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ANNEX 2

to the Commission Implementing Decision on the financing of the multiannual action plan in favour of Sub-Saharan Africa for 2024-2025

Action Document for Support to African Public Health Institutes

MULTIANNUAL PLAN
This document constitutes the multiannual work programme within the meaning of Article 110(2) of the Financial Regulation, within the meaning of Article 23 of the NDICI-Global Europe Regulation.

1 SYNOPSIS

1.1 Action Summary Table

1. Title **CRIS/OPSYS business reference** **Basic Act**	Support to African Public Health Institutes OPSYS number: ACT-62357 Financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)
2. Team Europe Initiative	Yes: Regional Team Europe Initiative on Support to African Public Health Institutes in Sub-Saharan Africa health
3. Zone benefiting from the action	The action shall be carried out in Africa.
4. Programming document	Multi-Annual Indicative Programme for Sub-Saharan Africa 2021-2027 (SSA Regional MIP)
5. Link with relevant MIP(s) objectives / expected results	Priority area 1: Human Development Specific Objective: Strengthen the African health security architecture, pharmaceutical systems and public health capacity, contributing to stronger health systems and improved health, including sexual and reproductive health rights (SRHR) outcomes. Result 1.3: The Africa-based public health capacity is enhanced. Priority Area 4: Digital and Science, Technology, and Innovation Specific Objective 1: Support an inclusive and human-centric Digital transformation in Africa. Result 1.1: Secure, human-centric, and harmonized digital standards, legal and regulatory frameworks are promoted at regional/continental levels.
PRIORITY AREAS AND SECTOR INFORMATION	
6. Priority Area(s), sectors	Priority Area 1: Human Development 120: Health

	22040: Information and Communication Technology (ICT)
7. Sustainable Development Goals (SDGs)	Main SDG (1 only): SDG 3 Good Health and Well-being. Other significant SDGs (up to 9) and where appropriate, targets: SDG 4 Quality Education and Lifelong Learning for all SDG 5 Gender Equality SDG 10: Reduced inequalities. SDG 17 Partnership
8 a) DAC code(s)	12110: Health policy and administrative management 20% 12196: health statistics and data 15% 12182: General Medical Research 15% 12382: Research for prevention and control of NCDs 5% 12261: Health education 15% 11420: Higher education 10% 22040: ICT 20%
8 b) Main Delivery Channel	11004: Other public entities in donor Country 4100: United Nations agency, fund or commission (UN)
9. Targets	☐ Migration ☐ Climate ☒ Social inclusion and Human Development ☒ Gender ☐ Biodiversity ☒ Education ☒ Human Rights, Democracy and Governance

10. Markers

(from DAC form)

General policy objective @	**Not targeted**	**Significant objective**	**Principal objective**
Participation development/good governance	☐	☐	☒
Aid to environment @	☒	☐	☐
Gender equality and women's and girl's empowerment	☐	☒	☐
Reproductive, maternal, new-born and child health	☒	☐	☐
Disaster Risk Reduction @	☒	☐	☐
Inclusion of persons with Disabilities @	☒	☐	☐
Nutrition @	☒	☐	☐
RIO Convention markers	**Not targeted**	**Significant objective**	**Principal objective**
Biological diversity @	☒	☐	☐

	Combat desertification @	☒	☐	☐
	Climate change mitigation @	☒	☐	☐
	Climate change adaptation @	☒	☐	☐
11. Internal markers and Tags:	**Policy objectives**	**Not targeted**	**Significant objective**	**Principal objective**
	Digitalisation @	☐	☒	☐
	digital connectivity digital governance digital entrepreneurship digital skills/literacy digital services	YES ☐ ☒ ☐ ☒ ☒	NO ☒ ☐ ☒ ☐ ☐	
	Connectivity @	☐	☒	☐
	digital connectivity energy transport health education and research	YES ☐ ☐ ☐ ☐	NO ☐ ☐ ☐ ☐	
	Migration @	☒	☐	☐
	Reduction of Inequalities @	☐	☐	☒
	Covid-19	☒	☐	☐
BUDGET INFORMATION				
12. Amounts concerned	Budget lines (article, item): 14.020120: EUR 19 600 000 14.020121 : EUR 19 600 000 14.020122: EUR 10 800 000 Total estimated cost: EUR 50 000 000 Total amount of EU budget contribution: EUR 50 000 000 Ten EU Member States are involved in the Regional TEI on Support to Public Health Institutes including Belgium, Czechia, Germany, Finland, France, Ireland, Italy, the Netherlands, Portugal, Sweden. The combined indicative financial contributions towards the TEI amount to EUR 71 800 000.			
MANAGEMENT AND IMPLEMENTATION				
13. Type of financing	**Indirect management** with entrusted entities to be selected in accordance with the criteria set out in section 4.4.1.			

1.2 Summary of the Action

This action is proposed in the framework of the Global Gateway Health Package presented at the 6th European

Union (EU) – African Union (AU) Summit in 2022. It operationalises the EU's contribution to the Team Europe Initiative on supporting National Public Health Institutes (NPHIs) in Sub Saharan Africa (SSA) that has support from ten EU MS[1] with a total financial contribution amounting to EUR 71,8 million. The TEI aims to contribute to the population's health and wellbeing (SDG 3) via the provision of essential public health services by NPHIs.
This action will strengthen the EU's strategic partnership with the Africa Centers for Disease Control and Prevention (CDC), mandated to support NPHIs in African Union Member States. It responds to the call for a new public health order in Africa and contributes to the implementation of Africa CDC's Framework for Development of Public Health Institutes.

The action will focus thematically on reducing inequities in addressing the double burden of disease and addressing public health priorities linked to integrated and holistic health systems. However, in case of a health emergency of international concern or a serious epidemic, becoming then an urgent public health priority, the thematic focus of this action can be adapted to address the emergency.

A first specific objective "Establish/enhance regional and international links and capacity among African and European NPHIs for public health research, knowledge and information gathering that drive evidence-based policy advice, public health workforce training, and advocacy" aims to build and strengthen collaboration between African NPHIs at regional level and between African and European/international NPHIs. In addition, this component intends to improve coordination and mobilisation of additional resources and support to NPHIs through the organisation of a NPHI stakeholder (duty-bearers) forum, spearheaded by Africa CDC. This component also intends to increase the integration and active participation of NPHIs, specifically those supported in a number of targeted countries, in regional and international public health network activities.

A second specific objective "To enhance NPHI capacity development to deliver Core public health functions" intends to sustainably strengthen NPHIs' core functions[2] and attributes to enhance evidence-based policy advice, under the leadership of Government Authorities in about 10 countries. The action will support a more coordinated and collective action of stakeholders (duty-bearers) to address public health issues. This support will be provided through support from regional level stakeholders (duty-bearers), but more importantly through the collaboration with other African NPHIs and European and international NPHIs. This component intends to focus on strengthening NPHIs, in priority public health areas, identified by the national authorities, for the provision of health workforce development, as well as the provision of evidence-based policy advice through data/information generation, monitoring and evaluation of intervention implementation and research, that will be analysed and translated into knowledge and intelligence that will form the evidence base for formulating policy advice. The data collection could be disaggregated by gender and disabilities, as well as systematised in such a way that ensures the integration of an inclusive and intersectional perspective. In addition NPHIs will be strengthened in leadership skills, social mobilisation and communication, - ensuring the gender and inclusive perspective-, and specifically to provide evidence-based policy advice in the framework of a structured policy dialogue.

