ALIGNING WHO COUNTRY OFFICES TO NATIONAL HEALTH PRIORITIES

WHO in an era of transformation

African Region

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Abbreviations

AICS	Accountability and Internal Control Strengthening Initiative
ALIMA	Alliance for International Medical Action
AMMIE	Appui Moral Materiel et Intellectuel a l'Enfant
BCP	Business Continuity Plan
BFA	Budget & Finance Assistant
BMGF	Bill & Melinda Gates Foundation
CAR	Central African Republic
CCA	Common Country Analysis
CCM	Country coordinating mechanism
CCS	Country Cooperation Strategies
CDs	communicable diseases
CL	cluster leads
CRMC	Compliance and Risk Management Committee
CSOs/NGOs	Civil Society/Non-Governmental Organizations
DFC	Direct Financial Cooperation
DFC	Direct Financial Cooperation
DHIS-2	District Health Information Software
DI	Direct Implementation
DRC	Democratic Republic of Congo
DWRs	Deputy WHO Representatives
EPR	Emergency Preparedness and Response
ERO	External Relations Officer
EVD	Ebola Virus Disease
FENSA	Framework of Engagement with Non-State Actors
FR	Functional Reviews
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPW13	13th Global Programme of Work
GSM	Global Management System
HeRAMS	Health Resources Service Availability Monitoring System
iAHO	integrated Africa Health Observatory
IATI	International Aid Transparency Initiative
IFIs	International Financial Institutions
IRC	International Rescue Committee
IST	Inter-Country Support Teams
JTMEC	Joint Technical and Monitoring Evaluation Committee
KPIs	Key Performance Indicators
LTAs	Long-Term Agreements
MCATs	Multi-Country Assignment Teams
MDGs	Millennium Development Goals
MOHW	Ministry of Health and Wellness
NCDs	Non-communicable diseases
NDoH	National Department of Health
NFPA	United Nations Population Fund
NHI	National Health Insurance
NHPSP	National Health Policies Strategies and Plans
NPC	National Planning Commission
NSAs	Non-State actors
OHSC	Office of Health Standards Compliance
OO	Operations Officer
PBs	Programme Budgets
PMDS	Performance Management and Development System
PMOs	Programme Management Officers
Pos	purchase orders
RMNCH	Reproductive, Maternal, New-born, Child and Adolescent Health
RRR	Rehabilitation, Recovery, and Reconstruction
SDGs	Sustainable Development Goals
SIDA	Swedish International Development Cooperation Agency
SOPs	standard operating procedures
SRHR	Sexual and Reproductive Health and Rights
TA	Transformation Agenda
UHC	Universal Health Coverage
UN AFPs	United Nations Agencies/Funds/Programmes
UN PMT	UN Programme Management Team
UNCT	UN Country Team
UNRC	United Nations Office of the Resident Coordinator
UNRCO	UN Resident Coordinator's Office
UNSDCF	United Nations Sustainable Development Cooperation Framework
WCOs	WHO Country Offices
WRs	WHO Representatives

Executive Summary

The Transformation Agenda (TA) in the WHO African Region, which aims to ensure a WHO capable of meeting stakeholder expectations, set the stage for the review of WHO's functions in countries. The review clearly demonstrated the need to reposition WHO Country Offices (WCOs) to respond to national priorities. These efforts have begun to show early signs of the desired outcomes in areas such as coordination and leadership, partnerships and external relations, among others.

Prior to 2015, there were numerous challenges in the health sector, with Ministries of Health off-track and WHO struggling to effectively support countries to address their challenges. The pressure to change was highlighted by the Ebola Virus Disease (EVD) epidemic in West Africa, which prompted widespread concern about WHO's response. This presented the need for a review of WCOs, which involved visits to 47 countries, with over 300 stakeholder consultations, workshops in country offices and surveys including up to 900 respondents. The principal objective of the Functional Reviews (FRs) was to ensure better alignment of WHO's workforce and operations with host countries' health situations, needs and priorities. The results highlighted health sector priorities and key stakeholder expectations, fostering recommendations which made it necessary for country offices to change their focus and double their technical expertise. The number of both national and international experts was increased by 41% and 68% respectively. This required a significant infusion of funds, to the tune of US$ 433 million, which added US$ 131 million funding gap to the existing available funding (US$183m).

Executive Summary

A Stepwise approach to address the funding challenges was proposed, starting with a minimum presence involving three functional pillars: leadership, technical support and operations. Depending on funding, WCOs would be expanded to include additional technical capacities, including sub-national presence. The implementation saw the WHO reinforce capacities in country offices with new expertise, including Health Policy and Planning Officers (35), Programme Management Officers (38) and External Relations and Partnerships Officers (36), among others. The improved capacities, in combination with other actions, resulted in the following:

Strengthened coordination and leadership – The WHO Representatives (WRs) were able to improve their policy dialogue, advocacy, convening and coordination roles. This was demonstrated in leading the COVID-19 response, but also addressing other health priorities. In South Africa for example, the WHO played an instrumental role towards Universal Health Coverage (UHC) reforms, via efforts to advance the implementation of the National Health Insurance (NHI). It also organized several high-level stakeholder policy dialogues towards achieving UHC. Some of these meetings attracted high-level representation, including the South African President and Minister of Health. The WCO, in partnership with the National Department of Health (NDoH), organized the National Colloquium on UHC and led consultations on NHI, with the summit attracting nearly 600 delegates.

Reinforced partnerships and external relations – Since capacity was strengthened, there has been a continuous increase in the number and diversity of partners. There was also an 8% increase (US$ 140 million) in available resources for the 2020–2021 biennium, when compared to 2018–2019, US$ 246 million of which was raised at country level. The External Relations Officer (ERO) deployed to Burkina Faso facilitated and coordinated the development of over 24 project proposals. During the 2018–2019 biennium, the WCO mobilized US 1.3 million at national level. However, following the engagement of the ERO, this increased (655%) to sevenfold to US$ 10.3 million in the 2022–2023 biennium. The ERO conducted over 30 bilateral engagements with donors and partners, resulting in a significant improvement in donor perception compared to three years previously. There has also been increased engagement with civil society and other Non-State actors (NSAs), through the Framework of Engagement with Non-State Actors (FENSA). This has broadened the partner base and amplified the impact of interventions at country level, as well as improved partner alignment in responding to government priorities. This resulted in a threefold increase in the number of partnerships with NSAs in the 2020–2021 biennium compared to the previous one – up from 62 to 171.

Improved technical leadership and support – WHO has provided improved technical support to countries. At various stages of the NHI Bill in South Africa, WHO submitted technical contributions which have influenced and informed several key policies in respect of health financing, strategic purchasing and service delivery of NHI. With the recently formed Multi-Country Assignment Teams (MCATs), WHO is raising the bar for improved high-level technical support. The integration of the MCATs into the WCOs has already enhanced technical support, and is helping to strengthen planning, implementation, coordination and management of country activities. This has also begun to reduce overlaps among priority programme interventions.

Executive Summary

Enhanced planning, monitoring and evaluation – The strengthened capacity enabled the creation of programme management functions, the engagement of over 38 Programme Management Officers (PMOs), and the bottom-up development of Programme Budgets (PBs) in countries. The PMOs assured alignment of country priorities with the objectives of the PBs. Placement of PMOs in country offices, coupled with the creation of implementation plans, has enhanced the coordination of Key Performance Indicators (KPIs) in the Africa Region. In Cabo Verde, for example, dissemination of information improved, with staff regularly briefed on the budget situation. Planning has also improved in São Tomé and Príncipe, with the 2020–2021 PB End-of-Biennium exercise completed early. The structure of the 2022–2023 PB was of better quality, and aligned considerably with strategic plans. The PMO has been strengthening teamwork, by encouraging improved collaboration between various programmes. As a result of these efforts, new work dynamics in communication and interrelationships between team members are emerging.

Better management practices to drive performance – Numerous transformation-related changes have resulted in better staff engagement, with an improved sense of transparency and accountability, and behavioural change. The virtual town hall meetings have now become the most effective way for the Regional Director to engage directly with WHO staff across the Region. About 65% of staff have reported experiencing tangible improvements in their day-to-day work environments since the start of the transformation initiative. KPIs indicate significant reductions in the number of overdue reports for Direct Financial Cooperation (DFC), Direct Implementation (DI), and donors. A new initiative allowed for funds to be transferred to WCO accounts within less than 24 hours, and for the digitization of disbursement mechanisms used by WCOs. A total US$ 3.7 million was saved between 2019–2021 through Long-Term Agreements (LTAs), while a further 50% was saved on recurrent operational services/consumables compared to the previous biennium. A 70% decrease was achieved between the two biennia through utilization of more competitive procurement options.

Going forward, the WHO should continue implementation to ensure the full realization of the desired objectives, which also align with the organization's five future priority objectives highlighted in the White Paper on accelerating health.

1 Contextualizing the situation

1. Contextualizing the situation

Time to act on the requisite change

Despite the progress made in certain health-related areas prior to 2015, several health challenges remained in the WHO Africa Region. There were numerous epidemics and humanitarian emergencies, an increased burden of communicable and noncommunicable diseases, health systems were struggling, and challenges to maternal, adolescent and child health remained.[1] (Figure 1.1).

Figure 1.1 A nursing mother waits with other mothers and caregivers to see a health professional

Other concerns include the "unfinished business" of translating the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs), and the perceived misalignment of functions within the WHO in the region. There were questions around the organization's technical capacity to deliver on its objectives, the management of its human resources and operations, and its readiness to meet the needs of Member States, development partners and other stakeholders in a manner consistent with its mandate.

It was within this context that the Transformation Agenda (TA) was conceived, with a view to providing solutions to these concerns, and optimally meeting the needs of WHO Africa Region stakeholders. This was expected to be accomplished via the various mechanisms of the TA, designed as a vision and strategy for change, aimed at facilitating the emergence of "the WHO that the staff and stakeholders want".[2]

1 The Transformation Agenda of the World Health Organization Secretariat in the African Region: Phase 2: Putting People at the centre of change, 2017, [Online] accessed May 10th May 2022. Available at: https://www.afro.who.int/publications/transformation-agenda-world-health-organization-secretariat-african-region-phase-2

2 The Transformation Agenda of the World Health Organization Secretariat in the African Region, 2015-2020 [Online] accessed May 10th May 2022. Available at: https://www.afro.who.int/sites/default/files/2018-03/Transformation_agenda_english.pdf

1. Contextualizing the situation

Reviewing functions of WHO Country Offices

The TA aimed to make WHO a more transparent, responsive and results-driven organization. Several measures to strengthen WHO Country Offices (WCOs) were proposed to provide leadership in health, and technical assistance in priority areas at country level. In addition, these interventions were expected to enhance WHO's operational responsiveness and expand partnerships, as well as its resource base. This would allow WHO in the Africa Region to develop into an organization with the capacity to deliver on its mandate.

It was against this background that a Functional Review (FR) of WCOs was undertaken, with a view to aligning human, financial and material resources with identified national priorities, to deliver relevant, high-quality technical advice to host governments and partners in the African Region.[3] With resources optimally realigned with country priorities, and a new way of doing business to ensure quality technical assistance and better results, the organization would be optimally repositioned to deliver on its mandate. The main objective of the FRs was to ensure better alignment of WHO's workforce and operations with host countries' health situations, needs and priorities.

The key expected results of these actions include the development of an optimal WHO workforce capable of delivering on strategic priorities, a revised structure comprising appropriate numbers of positions and competencies in WCOs, as well as improved managerial practices that promote integration to achieve the desired impact. This would enable WHO to influence health interventions in host countries, and to attract the attention of partners as well as their support to sustain country office interventions.

