AFR/AHEAC/06.01

AFRICAN HEALTH ECONOMICS ADVISORY COMMITTEE

Brazzaville, Republic of Congo
23 –25 November 2004

FINAL REPORT OF THE FIRST MEETING

AFRICAN HEALTH ECONOMICS ADVISORY COMMITTEE

Brazzaville, Republic of Congo
23 –25 November 2004

FINAL REPORT OF THE FIRST MEETING

WORLD HEALTH ORGANIZATION
Regional Office for Africa
Brazzaville • 2004

AFR/AHEAC/06.01

© WHO Regional Office for Africa, 2006

Publications of the World Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. All rights reserved. Copies of this publication may be obtained from the Publication and Language Services Unit, WHO Regional Office for Africa, P.O. Box 6, Brazzaville, Republic of Congo (Tel: +47 241 39100; Fax: +47 241 39507; E-mail: afrobooks@afro.who.int). Requests for permission to reproduce or translate this publication – whether for sale or for non-commercial distribution – should be sent to the same address.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization or its Regional Office for Africa be liable for damages arising from its use.

Printed in the Republic of Congo

CONTENTS

Pages

ANNEXES

1. INTRODUCTION

The first meeting of the African Health Economics Advisory Committee (AHEAC) took place from 23 to 25 November 2004 at the WHO Regional Office for Africa in Brazzaville, Republic of Congo. Seven members of the Committee, together with five members of the Secretariat attended the meeting. The list of participants is in Annex 1.

The meeting was opened by Dr Ebrahim Malick Samba, Regional Director, WHO Regional Office for Africa. The opening session was attended by the Director of Programme Management and the Division Directors.

The Regional Director welcomed members of AHEAC to the WHO Regional Office. He thanked them for volunteering their time to assist WHO in charting the future of health economics development in the Region. Dr Samba expressed concern regarding the apparent lack of female membership of AHEAC. Though one woman health economist had been invited, she had been unable to attend. He said that while acknowledging that there might be a dearth of female health economists in the Region, it was vitally important to try to address the issue of gender balance on the Committee.

The Regional Director urged the African governments to come to terms with the emerging global consensus that there is a direct link between health and development. He said that healthy people are productive people, yet the idea that health is a part of productivity was slow to catch on. He argued that good health and economic prosperity seemed to go together because healthy people could more easily earn an income, afford and seek medical care, acquire better nutrition and experience more freedom to lead healthier lives. He underlined that tackling health problems should be part of the economic development equation which could help our countries achieve sustainable development.

Dr Samba stated that the time is now ripe for African governments to examine how adequate financial allocations to the health sector could be ensured for adequate health care. In this regard, he underscored the necessity for ministers of health to work closely with ministers of economic development planning and finance to secure sustainable financing for the health sector.

Dr Samba also said that the view that health was “all about disease, and the exclusive domain of health professionals” had changed radically over the past four decades, pointing out that non-health professionals, including economists, could and should play a role in structuring and analysing data that facilitate the choice, design, implementation, monitoring and evaluation of health interventions.

The Regional Director explained that the purpose of the Committee was to provide advice and guidance to the Regional Office on all aspects of health economics as requested. This will include how to strengthen the health economics capacities of Member States for generating and using evidence in decision-making.

He surmised that the inaugural session of AHEAC had a heavy responsibility for developing a ten-year strategic plan for enhancing health economics capacities in the

Region. He said that, subsequently, the Committee would be called upon to provide advice on the implementation, monitoring and evaluation of that plan.

In his remarks, the Regional Adviser on Health Economics (HEC) in the WHO Africa Region, Dr Joses M. Kirigia, stated that the growing importance and recognition of the need to use economic tools to compare and prioritize health interventions in the Region had been demonstrated by the exponential increase in the number of economists in the regional and country offices in the past decade: from one at the Regional Office in 1995 to seven by mid-2004; and from five in country offices prior to 1999 to 20 this year.

There are currently six economics programmes at the Regional Office. Prior to 1999, there was only one. These programmes are involved in the preparation of economics-related documents for WHO Regional Committee meetings, the development of guidelines, the generation and dissemination of evidence for health policy, the organization of capacity strengthening workshops, and support to regional health economics training institutions in examining dissertations.

2. OBJECTIVES

2.1 General Objective

The general objective of this meeting was to contribute to the strengthening of health economics capacity in the WHO African Region.

2.2 Specific Objectives

The specific objectives were as follows:

(a) to appoint a chairperson and two vice-chairpersons of AHEAC;
(b) to discuss and adopt the terms of reference of AHEAC;
(c) to develop a ten-year (2006-2015) strategic plan for enhancing health economics capacity in the African Region;
(d) to develop an implementation, monitoring and evaluation framework for the health economics strategic plan.

3. APPOINTMENT OF CHAIRPERSON AND VICE-CHAIRPERSONS

The Committee elected the leadership of the AHEAC for a period of four years as follows:

- Chairperson: Dr Chris Atim;
- Vice-Chairperson: Professor Capela Tepa;
- Vice-Chairperson: Professor Mamadou Moustapha Thiam.

4. ADOPTION OF TERMS OF REFERENCE

Dr Tuoyo Okorosobo, Regional Economic Advisor for the Malaria Programme at the Regional Office, presented an overview of the proposed terms of reference of AHEAC. He informed the meeting that: (i) the Committee consisted of eight distinguished health economists from Africa drawn from national universities (and

research institutions) and non-governmental research institutions; (ii) members of the committee, were appointed in their personal capacities at the Regional Director's invitation, and not as representatives of their respective governments; (iii) membership will be for four years in the first instance; (iv) the inaugural session of AHEAC shall elect a chairperson and two vice-chairpersons.

Dr Okorosobo explained that, based on an analysis of strengths, weaknesses, opportunities and threats (SWOTs) of the current status of health economics training and research in the Region, the Committee was expected to advise the Regional Director on:

(a) ***Strategic Planning:*** Development of a regional strategic plan for strengthening health economics capacities;
(b) ***Advocacy:*** Strategies for sensitizing health decision-makers on the importance of health economics;
(c) ***Resource Mobilization:*** (i) ways of mobilizing resources for implementing the strategic plan for health economics, (ii) preparation of joint training and research project proposals for mobilizing funds;
(d) ***Training:*** (i) sustainable long- and short-term strategies for strengthening Member State capacity in health economics, (ii) strategies for ensuring sustainability of regional institutions that offer post-graduate training in health economics.
(e) ***Research:*** (i) ways of strengthening Member State capacity for generating health economics information and evidence to improve health systems performance, (ii) strategies for generating economic evidence on regional priorities;
(f) ***Dissemination:*** ways of making the internationally available health economics literature available to health decision-makers, managers, and training and research institutions in Member States;
(g) ***Utilization:*** ways of strengthening Member State capacity for generating and utilizing health economics information and evidence to improve health systems performance;
(h) ***Partnerships:*** (i) establishment, maintenance and sustenance of a health economists network to ensure promotion and coordination of health economics work; (ii) establishment, probably through a memorandum of understanding, partnerships with regional organizations and institutions with demonstrated commitment to strengthening health economics capacities; (iii) forging partnerships with international organizations (e.g. Ford Foundation, Rockefeller Foundation, IDRC, DANIDA, SIDA, CIDA, TDR) with demonstrated long-term commitment to strengthening health economics capacities in the Region; (iv) designation of WHO collaborating centres on health economics;
(i) ***Others:*** Any other issues related to health economics that may be referred to either by the Regional Director or initiated by the AHEAC itself.

