditions of the population by means of enhanced quality of health delivery services in the PALOPs.

The specific objective is the improvement of national and regional capacities to develop HRH in the PALOPs.

The WHO collaboration shall focus on the following objectives:

Strengthening of the national capability of PALOPs for development and implementation of HRH policies;
Development and strengthening of the HRH Information Systems in the PALOPs, including mechanisms of exchange and cooperation among countries and the HRH observatories in Africa;
Evaluation of the educational and training systems followed by the development of technical cooperation programmes;
Strengthening access to information and knowledge in health, in Portuguese, throughout the institutions in the PALOPs (ePORTUGUESe).

2. Summary of the achievements and results

Activities	Indicators	Verification methods	Summary of the results by August 2011
Expected result: National capacities to develop and implement HRH policies are strengthened			

Activities	Indicators	Verification methods	Summary of the results by August 2011
1.1To update, with the support of WHO, the HRH sector assessment carried out in the PALOP, as well as existing policies, strategies and action plans and levels of execution	HRH sector assessment in PALOPs has been completed	Assessment report	– The situation analysis for the 5 countries were finalized, published and disseminated in all PALOP as well as with key partners and made available through the WHO's website http://www.who.int/hrh/resources/observer2
1.2Inter-country meeting with representatives of all PALOP HRH units/directorates of the Ministry of Health and key partners to allow to define the next steps and activities and support to the follow-up and implementation activities	2 meetings	Meeting report and follow-up report	– The first inter-country meeting was organized in December 2008, Praia, Cape Verde; the report published and disseminated in all PALOP countries as well as with key partners and made available through e-PORTUGUESe collaborative space http://cspace.eportuguese.org] – The first coordination committee meeting was organized in March 2009; the report was prepared and disseminated to the participants.
1.3To cooperate with the HRH units of the MoH to understand and strengthen the current capacities on HRH governance capacities of the countries, including aid effectiveness of support directed at HRH	2 studies and mission reports	– Study reports – Mission reports	– A template was developed and applied in Mozambique; a report was prepared and shared with the MoH and "WG-RHS" in Mozambique; – A similar exercise was developed for Guinea-Bissau and São Tomé and Principe – An “Advanced Training Programme on HRH Management and Planning” was carried out to reach key HRH managers and policy makers of all PALOP and Timor Leste.

Expected result: HRH information systems are developed and strengthened in the PALOP, including linking mechanisms for PALOP and African HRH observatories

Activities	Indicators	Verification methods	Summary of the results by August 2011
2.1 To carry out an assessment of HRH information systems being used in the PALOPs	HRH information systems assessed	Assessment report	– An initial assessment was done together with the situation analysis and already published ("Analysis of human resources for health in African Portuguese-speaking countries" http://www.who.int/hrh/resources/observer2/en/index.html).
2.1 To carry out an assessment of HRH information systems being used in the PALOPs	HRH information systems assessed	Assessment report	– An in-depth analysis tool was developed and tested in Angola; a draft report was prepared and shared with MoH and key partners; a final report was disseminated. – A similar exercise has been conducted in all PALOPs. – A comparative summary analysis has been finalized for publication and dissemination
2.2 Based on the results of the preliminary analysis, to revise/strengthen the HRH component of the National Health Information System so that the implementation of HRH policies and action plans can be monitored and evaluated	Strategy to strengthen HRH information systems and HRH Observatories	Document, reports	– A final report was disseminated with the HRH units of MoH of all PALOP and key partners. – A comparative analysis of all PALOP was done and it is in final review for publication and dissemination
2.3 To support the development of national HRH observatories in each PALOP in an harmonized manner with the African HRH observatories	HRH national observatories implemented	– Progress reports – HRH profiles – Publications	– The HRH profiles for the 5 countries were finalized and are available at the HRH Africa Observatory website and with each HR unit at the MoH and key partners. – The HRH Observatory in Mozambique will be launched in November 2011. In Guinea-Bissau the HRH Observatory is projected to be launched early 2012. It is expect that a definition from the MoH for the Angola observatory