This document highlights how the FR process was carried out to assess the functions of WCOs, detailing approaches and key expectations of various partners, and how crucial challenges encountered were overcome in an effort to align WCOs with national health priorities. It also revealed vital early results of the FR changes in relation to strengthened coordination and leadership, improved technical support, reinforced partnership and external relations, including the change in the resource mobilization narrative in countries, as well as country examples of demonstrated results. It concludes with the next steps going forward.

3 Delivering at Country Level: Update on the Functional Reviews of WCOs in the AFR Region – Aligning WHO Country Offices with Country Priorities (Internal document)

2 Functional Review approaches

2. Functional Review approaches

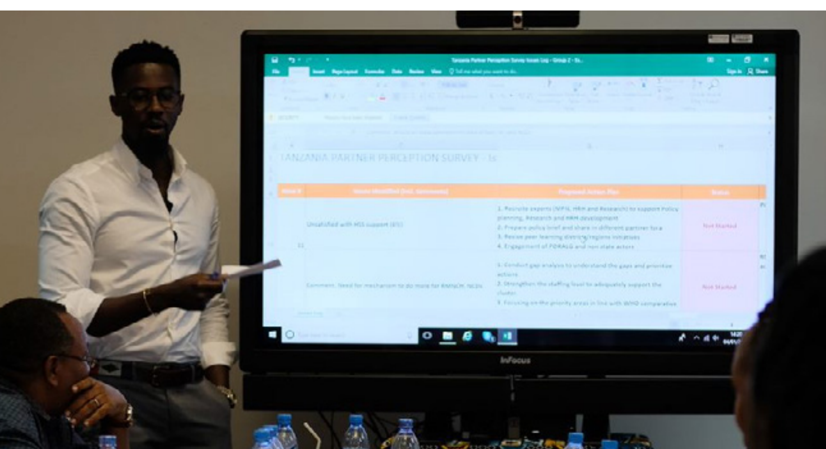
Stakeholder consultations

The aim of the FRs was to ensure a well-resourced and consistent country presence that aligned with host countries' requirements to improve healthy living, achieve "Health for All", as well as prepare, detect and respond to public health emergencies.[4] The FRs of the 47 WCOs were conducted between 2017 and 2019, and included detailed needs analyses to enable WHO to deliver on its core mandates, including expectations of its stakeholders. (Figure 2.1)

Figure 2.1 Functional Review stakeholder consultations in Tanzania

The reviews comprised over 300 detailed consultations with all stakeholders, carried out by a multidisciplinary team. Governments were represented by senior Ministry of Health leadership and some sectoral ministries, who discussed their expectations of WHO. Other participants included a wide range of partners, including UN country teams, donor agencies, academic institutions, bilateral partners and civil society organizations. This allowed WHO to gain a deep understanding of partner perceptions, country priorities and their expectations of the organization across the region.

Figure 2.2 Reviewing the partner perception survey during one of the Functional Review sessions



Each WCO also hosted comprehensive staff workshops on aligning operations with country priorities. A Steering Committee comprising Regional Office directors, senior staff and representatives from WHO headquarters in Geneva was constituted, to provide inputs to inform the rollout of recommendations. Lastly, an anonymous survey was conducted to obtain honest feedback on expectations of WHO in all countries, which received over 900 responses. All information and feedback from the various stages of the process were collated and utilized as the premise for recommendations to be implemented subsequently. (Figure 2.2)

4 Strengthening WHO African Region country offices' capacity through the implementation of the Functional Review recommendations.

2. Functional Review approaches

Fine-tuning the process

A phased approach to the FR process was adopted, starting with four pilot countries.[5] Taking the lessons learned during the process, the aim was to fine-tune and improve the FR process as it progressed. The operational guidelines and methodology were also revised to incorporate lessons from the pilot countries. In addition, a mid-term assessment was conducted to appraise the relevance of key elements of the FR approach. Other areas for assessment included the extent to which it was achieving the desired result, while helping to identify best practices, key gaps and challenges. It concluded with recommendations for quality improvements of future FRs.[6]

The findings revealed that the FR process was adjudged to be timely and well-received by stakeholders, including WRs, country office staff and other interviewees. The mid-term assessment highlighted several achievements, including the production of effective communication and comprehensive operational guidelines, among others. It also highlighted issues such as the unease amongst staff, the need for more time to adequately prepare for country visits, and requirements for a review of the implementation plans to ensure they are concise, and include clearly articulated actions.

Specific recommendations followed. These included strengthening individual steps and governance of the FR process, enabling the project team to function more effectively, and increasing support for WRs and country offices towards change management. Others were the need to ensure adequate consideration of resource mobilization and financing aspects of the review process. The information provided by the mid-term assessment was utilized to further improve the FR process, enabling significant improvements in the second part.

Outcomes of stakeholder consultations

The primary outcomes of the FR consultations have been the articulation of crucial health sector priorities, as well as expectations of WHO by Member States and partners on health-related challenges and difficulties in the region, along with ways to effectively mitigate these.

Highlighted health sector priorities

Health sector coordination for concerted action to address causes of the high burden of disease and mortality from communicable diseases (CDs) and non-communicable diseases (NCDs) emerged as a major priority, as did the need to address the causes of maternal and child ill-health and mortality, and the use of information and evidence to guide interventions, resource allocation and evaluation of impacts from implemented interventions.

5 Togo, Senegal, South Africa, South Sudan
6 Mid-term assessment of the functional reviews of WHO country offices in the African Region, 2018

2. Functional Review approaches

The need to build health systems capacity (governance, financing, functionality of district health teams and other elements) was also highlighted, together with the need to strengthen preparedness and response to health emergencies, promote multisectoral approaches to health care, and to improve corporate communication.

Key stakeholder expectations from the WHO

The key expectations by Member States and partners, including donors, in the region were for WHO to strengthen its leadership role in building partnerships, coordinating partner interventions, engaging stakeholders, priority setting, brokerage for health, and the generation and sharing of health information to inform interventions. Another was the improvement of its technical support, although this varied between countries, in line with the organization's core mandate.

However, each group of stakeholders had a slightly different set of key expectations. While governments specifically expected WHO to improve the quality of its technical support to address essential technical priorities, the donor group called for increased capacity for coordination, provision of health information, and brokerage with a view to improve donor relations. The Civil Society/Non-Governmental Organizations (CSOs/NGOs) asked for better WHO guidance, leadership, brokerage and coordination, while the United Nations Agencies/Funds/Programmes (UN AFPs) sought greater integration of WHO into the UN system. (Figure 2.3)

Figure 2.3 Key quotes on what Member States expect and partners' perceptions of the WHO

UNCT

"[We expect WHO to] aggressively promote the One Health Approach and coordinate related efforts."

Donor

"WHO doesn't communicate much public health information."

Member State

"[We expect WHO to] engage a big percentage of civil society in all processes and to strongly collaborate and partner with civil society organizations."

3 Meeting stakeholder expectations

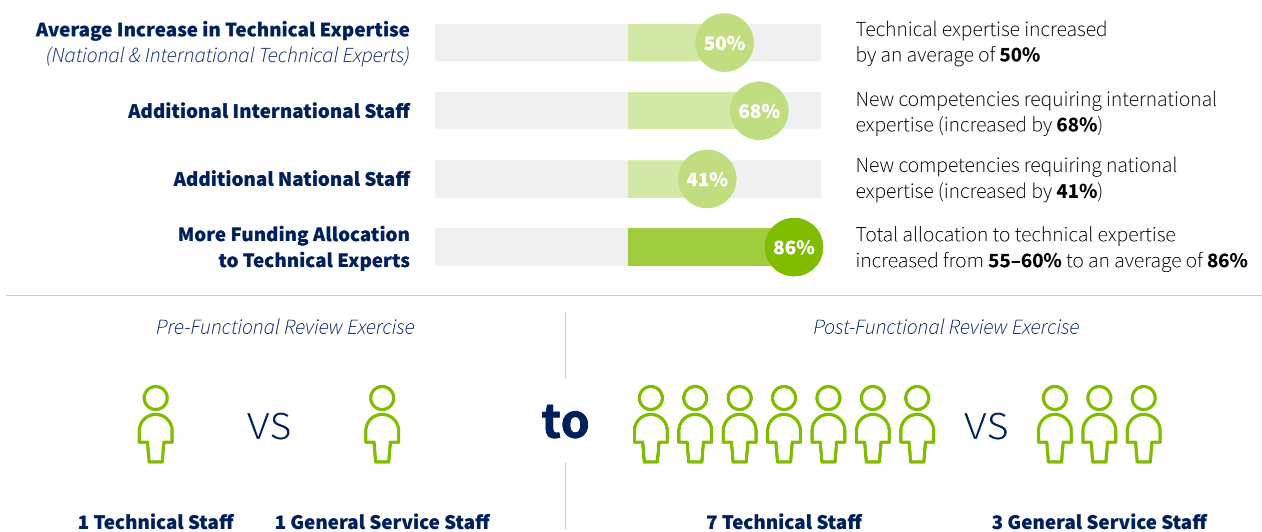
3. Meeting stakeholder expectations

Becoming fit-for-purpose

Meeting expectations of Member States and partners in the African Region requires a change in the focus of country offices, including engaging new talent with essential competencies, improving aptitude for current staff and modifying operational procedures to enhance efficiencies. This requires the engagement of new personnel with international experience, and a significant overall increase in staff numbers in most WCOs. As a result, a new configuration of WCOs was defined and approved, with a view to enabling WHO to become fit-for-purpose to meet these expectations and priorities.

The new technical and general service staff quota needed to be proportionate to country contexts, priorities, and the need to ensure operational efficiencies and effectiveness. This resulted in an average increase in the number of both national and international experts, from 719 to 1015, and 294 to 493 respectively, translating to a 50% increase in the number of technical experts. This changed the ratio of technical to general service staff from about 1:1 (pre-FR) to 7:3 afterwards. (Figures 3.1 and 3.2)

Figure 3.1 The human resource implications as per the requirements post-Functional Review



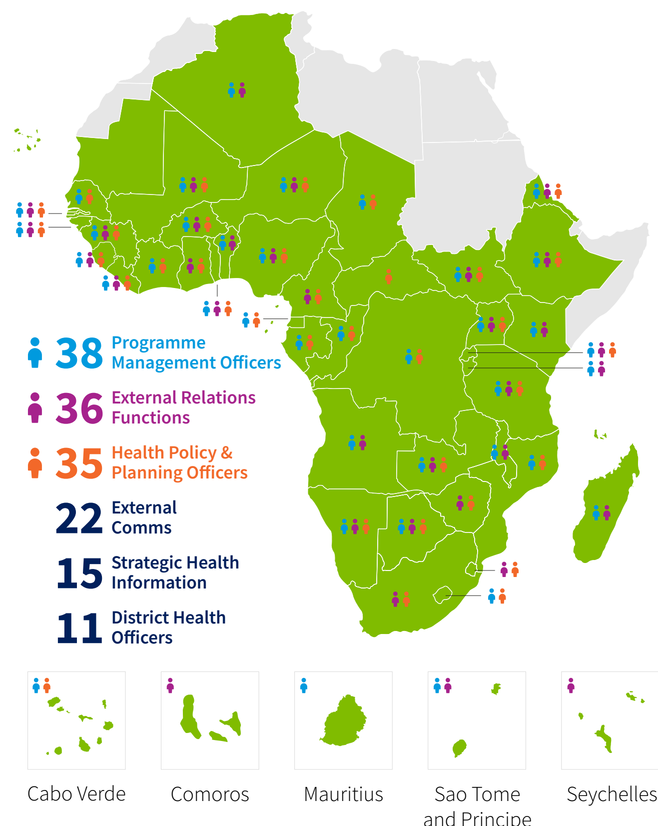
However, the competencies recommended for general service staff ensured that accountability and compliance functions were not compromised, with the general service staff structure reflecting individual country risk analysis. The proportion of funds allocated to technical experts increased from about 60% to 86%. The significance of this was that more funds were made available for technical support, without compromising accountability and compliance, thereby achieving more with less.