He surmised that the AHEAC was expected to be proactive and reactive, i.e. responding to requests for advice, guidance and counsel from the Regional Director, as well as asking the WHO Regional Office to respond to suggestions from the Advisory Committee.

In the discussions that followed, the Committee made several amendments to the proposed terms of reference, which were simultaneously incorporated in the revised document in Annex 2.

5. STRATEGIC PLAN FOR ENHANCING HEALTH ECONOMICS CAPACITY IN THE AFRICAN REGION

Dr JM Kirigia presented an outline of the draft "Strategic Health Economics Plan for the WHO African Region: 2006-2015" consisting of the following sections: introduction; overview of the public health situation; justification for health economics; strengths, weaknesses, opportunities and threats; the regional strategic plan for health economics; implementation framework; partnerships for plan implementation; monitoring and evaluation; and conclusion. He indicated that after revision by the Committee, the document would be presented to the Regional Office Management Development Committee for discussion before being tabled at the fifty-sixth session of the WHO Regional Committee for Africa for review and adoption.

The Committee made a number of general comments. The document is big and covers a wide area. There is a need to focus and make it a practical reference and framework document to facilitate its marketing. The major issues should be grouped under broad areas and objectives which can subsume much of the issues contained in the draft. Indicators should be developed for measuring achievement of targets. There is a need to establish a baseline against which to monitor and evaluate the achievement of the various targets, highlighting the qualitative and quantitative analyses. Concrete action should target specific areas and provide advice for the Regional Office.

The Committee did a commendable job of shortening the document; grouping the objectives into three broad categories; developing indicators for monitoring the achievement of the targets; and revising specific sections of the draft plan. The revised document can be found in Annex 3.

6. CLOSING CEREMONY AND RECOMMENDATIONS

The closing ceremony was presided over by Dr Ebrahim Malick Samba, Regional Director; Dr Doyin Oluwole, Acting Director of Programme Management; and Dr Chris Atim, Chairperson of AHEAC.

Summarizing the proceedings of the meeting, Dr Atim said that the Committee had done commendable work. He said that it had realized all the expected outcomes, namely: appointed the Chairperson and two Vice-Chairpersons; revised the terms of reference for AHEAC; a Strategic Health Economics Plan for the WHO African Region: 2006-2015 and its implementation, monitoring and evaluation framework.

Dr Atim thanked the Regional Director for creating AHEAC and for personally facilitating the work of the Committee in the course of its first session. He thanked him for creating time to interact informally with individual members of the Committee. The Chairman thanked Mrs Angele Mandzoungou (AA/PDC) for making all the logistical arrangements and for the superb support during the meeting; Mr Sam Ajibola for preparing the Regional Director's press releases and for ensuring

dissemination of AHEAC agenda and proceedings to the media; and other staff for creating an enabling environment that facilitated the work of the Committee.

Subsequently, Dr Atim presented the recommendations adopted by the Committee.

Recommendations adopted

The WHO Regional Office for Africa should:

(a) expand Committee membership to ten to ensure enough members for meetings and meet the requirement for gender balance;
(b) invite a number of funding institutions to join AHEAC as institutional members to advise on resource mobilization aspects;
(c) subject to availability of resources, hold the AHEAC meeting every year;
(d) inform the WHO country representatives in all countries of the formation of the AHEAC;
(e) facilitate the establishment of an African journal of health economics;
(f) finalize the revision of the draft document and share it with Committee members before presentation to the Regional Director and Regional Committee (RC56);
(g) once the strategic plan has been adopted by the Regional Committee, the Regional Director should share it with the African Union Secretariat;
(h) develop a web-page for AHEAC-related work.

In order to popularize and increase awareness of the work of AHEAC, the Committee members should:

(a) advocate for inclusion and development of curricula for HEC modules in relevant national institutions;
(b) sensitize and, where possible, seek corporate membership of bodies or institutions such as AU, SADC, COMESA, CEEAC, ECOWAS, UEMOA, CEPGL, IHEA, etc.
(c) provide technical backstopping as appropriate;
(d) support the compilation and maintenance of inventory of HEC resources in countries;
(e) assist in identification of HEC priority research agenda in countries;
(f) spearhead the establishment of subregional health economics networks;
(g) make contacts at all levels to support the work of the Committee;
(h) explore efforts to facilitate the establishment of the *African Journal of Health Economics*;
(i) support and participate in multicountry studies of regional priority.

In his closing remarks, Dr Samba expressed great satisfaction with the outcome of the meeting, especially with the draft "Strategic Health Economics Plan for the WHO African Region: 2006-2015", which once adopted by the Regional Committee for Africa would guide efforts for strengthening health economics capacities among the WHO Member States in the Region. He said that his office would happily share the strategic plan, once adopted, with the Chairperson of the African Union. The Regional Director also welcomed the various recommendations made by the AHEAC which he said were relevant and feasible to implement. He repeated his thanks to members of

the AHEAC for volunteering their expertise to chart the way forward for health economics capacities development in the Region. He wished everyone a safe journey back home.

Annex 1: List of participants

AHEAC MEMBERS
Dr Chris Atim (Chairman)
Professor Capela Tepa (Vice-Chairman)
Professsor Mamadou Moustapha Thiam (Vice-Chairman)
Professor Germano Mwabu
Professor Kamiantako Miyamueni Antoine

REPRESENTATIVES OF AHEAC MEMBERS
Mr OKORE OKRAFOR (Representing Professor Di McIntyre)
Dr Mensah (Representing Professor Kodjo Evlo)

OBSERVER

WHO/AFRO SECRETARIAT
AFRO MANAGEMENT
Dr Ebrahim Malick Samba (RD/AFRO)
Dr Luis G Sambo (DPM/AFRO)
Dr Doyin Oluwole (DPMa.i./AFRO)

MEETING SECRETARIAT
Dr Ayayi Omar Mensah (PPE/DPM)
Dr Anthony Mawaya (LHD/DES)
Dr Benjamin Nganda (HIP/DES)
Dr Eyob Zere Asbu (HEC/Namibia)
Dr Joses M. Kirigia (HEC/AFRO)
Dr Tuoyo Okorosobo (HEC/MAL)

Annex 2: AHEAC terms of reference

Rev. 1

AFRICAN HEALTH ECONOMICS ADVISORY COMMITTEE (AHEAC)

TERMS OF REFERENCE

1. Purpose

The purpose of the African Health Economics Advisory Committee (AHEAC) shall be to provide advice and guidance to the Regional Director on all aspects of health economics as requested. This will include how to strengthen WHO Member States health economics capacities for generating and using health economics evidence in decision-making.