A third specific objective "To support NPHIs to become digital health literate on the sustainable use and effectiveness of digital applications and to reduce the digital skills gap" includes strengthening capacity in digital health of NPHIs and enable them to support the digital health transformation in their countries.
Stronger, mature, and performant NPHIs will benefit and strengthen public health systems and ultimately the health of the population. The preferred implementation modality for this action is through contribution agreements with entrusted entities (EU MS agencies or UN agencies).
Regarding SO3: this component will partly be implemented at the regional level (1 million Euro) by the same

[1] Belgium, Czechia, Germany, Spain, Finland, France, Ireland, Italy, Luxembourg, Netherlands, Portugal, Sweden are members of the working group of the TEI NPHIs

[2] AfCDC framework for PHI development identifies the following core public health functions (CF) for NPHIs i) assessment (CF1-2), Population Health and Health-Related Indicators, Public Health Laboratory and Surveillance Systems, and Emergency Preparedness and Response; ii) Policy development (CF3-5): disease prevention and health promotion, advocacy, communication and social mobilisation; Policies and Plans that Support Individual and Community Health Efforts; and iii) assurance (CF6-10) Health Protection and Support for Regulation and Enforcement, Evaluation and Promotion of Equitable Access to Services, Public Health Workforce Development; Evaluation, Prevention, and Control of Public Health Issues in Clinical Settings; and Research in Public Health

implementing agency that is selected for SO1 and partly in the targeted countries (9 million Euro) similarly implemented by the same entrusted entities as for SO2 in these countries.

1.3 Zone benefitting from the Action

The regional component (specific objective 1 and part of objective 3) of this action will cover the African continent. All countries are included in the list of ODA recipients.

For the country level support (specific objective 2 and part of objective 3) around 10 Sub-Saharan countries will be identified. Indicatively the following countries have been identified so far: Burundi, Chad, Democratic Republic of Congo, Guinea Bissau, Guinea Conakry, Malawi, Nigeria, Rwanda, and Zimbabwe. All countries are included in the list of ODA recipients.

2 RATIONALE

2.1 Context

The action contributes to the Global Gateway Health Package presented at the 6th EU-AU Summit in 2022. It is the first new EU funded regional program formulated in the framework of the regional Team Europe Initiative (TEI) to support Public Health Institutes (PHI) in SSA. This TEI is a part of flagship #3 "Strengthening health systems and capacity for pandemic preparedness, digital and public health" and complementary to the two other TEIs of this flagship: the TEI on Health Security with a One Health approach and the TEI on Digital Health. Furthermore, the action is aligned with the Global Gateway commitment to address gender equality throughout its five priority sectors.

The TEI on support to NPHIs aims to contribute to population's health and wellbeing (SDG 3) via the provision of multiple public health services by performant schools of public health and public health institutes. The TEI has strong EU MS support (Belgium, Czechia, Germany, Finland, France, Ireland, Italy, the Netherlands, Portugal, Sweden) with a financial contribution amounting to EUR 21,8 million from EU MS and a total TEI contribution of EUR 71,8 million.

The TEI intends to achieve greater efficiency of European programming by coordinating programmes and promoting synergies, while supporting the Africa CDC to become a fully operational continental Public Health Agency coordinating regional and national efforts and building a long-lasting partnership with other key African regional and international organisations mandated to support national public health institutes. Building on existing networks and collaboration, the TEI aims to harmonize methods and protocols, extend the geographical scope of such networks and expand the multisectoral dimension of existing programs while building bridges between programmes and partnerships to reduce fragmentation. When needed, the TEI will also supportthe creation of new networks and collaboration.

This action contributes to strengthening African health systems as prioritised in the new EU Global Health Strategy to improve global health security and deliver better health for all. The new EU Global Health Strategy underlines the importance of building ambitious partnerships (at national, regional, continental, and international level) based on co-ownership, amongst others with Public Health Institutes (NPHIs). The action contributes to the regional Africa MIP (multiannual indicative planning) 2021-2027, more specifically Result 1.3: The Africa-based public health capacity is enhanced. The MIP indicates amongst others as priorities: establishing or strengthening the performance of African Public Health Institutes enabling these institutes to provide training, research, advocacy, and context-specific policy advice to the health authorities, and fostering South-South and North-South cooperation.

The action is aligned with the vision for health described in the Agenda 2063 – The Africa We Want, more specifically with Aspiration 1 "A prosperous Africa based on inclusive growth and sustainable development, focusing on Goal 1 "A high standard of living, quality of life and well-being for all" and Goal 3 "Healthy and Well-nourished citizens, expanding access to quality health care services, particularly for women and girls". Likewise, the action is in coherence with the Aspiration 6 'An Africa Whose Development is people driven, relying on the potential offered by African People, especially its Women and Youth, and caring for children', particularly with its Goal 17 'Full Gender Equality in All Spheres of Life', as it intends to promote equitable health services as well as

ensure gender equality of the health workforce in access to training opportunities. It responds to the Call of the African Union for a New Public Health Order (NPHO), and Africa CDC's development and evolution into a continental public health agency. The ambitious New Public Health Order in Africa called by the African Union aims to address health security and health inequities on the continent. This call is defined by five pillars:

1. Strong African Public Health Institutions that represent African priorities in global health governance and that drive progress on key health indicators;
2. Expanded manufacturing of vaccines, diagnostics, and therapeutics to democratize access to life-saving medicines and equipment;
3. Investment in Public Health Workforce and Leadership Programs to ensure Africa has the workforce it needs to address health threats;
4. Increased domestic investment in health; and
5. Respectful, Action-Oriented Partnerships

This last pillar on respectful and action-oriented partnerships, which speaks to the coordination of partners and donors towards African priorities is particularly important. The increasingly complex challenges posed by the double burden of diseases in SSA countries takes place in an environment fragmented by a myriad of attempts to deliver often piecemeal improvements. Enhancing partnerships among African NPHIs and with European NPHIs and other academic institutions as well as more coherent and coordinated investments, in an interoperable and inter-sectoral health sector architecture, are needed to enable African partner countries to be durably prepared to prevent, detect, and respond to noncommunicable and infectious diseases, future epidemics and other health threats as well as to support the strengthening of integrated, highly performing and equitable health systems taking into account the potential impacts of climate change and environmental degradation. Fostering the collaboration between the Schools of Public Health and NPHIs in Africa to develop training programmes to support the implementation of the core public health functions at country level and to recognize public health as a profession is critical[3].

The full operationalization of the NPHO requires strengthening capacities at all levels (continental, regional, national and sub-national), and the new mandate of Africa CDC places the agency in central position in coordinating and supporting such efforts.
The action's scope is aligned with the Africa CDC Strategic Plan: 2023-2027, mainly contributing to Priority 1: Strengthen integrated health systems to prevent and control high-burden diseases and Priority 4: Strengthen NPHIs. It adheres to the guidance outlined in the "Framework for Development of National Public Health Institutes in Africa" which takes a holistic approach to strengthening NPHIs and identifies 10 core public health functions.
This Action will also contribute to the implementation of the Gender Action Plan (GAP) III for the EU's External Action, specifically to its key thematic area of engagement 'Strengthening economic and social rights and empowering girls and women'.
Additionally, the action will be aligned with the AU Strategy on Gender Equality and Women's Empowerment (GEWE), 2018-2028.[4]

2.2 Problem Analysis

Inequities in addressing the double burden of disease.