Staffing country office structures with new competencies

WHO has been placing various functional capacities in each of the 47 Africa WCOs to provide leadership support in External Relations and Partnerships (36), External Communications (22), and Strategic Health Information (15). (Figure 3.2)

3. Meeting stakeholder expectations

Figure 3.2 Indicates strengthened capacities for WHO functions in countries

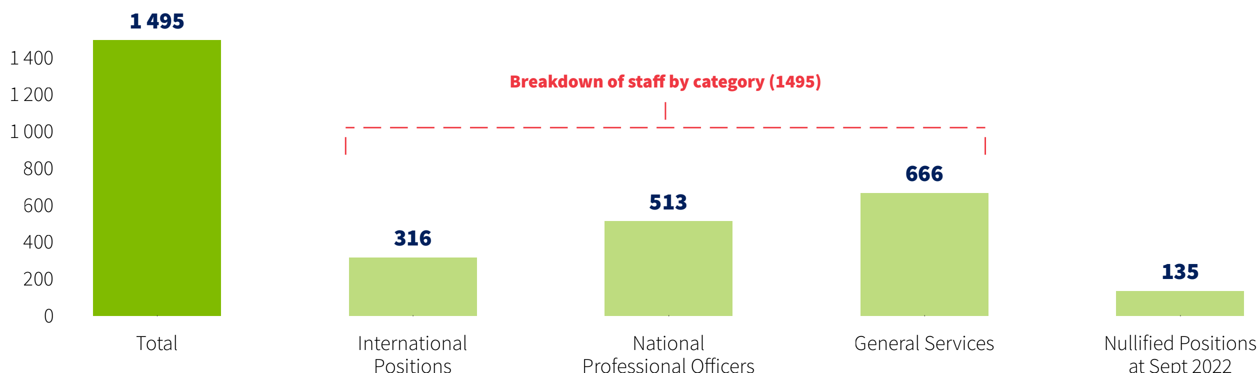


Others are Health Policy and Planning (35), District Health Officers (11), and Programme Management (38), which has enhanced WHO's credibility and trust, improved partner engagement and communications, while concurrently bolstering the quality of the UN's response to the COVID-19 pandemic in countries. Despite the huge effort to place capacities, implementation progress in countries has been slow and inconsistent. Funding and other constraints are impeding WHO's ability to provide all the required capacities.

Realigning existing staff to the new structures

Responding to the expectations of stakeholders also resulted in the review of job descriptions of positions occupied by staff members. In addition, staff positions that were performing functions not reflected in the new structures became redundant, and needed to be terminated. The need to match existing staff to positions in the newly-approved structures became necessary. A matching committee was set up to oversee the process. A total of 1495 staff were considered for matching to fill the approved, funded positions. Proposals for the matched positions were received from all the 47 WCOs, and subsequently approved. (Figure 3.3)

Figure 3.3 Existing staff considered for matching and category breakdown



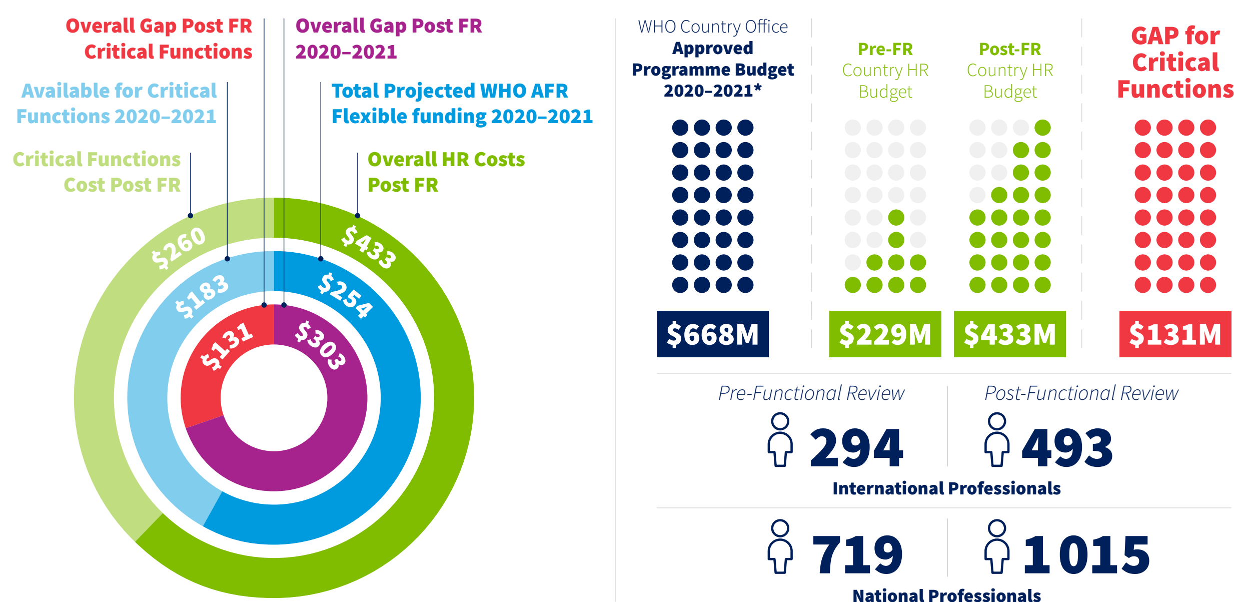
3. Meeting stakeholder expectations

The staff members not matched to any position in the new structure had to be separated. By the end of September 2022, 135 notices terminating positions had been issued in 42 of the 47 WCOs. The separation process was completed at the end of 2022 and respected staff rights in accordance with the WHO Staff Regulations and Rules.

Funding as a critical challenge

The approval of the new structures necessitated increased funding to the tune of US$ 433 million. This added an additional US$ 131 million to the funding gap on available resources (US$ 183 million), essential for placement of new competencies and capacities required for critical functions in countries to deliver on priorities, and to improve WHO's overall country focus. (Figure 3.4)

Figure 3.4 Shows the differences in both human resources and funding requirements, with funding gaps, for pre- and post- Functional Review scenarios



*The approved Programme Budget 2020–2021 for AFR Country Offices (excluding Polio, Special programmes, and Emergency operations and appeals) is $688 million for base programme; 2. Post functional review cost remains **within** the **approved Programme Budget 2020–2021**; 2. Biennium Figures in Million*

Although some progress has been made in meeting the staffing needs of the WCOs through recruitment and the matching exercise, progress is slow. WCOs have struggled to fully implement the approved structures due to lack of adequate funding to fill all the new positions, while covering the cost associated with existing staff liabilities. The slow implementation of the transformational changes posed a serious threat to the implementation of the functional changes in the short term, but also to the delivery of the 13th Global Programme of Work (GPW13) and the Sustainable Development Goals (SDGs) in the longer term. It also increased levels of disappointment, stress and anxiety among staff, and could raise WHO's reputational risk should stakeholder expectations not be met. This, in turn, heightens the risk of donors shifting their interests and contributions away from the organization. It was therefore imperative to find ways to overcome the funding challenge facing WCOs. It is also worth noting that all these changes were taking place in the background of the COVID-19 pandemic response, and the ramp down of polio activities.

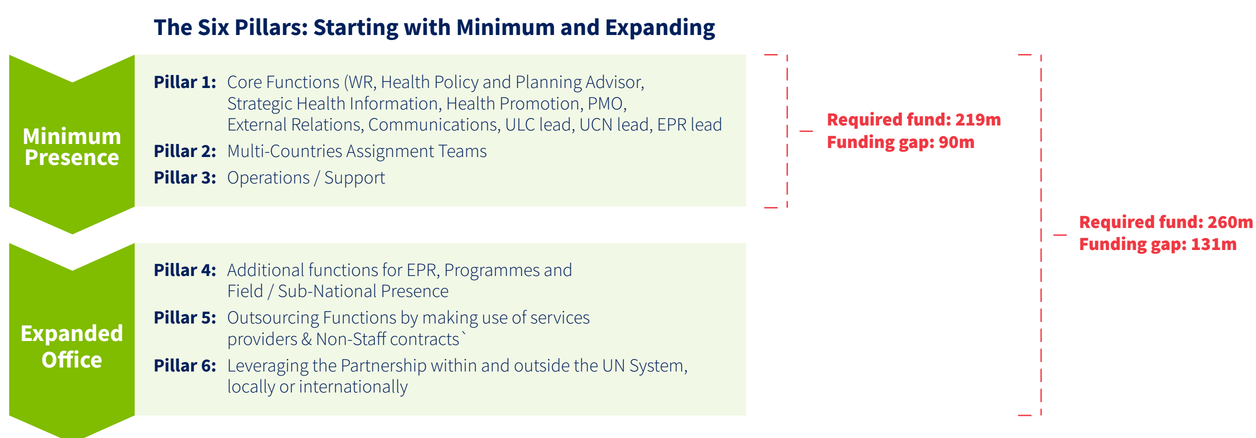
3. Meeting stakeholder expectations

Rethinking the implementation using a STEPwise approach

A STEPwise and transitionary approach was proposed to address the funding challenges. This involved categorizing functions identified for WCOs to allow for prioritization of funding and institutionalization of functions, based on availability of resources.

The approach comprised six pillars for each WCO, starting with a minimum presence involving three pillars, including Core Functions, Multi-Countries Assignment Teams (MCATs) and Operations/Support, (Figure 3.5)

Figure 3.5 The STEPwise model and funding requirements and gaps for minimum presence, plus expanded office, to address the implementation funding shortfall



Depending on funding availability, WCOs would subsequently be expanded to cover additional functions for Emergency Preparedness and Response (EPR) programmes, and field/subnational presence. The STEPwise approach encourages the outsourcing of functions, making use of service providers and non-staff contracts, as well as leveraging partnerships within and outside the UN system, locally or internationally. It was envisaged that the STEPwise approach would facilitate a speedy implementation progress.

Essential areas of focus

Five key focus areas were prioritized to reinforce WHO's functional capacities in countries. These were: Strengthening of health sector coordination and leadership; External relations and partnerships; Planning, monitoring and evaluation; Better management practices to drive performance; and Improved quality of technical leadership and support, including through the MCATs.

Overall, the drive to accelerate reform at country level through these focus areas was expected to address the misalignment between stakeholder expectations, country priorities, and WHO's capacity to deliver in these areas. In addition to WHO's contributions, donor funds served as a catalytic resource to position the technical experts to help WHO deliver effectively on its mandate, and rebuild trust and confidence in WHO as a health leader in all countries. This comprised the engagement of new staff in areas where capacities were inadequate or absent. The aim was to strengthen the WCOs' capacity to carry out the functions essential to improve their ability to meet stakeholder expectations and priorities. This would help maintain healthy gains from previous years, while driving progress towards achieving UHC and the SDG targets.

3. Meeting stakeholder expectations

To help reinforce capacities, co-financing from WHO, along with about US$ 20 million in seed funding from donors including the Swedish International Development Cooperation Agency (SIDA) and the Bill & Melinda Gates Foundation (BMGF), has been utilized to institutionalize key enabling functions. This will support WHO Representatives (WRs) to deliver the coordination and leadership function.

Strengthening health sector coordination and leadership

The implementation of the WHO functional transformation of WCOs aimed to strengthen WHO's leadership role in the health sector at country level. This included coordination, priority setting, brokerage, policy dialogue and the use of evidence in the definition and implementation of national health agendas. In addition, deputy WRs were deployed to two of the large countries in the region, while a third is in the process of being deployed. It was expected that the strengthening of the WHO leadership would have the desired impact on health in these countries.