Activities	Indicators	Verification methods	Summary of the results by August 2011
2.4 To support associations and professional bodies in the area of HRH information systems	Registration data on health workers available	Registration data	– An initial assessment was undertaken in all 5 PALOPs – Further activities were undertaken by the Agriconsulting consortium
Expected result: Training systems are assessed and technical cooperation programme developed			
3.1 Analysis of the existing HRH training systems, identification of possible cooperation among the PALOPs and other Portuguese-speaking countries in HRH training and in the improvement of the training quality	Training systems assessed and technical cooperation programme developed	Assessment report	– An assessment was done together with the situation analysis and already published ("Analysis of human resources for health in African Portuguese-speaking countries" http://www.who.int/hrh/resources/observer2/en/index.html). – Further evaluation was done by the Consortium, together with training programmes. A final report was disseminated to key partners
Expected result: Access to information and knowledge for health, in Portuguese, is strengthened in PALOP Institutions			
4.1 To carry out a situation analysis of access to health information and knowledge in the PALOPs, and to identify possible areas of cooperation among the PALOPs and other Portuguese-speaking countries	Health information and knowledge assessed and technical cooperation programme developed	Assessment report	– An assessment was done together with the situation analysis and already published ("Analysis of human resources for health in African Portuguese-speaking countries" http://www.who.int/hrh/resources/observer2)
4.2 Based on the results of the analysis, build capacity and empower each PALOP country to adopt, adapt and develop the VHL model according to local conditions, promoting access to relevant health information available in Portuguese	Each country capable to operate, maintain and update the contents of the VHL Portal	Progress reports	– National VHL developed and maintained in all PALOPs. Reports and further development can be seen at the portal: http://eportuguese.bvsalud.org/

Activities	Indicators	Verification methods	Summary of the results by August 2011
4.3 To establish communities of practice and collaborative spaces in the PALOPs, to help the sharing of health information, removing language barriers to facilitate the understanding, particularly on human resources for health issues	Virtual community developed and operational	Progress reports	– A Blog was established; further development can be seen at: http://eportuguese.blogspot.com/ – A Collaborative space was established and maintained; further development can be seen at: http://cspace.eportuguese.org
4.4 To facilitate the distribution of the Blue Trunk Library (BTL) in Portuguese to assist health workers in places where electronic means of communication are difficult or inexistent	40 Blue Trunk libraries (Bibliotecas azuis) distributed	Progress reports	– 55 BTL were distributed to all PALOPs and Timor Leste – An evaluation report was developed.

3. Difficulties encountered and measures taken to overcome problems

Upon signature in August 2008, WHO started implementation of the project. The Project Administration Unit in Luanda only started functioning in mid-2009. Therefore, the integrated implementation between both sides could thus only start almost in the second year of the implementation when the Unit started the creation of the Multi-year Activity Implementation Plan. Coordinated implementation between WHO and the Agriconsulting Consortium are now in place and special efforts are made to ensure effective coordination as well as supporting the Consortium in performing their tasks.

One important setback is still the difficulty in the establishment of the HRH National Observatories. Although the health national authorities of Angola, Guinea-Bissau and Mozambique, supported by partners, had made a decision to establish HRH national observatories, several factors, including changes in the senior management, political instability and concurrent priorities, led to a delay in the process. Nevertheless, Mozambique is ready to its launch early November 2011 and Guinea Bissau and Angola are moving now in the right direction.

4. Changes introduced in implementation

As approved, some changes were introduced from August 2010, with no additional cost, due to inclusion of Timor-Leste and increased demand in the component 4 (Improving access to information and knowledge for health, in Portuguese, in PALOP institutions).

4) *Health financing*

European Union/World Health Organization Programme Two

! This programme is not yet fixed and under review process in WHO HQ and EC !

Title: Strengthening health systems, improving health services and supporting capacity of partner countries to confront health challenges

Duration: approx. 3 ½ years

Budget: € 7 000 000

Supporting country universal coverage policy dialogues, development of health financing strategies and implementation of universal coverage reforms.