The Regional Director will give the final approval of the AHEAC Terms of Reference and appoint the Committee members. The Terms of Reference would be subject to revision in future, if deemed appropriate and necessary by at least six members of the Committee. The proposed revisions in the Terms of Reference would become valid after the Regional Director's approval.

2. Responsibilities

The AHEAC will be a forum that will advise the Regional Director on issues and initiatives as requested. The Committee would be expected to provide advice and guidance on development of a ten-year strategic plan for enhancing health economics capacities in the Region. The Committee would be called upon to provide advice on the implementation, monitoring and evaluation of the plan.

Specifically, based on a strengths, weaknesses, opportunities and threats analysis of the current status of health economics training and research in the Region, the Committee will advise on:

A: Strategic Planning

- Development of a regional strategic plan for strengthening health economics capacities.

B: Advocacy

- Strategies for sensitizing health decision-makers in health and other ministries and stakeholders in the health development area on the importance of health economics.

C: Resource Mobilization

- Ways of mobilizing resources for implementing the strategic plan for health economics.

- Preparation of joint training and research project proposals for mobilizing funds.

D: Technical Advice

- As and when need arises, AHEAC members would be called upon to provide technical advice to WHO programmes and countries on health economics issues.

E: Training

- Sustainable long- and short-term strategies for strengthening Member State capacity in health economics.

- Strategies for ensuring sustainability of regional institutions that offer post-graduate training in health economics.

F: Research

- Ways of strengthening Member State capacity for generating health economics information and evidence to improve health systems performance.

- Strategies for generating economic evidence on regional priorities.

G: Dissemination

- Ways of making the internationally available health economics literature available to health decision-makers, managers, and training and research institutions in Member States in a targeted manner. Support the publication and dissemination of research results from African researchers in regional and international journals. Facilitate the establishment and running of an African journal of health economics.

H: Utilization

- Ways of strengthening Member States capacity for generating and utilizing health economics information and evidence to improve health systems performance.

I: Partnerships

- Establishment, maintenance and sustenance of the African Health Economists Network to ensure promotion and coordination of health economics work, and promote collaboration with other networks.

- Establishment, probably through a memorandum of understanding, partnerships with regional institutions with demonstrated commitment to strengthening health economics capacities, e.g. African Economic

Research Consortium; Department of Economics at the universities of Benin, Dar es Salaam, Nairobi, Togo, Zambia; Health Economics Unit at the University of Cape Town; *Centre African d'Etudes Superieures en Gestation,* EQUINET.

- Forging partnerships with international (e.g. Ford Foundation, Rockefeller Foundation, IDRC, DANIDA, SIDA, CIDA, TDR) with demonstrated long-term commitment to strengthening health economics capacities in the Region.

- Designation of WHO collaborating centres on health economics.

J: Others

- Any other issues related to health economics that may be referred to it either by the Regional Director or initiated by the AHEAC itself.

AHEAC should be pro-active and reactive, responding to requests for advice and guidance or counsel from the Regional Director, as well as asking the WHO Regional Office to respond to suggestions from the Advisory Committee.

3. Method of Work

The AHEAC may use a number of methods of work: scheduled annual (depending on resource availability) meetings; teleconferences; emails; and ad hoc meetings as necessary. The first meeting of AHEAC would take place at the Regional Office in Brazzaville, Republic of Congo. The venues of subsequent meetings shall be decided upon by the Committee.

4. Membership

The Advisory Committee shall be composed of distinguished health economists working in the African Region. The Committee will be limited to eight members. They will be drawn from national universities (and research institutions) and non-governmental research institutions.

Members of the committee will be appointed in their personal capacities at the Regional Director's invitation, and not as representatives of their respective governments. However, the latter's prior approval of the appointments of the experts should be obtained by members where necessary. The Committee will meet biennially to deliberate on issues related to its mandate.

Membership will be for four years in the first instance, renewable once for a further four years.

The Advisory Committee, during its first meeting shall elect the Chairperson and Vice-Chairperson. The two will serve for four years.

5. Roles and Expectations of Committee Members

The structure of the Committee involves two categories of members: members and partners. The latter will consist of representatives from two organizations that fund health economics training and research. The role of all members is to serve the Committee by:

- Attendance at biennial AHEAC meetings.
- Fostering and contributing to open, collaborative discussions.
- Drawing on their knowledge, international contacts, institutions of affiliation and experience to actively provide constructive advice where appropriate.

In addition, the role of partners will include:

- Attendance at biennial AHEAC meetings.
- Offering input and advice on specific issues regarding sustainable development of health economics in the Region, including resource mobilization strategies.

Members will be paid full per diem and an honorarium (equal to the prevailing WHO consultancy rates) for the days of the AHEAC biennial meetings. The purpose of the honorarium is to ensure that members are not impoverished in the process of availing their expertise to the Regional Office. Partners will be financed by the organizations they represent.

6. Administration

The Regional Advisor for Health Economics (HEC) will be the Secretary of the AHEAC and will be responsible for seeking the Regional Director's approval for holding the Committee meetings, drafting and distributing the agenda and programme of work (in close consultation with Chairperson and Vice-Chairpersons), sending out invitations, making travel arrangements (issuance of Travel Authorization, per diem), preparing the files for the meeting, liaising with host WHO country offices to ensure hotel and conference facilities are booked, and other logistics.

Minutes of the meetings will be prepared by HEC and approved by the Chairperson. They will be distributed to all members and posted on the WHO Regional Office web site after clearance by the Director of Programme Management.

HEC will ensure that the Committee is continually updated on the progress made in the implementation of the health economics agenda postulated in the strategic plan.

The Secretariat (Regional Office economists) will establish a database and facilitate sharing of information on health economics issues across the Region.

Annex 3: Strategic Health Economics Plan for the WHO African Region, 2006–2015

INTRODUCTION

1. Health economics is the study of how people decide to use limited health resources to satisfy unlimited health-related needs. The mismatch between resources and needs implies that choices must be made regarding what needs to satisfy with the available resources. Choice entails an opportunity cost, that is, choosing one alternative means foregoing another. Health economics knowledge and skills are critically valuable for identifying true opportunity costs and alternative health investments for obtaining the greatest expected net gains.