To further its support to WRs to strengthen leadership capacity in countries, WHO in the Africa Region has improved its quarterly reporting system. This will enable WRs to regularly demonstrate leadership capacity, and report achievements, progress, challenges and lessons learned. The new platform is a simplified, online system which allows WRs to report leadership results in key areas such as strategic health leadership, diplomacy and advocacy, coordination of demand and results-driven technical assistance, as well as operational management and accountability. With this new platform, WHO can track its health sector leadership performance in countries, measure trends, identify good practices that can be adopted across the region, and identify any need for support to enhance leadership.

Reinforcing capacities for partnership and external relations

The nature of WHO's work requires extensive interaction, engagement and collaboration. One of the vital areas of focus for the Transformation Agenda was to improve effective communication and partnership. The intention was to foster a more active organization with the capacity for effective interaction internally, and externally with stakeholders. Internally, this included the entire WHO workforce and externally, Member States, development partners, donors and a wide variety of other stakeholders. The aim was to boost internal communication between and across all three levels of the organization, the country, regional and head offices. It was also expected to reinforce external communication and strengthen strategic partnerships, while facilitating improved communication of the organization's work through proactive engagement with regional and global media.

In fact, during the FR consultations with stakeholders, donors highlighted that WHO does not communicate sufficient public health information, while Member States requested more engagement. One indicated that WHO should "engage a big percentage of civil society in all processes and strongly collaborate and partner with civil society organizations". Following the consultations and recommendations, 36 External Relations and Communication officers have been engaged to reinforce capacities in WCOs. This is expected to contribute to strengthening partnerships, external relations and communication functions.

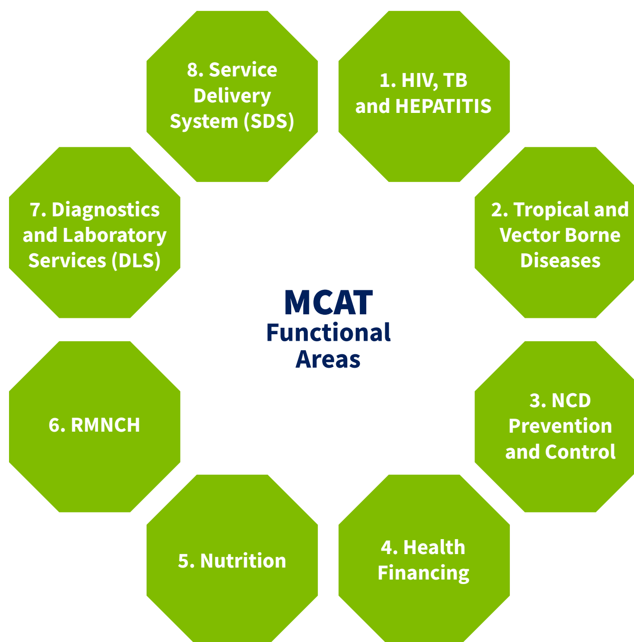
3. Meeting stakeholder expectations

Improving technical leadership and support

One of WHO's key functions is to provide technical leadership and support at country level, with contributions from the Regional Office and headquarters, depending on the context, complexity and scale of support required. However, the fundamental thrust of the improvement in technical leadership and support provided by WHO was achieved via the MCATs. These new teams were formed to provide high-level technical health support to countries in an integrated manner. The MCATs will also help implement strategies aimed at achieving programme goals, so contributing to GPW13. It was expected to be a cost-effective solution for countries to receive high-level technical support in critical programmatic areas, even if they could not "afford" to recruit country staff. This was a key area of need in countries. The additional higher calibre technical experts will cover a smaller number of countries than the former Inter-Country Support Teams (IST) arrangement, thereby providing more exhaustive, dedicated support. Supporting fewer countries will facilitate more constant engagement with national teams and technical agencies, to implement programmatic priorities.

The MCATs approach initially commenced with six areas[7], and has since been expanded to eight functional areas.[8] (Figure 3.6) Five of the technical areas constitute the major causes of morbidity and mortality in the region, which must be addressed to achieve GPW13 objectives, and to contribute to the SDG targets.

Figure 3.6 The current Multi-Country Assignment Teams (MCATs) functional areas



7 HIV / TB / Hepatitis, Tropical and Vector Borne Diseases, Non-Communicable Diseases Control, Health Financing, Nutrition and Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH).

8 Added two more areas which are Diagnostics and Laboratory Services (DLS) and Service Delivery System (SDS).

3. Meeting stakeholder expectations

Enhancing planning, monitoring and evaluation

Preceding the TA, prominent identified concerns within WHO in the African Region included inadequate planning and, in some instances, absence of proper implementation, monitoring and evaluation. These were identified as critical challenges within clusters and WCOs. However, it was the change ushered in by the TA that prompted the creation of the Programme Management function. This aimed to enhance the capacity of WCOs to coordinate programme management processes, such as strategic and operational planning, programme budgeting, resource allocation, implementation monitoring, evaluation, and reporting. This also included contributing to resource mobilization efforts, while ensuring strict adherence to organizational guidelines and standards to support countries to achieve health and development goals. (Figure 3.7)

Figure 3.7 Participants of a UN planning retreat in São Tomé and Príncipe with PMO representing WHO during the event

In addition, existing tasks being performed by Programme Management Officers (PMOs) were being shared amongst Operations Officers, Health Systems focal points and other programmes, depending on the country context and skills mix within WCOs. This resulted in some weaknesses that can partly be attributed to the deficiency observed in planning, monitoring and evaluation in the region. However, the placement of 38 PMOs in several countries has infused the necessary drive and competence. For example, programme management functions have now been streamlined and are being delivered effectively, in a timely manner.

3. Meeting stakeholder expectations

Better management practices

Several changes have been introduced across the WHO African Region at regional and country levels. These range from better staff engagement to improved transparency, accountability and risk management. Others include the introduction of the results-based framework (RF), coupled with managerial Key Performance Indicators (KPIs). There were also changes made to the management of finances, along with improvements in procurement practices, among others. This was aimed at increasing efficiency, effectiveness and achieving gains from synergy that will simplify operations but also save time, and ultimately costs.

4 Early results

4. Early results

Although the implementation process remains ongoing, efforts are being made to accelerate reforms and there are early signs of positive results, especially in areas where changes have been completed or are in advanced stages of implementation. These changes are beginning to demonstrate progress and, in some cases, the intended outcomes and impacts. Five key areas are highlighted in Figure 4.1 below.

Figure 4.1 Key areas which have already demonstrated early results of the implemented changes

There are also other outcomes worth noting. The fit-for-purpose structures arising from the African Region's FR of WCOs informed the definition of country office models, as part of the global transformation of WHO. Furthermore, the FR process has been adopted by the East Mediterranean and the European regions of the WHO, in modified forms.

4.1. Strengthened coordination and leadership

Enhanced partner coordination and policy dialogue

A health sector partner and donor coordination mechanism has been put in place in 45 (96%) countries in the Africa Region, resulting in better alignment of government and partner investments in health. This has also fostered better collaboration with Member States. (Figure 4.1.1)

Figure 4.1.1 WHO Country Office and Ministry of Health Lesotho participants at their annual retreat

In a recent health sector survey which included Member States, partners and donors, 96% of respondents reported that WHO has supported capacity building of health-related government organizations in a variety of health areas. These include policy and planning, services delivery, financing, human resources for health, monitoring and evaluation, as well as quality assurance, through daily contact and collaboration. These have improved health governance in several countries within the region. Support in health financing was a frequent request received from several countries.

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For example, WHO in South Africa has been playing an instrumental role in the Universal Health Coverage reforms through the National Health Insurance (NHI) Bill, and recently placed capacities, including a Health Systems adviser, in the WCO in that country. (Figure 4.1.2) This has enhanced WHO's coordination and leadership role in the health sector to strengthen health systems towards the realization of UHC. South Africa has been struggling to tackle various burdens of disease, with UHC still far from becoming a reality, despite being enshrined as a basic human right in South Africa's Constitution.

Figure 4.1.2 A WHO Health Systems adviser engaging civil society and partners in the build-up to a high-level meeting on UHC in 2019

This is partly due to inequitable health financing, with duality of health systems operated by both public and private sectors continuing to exacerbate inequities. This flawed financing model has resulted in 50% of total health expenditure on services benefiting only about 16% of the population working in the formal sector, who are covered by private health insurance and, in some instances, subsidized by the government. With the remaining 84% compelled to rely on largely inadequate public health facilities, many people are left with no or limited access. In the worst-case scenario, they have no option other than to forego health services altogether, raising the urgent need for an effective NHI system.[9]

Recognizing these challenges, the South African government initiated the process of establishing an NHI system, with the aim of ensuring UHC through improved access to good quality health services, while providing financial risk protection against rising health care costs. It intends achieving this by the pooling of financial resources under a single NHI fund, coupled with strategic purchasing of health services from both the public and private sectors.

Figure 4.1.3 Dr Owen Kaluwa, WHO Representative, with Minister of Health Dr Zweli Mkhize, on UHC Day in 2019

To advance these objectives, WHO organized and participated in several high-level stakeholder policy dialogues, not only for advocacy purposes but to also progress the achievement of the UHC agenda. Some of these dialogues attracted high-level representation, including the South African President and Minister of Health. WHO also facilitated the engagement of South African civil society groups in the UHC Steering Committee discourse. This engagement of civil society

9 R. Narwal (2022) Strengthening national efforts for Health systems strengthening to attain universal health coverage (UHC) in South Africa, WHO HSS South Africa Country Office.

4. Early results

sharpened advocacy efforts, prompting the signing of a political declaration prioritizing UHC by South Africa's President at the UN in September 2019.

The WCO, in partnership with the National Department of Health, also organized the National Colloquium on Universal Health Coverage in South Africa to commemorate UHC Day in 2019. (Figure 4.1.3) This conference mobilized high-level political leadership and global experts, who were instrumental in advocating for UHC and NHI in South Africa.

The WCO also supported the National Planning Commission (NPC) to organize a high-level UHC round table in Pretoria, to engage key stakeholders and identify ways to accelerate UHC-related health reforms in South Africa over the following five years. Various experts, including the Director Health Systems at WHO in the African Region and others from the WCO, shared learnings on global best practices and experiences in UHC implementation, while the WCO provided support on NHI, UHC and health systems strengthening in South Africa. Progress made in the rollout and implementation of the NHI and related health systems reforms in South Africa since its inception was also reviewed, and there were discussions to identify bottlenecks, underlying constraints and opportunities, and potential options for implementing NHI and systems reforms towards UHC in South Africa. The solution-oriented ideas collated at the round table informed the development of a framework for accelerating UHC in South Africa.

Leading consultation on National Health Insurance

WHO has taken a leadership role on UHC-related policy reforms in collaboration with South Africa's Presidency and Health Ministry, organizing a Presidential Health Summit in 2018 to deliberately highlight health sector challenges, and to collectively create a solution-oriented road map to accelerate the country towards UHC via the implementation of NHI. It was an unprecedented event which attracted the highest levels of political leadership, including the President and several ministers beyond the health sector, enabling direct engagement with UHC stakeholders. The summit brought together nearly 600 delegates from across the spectrum of stakeholders, from national and provincial departments of health, national planning, monitoring and evaluation, as well as the Treasury. Other participants included representatives of UN agencies, academia, NGOs, civil society, the private health sector and various labour unions. (Figure 4.1.4) The summit provided a unique opportunity for key stakeholders to exchange views on ways to significantly improve South Africa's health care system, to ensure that UHC becomes a reality for its people. The summit closed with all stakeholders unanimously agreeing on the need for NHI and for a unified health system to achieve UHC in South Africa.

WHO provided critical technical support for the successful organization of the summit, with a keynote video message from WHO Director General, Dr Tedros Ghebreyesus, and a critical presentation on "International experiences and lessons in health financing and systems performance" delivered by Dr Joe Kutzin, from WHO headquarters.