Africa is undergoing an epidemiological shift from disease-burden profiles dominated by communicable diseases to profiles with a growing prevalence of non-communicable diseases (NCDs). Adult, child and infant deaths caused by communicable diseases, especially HIV/AIDS, tuberculosis (TB), malaria, diarrheal diseases and vaccine-preventable infectious diseases, have been declining because of the extensive curative and preventative measures employed by African Union Member States.[5] In 2016, SADC advocated for a resolution at the UN Commission on the Status of Women, urging governments to allocate resources towards preventing new infections among women, girls, and adolescents. Mental health needs, and socio-psycho support, especially for young women, are frequently overlooked and under-funded.[6] While infectious diseases still have a severe impact, accounting for over 239 million

[3] https://iris.who.int/bitstream/handle/10665/363519/9789240060364-eng.pdf?sequence=1).
[4] Stretegy for Gender Equality & Women's Empowerment 2018-2028 | African Union (au.int)
[5] John N. Nkengasong and Sofonias K. Tessema, 2020, Africa Needs a New Public Health Order to Tackle Infectious Disease Threats, Cell Press, volume 183, Issue 2, p. 296-300.
[6] Strategy for Gender Equality and Women's Empowerment 2018-2028 (p.32) | African Union (au.int)

healthy years of life lost every year and producing an annual productivity loss of over US $800 billion; mortality and morbidity due to NCDs, injuries and mental health conditions, make up over 40% of the total disease burden in 2021[7] and have risen sharply over the last decade which will most likely continue to increase, accentuated by the impacts of climate change (which is already impacting vector-disease patterns) and extreme weather events (e.g. floods or heat waves which can have a strong impact on morbidity and mortality).. In addition, the burden of NCDs disproportionately affects populations in low- and middle-income countries in sub–Saharan Africa, where health systems are weak (for example hypertension[8] and type 2 diabetes[9]). Despite the double burden of infectious and chronic non-communicable diseases in Africa, health care expenditure favours infectious diseases. Moreover, most NCD care is paid for through out-of-pocket expenses. These inequities have implications for high morbidity and mortality as well as increasing financial hardship experienced by households with NCD patients. The total population of Africa is estimated to be close to 1.37 billion people (2021[10]). The African continent has the highest fertility rate in the world, and its population growth is projected to almost double to reach 2.5 billion by 2050. The expansion of health system infrastructure and services will be more and more critical to cater to the needs of Africa's population in the future. Moreover, 40% of Africa's population is under 15 years of age, while the population of those above 65 years has grown from 3% in 2006 to 4% in 2017[11]. Although the population above 65 years might stay relatively small in comparison to other continents, it will grow in numbers and Africa will have to deal with the long-term physical and mental disabilities and chronic conditions of an aging population that will require greater personal care. Africa still has the lowest life expectancy and the highest mortality rates for women, children and newborns compared to all other regions in the world. According to the Strategy for Gender Equality and Women's empowerment, the lifetime risk regarding maternal mortality remains at 1 in 38. In certain African countries, at least one every 25 women dies from complications of childbirth or pregnancy, and a much larger fraction will suffer long-term health consequences from giving birth[12]. Life expectancy in Africa increased from 46 to 56 between 2000 and 2019 but is still below the global average of 64[13]. It is estimated that in sub-Saharan Africa, 390 women will die in childbirth for every 100,000 live births by 2030, over five times the Sustainable Development Goals target of less than 70 per 100,000). The infant mortality rate is projected to be 54 deaths per 1,000 live births by 2030 (over double the Sustainable Development Goals target of fewer than 25 per 1000).[14]

Gaps in African public health systems

Although notable progress has been made over the past decades to build and strengthen Africa's public health systems, significant gaps remain in preventing and controlling diseases, promoting health and detecting and responding quickly and effectively to disease threats, with the risk of further increasing inequities. The challenge is to address the fundamental changes in the volume and composition of demand for healthcare, with a more complex case mix and more costly service utilization patterns (persistent, emerging and re-emerging infectious diseases and increasing prevalence of chronic NCD conditions) through more efficient public spending towards integrated, efficient and performant health systems, that specifically focus on health promotion and preventive actions to reduce the demand for care. Currently, however, many SSA countries face gaps in many aspects of their health systems, on efficient health care financing and service delivery, including specifically surveillance systems, health promotion and disease prevention, qualified health workforce - ensuring an equal representation of women and people with disabilities as well as the integration of the gender perspective-, access to medical products and technologies, effective community mobilisation and engagement, research, monitoring/evaluation of policy/strategy

[7] Africa CDC Non-Communicable Diseases, Injuries Prevention and Control and Mental Health Promotion Strategy (2022-26).
[8] Hypertension (who.int)
Hypertension prevalence, awareness, treatment, and control and predicted 10-year CVD risk: a cross-sectional study of seven communities in East and West Africa (SevenCEWA) | BMC Public Health | Full Text (biomedcentral.com)
[9] IDF-Atlas-Factsheet-2021_AFR.pdf (diabetesatlas.org) ;
[10] World Bank Data. Last accessed 1 October 2021.

[11] Second Session of the Specialised Technical Committee on Health, Population and Drug Control, Addis Ababa, Ethiopia 20-24 March 2017, state of Africa's population 2017.

[12] Strategy for Gender Equality and Women's Empowerment 2018-2028 (p.32) | African Union (au.int)
[13] World Health Organization (WHO) African Region. Tracking Universal Health Coverage in the WHO African Region, 2022.

[14] Atlas of African Health Statistics, WHO Africa Region, 2022.

implementation, and reliable health information systems that include a focus on underserved groups.

Gaps in progress of key health indicators in the indicatively targeted countries

In 2020, Sub-Saharan Africa accounted for around 70% of maternal deaths, and by 2030, the maternal mortality rate is expected to be 390 maternal deaths for every 100 000 live births, which is more than five times higher than the SDG global target of 70 maternal deaths/100 000 live births and well above the global average of 211 maternal deaths/100 000 live births. According to the WHO maternal mortality country profiles[15] the Maternal Mortality ratio in the so far targeted countries varies greatly and is still well above the SDG target (Rwanda 248; Malawi 349; Zimbabwe 458; DRC 473; Burundi 548; Guinea Conakry 576, Guinea Bissau 667; Nigeria 917; Chad 1140).

While the global Child Mortality (expressed in deaths of children under the age of 5 per 1 000 live births, -U5MR) fell to 37 deaths/1000 live births in 2020, it is still above the SDG target of 25 or fewer deaths/1000 live births, with geographic disparities. Sub-Saharan Africa continues to have the highest rates at 74 deaths/1000 live births. (Rwanda 39,4; Malawi 41,9; Burundi 52,6; Zimbabwe 54.6; DRC 62,4; Guinea Bissau 81, Chad 96; Guinea Conakry 98,8; Nigeria 110,8). Approximately half of the deaths occur among newborns in the first 28 days of life. The leading causes[16] of U5MR can be prevented or treated with access to affordable and basic lifesaving interventions such as skilled delivery at birth, postnatal care, breastfeeding and adequate nutrition, vaccination and treatment for common childhood diseases can save many lives. Nutrition related factors contribute to about 45% of deaths in children under 5.