2. A number of recent global and regional initiatives include the Millennium Development Goals (MDGs);[1] the New Partnership for Africa's Development (NEPAD); the Report of the Commission on Macroeconomics and Health (CMH);[2] the Regional Committee for Africa resolution on macroeconomics and health (AFR/RC53/R1); the Poverty Reduction Strategy Papers (PRSPs); and the multilateral trade agreements (MTAs).[3] All have served to raise awareness of the important role that health economics plays in decision-making.

3. Improved health is a critical pathway for promoting economic growth and addressing world poverty. This is attested to by the report of the Commission on Macroeconomics and Health (CMH). At the UN General Assembly in September 2000, world leaders resolved, as part of the Millennium Declaration, to eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other priority diseases; ensure environmental sustainability; and develop a global partnership for development by the year 2015. Health economics has a valuable role to play in costing of MDG-related interventions, guiding choices of public health interventions with greatest expected value for money, evaluating and designing sustainable and equitable health financing mechanisms.

4. The fifty-third session of the WHO Regional Committee for Africa adopted the resolution on macroeconomics and health[4] that urges Member States to strengthen health economics and public health capacity within ministries of health and other relevant sectors in order to enhance the effectiveness and efficiency of health investments, and pre-empt and mitigate negative effects of development projects on public health. In the same resolution, the Committee urged the Regional Director to provide support to regional institutions that train health economists and conduct research in health economics and related fields.

5. At no other time in the past half century has health featured so prominently on the international development agenda than now. The once narrow circle of medical

[1] UN, UN Millennium Development Goals (MDG), New York, United Nations, 2000.
[2] WHO, *Macroeconomics and health: Investing in health for economic development*, Geneva, World Health Organization, 2001.
[3] WHO and WTO, *WTO agreements and public health: A joint study by the WHO and the WTO secretariat*, Geneva, World Health Organization and World Trade Organization, 2002.
[4] WHO, Macroeconomics and health: The way forward in the African Region (AFR/RC53/R1), Brazzaville, World Health Organization, Regional Office for Africa, 2001.

professionals and public health advocates has widened to include a cadre of health economists and other development experts focussed on using targeted health interventions to achieve important economic and social objectives, including economic growth and poverty reduction.

6. This strategic plan aims at: (i) providing an overview of the public health situation; (ii) making a justification for health economics; (iii) analysing strengths, weaknesses, opportunities and threats; and (iv) outlining strategies and priority interventions for strengthening health economics capacities in Member States.

OVERVIEW OF THE PUBLIC HEALTH SITUATION

7. The health statistics of most countries of the African Region are unacceptably poor, with countries reeling under the double burden of communicable and noncommunicable diseases that caused 10.7 million deaths and accounted for 230 million disability-adjusted life years (DALYs) in 2002.[5]

8. The African Region is the worst affected area with regard to the HIV/AIDS pandemic, tuberculosis and malaria. The maternal mortality ratio in the Region is the highest in the world, and millions of children die before the age of five years from acute respiratory infections, diarrhoeal and vaccine-preventable diseases, and other diseases. The prevalence and incidence of noncommunicable diseases (NCDs) are also on the increase.

9. The key regional public health priorities include health systems development; HIV/AIDS; malaria; tuberculosis; maternal health; child health; mental health; cancer, cardiovascular diseases, diabetes and obstructive chronic respiratory diseases; blood safety; poverty; emergency and epidemic preparedness and response; youth and adolescent health; and health promotion.[6] Most countries of the Region have developed appropriate policies and strategies, with some undergoing reforms to position the health sector to adequately respond to these priorities.

10. Although many cost-effective interventions are available (e.g. use of insecticide-treated materials, directly-observed treatment, short-course [DOTS], condoms, vaccines against major childhood killer diseases), they are not reaching the poor. The average access of populations to health services is estimated at 53%, and 2 billion people are currently without access to essential medicines.[7] There is, therefore, need to substantially increase the coverage and use of public health interventions, especially among the poor, if the health-related MDGs are to be achieved.

11. Successful scaling up of cost-effective health interventions against priority public health problems greatly depends on the existence of adequately resourced, effective, efficient and equitable health systems (especially at the district and peripheral levels). Unfortunately, health systems in most of the Member countries remain weak. The major problems facing the health systems include inadequate

[5] WHO, *The world health report 2004*, Geneva, World Health Organization, 2004.
[6] WHO, WHO Proposed Budget 2002-2003, Part II: Regional Orientations, Harare, WHO, Regional Office for Africa, 2000.
[7] WHO, *WHO medicines strategy 2004–2007: Countries at the core*, Geneva, World Health Organization, 2004, p.72.

resources (inputs), lack of human resources (worsened by brain drain), poor financing, technical and allocative inefficiencies, low quality of care, and inequalities in the geographical distribution of health inputs and facilities which are aggravated by poor economic and political environments.[8]

12. The level of health spending in Member States is not sufficient to scale up cost-effective interventions. Government expenditure per person, per year averages around US$ 5 across countries of the Region, well below the minimum of US$ 30–40 estimate required to provide an essential package of public health interventions necessary to achieve both the MDGs and NEPAD targets.[9] Most governments are also allocating less than the recommended 15% of national budgets to the health sector agreed at the Abuja Summit of 2001.[10]

13. The CMH report underscores the magnitude of the gross levels of under funding in the health sector, estimating a global financing gap of US$ 27 billion per year (as measured against the current US$ 6 billion) which needs to be filled from external sources.[11] In addition, an estimated 47% of the population in the Region lack access to adequate sanitation facilities; 40.2% lack safe drinking water; 40% of adults are illiterate; 63% attend primary school; and 21% attend secondary school;[12] hence, there is a need for increased investments in sectors such as water, sanitation, education and agriculture, all of which have an impact on health, in order to achieve the relevant MDGs.

JUSTIFICATION FOR HEALTH ECONOMICS

14. Successful scaling up of effective health interventions against MDG-related public health problems greatly depends on existence of adequately resourced, effective, efficient and equitable health systems. In this context, health economics principles and evidence are important for informing policy and managerial choices related to advocacy, prevention, treatment and management of HIV/AIDS, malaria, childhood illnesses, maternal complications, priority noncommunicable diseases (e.g. cardiovascular diseases). Economists use economic evaluation methods (e.g. cost-effectiveness, cost-utility and cost-benefit analyses)[13] to choose those public health interventions that promise the greatest value for money.

---

[8] WHO, *Health-for-all policy for the 21st century in the African Region: Agenda 2020*, Harare, World Health Organization, Regional Office for Africa, 2000 (AFR/RC50/8 Rev.1).