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Figure 4.1.4 Deputy President Mr David Mabuza addressing the Health Leaders in the opening session of the 'Presidential health Summit' Oct 2018

Deputy WHO Representatives making a difference in countries

The responsibilities of Deputy WHO Representatives (DWRs) include the coordination of technical support to promote synergies among programmes, by providing direct oversight to technical clusters. DWRs also represent WHO as technical advisers in the joint work with UN agencies and other partners on a wide range of health priorities. WHO has recruited DWRs and deployed them to Ethiopia and Nigeria. The DWR deployed to Ethiopia coordinated the health sector's involvement in Rehabilitation, Recovery, and Reconstruction (RRR), and actively worked with that government to develop policies and guidelines using the findings of HeRAMS (Health Resources Service Availability Monitoring System) research carried out in selected regions. The DWR was also on ground in drought-stricken areas to help assess the impact on the continuity of delivery of essential health services. This led to the development of SOPs for emergency response in Ethiopia.

In Nigeria, the DWR advocated for the implementation of health priorities such as COVID-19 vaccination in States and Local Government Areas, in collaboration with various stakeholders. The DWR led the development and implementation of the COVID-19 vaccination strategy across States, in partnership with high-level Sokoto State leadership, which elevated the State's performance from the bottom five to the top 15. The DWR also engaged health officials of the 36 States on other health priorities with a view to strategizing to ensure continuity of health services delivery.

Strengthening health information platforms to lead with evidence

To enhance WHO's capacity to generate information and evidence to guide interventions, resource allocation and evaluation of results in Africa, 15 strategic health information officers were engaged in countries to strengthen the generation and sharing of health information to meet the expectations of Member States, partners and donors. Other interventions included the harmonization of the Digital Health Platform (DHP), standardization of the process for health sector monitoring and review, the creation of an integrated Africa Health Observatory (iAHO) architecture together with the National Health Observatories (NHO), and the formation of a regional Health Data Collaborative network. These have collectively acted as enablers for data generation, analytics and knowledge products. (Figure 4.1.5)

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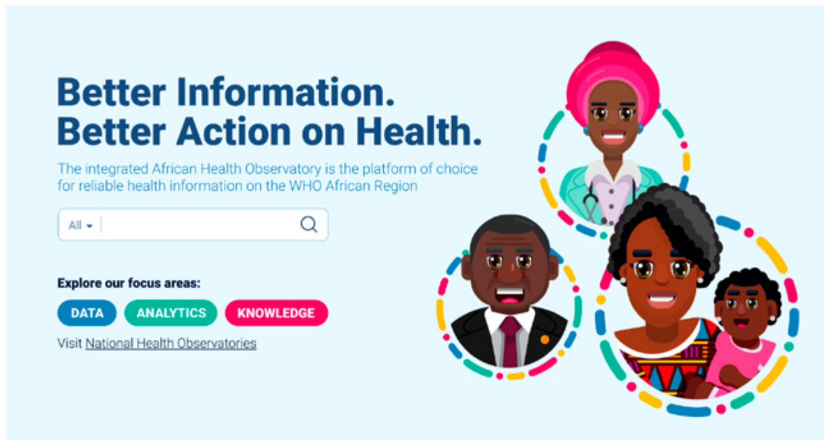
Figure 4.1.5 Part of iAHO interface on its website, indicating the type of information that is available



This strengthened capacity has enabled WHO to provide support for national cause-of-death mortality surveillance in hospitals and communities, as well as expanded the second-generation District Health Information Software (DHIS-2) and its utilization as a harmonized data management platform. The publication of the 2022 Atlas of Health Statistics also helped improve disease surveillance, alongside the provision of health services.

The facilitation of data analyses has highlighted the various drivers of health inequities in over 25 countries, promoting a deep understanding of the state of UHC in countries in the region. It also greatly assisted with COVID-19 monitoring during the pandemic, especially providing insight into COVID-19 patterns in all 47 countries to inform interventions, including frontline readiness for COVID-19 response in 14 countries. Further results included the provision of essential services in 46 countries, SDG 3 progress reports and tracking in over 17 countries, with assessments of health systems functionality, among others.

Finally, knowledge products like fact sheets on UHC, malaria, tuberculosis, cervical cancer and nutrition were produced, while the design and maintenance of a health facility master list for the region, COVID-19 information hubs, country health policy briefs, and country and regional peer-reviewed publications, was advanced.

Improved intersectoral collaborations

WHO has led health partner forums to promote multi-stakeholder and partner coordination in several countries. The recent functional changes have further strengthened coordination and intersectoral collaborations with several groups of stakeholders, such as Ministries of Finance, Education, Trade, Rural Development and Water Resources, among others. This has prompted an “All Government Approach to health”, as demonstrated by the collective approach utilized for COVID-19 interventions at the peak of the pandemic. Likewise, it has strengthened national and sub-national health systems response in delivering COVID-19 vaccinations, vaccine safety surveillance, and laboratory services. (Figure 4.1.6) It also helped maintain the continuity of essential services delivery during the pandemic, via preparedness and response planning, tracking of essential health services using key indicators, as well as advocacy and ensuring coordination between key stakeholders.

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Figure 4.1.6 A man being vaccinated against COVID-19

WHO has led the development of the UN's One UN Response Plan to COVID-19, based on a multisectoral approach building on the strengths of various UN agencies. Its coordination of the UN response plans, and resource mobilization efforts, has strengthened the UN's coordinated response. WHO also led the development of the UN Business Continuity Plan (BCP), infection prevention and control guidelines in UN workspaces, clinical care pathways for UN staff and dependents, the establishment of testing facilities at the International Organization for Migration (IOM), the facilitation of vaccination campaigns for UN staff, and the regular provision of technical updates and advice to the UN Country Team (UNCT) and the UN Crisis Group. This was highly appreciated by the United Nations Office of the Resident Coordinator (UNRC) and heads of agencies.

4.2. Reinforced partnerships and external relations

The strengthening of external relations capacity has prompted an ongoing increase in the number and diversity of partners, including International Financial Institutions (IFIs), multilaterals, semi-flexible funding, and access to new sources of funding such as the Peace Building Fund, with a significant rise in return on investment. There was an increase of over 8% in resources available for expenditure in the region for the 2020–2021 biennium (over US$ 1.78 billion) compared to 2018–2019 (over US$ 1.64 billion). Up to US$ 580 million was raised for the COVID-19 response in the 2020–2021 biennium, over 40% (US$ 246 million) of this at country level. The strengthened WCOs are also demonstrating increased collaboration and interaction with stakeholders. In addition, greater accountability, quality and timely reporting to partners has been observed. For example, the number of overdue reports decreased from 7% to 4% since January 2021. This has helped maintain strong relationships, fostering trust among partners by demonstrating a high level of accountability.

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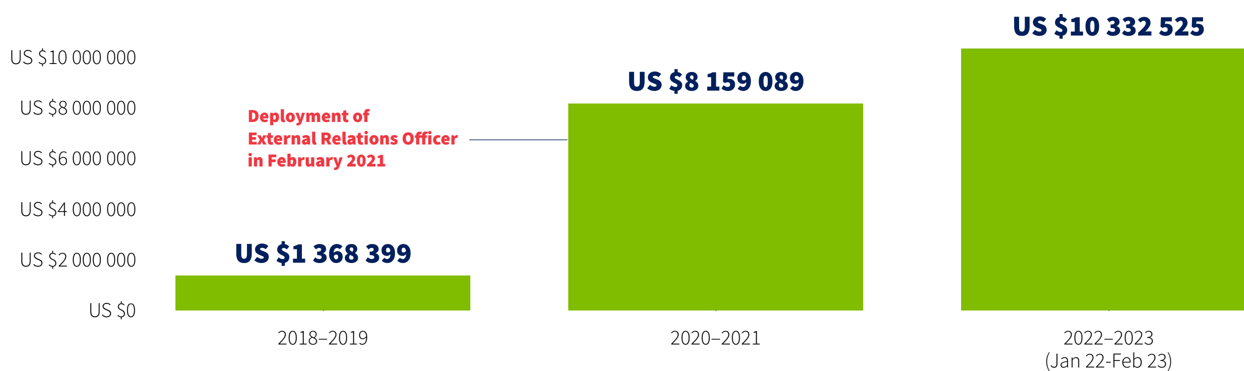
Preceding the regional transformation, for example, there was no designated officer specifically responsible for external relations in Burkina Faso. However, the structural changes that followed the FR in WCOs resulted in the recruitment of several EROs across the region, one of whom was deployed to Burkina Faso at the beginning of February 2021. The ERO has started to demonstrate the significant difference this position can make in terms of improved resource mobilization and donor perception, and robust partner engagement in the country.

Effective mobilization of resources

Resource mobilization was an area where improved outcomes were observed in Burkina Faso. These can be attributed partly to the creation of the ERO position, in combination with several other transformation-related efforts in the region. One of the major impacts of the ERO has been the facilitation and development of over 24 project proposals, which have positively influenced resource mobilization. During the 2018–2019 biennium, the Burkina Faso WCO mobilized US$ 1.3 million at the national level. However, in the 2020–2021 biennium, following the deployment of the ERO, the amount mobilized increased to US$ 10.3 million. This represents a growth of 655%, or a sevenfold increase in 2022-2023 biennium compared to the 2018–2019 biennium. (Figure 4.2.1) This does not only demonstrate a substantial improvement, but also highlights the significant difference made by the work of the ERO. In the same vein, preliminary data over the last fourteen months (January 2022 to February 2023) of the 2022–2023 biennium appear to be following the same trend, with over US$ 10 million already mobilized, and further increases expected by the end of the biennium.

Figure 4.2.1 Showing key data on the resources mobilized in Burkina Faso between 2018 and 2022, demonstrating the significant effect of the changes made as a result of the creation of a dedicated External Relations Officer position



In addition to the resources mobilized from conventional donors, funds from non-traditional donors to WHO, such as the government of Italy's Agency for Peacebuilding, have been mobilized. This was the first-ever contribution to Burkina Faso from this donor. This is further evidence of the benefit of this focused approach utilizing the ERO, and demonstrates the effectiveness of the ERO position in the mobilization of resources from non-traditional partners of WHO.

Significant improvement in donor perception

There has been a significant improvement in donor perception of WHO in Burkina Faso. Recently, a random interview of donors which included USA/USAID, Canada, EU, France and Italy was carried out by auditors on several aspects of donor/partner perception of WHO. The results from donor responses have shown significant improvements as demonstrated by the positive responses (100% positive) on WCO Burkina

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Faso's responsiveness to donor requests, reporting timeliness and quality, see Figure 4.2.2. This was a marked change compared to a previous partner perception survey conducted in 2019 during the FRs where up to 50% of donors reported to have had consistent disappointment with the country office in Burkina Faso within the past 2-3 years prior to the survey.

Since the resumption of the ERO, the WCO in Burkina Faso has maintained a positive track record with zero overdue reports, the WCO has made great progress in this area. This has not only set a standard but also an example for other WCOs in the region to emulate. However, there are also areas with room for improvement such as project planning and implementation.

Figure 4.2.2 Shows interview responses by auditors on donor perception in Burkina Faso

Challenges to resource mobilzation	Interview responses by auditors	
WCO: Burkina Faso Challenges to resource mobilzation are represented by scarce operational presence of WHO in the field, lack of adequate programme management (i.e slow implementation), weak accountability on donor visibility and communications.	Project/programme planning was inclusive	75%
	Project/programme implementation was in line with grant agreement	67%
	WCO was responsive to donor request	100%
	Donor reporting is of good quality	100%
	Donor reporting was timely	100%
	The WCO adequately recognized partners' contribution including donor visibility	100%
	Project / programme expected results were fully achieved	100%

Impressive donor engagements and visibility

There was also increased engagement with donors, leading to improved management of funding relationships with mature partnerships, and the development of funding streams from new sources including international development banks, funds and through multilateral mechanisms. Another area of improvement was the increased collaboration and interaction of WHO with the UN system, and with the UN Resident Coordinator's Office (UNRCO), including joint resource mobilization and actions to drive visibility of actions. There was a 23% increase in UN joint funding with other UN agencies at the country level.