Globally, almost a quarter of all children under 5 years of age are stunted, while at the same time, overweight and obesity are increasing rapidly in nearly every country in the world. Progress on malnutrition is too slow to meet the global targets and deeply unfair. New analysis shows that global and national patterns mask significant inequalities within countries and populations, with the most vulnerable groups being most affected. Underweight is a persisting issue for the poorest countries and can be ten times higher than in wealthier countries. The prevalence of stunting of children under the age of 5 years varies from 23% in Zimbabwe to 58% in Burundi in the targeted countries (Zimbabwe 23%; Guinea Bissau 28%, Guinea 29%; Rwanda 33%; Nigeria 35%; Malawi 37%; DRC 41%; Chad 35%; Burundi 58%) and prevalence of wasting from 1% in Malawi and Rwanda to 14% in Chad (Malawi and Rwanda 1%; Zimbabwe 3%; Burundi 5%; DRC and Nigeria 6%; Guinea Bissau 8%; Guinea 9%; Chad 14%)[17]

Additionally, it is worth noting the differentiated impact of inequalities on women and girls with disabilities in regards to health system . According to the World Bank Brief, 'Violence against women and girls with disabilities: ‘Discrimination against girls with disabilities occurs almost immediately after birth. Female infants born with disabilities may never be legally registered, due to social stigma and shame, which prevents them from accessing public health care, education, and social services. It also compounds their vulnerability and makes them more likely to experience violence and abuse. In countries such as Guinea, Kenya, Niger, Sierra Leone, and Togo, female babies with visible disabilities are more likely to be abandoned or killed than their male counterparts’.[18]

Gaps in Health Workforce density in Sub Saharan countries

All, so far, targeted countries figure on the WHO health workforce support and safeguards list 2023[19]. This list includes countries having a health workforce (doctors, nurses and midwives) density below the global median of 49/10 000 population and a UHC service coverage index of up to 55. These countries face the most pressing health workforce challenges related to Universal Health Coverage and should be prioritized for health personnel development and health system related support.

Because of the increasing prevalence of non-communicable diseases and of population ageing, the demand for health care workforce is increasing, particularly for primary health care – the level of the health system that is characterized by having the most difficulties in attracting and retaining health professionals. Health worker shortages are more than twice as high in rural areas than in remote areas[20]. Research shows that while crucial, financial systems and incentives focused on incentivization, if implemented as isolated interventions, rarely have

[15] Maternal Mortality country profiles maternal_health_bdi_en.pdf (who.int)
[16] The leading causes of death in children under 5 years are preterm birth complications, birth asphyxia/trauma, pneumonia, diarrhoea and malaria Child mortality (under 5 years) (who.int)
[17] Atlas of African Health Statistics, WHO Africa Region, 2022 9789290234852-eng.pdf (who.int)
[18] Brief on violence against women and girls with disabilities (p.6) | World Bank (worldbank.org)
[19] WHO health workforce support and safeguards list 2023 9789240069787-eng.pdf
[20] 20142_Retention of the health workforce in rural and remote areas_A systematic revue For Web.pdf (who.int)

the desired effect. They need to be complemented by other non-monetary incentives, such as job aids and logistics and supportive communities are reported as key factors for success. Lack of management of staff, supply line failures, lack of grievance procedures etc, but also contextual factors and family issues like employment opportunities for partners or education of children may influence retention. In addition, the increasing global demand for health workforce and the suboptimal working conditions, labour protection and rights in many lower-income countries, underpinned by limited health system capacity, budgetary constraints and weak planning and investment, contribute to the international mobility and attrition of health care workers[21]. WHO estimates a projected shortfall of 10 million health workers by 2030, mostly in low- and lower-middle income countries and Africa's share of the gap is projected to rise from approximately 25% in 2013 to 52% by 2030[22]. The health workforce density[23] for the targeted countries is well below the global median of 49/10 000 population and the UN threshold of 44,5/10 000 (Chad 2,65; Malawi 7,94; Burundi 8,32; Guinea 8,56; Rwanda 11,36; Guinea Bissau 12,74; DRC 14,8; Nigeria 20,6; Zimbabwe 23,35). The World Health Report of 2006 presented the threshold density of 23 doctors, nurses and midwives per 10 000 population, deemed necessary for countries to attain at least 80% of skilled birth attendance— a key target of the agenda of the Millennium Development Goals (MDGs) (WHO, 2006). However, as a threshold that was based on a single outcome variable, its limitations have been highlighted as the focus of global health policy shifted to the more ambitious SDGs, with UHC as the pivot of the health agenda. The "Health Workforce thresholds for supporting attainment of UHC in the African Region" report[24] concluded that a mix of 7.82 doctors per 10 000 population alongside 59 nurses and midwives per 10 000 is necessary for the attainment of 70% of the UHC service coverage index. This translates into a doctor to nurse/midwife ratio of one doctor to approximately eight professional and associate nurses.

Gender segregation in Health Workforce

While an analysis of 189 countries found that women constitute 67% of the health and care workforce, they encounter strong gender segregation, as women are underrepresented in the highest-paid occupations and overrepresented in low- or non-remunerated jobs. Gender gaps are higher than in many other sectors and include a 24% gender pay gap.

Moreover, Africa has the lowest proportion of female doctors and nurses across the globe. A 2019 WHO analysis of 91 countries revealed that only 28% of physicians in Africa are women. Among other reasons to understand this structural inequality, it is important to stress the difficulties for women and girls to access education in the continent.[25] Thus, the African Gender Index Report (2019) indicates that 'African girls and women continue to be disadvantaged in education and training. They face health-related barriers, and are more vulnerable to violence, including sexual violence. The AGI average score for the social dimension is 96.6% and its scores for different countries range widely reflecting considerable variation in services and contexts for African women'[26].

Gaps in progress towards Universal Health Coverage

The "Tracking Universal Health Coverage, 2021 Global Monitoring Report[27]" identifies strengthening health systems based on primary health care crucial to accelerate progress towards UHC, including through (a) actions to address integrated health services emphasizing primary health care and essential public health functions, empowered people and communities and the determinants of health; and (b) critical investments in the health and care workforce, physical infrastructure, and access to medicines and other health products. Investments in these areas should be informed by health system performance information to address critical gaps. Good-quality, timely and disaggregated data (by sex and persons with disabilities) to track progress towards UHC, and the policies that support it, require investment and political commitment to enhance country health information systems. In addition to the traditional household surveys, nimbler forms of monitoring progress towards UHC, using other modalities

[21] WHO "Working for Health, 2022-2030 Action Plan" 9789240063341-eng.pdf
[22] Microsoft Word - 20230818 GMR - key points for HWF advocacy_draft.docx (who.int)
[23] The National health Workforce Accounts database, World Health Organization, Geneva Welcome NHWA Web portal (who.int)
[24] Health Workforce Thresholds for supporting attainment of UHC in the African Region 9789290234579-eng.pdf (who.int)
[25] https://www.teamscopeapp.com/blog/gender-inequality-in-african-healthcare-workers-5-facts-you-need-to-know
[26] Africa Gender Index Report 2019 - Analytical report | African Development Bank Group - Making a Difference (afdb.org)
[27] Tracking Universal Health Coverage, 2021 Global Monitoring Report 9789240040618-eng.pdf

such as for example mobile phone and social media surveys to track both service coverage and financial hardship are needed, for which Public Health Institutes can play an important role. The universal health coverage index[28] of the targeted countries is equal or up to 55 (Low coverage: Chad 29, Guinea Bissau 37, Nigeria 38; Medium Coverage: Guinea 40, Burundi 41, DRC 42, Malawi 48, Rwanda 49, Zimbabwe 55).