[9] WHO, *The world health report 2002: Reducing risks, promoting healthy life*, Geneva, World Health Organization, 2002.

[10] OAU, Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases, Addis Ababa, Organization of African Unity, 2000.

[11] Bloom DE and Canning D, The health and, wealth of Africa, *World Economics*, April–June, 5(2): 57–81, 2004.

[12] UNDP, *Human development report 2002*, New York, Oxford University Press for United Nations Development Programme, 2002.

[13] See examples in Binka FN, Mensah O and Mills A, Cost-effectiveness of permethrin impregnated bed nets in preventing child mortality in Kassena-Nankana district of Northern Ghana, *Health Policy*, 41: 229–239; 1997; Nganda B et al, Cost and cost-effectiveness of increased community and primary care facility involvement in tuberculosis care in Machakos District, Kenya, *International Journal of Tuberculosis and Lung Disease*, 7(9): S14–20, 2003; Kirigia JM, Cost-utility analysis of schistosomiasis intervention strategies in Kenya, *Environment and Development Economics* 3(3): 319–346, 1998; Kirigia JM, Sambo LG and Kainyu LH, A cost-benefit analysis of preventive schistosomiasis interventions in Kenya, *African Journal of Health Sciences*, 7(3–4): 4–10, 2000.

15. With regard to the achievement of the health-related MDGs, policy-makers are faced with the challenge of promoting behavioural change among individuals so as to ensure use of cost-effective promotive, preventive and curative interventions. Economists employ econometric methods to model the relationships between care-seeking behaviour, individuals' characteristics and system-specific attributes.[14] The cause-effect information generated in these analyses is useful in identifying variables that can be manipulated (through regulatory or financial incentives) to bring about the desired human behaviour.

16. Given that health-producing resources (inputs) are available in limited supplies, it is critically important to use them efficiently to reduce the burden of HIV/AIDS, malaria and priority noncommunicable diseases as well as improve maternal and child health. Inefficiencies represent wasted opportunities for improving a person's health at no extra cost. Health economists often use qualitative (e.g. stakeholder and policy analyses) and quantitative techniques to assess inequalities in health and inequities in distribution and utilization of health inputs and services.[15] They employ econometrics and mathematical programming methods to estimate efficiency scores and excess inputs (or output deficit) for individual decision-making units, e.g. hospitals and health centres.[16]

17. The effectiveness of disease prevention and management services hinges on the effectiveness of the underlying health system. The extent of health system performance in improving health status of populations; responding to clients' non-medical expectations; and fairness in financing depends on the effectiveness, efficiency and social fairness with which functions such as stewardship, resource generation, financing and provision of health services are carried out.[17] Knowledge and skills of health economics and public health are necessary in the assessment of health system performance and the analysis of its functions to inform policy, planning, resource allocation and use.

18. As proven by the CMH work, evidence on the synergistic relationships between health (or ill-health), development, poverty and trade is an invaluable tool for advocating for inclusion and prioritization of health in national and international development agenda. Health economists usually employ parametric and non-parametric methods to study the cause-effect relationship between health, development, poverty and trade. In addition, qualitative methods are used to document the voices of the poor.[18]

---

[14] Jones AM and Kirigia JM, The determinants of the use of alternative methods of contraception among South African women, *Applied Economics Letters*, 7:501–504, 2000.

[15] McIntyre D and Gilson L, Putting equity back onto the social policy agenda: Experience from South Africa, *Social Science and Medicine*, 54: 1637–1656, 2002.

[16] See Kirigia JM, Emrouznejad A and Sambo LG, Measurement of technical efficiency of public hospitals in Kenya: Using data envelopment analysis, *Journal of Medical Systems*, 26 (1): 29–45, 2002; Asbu EZ, McIntyre D and Addison T, Hospital efficiency and productivity in three provinces of South Africa, *South African Journal of Economics*, 69(2): 336–358, 2000; Kirigia JM et al, Using data envelopment analysis to measure the technical efficiency of public health centres in Kenya, *Journal of Medical Systems*, 28(2): 155–166, 2004.

[17] Murray CJL and Frenk J, A framework for assessing the performance of health systems, *Bulletin of the World Health Organization*, 78(6): 717–731, 2000.

[18] Narayan D et al, *Voice of the poor: Crying out for change*, New York, Oxford University Press for the World Bank, 2000.

19. Lastly, decision-makers are cautioned that without a wider use of economics in health care, inefficiencies will abound. "We will go on spending large sums to save life in one way when similar lives in greater numbers could be saved in another way. The price of inefficiency, inexplicitness and irrationality in health care is paid in death and sickness."[19]

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

20. At the regional level, there are certain internal strengths (i.e. organizational controllable activities that are performed well) with implications for health economics:

- increased regional awareness of the potential role of health economics following the discussion of the agenda item on macroeconomics and health at the fifty-third session of the Regional Committee;
- existence of regional priorities and strategies which help to highlight areas where generation of health economics evidence is needed;
- existence of the Health-for-all policy for the 21st century in the African Region;
- availability of five economists at the Regional Office;
- availability of economists in 20 WHO country offices;
- existence of the African Health Economics Advisory Committee (AHEAC);
- availability of various health economics related tools of analysis, e.g. Cost-It, WHO-CHOICE;
- existence of country cooperation strategies (CCSs) in all the 46 countries, which directly or indirectly indicate areas that need health economics research;
- growing body of literature published by economists working for WHO in the African Region;
- *The world health report 2000* on improving health system performance;
- email and internet connections in all regional and country offices;
- management that is supportive of health economics work.

21. However, efforts to seize and exploit the aforementioned strengths might be hampered by, among others, the following internal and external weaknesses:

- limited opportunities to update knowledge of new methodological developments in health economics due to non-participation in the International Health Economists Association conferences;
- absence of Regional Office library subscription to mainstream journals of health economics;
- lack of an African journal of health economics;
- lack of economists in 26 WHO country offices and two Regional Office technical divisions;
- many WHO country office economists have had no formal training in health economics;
- low budgetary allocations for health economics training and research;

[19] Mooney G, *Economics, medicine and health care*, New York, Harvester Wheatsheaf, 1986.

- lack of an evidence-based culture in health decision-making;
- the majority of the health economics literature and tools in the international arena are in English which limits access in French and Portuguese speaking countries;
- lack of access to computing and internet facilities in some of the universities in the Region limits their access to freely available online literature and tools for analysis;
- lack of a career path for health economists within ministries of health;
- poor governance, and hence, lack of appreciation of health economics by policy-makers.