As a result of the deployment of the ERO to Burkina Faso, the WCO has greatly improved its relations with donors and partners. Within just 18 months of the establishment of the position, the WCO conducted over 30 bilateral meetings with donors and partners to foster partnerships., including from Canada, France, Germany, Italy, Luxembourg, the Netherlands, Saudi Arabia, Sweden, and the United States, along with the Bill & Melinda Gates Foundation, the European Union, the GAVI Alliance, the United States Centers for Disease Control and Prevention, and the World Bank.

Furthermore, the WCO held monthly meetings with all humanitarian partners and donors, and organized several field visits, launch ceremonies and other donor-related events, attended by the Ministry of Health and high-level diplomatic delegations. This has contributed significantly to the visibility of the work WHO has been carrying out in Burkina Faso.

Some of the key highlights with regard to external relations and donor engagement included a first-ever

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bilateral meeting between the WHO Representative and the US Ambassador to Burkina Faso, a maiden donor field visit organized and attended by the Ambassador of Canada, as well as the production of outreach/advocacy material which is shared regularly among over 120 donors/partners of WHO Burkina Faso.

Due to the increased capacity of WHO to deliver, there was a significant increase in Non-State Actor (NSA) engagement, leading to WHO being recognized and funded as a humanitarian actor. There was a 66% increase (118) in the number of NSAs contracted as implementing partners to deliver concrete interventions in 2021, up from 71 in 2020.

Within the last 18 months, the ERO in Burkina Faso has engaged several NSAs as implementing partners. This has enabled WHO to implement activities in the field which have had a significant humanitarian impact, including the establishment of mobile clinics, advanced medical posts, and the delivery of vaccines and essential drugs in regions worst affected by humanitarian and security crises.

WHO has entered into agreements with 14 NGOs and civil society groups, including Abba's International Healing Center, the Alliance for International Medical Action (ALIMA), Appui Moral Materiel et Intellectuel a l'Enfant (AMMIE), the Burkinabe Red Cross, Concern Worldwide and the International Rescue Committee (IRC), to the total value of approximately US$ 4 million.

In Burkina Faso, the WCO acknowledges and appreciates partners' contributions, including donor visibility, with 100% of donor/partners interviewed responding positively to the question of whether the WCO adequately recognizes their contributions.

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4.3. Improved technical leadership and support

WHO in the region has been providing high-level technical support to countries, including for health systems strengthening through health system advisers funded by the EU-Lux-WHO UHC Partnership. In South Africa, WHO provided high-level technical support to the Lancet National Commission on High Quality Health Systems. The report's recommendations served as the guiding principles for strengthening policies and practices related to the quality of health services in that country.

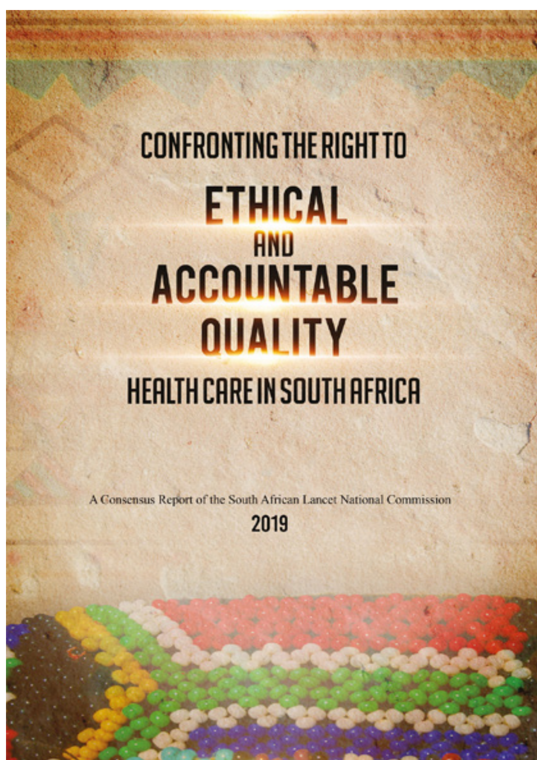

Figure 4.3.1 South Africa's Lancet National Commission: Confronting the right to ethical and accountable quality health care in South Africa, was released December 2018

In addition, the WCO, in association with the University of Cape Town, developed a technical report on health inequalities and financial resource allocation in South Africa, with a focus on left-behind populations. The report was instrumental in informing financing policies and equity measurement. (Figure 4.3.1)

Similarly, quality improvement in public health facilities is one of the two major outcomes sought by the implementation of NHI in South Africa, and WHO has supported the establishment and launch of applicable health standards, regulations and guidelines. WHO continues to support the Office of Health Standards Compliance (OHSC) in the implementation of quality standards in the public and private health sectors. Also, at the request of the OHSC, the WCO, with support from the Africa Regional Office, assisted in the development and finalization of norms and standards for the public and private sectors. WHO also developed technical advice for regulating health sector establishments, with a focus on strategies for private sector regulation as part of NHI implementation.

Furthermore, in 2018 WHO developed the technical report for the integration of health information systems, towards achieving a fully integrated information system. The aim was to enable easy and equitable access by all stakeholders to relevant information, to monitor provider behaviours and health outcomes, as well as to facilitate the delivery of quality and effective health care services, and to support transparent and efficient provider payments.

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Development of the Presidential Health Compact for accelerating UHC

As part of the "Presidential Health Steering Committee' WHO provided technical support to various task teams to finalize the 'Presidential Health Compact" which builds on the recommendations from the Presidential health Summit. It was unveiled by the president of SA in July 2019 and lays down a five-year roadmap for health systems strengthening reforms, under 9 pillars towards accelerating UHC. It outlined the roles of all key stakeholder groups in the implementation of critical tasks related to UHC and NHI in SA, see Figure 4.3.2.

Figure 4.3.2 President of SA and Minister of Health with key stakeholders launching the Presidential Health Compact

WHO was the only UN and or development partner on the Joint Technical and Monitoring Evaluation Committee (JTMEC) established in the President's office to provide technical support and monitor progress on implementation of the Presidential Health Compact. WHO developed the evaluation framework to assess the progress of implementation of the Presidential health Compact.

Raising the bar for high-level technical support with MCATs

WHO recently improved its technical leadership and support through the MCATs, each of which corresponds to a group of three or four WCOs, based on geographical proximity, public health similarities, and commonalities including language. (Figure 4.3.3) The MCATs are hosted in 11[10] WCOs.

The MCATs arrangement excludes large countries with sizable budget envelopes, which require permanent in-country presence of high-level experts. These include the Democratic Republic of Congo (DRC), Ethiopia, Nigeria and countries under emergency operations, like the Central African Republic (CAR) and South Sudan. These countries usually have funding to support their functions. It also excludes the Republic of the Congo because of its special MOU with the WHO Regional Office, which provides direct support.[11]

10 Burkina Faso, Cote d'Ivoire, Gabon, Ghana, Kenya, Madagascar, Mozambique, Senegal, South Africa, Uganda, Zimbabwe
11 Multi-Country Assignment Teams (MCATS) Operational Guidelines 2022

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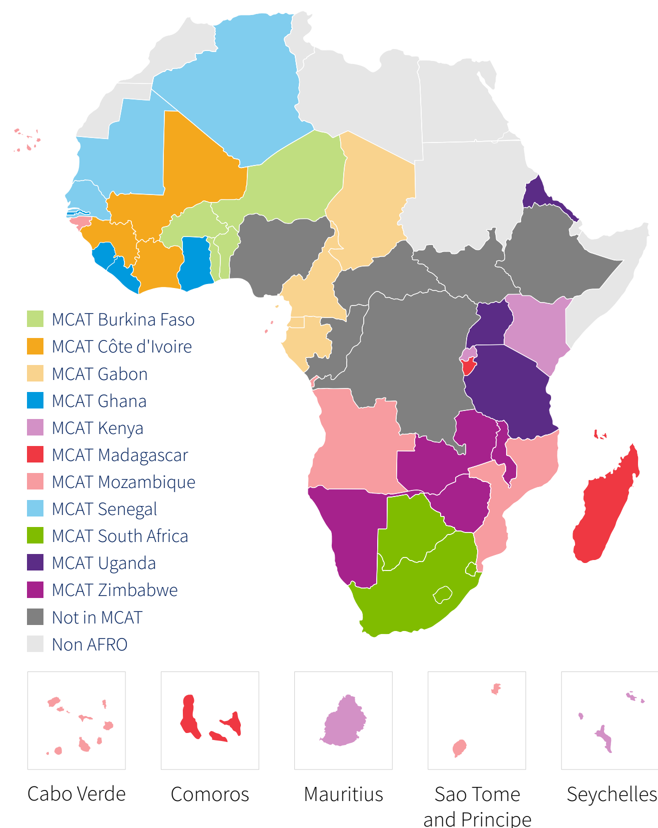
Figure 4.3.3 The allocation of Multi-Country Assignment Teams (MCATs) for the provision of high-level technical support in countries



WHO began the establishment of the MCATs with the development of operational guidelines to direct the implementation process, and rollout of HR actions to position the MCATs in their assigned countries. Currently, an MCAT coordinator has been recruited, and one-third of the required 80 MCAT positions have been filled through reassignments. The recruitment process for the remaining positions is ongoing. WRs, countries and Africa Region clusters, along with Ministers of Health, have been extensively briefed, and plans for full operationalization to execute and properly monitor the effectiveness of the MCATs have been developed. (Figures 4.3.4 and 4.3.5)

Figure 4.3.4 A cross-section of participants at one of the MCATs planning forums in 2022, which brought together the Regional Director, WRs, cluster directors and ministers, to fine-tune the operationalization of MCATs

4. Early results

Figure 4.3.5 Participants at a MCATs planning forum in early 2022

Less than one year into the establishment and implementation of the MCATs in the Africa Region, WHO has already reassigned personnel to lead the Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCH) and Non-communicable Diseases (NCDs) teams in the host country, Zimbabwe. The MCATs staff in Zimbabwe are responsible for supporting the host country, as well as Malawi, Namibia and Zambia. Although the full contingent of required competencies has not yet been achieved, early developments point to sufficient capacity being made available to enhance technical cooperation with Member States and partner agencies. The integration of the MCAT into the WCO structure has enhanced the provision of more robust day-to-day technical support, which is helping the countries to strengthen planning, implementation, coordination and management of activities. This has started to reduce overlaps in priority programme interventions. The expectation is that this will create the necessary synergies to maximize resources for increased effectiveness and efficiency of high-level support to the countries going forward.

In addition, the MCAT technical officers continue to have regular interactions with Ministries of Health staff and other partners through in-person visits and/or virtual platforms to enhance technical support. Given the teams' greater scope and depth of technical experience and networking, results have shown significant improvement in the quality of WHO's technical support, and reduced response times as the team is already on ground to provide direct support. So far, countries have been supported to develop and update normative guidelines as well as training materials in RMNCH and NCD programme areas. Support has also been provided to countries to conduct assessments and to strengthen capacity of health workers to facilitate improvements in service provision, towards achieving national health goals, while contributing to the GPW 13 targets.