Underspending for the Health Sector

The World Health Organisation (WHO) report titled "Spending Targets for Health: No Magical Number" estimated the total health expenditure[29] (THE) required to deliver a set of essential health functions at 86$ per capita per year (2012 US dollars). While the report notes that Universal Health Coverage performance increases more rapidly once THE is above 40$ per capita, great variation in progress is observed among countries with similar spending levels. However, the report notes that significant progress is observed once total health spending is above 200$ per capita per year. The report put forward two central messages: - first that countries need to ensure adequate spending on health and second the importance of improving spending efficiency. This perspective has been reinforced by the adoption in 2015 of both the Sustainable Development Goals (SDGs), and the Addis Ababa Action Agenda on Financing for Development. In the so far identified countries total health expenditure (THE) varies greatly[30]: four countries spend less than 40$ per capita per year on health (Burundi 16$, DRC 21$, Malawi, 33$, Chad 35$), in three countries the THE lies between 40$ and 59$ per capita per year (Guinea Conakry 47$, Zimbabwe 51$, and Rwanda 57$) and two countries are spending 60$ or more per capita per year on health (Guinea Bissau 61$ and Nigeria 70$). The allocation to health as a proportion of the government budget is less than the 15% AU target of Abuja Declaration of 2001[31] in all of the above countries (ranging from 2,8% in Guinea Bissau to 8,9% in Rwanda). Out of Pocket spending is over 50% in three countries (Chad 59,5%, Guinea Bissau 64,4%, Nigeria 74,7%), between 20% and 49% in three countries (Burundi 30,2%, DRC 39,7%, Guinea Conakry 47,3%) and lower than 20% in three (Rwanda 10,3%, Zimbabwe 10,4%; Malawi 19,5%).

Gaps in the provision of core functions of NPHI

The double burden of communicable and non-communicable diseases in Africa have reconfirmed the crucial role of African NPHIs. The need and recognition of the broader NPHI core functions[32], attributes and mandate is increasingly acknowledged by African countries to drive integrated holistic health system strengthening and progress towards Universal Health Coverage. On this topic, the International Association of National Public Health Institutes (IANPHI) is collaborating with WHO on the operationalisation of public health through identification of Essential Public Health Functions (EPHFs). NPHIs are seen as instrumental to ensure an inclusive public health response and a comprehensive evidence-based policy and agenda setting in health.

Africa needs performant institutes of public health able to perform the core public health functions for NPHIs as defined in the Africa CDC Framework for PHI Development: i) assessment (CF1-2), Population Health and Health-Related Indicators, Public Health Laboratory and Surveillance Systems, and Emergency Preparedness and Response; ii) Policy development (CF3-5): disease prevention and health promotion, advocacy, communication and social mobilisation; Policies and Plans that Support Individual and Community Health Efforts; and iii) assurance (CF6-10) Health Protection and Support for Regulation and Enforcement, Evaluation and Promotion of Equitable Access to Services, Public Health Workforce Development; Evaluation, Prevention, and Control of Public Health Issues in Clinical Settings; and Research in Public Health. However, many challenges remain to be tackled to achieve the required NPHIs maturity and mandate. For instance, the landscape of institutions and capacity

[28] UHC effective coverage index worldwide 2021, by country | Statista
[29] Spending targets for health: no magic number (who.int)
[30] Global Health Expenditure Database (who.int)
[31] Declaration.PDF (au.int)
[32] AfCDC Framework for PHI Development identifies the following core public health functions (CF) for NPHIs i) assessment (CF1-2), Population Health and Health-Related Indicators, Public Health Laboratory and Surveillance Systems, and Emergency Preparedness and Response; ii) Policy development (CF3-5): disease prevention and health promotion, advocacy, communication and social mobilisation; Policies and Plans that Support Individual and Community Health Efforts; and iii) assurance (CF6-10) Health Protection and Support for Regulation and Enforcement, Evaluation and Promotion of Equitable Access to Services, Public Health Workforce Development; Evaluation, Prevention, and Control of Public Health Issues in Clinical Settings; and Research in Public Health

contributing to the provision of public health core functions is highly fragmented and diverse. As of July 2023, 22 (40%) AU Member States have established NPHIs while 18 (33%) are in the process of establishing one. Fifteen (27%) of Member States have no NPHIs. The greatest gaps in NPHI establishment are found in Central Africa, with only two Member States with established NPHIs. Only 18 (82%) of the officially established NPHIs are fully functional. Addressing this deficiency is crucial for the effective coordination of resources and response during public health emergencies and in fulfilling the International Health Regulation (IHR) 2005 obligation[33].
Inefficiencies are also observed, such as duplicated efforts, lack of leadership and accountability, slow response times to public health emergencies due to uncoordinated efforts leading to reduced impact on health for population. The established NPHIs have distinct levels of autonomy depending on the status of their legal structure. Only nine of them have publicly accessible strategic plans that clarify priorities and resource needs, and most have limited sources of sustainable and predictable funding to perform core functions[34].

Structured collaboration between NPHIs, government agencies, healthcare providers, and international organizations is vital to ensure an effective policy dialogue. Challenges in achieving this collaboration can hinder the coordinated response to public health issue within and between countries.

Most NPHIs are dedicated to functions related to epidemiological surveillance, and providing laboratory services to support the identification, monitoring and response to public health threats (CF2). Almost all NPHIs perform the function of developing human resource capacity for epidemiologic assessments (CF8). A study of individual African countries' WHO Collaborating Centres (WCCs) highlighted their greatest involvement to be in activities relating to workforce development (CF8), mainly offered by schools of public health, and provided limited evidence of their participation in research and evidence generation to inform the policy development process (CF10). NPHIs need strengthening to improve data collection, knowledge and information and analytic capacity to provide evidence-based policy advice for disease prevention and health promotion (CF3), advocacy, communication and social mobilisation to solve health problems (CF4) as well as increasing equitable access to health care (CF7). The critical function of Enforcing laws and regulations that protect and ensure safety of individuals (CF6) is often assigned to specialized agencies that collaboratively perform these functions in support of Ministries of Health and protecting population health. Schools of public health and national public health institutes usually belong to different ministries and have different roles/mandates.

The digital skills gap

The 2030 Agenda on Sustainable Development highlights that the spread of information and communications technology and global interconnectedness has great potential to accelerate human progress, to bridge the digital divide and to develop knowledge societies. UNGA 2015 on the overall review of the implementation of the outcomes of the World Summit on Information Society highlighted that digital technology enabled numbers of people having access to services and data that might previously have been out of reach or unaffordable. There is also growing recognition that digital health presents new opportunities for the achievement of SDG3[35]. The effective use of digital technology in public health is crucial. Many NPHIs have insufficient digital skills and infrastructure for data collection, analysis and communication.

However, despite considerable progress made by some countries, many countries still require support for the development of digital health strategies and the implementation of their action plans. In addition, challenges such as poor coordination leads to fragmented implementation and issues on affordability and equity, development of locally adapted and relevant solutions, interoperability of systems, etc. Digital health is rapidly evolving, and numerous new applications are introduced and piloted in many countries in a fragmented way. There is an urgent need to assess and exchange knowledge on: what works and what not, the feasibility and preconditions needed for introducing digital applications, as well as the cost/benefit of them. SSA countries may be unable to afford the high costs associated with digital health such as the cost of hardware and internet coverage, durable electricity, software, training facilities and maintenance costs. SSA is faced with the challenge of inadequately trained workforce to

[33] Africa CDC - National Public Health Institutes (NPHIs) Development in Africa, Assessment Report.