22. There are opportunities that can be seized to strengthen health economics capacities in the Region. These include:

- ongoing health sector reforms that entail economic evidence and skills;
- increased international visibility of health economics following publication of the report of CMH, and its subsequent discussion at the Fifty-fifth World Health Assembly;
- availability of free published health economics literature (including tools of analysis) online;
- limited health care budgets, and hence, need to set priorities;
- growing need for understanding the effect of multilateral trade agreements on public health;
- growing pressure on countries to demonstrate good governance (stewardship, transparency) and accountability (demonstrate efficient use of resources);
- subregional health economics networks;
- presence of regional health economics centres of excellence;
- increase in the number of international health initiatives (e.g. the Global Fund to Fight AIDS, Tuberculosis and Malaria) that demand economics evidence;
- the development of poverty reduction strategy papers;
- the development of effective subregional economic groupings.

23. The exploitation of these opportunities and the weaknesses notwithstanding, the development of health economics in the Region may still face difficulties. Although health economics is increasingly becoming popular worldwide, there is no guarantee that those trained will remain in the Region. Global development partners may not think this a priority area and may therefore discourage countries. Frequent civil conflicts afflicting many countries in the Region may continue to put pressure on governments to address issues on an emergency basis rather than through a planned approach which is amenable to the application of health economics principles. Finally, the threat of the HIV/AIDS epidemic continues to deplete the Region's trained personnel.

REGIONAL STRATEGIC PLAN FOR HEALTH ECONOMICS

Vision

24. The vision of this strategic plan is that by 2015, countries in the African Region will use health economics principles and evidence to inform policy; to advocate for, justify and utilize resources efficiently, effectively and equitably within their health sectors to improve the health status of their populations and to ultimately achieve the health-related MDGs.

Mission

25. The mission of regional health economics programmes is to advise, advocate and technically support Member States on the most effective use of economics-based models in building systems, promoting equity and efficiency in resource mobilization, utilization, health financing and comprehensive service delivery. The programmes will employ a country focus and Member State approaches to define specific country priorities in collaboration with other development partners and nongovernmental organizations.

Goal

26. The goal is to evolve a culture for using health economics principles and evidence in policy-making, planning, choice of interventions and resource allocation and utilization. This will ensure maximized health benefits while reducing health inequalities and inequities in access to health promotion, prevention, curative and rehabilitative interventions within the population.

Guiding Principles

27. In order to achieve the abovementioned goal, the following principles must underpin the process of strengthening health economics capacities in countries:

- *Multidisciplinarity:* It must be multidisciplinary, i.e. involving other disciplines outside health.
- *Integration into development agenda:* It must foster integration of health issues in the development agenda.
- *Responsiveness to country needs:* It must be relevant to the different health needs and problems of each country, i.e. contribute to the formulation and implementation of policies that will support health development.
- *Efficiency and equity:* It must enhance efficient and equitable choice of interventions, allocation and use of all health resources.
- *Promotion of pro-poor policies:* It must ensure that the application of health economics evidence in decision-making enhances poor people's access to cost-effective interventions.
- *Bioethics:* It must ensure that collection, analysis and interpretation of information obtained from human beings is undertaken in an ethical manner that assures protection of the integrity and safety of all actual or potential research participants.

Objectives

28. The major objectives of the strategic health economics plan are:

(a) to support Member States to develop or strengthen health economics capacity to generate and utilize health economics evidence for decision-making and improvement of health system performance with a view to achieving the health-related MDGs, reducing disease burden, and developing long-term pro-poor health development and financing strategies;
(b) to support countries in monitoring health inequalities and inequities in distribution (by gender, race, social groups, education, income and geographical location), access and utilization of promotive, preventive and curative services;
(c) to forge regional and international partnerships for promoting, coordinating and funding health economics research and training.

Targets

29. By the end of the strategic plan period (2015),

(a) at least 50% of the countries in the Region will have at least one health economist based at the Ministry of Health;
(b) at least 20% of the countries will have included health economics in the undergraduate and postgraduate curricula for national medical, public health schools and other institutions;
(c) at least 25% of the countries will have undertaken a statistically representative national study and 50% will have undertaken other studies to monitor the impact of health sector reforms on the functions and goals of health systems;
(d) at least 15% of the countries will have generated evidence on one or more of the following: cost of health facility-based services; technical and allocative efficiency; equity in resource allocation; trade and health;
(e) all the regional priority programmes, in line with the MDGs, will have generated evidence on economic impact, economic cost and cost-effectiveness of their interventions;
(f) at least 50% of the eligible countries will have been supported to formulate (or revise) the health component of poverty reduction strategies;
(g) at least 50% of the countries will have been supported to develop comprehensive health investment plans;
(h) at least 25% of the countries will have implemented their comprehensive health investment plans;
(i) at least 50% of the countries will have institutionalized national health accounts;
(j) at least 40% of the countries will have developed (or revised) pro-poor health financing policies;
(k) the Regional Office will have facilitated the establishment and functioning of three subregional networks of health economists;
(l) at least three regional health economics centres of excellence will have been designated as WHO collaborating centres.

Strategic Thrusts

30. In order to achieve the objectives and targets listed above, the strategic thrusts will be advocacy; country capacity strengthening; support for regional health economics institutions; strengthening of mechanisms and processes which support health economics; technical support to countries; economic evidence generation and dissemination; regional linkages and networking; strengthening of the Regional Office health economics capacity; and resource mobilization.

31. ***Advocacy:*** Social marketing of the importance of health economics in health decision-making at all levels of national health systems will be an important element of the implementation of the strategy. It is necessary for cultivating, institutionalizing and sustaining national commitment for health economics capacity strengthening.

32. ***Country capacity strengthening:*** Successful application of health economics in health policy development, decision-making and management to optimize health gains from the available health resources entails availability of a critical mass of nationals trained in health economics Countries with limited (or no) health economics capacities will need to make arrangements for training of trainers who can in turn spearhead the introduction of health economics in the curricula of undergraduate and postgraduate schools of economics and public health. There would be need to create career paths for health economists, especially in ministries of health, in order to increase their retention.

33. ***Support for regional health economics institutions:*** The fifty-fourth session of the Regional Committee for Africa recommended that fellowships should be awarded to people training in regional institutions to curtail the brain drain to developed countries. The challenge of strengthening Member States' capacities in health economics entails utilization of regional health economics centres of excellence. Thus, it is in the interest of both WHO and Member States to develop collaborative strategies for ensuring sustainability of those centres that produce health economics resources for the Region.

34. ***Strengthening of mechanisms and processes which support health economics:*** Such mechanisms as the African Health Economics Advisory Committee (AHEAC), African Advisory Committee on Poverty and Health (AACPH), biennial WHO health economists workshops and occasional workshops with economists from national universities are important for evolving effective ways for strengthening WHO Member States' capacities for generating and using health economics evidence in decision-making.