Overall objective: to increase financial risk protection and reduce financial barriers for people, especially vulnerable groups, thereby increasing coverage with needed health services and health equity in 10 selected countries (which have not yet been selected).

SO I. To support selected low- and middle-income countries to modify their health financing strategies and systems to move more rapidly towards universal coverage (UC), with a particular focus on the poor and vulnerable.

SO II. To increase countries' technical and institutional capacities, knowledge and information to assess and adapt their health financing (HF) systems.

Target Groups:

country level→ health financing policy advisors and policy-makers from various ministries (particularly health, finance, planning, social welfare/labour), health financing stakeholders (public and private health providers, purchasers, employer and employee associations, health worker associations), civil society & private sector

global level→ donor and development partners including members of P4H network, IHP+ etc.

Rationale for action:

The actions proposed are in line with the **WHR 2010** and the **resolutions** passed in **WHA 2011** on sustainable health financing structures and universal coverage (WHA64.9), requesting WHO, among other actions, to prepare an Action Plan to support Member States in their efforts to adapt their health financing systems to move towards UC.

The Communication and Council Conclusions 2010 on ***The EU's Role in Global Health***[3] outlines the commitment of EU Member States to achieve *"equitable and universal coverage of quality health services"* and supporting countries *to "put in place fair financing of health systems and develop or strengthen social protection mechanisms in the health sector".* In the mid-term review of the *Investing in People Programme*, *Theme 1: Good health for all*[4], strengthening of health systems and universal access

[3] Communication from the European Commission COM(2010)128 final. The EU Role in Global Health. 2010. (http://ec.europa.eu/development/icenter/repository/COMM_PDF_COM_2010_0128_EN.PDF.)

[4] EuropeAid. Investing in People - Strategy Paper for the Thematic Programme 2007-2013. Brussels, European Commission Development and Cooperation, EuropeAid. 2007. (http://ec.europa.eu/development/icenter/repository/how_we_do_strategy_paper_en.pdf).

to basic health care have been identified as key areas, and EU Member States emphasized that efforts should be made to pursue thematic action that adds value to country programmes in these specific areas.

This is the context and rationale for the cooperation between European Commission and WHO for the proposed programme in the area of UC. The WHO Plan of Action underlines the importance of the planned EU-WHO programme.

Expected Results:

Ad ER I.1.

1. Propose indicators for tracking progress of HF systems;
2. Support regular assessments of where countries stand in terms of UC and how (well) the HF system is functioning through country-led analysis of the institutional design, organization and operation of country HF systems;
3. Provide technical support to countries to obtain and analyse the required data;
4. In collaboration with relevant partners, guide and support the domestic monitoring and evaluation (M&E) agenda related to HF reforms for UC.

Ad ER I.2.

1. Develop guidance documents to support the country HF policy dialogues and analyses;
2. Support national stakeholders (Ministries of Health, Finance, Social Affairs, Labour, civil society, social partner etc.) in facilitating an inclusive policy dialogue on HF systems reforms with national and international stakeholders, in cooperation with other country-based partners, including P4H partners;
3. To assist selected countries in their HF policy analysis;
4. Support countries to improve transparency and accountability on how health funds are raised and spent and to feed this into policy dialogue, also by supporting governance and control processes, including NGO watchdogs and parliamentarian scrutiny, of health budgets and expenditures;
5. To develop an information base on country requests for technical and policy support in HF and channel these requests to other donors and partners to ensure that all countries have obtained support through at least one partner.

Ad ER I.3.

1. To assist selected countries in operationalizing their implementation plans, including an exploration of international evidence;
2. Support countries to establish mechanisms for evidence-informed planning and resource allocation (e.g., to ensure that additional investments generate the 'most health for the money;
3. To support the design and evaluation of innovative approaches for universal coverage where these are being developed;

Ad ER I.4.