[34] Africa CDC - National Public Health Institutes (NPHIs) Development in Africa, Assessment Report.

[35] WHO Recommendations on digital interventions for health system strengthening: evidence and recommendations WHO-RHR-19.10-eng.pdf

exploit the opportunities of digital health. Digital health success in SSA will depend on the knowledge and expertise of the health workforce about digital technologies[36].

Gaps in the Team Europe Initiative coordination

The co-creation and operationalisation of the Team Europe Initiative (TEI) Support to Public Health Institutes in SSA requires a certain traction force to ensure focus on identifying critical common priorities, eventually resulting in transformative impact. So far, this coordination has been ensured by the EU who has been facilitating the collaborative dynamics through the TEI working group gathering the EU, Member States cooperating in a Team Europe approach. The co-creation process has proven to be time-consuming. Support is needed in the form of a dedicated expert to support the joint, collaborative processes, the day-to-day management and coordination between the EU, Member States and European financing institutions cooperating in a Team Europe approach. These actors who follow a Team Europe spriti should contribute to ensuring the coherent articulation of all TEI PHI components (e.g. knowledge management, theory of change and programme monitoring, stakeholder (duty bearers) outreach, further identification of activities for the programming of the TEI components, development and implementation of a communication plan, ensuring operational alignment/exchange with and between other relevant TEIs in the health sector, etc.).

Identification of main stakeholders and corresponding institutional and/or organisational issues (mandates, potential roles, and capacities) to be covered by the action

Africa CDC, the Africa Centres for Disease Control and Prevention, and Regional Coordination Centers is the technical organisation of the African Union working on public health at a continental scale. Given its unique positioning on the continent, its expanded mandate and institutional autonomy, it is playing a key role in driving the continent's public health agenda and in providing the crucial political link to the AU Member States. The Africa CDC has a three-tiered organisational structure: headquarters in Addis, five Regional Coordinating Centers (RCCs in North, West, Central, East and Southern Africa, at different stages of operationalization) and National Public Health Institutes. NPHIs are the structural foundations of Africa CDC in Member States. Africa CDC and contracted entrusted entities will co-lead the implementation of the support.

Regional and continental partners (the RECs, the AU), partners engaged in and accountable for the health sector in the global health system (African National Public Health Institutes (NPHIs) are the target beneficiaries of this support and are mandated to coordinate public health responses in their respective countries. The mandate of an NPHI includes monitoring population health status, conducting disease surveillance, lead emergency preparedness and response, health workforce development, public health research, prevention of high burden communicable and non-communicable diseases as well as health promotion. NPH is from Burundi, Chad, DRC, Guinea, Guinea-Bissau, Malawi, Nigeria, Rwanda, and Zimbabwe are targeted as as specific indicative beneficiaries of this activity.

Schools of Public Health in Africa and other academic institutions for workforce development data collection, public health research and evidence generation to inform policy development processes.

European National Public Health Institutes (NPHI's), working in collaboration with the Africa CDC will provide technical assistance and share experiences to facilitate the north to south collaboration that is intended to be achieved through this partnership.

West Africa Health Organization (WAHO), is the health agency of ECOWAS responsible for health promotion and disease prevention in the West African region. The Africa CDC West Africa RCC is based in Abuja, Nigeria and works in synergy with WAHO. The two institutions will support implementation in the West African Region.

The International Association of National Public Health Institutes (IANPHI) has NPHI members in 98 countries including African National Public Health Institutes, which belong to the IANPHI Africa network. IANPHI members are often engaged in twinning programmes. IANPHI is envisioned to support Africa CDC in the implementation of these activities, such support fits well with the existing collaboration set in the letter of intent

[36] Overview of Digital Health in Sub-Saharan Africa: Challenges and Recommendations D1201041921.pdf (iosrjournals.org)

that was signed by the two organizations in 2019 to support one another in strengthening African NPHI, which is to be renewed in 2024.

The national decision-/ policy makers, the Ministries of Health and other Line Ministries (e.g., Ministry of Finance, Ministry of Education, Ministry of Technology, Ministries analogous to the Ministry of Women etc....) are key stakeholders (duty bearers). NPHIs' key role is to provide evidence-based policy advice to the respective decision-makers.

EU MS Development Agencies have, within the scope of the Team Europe Initiative ongoing activities in strengthening of NPHI at regional and country level. Close collaboration and coordination will be fostered to ensure the harnessing of synergies for maximum impact at country level.

EU Delegations act as the cornerstone to coordinate the activities of Specific Objective 2 & 3 at the country level and ensure an overall consistent and effective programming for the national public health institutes strengthening and ensure complementarity with other regional Team Europe Initiatives and with the bilateral health programmes.

Other relevant stakeholders (duty bearers) can be invited as appropriate and may include amongst others:

- World Health Organization and other UN agencies
- Other Financial and Technical Partners
- Association of schools of public health in Africa (ASPHA)
- Association of School of public health in Europe (ASPHER)
- International Medical Informatics Association (IMIA);
- European Federation for Medical Informatics (EFMI);
- Health Informatics in Africa (HELINA):
- Other actors or networks (public or private): including the population and communities, non-state actors, financial and technical partners, professional associations, rights holders such as youth, women organizations, and persons with disabilities organisations, NGO's and CSO's at regional, national or local level, to ensure women's representativeness, empowerment and long-term sustainability, and organizations representing vulnerable and marginalized groups

3 DESCRIPTION OF THE ACTION

3.1 Objectives and Expected Outputs

The Overall Objective of this action is to contribute to the population's health and wellbeing (SDG 3) via the provision of essential public health services by National Public Health Institutes (NPHIs).

The Specific Objectives of this action are to

1. Establish/enhance regional and international links and capacity among African and European NPHIs for public health research, knowledge and information gathering that drive evidence-based policy advice, public health workforce training, and advocacy;
2. Enhance NPHI capacity development to deliver Core public health functions;
3. To support NPHIs to become digital health literate on the sustainable use and effectiveness of digital applications and to reduce the digital skills gap for each of the targeted countries.

The Outputs to be delivered by this action contributing to the corresponding Specific Objectives are:
Contributing to Specific Objective 1

1.1 Enhanced regional networking and bilateral South to South and North-South collaboration among NPHIs to develop and promote evidence-driven policy and practices, and formulation of strategies, by sharing technical expertise and experience.

1.2 Enhanced donor, and resource, coordination of support to NPHIs, spearheaded by Africa CDC

Contributing to Specific Objective 2

2.1 NPHIs have improved public health expertise, knowledge and leadership skills for example to convene decision-makers and key stakeholders; for the provision of evidence-based and locally adapted policy advice.

2.2 NPHIs have generated context, culturally and gender sensitive data, information, knowledge and evidence on public health priorities to drive the policy response and formulate strategies

2.3 NPHIs generated data, information, knowledge and evidence are translated into policies, focusing on public health priorities.

Contributing to Specific Objective 3

3.1 National digital infrastructure and data systems that securely and ethically store, protect and analyse large public health data from different sources are established.