35. ***Technical support:*** Adequate technical support should be provided to countries for (i) costing minimum essential packages of interventions; (ii) choosing cost-effective interventions; (iii) developing long-term health development plans; (iv) formulating the health component of poverty reduction strategies; (v) developing pro-poor health investment plans for scaling up cost-effective interventions; (vi) institutionalizing national health accounts; (vii) developing sustainable and pro-poor health financing policies and strategies; (viii) designing and monitoring the effects of health sector reforms; (ix) monitoring the technical and allocative efficiency of health facilities; (x) monitoring health inequalities and inequities in access to preventive and

curative services; (xi) monitoring the effects of MTAs on public health. Mechanisms will be put in place to make the required technical expertise available to meet country demand from the proposed networks and WHO.

36. ***Evidence generation and dissemination:*** In most cases, economic evidence provides decision-makers with compelling arguments to complement existing epidemiological information upon which decisions are made. Ideally, all the health economics technical support should be evidence-based. Whenever the available evidence is non-conclusive or conflicting, the pros (benefits) and cons (costs) of alternative courses of action should be explicitly stated for the decision-makers. Health economics evidence generation should be proactive (visionary) rather than reactive. To ensure utilization of economic evidence, health policy-makers should be closely involved at all stages of all health economics studies undertaken or commissioned by the WHO.

37. ***Regional linkages and networking:*** Existing and new subregional networks on health economics should be used to complement Regional Office efforts. Those networks should be actively pursued to enhance national health economics capacities and to undertake multicountry studies on regionally identified priority research issues.

38. ***Strengthening of Regional Office health economics capacity:*** Health economists at the Regional Office should be encouraged to plan and budget for their participation in the biennial conferences of the International Health Economists Association, and other relevant regional conferences and short-duration capacity-enhancing courses offered regionally or internationally.

39. ***Resource mobilization:*** Mobilization should be carried out at the national level through WHO country offices, advocacy among national authorities, NGOs, bilateral and multilateral agencies. At the regional level, regional economists in collaboration with AHEAC members should develop joint training and research project proposals for mobilizing funds at regional and international levels.

IMPLEMENTATION OF THE PLAN

40. At country level, the Ministry of Health should:

(a) undertake a situation analysis of the existing national health economics capacity and estimate the additional number of health economists that need to be trained;
(b) include the training of health economists in national policies, plans and budget for health human resource development;
(c) encourage and sponsor national staff to enrol in health economics certificate, short-term, diploma and degree (including online) courses offered by accredited national and international institutions;
(d) provide fellowships to appropriate nationals for post-graduate training in health economics regional institutions with a view to creating a local pool of trainers;

(e) spearhead the inclusion of health economics modules in the undergraduate and postgraduate curricula of national medical schools, public health schools and national universities departments of economics, and other institutions;
(f) compile and maintain a national inventory of health economics research undertaken by various stakeholders in the country;
(g) identify, in close collaboration with all relevant stakeholders in the country, the national priority health economics research needs;
(h) utilize, whenever available, health economists based in the country to undertake health economics research and advise on health economics-related aspects of health systems;
(i) create an enabling environment for ensuring retention of health economists within the country.

41. WHO country offices should support Member States in the performance of the functions listed above and play a leading role in advocating for training of health economists and utilization of health economics evidence in decision-making; identifying the actual and potential needs for economic evidence; promoting the use of the internationally and regionally available health economics tools; providing technical support for the generation of evidence and sourcing for external health economics support, where necessary; ensuring that nationals are involved in all health economics studies (even those undertaken by partners); disseminating health economics evidence.

42. The Regional Office should:

(a) facilitate the designation of the main regional health economics centres of excellence as WHO collaborating centres;
(b) support Member States in soliciting for training grants for nationals to train in regional health economics centres of excellence;
(c) participate in teaching and co-supervising students in the regional health economics institutions; and act as external examiners when requested by the regional institutions;
(d) provide support to regional institutions willing to set up health economics training programmes to ensure standards in curriculum;
(e) encourage regional priority programmes to budget for and undertake studies for generating relevant economic evidence;
(f) develop and update databases on regional health economics experts and research;
(g) develop a web site on health economics and update it regularly;
(h) promote sharing of health economics expertise between countries;
(i) facilitate the establishment of subregional health economics networks where they do not exist;
(j) organize a biennial conference with subregional health economics networks to share methodologies and research results;
(k) proactively generate and publish relevant evidence in regional and international journals to increase awareness of health economics, and take the lead in the establishment of an African journal of health economics.

PARTNERSHIPS FOR IMPLEMENTATION

43. To ensure implementation of the strategic health economics plan, a variety of stakeholders will be involved.

Country Level

44. In the process of identifying appropriate fellowship grantees, it will be necessary for ministries of health to involve national universities, regional health economics centres of excellence and organization(s) providing the fellowships.

45. It will also be necessary to closely involve all relevant stakeholders in the country, such as the private (for profit and not-for-profit) health subsector representatives, national universities (especially schools of economics and public health), national health research institutions, and potential funding agencies in the process of delineating national priority health economics training and research needs.

46. WHO country offices should promote development of health economics capacity at country level through advocacy with ministries of health and planning, other relevant UN agencies, bilateral and multilateral agencies situated in the country, national public and private universities.

47. Country office health economists should provide support to ministries of health in health economics capacity strengthening, economic evidence generation, advocacy for inclusion of health in development agendas, and programme design and implementation. The latter includes support for the (i) development of the health component of PRSPs; (ii) preparation of health investment plans for scaling up pro-poor interventions, (iii) design and implementation of pro-poor financing mechanisms; (iv) preparation of proposals for funding from global financial initiatives; (v) design and application of resource allocation formula; (vi) collaboration in health economics studies; and (vii) negotiations with ministries of finance and donors for support to the health sector.

Regional Level

48. The WHO Regional Office has a health economics programme with responsibility for the overall coordination of health economics in the Region. Its functions include promoting health economics as a discipline in the Region; facilitating strengthening of health economics capacity in WHO country offices and Member States; provision of back-up support to the work of country office health economists; provision of technical assistance to Member States to gather and utilize economic evidence for policy; generating and disseminating health economics evidence on regional priority programmes; facilitating designation of regional health economics institutions as WHO collaborating centres; supporting the formation of subregional health economics networks; and establishing strategic and operational linkages with organizations that support health economics.

49. In addition, the Regional Office has specific programmes focused on economics of communicable diseases, poverty and ill health, macroeconomics and health, health financing and national health accounts, and long-term health

development through which targeted technical support and backstopping are provided to countries of the Region in a proactive manner.

50. The African Health Economics Advisory Committee (AHEAC) was constituted by the Regional Director to provide advice and guidance to the Regional Office on ways of strengthening WHO Member States' health economics capacities for generating and using evidence in decision-making. Specifically, the Committee's terms of reference include advising on strategic planning, advocacy, resource mobilization, training, research, dissemination, utilization and forging of partnerships (including networking) aimed at strengthening health economics capacities in the Region.