Furthermore, in just a short space of time the MCAT technical officers have utilized their networking and negotiation skills to mobilize catalytic funds to support country activities in their MCAT zones. In another MCAT zone hosted by Burkina Faso, resources have been mobilized for previously under-funded areas such as mental health, NCDs and nutrition. For example, there has been no direct nutrition-related funding at the country level in Burkina Faso since 2013. The MCAT in Burkina Faso, which also represents Benin, Niger and Togo[12], embarked on a resource mobilization drive, advocating for and developing projects in Benin, Burkina Faso and Niger. As a result, funding from bilateral and multilateral partners has been obtained for the expansion of mental health projects. This included US$ 260 000 from Italy and US$ 500 000 from the UN

12 Documenting resource mobilization for NCDs in MCAT Burkina Faso by Ould Sidi Mohamed, NCD Management, WHO Multi Country Assignment Team (MCAT)

4. Early results

for mental and reproductive health. This was jointly mobilized by the WCO in partnership with the United Nations Population Fund (NFPA) in Burkina Faso.

In Benin, US$ 85 415 was obtained from Canada for health system strengthening and to accelerate integrated management of NCDs in relation to COVID-19 prevention. For Niger, a funding pledge to the tune of US$ 150 000 was acquired from COVID-19 funds. Other funds for NCD prevention from these efforts included US$ 245 341 that was mobilized and utilized in Burkina Faso, and several others amounting to US$ 184 817.

Although these mobilized resources remain far below what is needed, they enabled the implementation of several projects towards NCD prevention. However, additional efforts must be made to raise more funds if all the set targets for GPW13 and the SDGs are to be achieved.

4.4. Enhanced planning, monitoring and evaluation

The creation of the programme management function, and engagement of over 38 Programme Management Officers (PMOs) in various country offices, greatly improved the operational capacities of WCOs. The early achievements are discussed below:

Strategic and operational planning

Figure 4.4.1 Showing the 2020–2023 programme budget

The strengthened capacity at country office level has enabled bottom-up development of programme budgets in countries. It has ensured that all work plans developed through peer-review mechanisms within WCOs have clear established linkages with goals and objectives. These work plans were subsequently developed into a Programme Budget 2022–2023 booklet which was made available to WHO staff and to Ministries of Health (MoH) and development partners for better transparency, and to enhance understanding of WHO's activities at country level. (Figure 4.4.1)

The PMOs have ensured alignment of country priorities with strategic objectives. They have drafted Country Cooperation Strategies (CCS) for discussion with Ministries of Health and donors, utilizing in-house capacity. They were involved in the operationalization of the Programme Budget in countries, including the development of salaries and activity work plans. The PMOs have also facilitated a shift from activity-based to results-based planning, and further consolidated additional evidence and information, such as country progress on GPW13 outcome indicators, scope of the output, and health priorities. This was based on CCS evaluations, National Health Policies Strategies and Plans (NHPSP), regional output KPIs, and value for money for more focused biennial planning.

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Budget management, performance monitoring and results-based reporting

The PMOs participated in the Programme Budget allocations to identify country priorities and have ensured the alignment of results with resources/income inflows. PMOs also systematically monitor International Aid Transparency Initiative (IATI) data on a weekly basis, against budgets and spending, to reconcile any variance.

The placement of PMOs, coupled with the creation of implementation plans, has enhanced the coordination of KPIs in country offices. Each country plan was developed in collaboration with all cluster leads (CL), with weekly monitoring by the WR and CLs. The current changes associated with the Functional Reviews have led to the reprogramming of work plans/projects to align with country contexts, including emerging health threats such as outbreaks.

Figure 4.4.2 Visit to a hospital in Mauritius to conduct IPC Score card assessment with WCO team, including PMO

The effective coordination of WCO's annual reports has also led to increased advocacy for WHO's work in countries. The application of new tools, such as output score cards, has enabled country teams to participate in organization-wide statutory monitoring activities, like the semi-annual, mid-term and end-of-biennium monitoring and reporting. (Figure 4.4.2) In addition, the quality reviews of programme implementation have supported the optimal utilization of resources within countries. Through the combination of a guidance note, staff capacity building and video job aids, the PMOs made reporting processes to the Global Management System (GSM), KPI portals, output score cards and donor reporting more convenient, while ensuring complete, timely, and good quality reporting. PMOs also facilitated a shift from action-based reporting to results-based reporting.

In South Africa, several success stories have been documented and reported. These relate to the effective COVID-19 response in Mpumalanga and the Free State provinces, and Voluntary Medical Male Circumcision (VMMC), among others. The PMO developed several reports, including annual reports (2017, 2018) and 2016–2021 Country Cooperation Strategy (CCS) evaluation reports, showcasing WHO's work in the country. Output reporting compliance in GSM, which was previously at 68%, has remained consistent at 100% since the PMO was put in place. There was no late submission of donor reports, which has remained at zero for South Africa. In collaboration with the Operations Officer (OO) and Budget & Finance Assistant (BFA), the PMO facilitated the introduction of several budget management good practices in the office, such as the monthly sharing of budget utilization with balance of expiring awards, active follow-up with programme

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staff in the case of balances and encumbrance of expiring awards, routing of memos through the PMO to ensure alignment of activities with work plan tasks, and CCS priority. Others are the development of expenditure types task mapping for COVID-19 work planning, to help correct mapping of expenditure to work plan tasks and COVID-19 response pillars. This has resulted in complete and timely utilization of funds.

In addition, the PMO managed the CCS evaluation for South Africa and provided support to WCO-Eswatini, in collaboration with the Regional Office and WHO HQ. The collaboration enabled an evaluation which captured WHO's contributions to the health of the population of Eswatini and South Africa for the five years covering the CCS period (2016–2021). Findings were used in combination with other information to set the CCS agenda for the following five years. Such an extensive evaluation and robust prioritization has not previously been done in these countries.

Contributing to building partnerships and resource mobilization

Prior to onboarding the ERO in Uganda, the PMO supported raising of funds. This enabled the mobilization of about US$ 50 million under Programme Budget 2020–2021. The amount was over 250% of the initial PB allocation of US$ 18.1 million for WHO Uganda. In Mauritius, the PMO supported the country coordinating mechanism (CCM) for HIV to submit grant proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The first proposal resulted in the mobilization of US$ 2 265 213 to ensure the sustainability of Mauritius's fight against HIV. A second proposal garnered US$ 645 690 to support COVID-19 activities to December 2023. (Figure 4.4.3) The PMO drafted three proposals to new donors (ECHO, USAID and the Africa Re Foundation), securing a total of US$ 1 million. Prior to the deployment of the PMO to the WCO, the Ministry of Health and Wellness (MOHW) never succeeded in mobilizing funds in this manner.

Again, with the support of the PMO, the WCO has been more actively engaged in the UN Country Team, supporting the implementation of the UN Strategic Partnership Framework, carrying out Common Country Analysis (CCA) as a prelude to the elaboration of United Nations Sustainable Development Cooperation Framework (UNSDCF) implementation, and monitoring the UN Programme Management Team (UN PMT) network.

Figure 4.4.3. Discussing national COVID-19 response and vaccine deployment plans with Mauritius Minister of Health and Wellness, WR Mauritius, PMO, and other government representatives

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Similarly, in collaboration with HQ and the Regional Office, the PMO has contributed to winning a multi-country grant on Sexual and Reproductive Health and Rights (SRHR) for South Africa. The PMO also played an important role in mobilizing US$ 470 000 for COVID-19 and a US$ 1.7-million Contingency Fund for Emergencies grant from WHO Head Office for the COVID-19 response, while contributing to the drafting of the UN COVID-19 proposal for Lesotho's Joint SDG Fund which resulted in the mobilization of US$ 1 million for UN-Lesotho.

Figure 4.4.4 WCO Lesotho's joint annual retreat with MOH in June 2022 to identify key strategic priorities for fourth generation CCS. PMO briefs MOH representatives including the Permanent Secretary, with the WR for Lesotho present

Balancing heads, hands and heart to achieve positive change

A vital aim of the TA was to strengthen WHO's response to countries' priorities. In consonance with this goal, and changes taking place, the Regional Office's Planning, Budgeting, Monitoring & Evaluation (PBM) unit created a roster of PMOs, based on lessons learned from a pilot project that started in mid-2017. As a result of improvements observed in operations, which were partly attributed to efforts by PMOs, positive changes triggered by the Functional Review process led to strengthened capacities in countries. A new PMO was recruited in 2021 to cover Cabo Verde and São Tomé and Príncipe.

Figure 4.4.5 PMO participating in a field visit for UHC scoping mission in Sao Tome and Principe

The addition of the PMO has contributed to the reorganization of the programme management function, which has in turn positively impacted WHO operations in the two countries. This has been observed in several areas, one being the increase in the dissemination of information. Staff members are now regularly briefed on the budget situation to define approaches for early, appropriate, and timely utilization of available resources.

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Other observed improvements include the systematizing of monthly monitoring of the budget process, as well as regular provision of information and guidance to support critical business decisions. The team has also been sensitized to produce and record evidence on interventions conducted in each country. In addition, partner mapping that was carried out has helped in the formulation and implementation of resource mobilization strategies. These have enhanced strategic and operations planning at country level.

Figure 4.4.6 PMO in planning meeting with the Cabo Verde women's team

Furthermore, improved planning has resulted in the timely completion of the 2020¬–2021 End-of-Biennium exercise, while the approved structure of 2022–2023 Programme Budget was adjudged to be of higher quality and considerably better aligned with other strategic plans, such as those for Cabo Verde. There was also a 30% reduction in the number of top tasks and 80% of sub-tasks in the 2022–2023 plan, compared to the previous biennium. Similarly, there was a 62% reduction in the number of top tasks and 73% of sub-tasks in the 2022–2023 plan for São Tomé and Príncipe. A country-specific set of KPIs was compiled for better monitoring, and a mechanism to monitor overdue donor technical and financial reports was created and implemented. This has markedly improved monitoring in both countries.

Finally, the strengthening of teamwork and the incorporation of human and gender rights into programmes and projects has commenced in both countries. (Figure 4.4.6) The PMO has pushed to improve working relationships among various programme areas in the office, and among counterparts, with a view to fostering collaboration at work and promoting better team dynamics. (Figure 4.4.7) As a result of these efforts, new work dynamics in communication, and inter-relationships between team members, are emerging.

Figure 4.4.7 Participants at the Sao Tome and Principe WCO's 360 teamwork retreat, organized, facilitated and presented by the PMO

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4.5. Better management practices to drive performance

As part of the TA, various management practices have been improved and several others strengthened. This was intended to make WHO in the African Region more efficient, by sharpening performance in various areas and improving management practices. These achievements align with the pro-results values and responsive strategic operations focus areas of the TA.

Better staff engagement

Vigorous staff engagement was promoted from the start of the TA process. Staff were consulted on the change process and asked to reflect on their potential contributions to WHO over the following five years. Consequently, engagement of WHO staff at all levels has now become a norm in the Regional Office and is being institutionalized in the organization. Since 2015, various communication efforts, including surveys and town hall meetings, as well as channels such as the WHO intranet and the Regional Director's reports, have been utilized. These have been beneficial for staff engagement and the sharing of information on the progress of the TA. In fact, the virtual town hall meetings have now become the most effective way for the Regional Director to engage directly with WHO staff across the Region. Other means of staff engagement that were employed include staff retreats and cluster/WCOs meetings.

Better sense of transparency, accountability and behavioural changes

In 2015, an Accountability and Internal Control Strengthening Initiative (AICS) was launched to address weaknesses and improve effectiveness of the internal control environment within WHO in the African

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Region. Following on from this, a Compliance and Risk Management Committee (CRMC) was formally set up in April 2016 to improve governance and oversight. These led to considerable changes which have resulted in improved managerial accountability, transparency and management of risk in WHO's work across the region. These also included improved compliance and quality assurance, enhanced information sharing, better targeted training, while strengthening governance and oversight. In addition, a mid-term assessment conducted in 2017 included a survey designed to review the implementation of the TA. The survey, coupled with several focus groups and individual interviews, examined the transformation changes,[13] revealing that a stronger culture of accountability has started to emerge. The results also suggested a change in staff approach to working together, with 65% of staff respondents agreeing that they had experienced tangible changes in their day-to-day work environments. In addition, 87% acknowledged having better clarity of their roles and responsibilities, as well as how they could be held accountable, suggesting an improvement in work practices. Furthermore, over 70% suggested that managers were being held accountable for delegated authority and expressed that the Performance Management and Development System (PMDS) successfully appraises staff performance in a transparent and impartial manner. WHO staff perceived a greater emphasis on results, improved teamwork, an improved culture of accountability, and a considerable connection between the KPIs and Performance Management Development System.[14] WHO in the Africa Region also engaged a full-time Ombudsperson at the Regional Office to further enhance transparency, accountability and ethical behaviour, and to provide support to staff.