3.2 NPHIs have gained digital health and data science expertise

3.2 Indicative Activities

Activities relating to Output 1.1:

- Enhance/Facilitate South South, North South and peer-to-peer collaboration and exchange among African NPHIs and between African and European institutions through sharing expertise and technical experience to strengthen NPHIs provision of core public health functions in targeted countries
- Organise regional networking events (conferences, I, workshops, think tanks, etc.), that involve policy makers, partners and other key stakeholders (duty bearers); covering priority public health topics; to exchange of knowledge, practices, lessons learned and develop best practice guidance or regional policies/strategies and joint projects.
- Support targeted NPHIs to actively participate in the regional networking events and share experiences, knowledge, lessons learned.
- Support NPHIs in coordinating research on regional priority public health issues in collaboration with African and European academic and research institutions through sharing of expertise and experience
- Provide support and monitor implementation and progress of NPHIs in the targeted countries

Activities relating to Output 1.2:

- Update NPHIs maturity assessment, establish roadmaps, identify needs/gaps, regulatory framework and organize a partner/advocacy event to present assessment outcomes and mobilize additional resources in the targeted countries
- Conduct a mapping of NPHIs' available resources to implement the roadmaps, identify gaps (also considering gender and disabilities-related issues)
- Organise a NPHIs stakeholder (duty bearer) forum at regional/continental level, spearheaded by Africa CDC, to present the mapping, discuss gaps and mobilize additional resources where needed
- Support the coordination of the Team Europe Initiative by endorsing the role of secretariat for the TEI, including providing regular update of the TEI key documents, prepare briefings and reports on the TEI implementation progress to facilitate reporting

Activities relating to Output 2.1:

- Carry out assessments on public health human resources gaps in numbers and skills gaps, as well as collection of information on incentives and contextual factors influencing attraction, retention and detraction.
- Support NPHIs to review/establish post- and undergraduate level courses in priority public health areas - ensuring its equal access for women and people with disabilities- (for example MSc in public Health with multiple possible orientations (for example health economics, statistics, Health Care Management, Environmental Health and Climate Change, human resources for health, organisational management and leadership skills, etc…)
- NPHIs, Schools of public health, Ministries of Health and other relevant public health agencies develop and implement online and in-person trainings (with a gender and inclusive perspective) as well as courses for continued health professional training for all levels of cadres having a responsibility to implement core public health functions - ensuring its equal access for women and people with disabilities-and other vulnerable groups.

Activities relating to Output 2.2:

- Establish an integrated disease surveillance system (including communicable and non-communicable diseases as well as information on accidents and trauma, environmental and climate change issues)

- Strengthen NPHI capacity in quality control of the environment water supply, air, use of pesticides or food or drugs and health products
- Train NPHIs to conduct operational research and surveys
- Support NPHIs to conduct studies for example on equitable access to health services, specifically of vulnerable groups (also including women or people with disabilities) (rights-holders), availability of public health workforce, including workforce responsible for health promotion and disease prevention activities; cost of services, programmes and strategies; feasibility of setting up mechanisms to progress towards Universal Health Coverage
- Build NPHIs analytic capacity to enable data and information translation into robust knowledge and evidence-based intelligence
- Build NPHI capacity to develop scientific advice and policy briefs
- Build NPHI capacity to communicate data, organise events/retreats, under the leadership of decision makers to review findings and recommendations towards improved policy and strategy formulation

Activities relating to Output 2.3:
- Organize scientific conferences to disseminate research findings and influence priority public health policies and programmes, integrating the HRBA, inclusive and gender perspective.
- Support NPHIs, under the leadership of the MoH, to coordinate key stakeholders for policy dialogue, organise yearly reviews of progress and results of national policy implementation.
- NPHIs organise a dialogue with the population, civil society, private sector for the development of context adapted messages for disease prevention and health promotion
- NPHIs provide evidence for better regulations for example on disease prevention and health protection and promotion, environmental health and safety, on food safety and/or water quality and/or use of pesticides, etc.

Activities relating to Output 3.1:
- Establish national structures to enable and improve data management
- Ensure interoperability of different disease and health status surveillance systems
- NPHIs review/initiate digital health regulation
- NPHIs organise feasibility studies for introducing as well as assessment of effectiveness, efficiency and impact of ongoing digital health applications (for example EHR, EIR, digital reporting of health facilities, digital applications for supply chain management, clinical decision support applications, etc…
- Develop/review digital policies/strategies through the organisation of effective digital health policy dialogue and the communication of the findings with decision-makers and digital health stakeholders (duty-bearers)

Activities relating to Output 3.2:
- Develop digital capacity of NPHIs to be able to advice on the sustainable use and effectiveness as well as on data protection and privacy of digital applications
- Organise graduate level courses in digital health, amongst others on setting up a health enterprise architecture,
- Establish digital libraries in NPHIs
- Organise or increase the participation in existing online courses

The commitment of the EU's contribution to the Team Europe Initiative to which this action refers will be complemented by other contributions from Team Europe members, It is subject to the formal confirmation of each respective member's meaningful contribution as early as possible. In the event that the TEIs and/or these contributions do not materialise, the EU action may continue outside of a TEI framework.

3.3 Mainstreaming

Environmental Protection & Climate Change

NPHIs in several targeted countries intend to support building integrated disease surveillance systems (including communicable and non-communicable diseases as well as information on accidents and trauma, environmental and climate change issues) and monitoring information which may include changing disease patterns due to climate change. In addition, some countries intend to strengthen testing and research capacity in areas such as water and air quality, quality of food, use of pesticides. This might enhance timely generation of evidence-based policy advice and if communicated and disseminated by NPHIs may be addressed sooner and more effectively or brought on the

agenda at regional level. Some of the countries would consider introducing courses in environmental health and climate change and/or support the generation of evidence to advocate for better regulations regarding environmental health and safety, on food safety and/or water quality and/or use of pesticides. While these activities may generate additional knowledge that can be shared with other NPHIs, or inform future programmes and regional agenda setting if successful, the action's effect on environmental issues will be minimal.

Outcomes of the SEA screening. The Strategic Environmental Assessment (SEA) screening concluded that no further action was required.
Outcomes of the EIA (Environmental Impact Assessment) screening. The EIA (Environment Impact Assessment) screening classified the action as Category C (no need for further assessment).
Outcome of the CRA (Climate Risk Assessment) screening. The Climate Risk Assessment (CRA) screening concluded that this action is no or low risk (no need for further assessment)

Gender equality and empowerment of women and girls
As per the OECD Gender DAC codes identified in section 1.1, this action is labelled as G1. G1 means that gender equality will be mainstreamed across this Action, defining specific activities aiming at gender equality.

Public health institutes play an important role in monitoring population and sub-population (e.g., women and vulnerable populations) health status. Similarly, NPHIs public health research and monitoring and evaluation of policy implementation intend to take gender among other issues such as environment issues, human rights and effects on inequality into account to ensure sustainable strengthening of resilient, equitable and quality health system that leave no-one behind. The analysis of gender sensitive data could enable NPHIs to formulate policies/guidelines that specifically address health needs of women and girls. One of the core functions of NPHIs is the evaluation and promotion of equitable health services which include the identification of needs and barriers to health access, specifically those that impact certain subpopulations disproportionately. The implementing partners will ensure gender equality of the health workforce in access to training opportunities. NPHIs will engage in social mobilization through dialogue with civil society organisations (rights holders) and communication and messaging to the public that will take gender issues into account. The action will ensure that this communication ensures inclusive participation of different subpopulations, advances social rights and ensures the application of the non-discrimination principle in the selection of targets.