51. The African Advisory Committee on Poverty and Health (AACPH) was formed by the Regional Director to provide advice and guidance to the Regional Office on health-related poverty reduction policies, strategies and programmes; to serve as the first audience for any newly-developed regional poverty reduction initiatives; to advise on ways of encouraging research to generate evidence for use in advocacy, choice of poverty reduction strategies and design of relevant programmes; and to evaluate health systems responsiveness to health and health-related needs of the poor.

52. The regional institutions that offer training in health economics have not yet been designated as WHO collaborating centres (WCCs). Since these institutions are represented in the AHEAC, two-year pre-designation period plans of action will be developed with them, after which they will make a formal application to the Global Screening Committee (through the Regional Research Development Committee) to be designated as WCCs. WHO will work with these regional centres of excellence to ensure their sustainability so that they can be optimally leveraged to train national health economists, provide technical support, and conduct and promote health economics research.

Global Level

53. Alliances with international agencies will be built and nurtured to support the implementation of the strategic health economics plan. These include stakeholders such as bilateral agencies (e.g. CIDA, DAAD, DANIDA, DFID, GTZ, JICA, NORAD, SIDA, USAID), multilateral agencies (e.g. African Development Bank, IMF, Islamic Development Bank), international foundations (e.g. African Capacity Building Foundation, Bill and Melinda Gates Foundation, Ford Foundation, Rockefeller Foundation), special programmes (e.g. the Special Programme for Research and Training in Tropical Diseases), International Development Research Centres (e.g. IDRC), professional organizations (e.g. the International Health Economics Association), international universities that undertake health economics research and offer health economics training.

54. With a view to strengthening Member States' capacities in health economics, WHO would collaborate with these international bodies:

(a) to mobilize training grants to enable eligible students to pursue post-graduate and short-term training health economics at the regional training institutions;

(b) to mobilize funding for researchers undertaking priority health economics research in the Region;
(c) to facilitate dissemination and utilization of health economics evidence for policy and management;
(d) to train practising general economists in health economics research methods;
(e) to provide support to countries in the development or revision of PRSPs, health investment plans, and pro-poor health policies and strategies;
(f) to provide funding for the conferences of subregional health economics networks;
(g) to forge partnerships between regional health economics centres of excellence and similar centres based in both developing and developed countries.

MONITORING AND EVALUATION

55. In order to ascertain the progress in the realization of the planned targets, monitoring will be carried out at the end of each year at both country and regional levels. Detailed evaluation will be carried out after every five years. Monitoring and evaluation will be carried out using the indicators contained in the appendix.

56. The WHO country office health economist (or national professional management officer where there is no economist) will be responsible for annual monitoring of the progress in achievement of the targets contained in the strategic plan.

57. The various Regional Office economics programmes are in charge of monitoring and reporting on the targets and interventions related to their functions. Each collaborating regional institution is required to submit an annual report indicating clearly how the training grants and research funds were administered. HEC should prepare a consolidated report using inputs from the collaborating Regional Office economics programmes, regional institutions and country office health economists. The Regional Director makes a biennial report back to the WHO Regional Committee for Africa on the progress made in the achievement of the targets.

CONCLUSION

58. This strategic plan (i) gives a justification for strengthening health economics capacity and the use of economics evidence in decision-making in Member States; (ii) provides an overview of the public health situation; (iii) makes an analysis of strengths, weaknesses, opportunities and threats; and (iv) proposes strategies and priority interventions for strengthening health economics capacities and use of evidence in Member States.

59. In order to strengthen health economics capacities in the Region, it proposes a multi-pronged strategic thrust, including advocacy; country capacity strengthening; support for regional health economics institutions; strengthening of mechanism and processes which support health economics; technical support to countries; economic evidence generation and dissemination; regional linkages and networking;

strengthening of the Regional Office health economics capacity; and resource mobilization.

60. The plan underscores the vital roles of the ministries of health, regional health economics centres of excellence, WHO and other organizations in the process of strengthening health economics capacities in the countries of the Region.

Appendix: Monitoring Indicators

Objective 1

Support Member States to develop or strengthen health economics capacity to generate and utilize health economics evidence for decision making and improvement of health system performance with a view to achieving the health-related MDGs, reducing disease burden, and developing long-term pro-poor health development and financing strategies

Targets

At least 50% of the countries in the Region will have had at least one health economist based at the Ministry of Health (MOH, WHO)

At least 20% of the countries will have included health economics in the under- and postgraduate curricula for national medical/ public health schools and other institutions (MOH, WHO)

At least 15% of the countries will have generated evidence on one or more of the following: cost of health facility-based services; technical and allocative efficiency; equity in resource allocation; trade and health (MOH, WHO)

All the regional priority programmes in line with the MDGs will have generated evidence on economic impact, economic cost and cost-effectiveness of their interventions (WHO)

At least 50% of the eligible countries will have been supported to formulate (or revise) the health component of poverty reduction strategies (WHO)

At least 50% of the countries will have been supported to develop comprehensive health investment plans (WHO)

At least 25% of these countries will have implemented their comprehensive health investment plans (MOH, WHO)

At least 40% of the countries will have developed (or revised) pro-poor health financing policies (MOH, WHO)

Indicators

Number of countries with at least one health economist

Number of countries with institutions or medical schools with health economics training at under graduate and postgraduate levels

Number of countries with reports on studies on costs of services, technical and allocative efficiencies, equity in resource allocation, trade and health

Number of priority programmes with reports

Number of eligible countries supported

Proportion of countries in Region supported to develop health investment plans developed

Proportion of countries implementing pro-poor policies

Number of countries with pro-poor health financing policies in place

Objective 2

Support countries in monitoring health inequalities and inequities in access to preventive and curative services, including differences that occur by gender, race and social groups, education and income, geographical location (including rural-urban divide), and to monitor and evaluate health interventions (including health impacts of non-health targeted policies on health)

Targets

At least 25% of the countries will have undertaken a statistically representative national study and 50% will have undertaken other studies to monitor the impact of health sector reforms on the functions and goals of health systems (MOH)

At least 50% of the countries will have institutionalized national health accounts (MOH, WHO)

Indicators

Number of countries that have taken studies on health sector reform

Number of countries undertaking national health accounts on a regular basis

Objective 3

Forge regional and international partnerships for promoting, coordinating and funding health economics research and training

Targets

The Regional Office will have facilitated the establishment and functioning of three subregional networks of health economists (WHO)

At least three regional health economics centres of excellence will have been designated as WHO collaborating centres

Indicators

`

Number of functional networks

Number of collaborating centres established