13 Mid-term assessment of the functional reviews of WHO country offices in the African Region, 2018
14 The Transformation Agenda of the World Health Organization in the African Region> Delivering Results and making Impact, 2018

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Another area that saw a notable improvement was compliance and quality assurance, with 14 internal and 12 external audits concluded between February 2015 and April 2018. The results showed that all audit reports issued since 2016 were either fully or partially satisfactory, with none in the unsatisfactory category. This is a significant improvement compared with years prior to the start of the TA. Also, the results of a review from the Office of Internal Oversight Services (IOS), based on internal and external audits, showed that compliance and quality assurance functions have improved significantly. It demonstrated that between August 2015 and September 2017, for example, overall control effectiveness improved from 50% to 77%. To improve sharing of information, an intranet site for use by staff has been created and populated with information and guidance documents on accountability and internal control. It comprises more than 600 policy documents, standard operating procedures (SOPs) and internal control checklists. In addition, collaborative workspaces have been established to facilitate the sharing of information and best practices, which has strengthened the internal control environment in the region.

Results Framework and Managerial Key Performance Indicators (KPIs)

Results Framework (RF) and Key Performance Indicators (KPIs) have been developed for use in monitoring and evaluation to measure WHO's performance in contributing to priority health goals. Since their introduction, the KPIs have been progressively improved, leading to a significant reduction in overdue Direct Financial Cooperation (DFC), Direct Implementation (DI) and donor reports. The number of overdue DFC reports was reduced by 60% between February 2015 and April 2018, and was down to 1% by 2021. Between 2016 and 2021, there were no overdue DI reports, while overdue grant letters of agreement reports were reduced to about 7% within the same period.

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The results framework comprised of 23 managerial KPIs, with 32 programme-related KPIs. All countries in the WHO Africa Region are monitored against 13 managerial and programme KPIs, with a further seven KPIs selected by each WCO to address country-specific priorities. The framework also highlighted neglected programme areas and provided clarity as to where WHO should prioritize funding. Furthermore, the managerial KPIs covered enabling functions related to finance, budgeting and security. They also included administrative services, human resource management, as well as audit and compliance. In addition, the KPI framework linked managerial performance to KPI achievements with the existing performance management and development system (PMDS). This has improved reporting and transparency of progress via three dashboards, providing for the recognition of staff and country office performance.

Enhanced financial management

WHO has implemented several changes in respect of how the organization manages its finances. One of these was the implementation of an effective Imprest Account replenishment system. The new initiative allows for programme-related funds to be transferred to WCO accounts within less than 24 hours. Another achievement was the digitization of disbursement mechanisms which WCOs utilize for payments of final beneficiaries, which were previously made in cash. This has introduced transparency and eased the process of following the digital footprint for efficient auditing. The Africa Region has maintained an impressive 95% “A rating” for all its 215 Imprest Accounts, reflecting a significant improvement in financial management at country level compared to previous years. Pre-checks of requisitions were intensified with the aim of off-setting the impact of the COVID-19 disruptions on inspections of activities funded through DFC, DI, and grant letters of agreement. The pre-checks served as a first line of quality assurance. There was also an improvement in the number of purchase orders (POs) with outstanding reports exceeding 180 days, with the period reduced to between five and 14 days.

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Improved procurement practices

Strengthening supply chains has been an integral part of efforts to improve procurement practices in the WHO Africa Region. One of the best practices being utilized is to proactively secure long-term pricing for regular goods and services, known as Long-Term Agreements (LTAs). Another is the renewal of supplier contracts or the negotiating of new ones via open and broad competition processes. These practices have resulted in significant savings of more than US $ 3.7 million over the three years to 2021. In 2021, savings of approximately US$ 1.6 million were achieved despite disruptions caused by the COVID-19 pandemic, which imposed emergency processing of most transactions.[15] In addition, the regular renewal of LTAs through competitive bidding after four consecutive years of assignment also resulted in a 50% reduction, from US$ 1.4 million to US$ 0.7 million, in spending on operational recurrent services/consumables compared to the previous biennium. WHO in the Africa Region also pursued more competitive options via newly established companies. This has led to a 70% decrease in costs between the two biennia, from US$ 0.6 million to US$ 0.2 million, when comparing traditional contracts during 2020–2021 and 2022–2023.

15 Annual Report of the Regional Director on the work of WHO in the African Region, 2020-2021

4. Early results

Challenges encountered

Sub-optimal functioning of Steering Committee – Oversight of the FR process was to be provided by a steering committee chaired by the Director of Programme Management, and comprised of regional cluster directors, two directors from headquarters, two WRs and the Functional Review project manager. The key role of the Functional Review Steering Committee[16] was that of oversight. Its duties were fourfold: to oversee the process and ensure coherence with the TA; to provide direction and arbitration for the project team; to ensure organization-wide consistency; and to provide regular updates to the Regional Director.[17] The committee was expected to review the process and discuss key issues arising from country missions. However, these efforts were hampered by difficulties in balancing the ownership of the country office represented by the WR, and requests from the Steering Committee to play a greater role in the entire process. Another hurdle was the conflict between the type of information the committee required to function effectively, and confidentiality issues around sensitive information. These constraints have prevented the committee from functioning optimally to achieve the desired objective.

Inadequate funding – The investment case for mobilizing resources to strengthen the capacity of WCOs to staff the recommended functions was underfunded. This delayed implementation, resulting in disappointment, stress and anxiety among some staff. The slow progress posed a serious performance threat to support countries to achieve "Health for All", improve healthy living, as well as to prepare, detect and respond to public health emergencies. This forced a rethink of the implementation process, which included the redistribution of existing funds (especially flexible) and the use of UN Volunteers to perform some functions.

Attempted push-back by some staff – The FR recommendations aimed to address the changing needs and expectations stakeholders had of WHO. This required a change in the focus of WCOs, including the introduction of new talent, bringing in new competencies and experiences including international experience, as well as a significant increase in staff numbers for most WCOs. This required increased funding, which was not available. Prioritizing what to implement with the available resources consequently resulted in some staff losing their positions, prompting resistance to the recommendations from some WHO staff. This was effectively managed through a variety of solutions, including personal engagement of staff by the Regional Director, involvement of the Ombudsman and Staff Association, and ensuring transparent implementation of the HR process.

Managing separations coupled with the COVID-19 polio ramp down – This resulted from timing issues, with implementation of the FR process coinciding with the downscaling of the polio programme, alongside the ongoing COVID-19 response. This created difficulties in managing different HR actions and ensuring that the required talents to address new challenges were not lost.

Managing change in roles – Conflictual relationships arose in some WCOs in relation to the terms of reference for some of the new functions, such as PMOs, EROs and communications staff. Some of these roles had previously been performed by other technical or administrative staff. Adjustments required by the changing of roles posed some challenges.

16 The functional Review Steering Committee was chaired by the Director Programme Management (DPM), the members comprised of regional cluster directors, two directors from headquarters, two WHO Representatives and the project manager of the functional review

17 Functional Review Operational Guidelines Version 2.0, 2018

5 Next steps

5. Next steps

The early results in several areas, as demonstrated in this report, are evidence that the few changes introduced, coupled with diverse actions being implemented, are beginning to have the desired effect. Even though it is still early days, these signs hold a lot of promise as the transformation progresses. For this reason, WHO in the African Region should continue these efforts towards ensuring all objectives are largely or completely accomplished.

The acceleration of these results would contribute to achieving the five interconnected priority areas highlighted in the WHO White Paper[18] on accelerating health. The areas indicated include strengthening support for Member States towards more robust pandemic preparedness and leveraging emergency interventions, as well as a renewed focus on building more resilient health systems. Others include boosting health promotion and prevention, and improving health care delivery and access to services via an emphasis on primary health care.

Although the region had an early start through the Transformation Agenda process, the organization should continue to act with a view to accelerating achievements on the following going forward:

Focus on strengthening WCOs by placing the required capacities to deliver better – Continue to prioritize implementation of the country-focus approach for greater and sustained results. Utilize the STEPwise approach, while remaining cognisant of funding constraints to ensure efficiency, accountability for results, and responsiveness. This will support the goal of better resourcing as well as the development of integrated country office platforms to deliver greater impact at country level for improved results. These are central to achieving the requisite outcomes to deliver measurable GPW13 impact at country level, and to achieve the health-related SDGs.

In addition, for personnel who have already been recruited into new roles, including PMOs and EROs, there is a need to provide these staff with strong coaching and guidance, including weekly/monthly briefing sessions to assist their integration into WHO, to enable effective delivery.

18 WHO White Paper: Accelerating Health, 2022

5. Next steps

Strengthen coordination and leadership of WHO in the health sector to demonstrate the necessary brokerage, influence and guidance, as illustrated by the strong role WHO has played in the development of South Africa's NHI efforts. WHO should show leadership in global health, whether in emergencies or other technical areas, or the WHO Representatives demonstrating effective leadership and coordination of stakeholders in health sectors to achieve country priorities. Improved information platforms should be utilized to provide evidence to help to set priorities and steer national health agendas towards achieving "Health for All" in the region. These platforms are critical enablers that provide information to help achieve other priorities, which aligns with WHO's aim of harnessing the power of data and digital technologies to facilitate its work.

Optimize capacity for partnerships, external relations and resource mobilization by ensuring that the new functional competencies continue to have the desired impact at country level. Although some countries, like Burkina Faso, have demonstrated success in broader stakeholder engagement, WHO should encourage all WCOs to learn from these lessons with a view to achieving stronger partnerships between WHO and its stakeholders, including multilateral agencies, via the implementation of specific engagement strategies.[19] Improved results from resource mobilization at country level, as observed from the early results, will also contribute to making funds available in line with WHO's aspirations to increase its core budget and funding share for country offices to 51% in the Programme Budget, as highlighted in its White Paper on accelerating health.

Continue to enhance technical leadership and support through the usual generic model, but most importantly, optimize the utilization of the MCATs for high-level technical support. Funding should be prioritized to accelerate MCAT implementation up to critical levels, to include all the six pillars for optimal results. This will have an improved impact at country level, and support WHO's goal of increasing capacity for country impact, including "changes in human resources policy, planning and deployment to target country support for impact". This will not only assist in implementing technical priorities across the Triple Billion targets, but also in areas that accelerate SDG progress.

Promote effective planning, monitoring and evaluation throughout the region utilizing the newly-placed capacities (38 Programme Management Officers) in countries, and accelerate the implementation of the recommendation to establish an effective culture of planning, monitoring and evaluation across the region. These would be effectively enabled by obtaining quality data from WHO in the Africa Region's integrated information platforms, which continue to be strengthened. This also aligns with WHO's goal to "support the application of a delivery approach with regular monitoring of progress towards health targets to maintain a relentless focus on achieving the SDGs".

Sustain the ongoing improvements in management practices for effective performance. Find more innovative ways to improve on savings being made within existing procurement practices. Also intensify efforts in respect of the Performance Management and Development System (PMDS) and travel compliance, to enhance performance in these currently underperforming areas.

19 WHO White Paper: Accelerating health, Priority 5, strengthen incentives for collaboration

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African Region

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