1. Provide technical support to clarify policy objectives and build consensus among key stakeholders on HF policy within the specific context of a country's overall national health policy, strategy and plans (NHPSP);

2. Provide technical support to develop strong synergies between ongoing dialogues on health or health systems (e.g. country strategic reviews, development of national health plans) and HF dialogues;
3. Support mechanisms to develop and maintain dialogue between HF and other health experts.

Ad ER II.1.

1. Undertake collaborative analytic work with national HF experts;
2. Provide training opportunities on HF for UC, in collaboration with partner agencies and national experts, to support country capacity strengthening;
3. In the context of each supported country, assess and develop options for creating appropriate institutional platforms for attracting and retaining national staff with needed HF policy analytic skills.

Ad ER II.2.

1. Collate, analyse and disseminate the best available evidence to participating countries on what has worked in other settings;
2. Disseminate and actively share this evidence to national experts;
3. Facilitate South-South learning and sharing of experiences, particularly for the countries covered by this grant (e.g. through workshops, peer engagement and country visits).

5) *Essential medicines*

! The Contribution Agreement for this programme is in process of finalization.

Title: Renewed EU/ACP/WHO Partnership: strengthening pharmaceutical systems and improving access to quality medicines in African ACP countries.

Background: The renewed EU/ACP/WHO Partnership: strengthening pharmaceutical systems and improving access to quality medicines in African ACP countries is the follow-on of a 6 years' collaboration with the EC on the EC/ACP/WHO Partnership on Pharmaceutical Policies which was finalized in 2010 and included all ACP countries. The first partnership has been instrumental to support ACP countries to generate reliable medicines information, to develop and endorse policies, regulations and best practices and to strengthen capacity of the pharmaceutical sector. The proposed renewed Partnership will build on this momentum, focusing on the implementation of national medicines policies, regulations and practices through multi stakeholder policy dialogue, for improving access and use of quality assured medicines in African ACP countries.

Duration: 4 years

Budget: Approx. Euro 10 million

Target countries: The Renewed Partnership will support global and regional work as well as work in ACP countries in Africa such as Burundi, Cameroon, Central African Republic, Congo, DRC, Ethiopia, Ghana, Guinée Conakry, Kenya, Mali, Nigeria, Senegal, Tanzania, Uganda and Zambia.

Rationale for action: The acknowledged failure of health systems to provide adequate health care, in particular, access to medicines is compounded by weak or failing national systems for the regulation, supply and appropriate use of medicines. Therefore health systems' strengthening includes, per se,

strengthening of the pharmaceutical systems. The renewed partnership will contribute towards the implementation of the 10th EDF Intra-ACP Strategy Paper and Multi-Annual Indicative Framework 2008-2013 (strengthening health systems and human resources capacity); the 2nd Joint Africa-EU Strategy Action Plan 2011-2013 (scaling up MDGs as one of the eight thematic partnerships for joint actions between Africa and Europe) and the *EU Role in Global Health* (by providing evidence of country needs, priorities and national health policies, strategies and interventions).

Overall objective: The overall objective is to contribute to the achievement of health-related MDGs and of universal health coverage in African ACP countries by improving availability, affordability and use of quality essential medicines for priority acute and non-communicable diseases thereby contributing to improved cost effective health care and better patient health outcomes.

The renewed partnership will focus on the implementation of policies, enforcement of regulations and adoption of best practices and on strengthening pharmaceutical systems. The 5 areas of work (or results areas) are:

Result 1: Improved availability and supply of essential medicines in national, regional and community health facilities in African ACP countries;

Result 2: Lowering medicines prices, increased affordability and advocacy for fair financing schemes for medicines to ensure sustainable and equitable access to medicines;

Result 3: Improved quality of medicines and reduced occurrence of substandard medicines and of medicines that do not meet safety standards;

Result 4: Improved medicines selection, prescribing, dispensing and use and strengthening capacity of health care providers;

Result 5: Improved access to reliable information for more transparency, accountability and efficiency of the pharmaceutical sector; formulation of evidence based policies and monitoring their implementation.