Human Rights
Contributing to the achievement of population's health and wellbeing (SDG 3) and towards achieving universal health coverage contributes to health as a fundamental human right. This action actively supports the adoption of policies and strategies to strengthen integrated health systems in Africa as well as monitor progress, collect information, conduct research on the implementation of these, thus contributing to the realization of this right across the continent. Moreover, all activities outlined in this action document will be meticulously planned and executed in alignment with the principles of a rights-based approach, good governance, human rights, and the inclusion of socially or economically disadvantaged groups.

Disability
As per OECD Disability DAC codes identified in section 1.1, this action is labelled as D0. While the action will monitor access to services of vulnerable groups, including of people with disabilities, specific work on formulating strategies and policies may more generally focus on inclusiveness to ensure access of all vulnerable groups.
Attention will be paid to ensure and enable the participation of persons with disabilities in the activities (accessibility of actions, consulting with disabilities organisations and encourage inclusive communication)
Article 4 of the Convention on the Rights of Persons with Disabilities (CRPD) requires governments to include persons with disabilities and their representative organisations in policy planning
The Action will be in line with the EU Strategy for the Rights of Persons with Disabilities 2021-2030, and the EU Guidance Note Disability inclusion in EU external action.

Reduction of inequalities
Public health institutes, in supporting the strengthening of integrated holistic health systems addressing the double burden of diseases can contribute to a more equitable access to health services, which include health promotion and prevention. Public health institutes play an important role in monitoring population and sub-population (e.g.,

women, persons with disabilities, and vulnerable populations) health status. Similarly, NPHIs public health research and monitoring and evaluation of policy implementation will take gender, disabilities, environment issues, human rights and effects on inequality into account to ensure sustainable strengthening of resilient, equitable and quality health system that leave no-one behind. One of the core functions of NPHIs is the evaluation and promotion of equitable health services which include the identification of needs and barriers to health access, strengthened health promotion and disease prevention, specifically for certain subpopulations that are disproportionately impacted

Democracy
N/A

Conflict sensitivity, peace and resilience
N/A

Disaster Risk Reduction
This action will be complementary to the One Health TEI, which focusses on pandemic preparedness and response this action will focus on integrated health systems strengthening addressing the double burden of diseases. In this way a better functioning health system may reduce the impact that disasters may have on continued access to health care.

Other considerations if relevant

3.4 Risks and Lessons Learnt

Category	Risks	Likelihood (High/ Medium/ Low)	Impact (High/ Medium/ Low)	Mitigating measures
External environment	Risk 1: Country Governments/Ministries of health fail to increase political commitment and investments according to NPHIs evidence-based policy advice	Medium	Medium	This action will specifically engage with the country decision making authorities to identify specific public health priority areas that NPHIs should focus on under the current action - with a gender equality, human rights and inclusive perspective. Intense technical assistance; regional and international networking of NPHIs; support for advocacy, leadership skills and evidence-based policy dialogue with key stakeholders (duty bearers) on public health topics; support for coordination to avoid duplication; and supporting increased resource mobilisation are the principal mitigating measures.
External environment	Risk 2: political instability	Medium	Medium	This is a risk beyond the control of the Action that can generate a detrimental turnover of civil servant main partners. Identification and regular monitoring of political key events will help anticipate potential issues and adapt activity implementation. Should the political landscape alter dramatically in one target country, the implementing partners will reassess the context and related risks and, if need be, will realign activities or target countries.

External environment	Risk 3: emergence of a public health emergency of international concern or a serious epidemic	Medium	Medium	This is a risk beyond the control of the Action for which the action could reallocate funding to address the emergency and/or ensure continuity of services to minimise impact of this emergency.
Planning, processes and systems	Risk 4: insufficient capacity and qualified staff of supported agencies	Medium	Medium	The action will support improving organisational management of public health agencies, avoid duplications of agencies and increase synergies and complementarity, look at staff issues and the most efficient way of allocating staff to agencies. In this way if an agency does not have staff capacity the action will look at what other agencies would be best positioned to add specific activities.
Planning, processes and systems	Risk 5: Health Workforce leaving after training or failing to apply training	Medium	Medium	The action will also ensure a post-training follow-up and support staff to use their new knowledge and skills and could advice trained public health staff how to implement what they learned (kind of practical/on the job training)
Planning, processes and systems	Risk 6: Available resources are invested too thinly to make substantial difference and impact on the health status of the population	Medium	Medium	Close monitoring and support to project implementation in - amongst others: - ensuring that resources are being strategically invested, through linking workforce development, research and knowledge development – - ensuring support to the policy advice and advocacy for additional resource mobilisation is focused on specific policy outcomes of priority public health issues in the countries - with a gender equality, human rights and inclusive perspective.
Gender Equality	Risk 7: A gender-blind, neutral, or negative context and problem analysis could reinforce existing gender inequalities and non-realization of human rights in the sector, and hinder the efficiency and sustainability of the action.	Medium	Medium	Knowledge and tools of gender mainstreaming are available. Gender-sensitive monitoring, use of sex-disaggregated data, and gender-sensitive indicators. Gender mainstreaming is applied in all phases of the support services.
Lessons Learnt: Experience and lessons learned from implementation of the Support to Public Health Institutes Programme (SPHIP) programme[37]. The SPHIP was a five-year programme (2015 – 2020) consisting of projects implemented in eight countries in Asia,				

[37] Lessons learned from the Support to Public Health Institutes Program

Africa and Latin America. The overall objective of the SPHIP was to enhance expertise, knowledge, and resources of selected schools of public health or public health research or training institutes in low-income countries in order to provide national health authorities and stakeholders (duty bearers) with evidence-based and locally adapted policy advice, training, and other support to feed decision- and policy-making and to monitor implementation at national or sub-national level. The SPHIP took place in the framework of the EU Thematic Programme 'Investing in People' for an overall amount of EUR 23 million. The evaluation report mentioned amongst others the following lessons learned:

Strengthening the capacity of NPHIs to deliver the core functions, necessary to provide evidence-based policy advice, was very beneficial to the Ministries of (Public) Health and reduced their reliance on external advice obtained with the support from international organisations.

The process of change is hard and demanding but with continued investment, it gets good results and increased ownership. Continuous dialogue with decision and policy makers on the activities of the programme were crucial in obtaining the envisioned results.

Improved operational research and study capacity of NPHIs proved that it was possible to find locally, and context adapted solutions at low cost. The research supported was useful as learning experience, especially when linked to Master and PhD trainings.

Information and knowledge dissemination, translation into policy advice and advocacy proved to be much more complicated than anticipated and required more weight than initially foreseen, specifically on the formulation of communication plans, organisation of a policy dialogue, lobby and advocacy and the generation of policy briefs, fact sheets, case studies, blogs and other products needed more support.

The capacity building regarding the Workforce Development capacity of NPHIs, was one of the most appreciated elements in the projects, as it helped the Professors/teachers and researchers in the institutions with concrete knowledge and skills. It made the projects more visible within the institution. In addition, they became more conversant with new training methodologies that they also applied in other courses.

Institutional strengthening (strategic planning) proved more complicated in those cases, where the institutes were not an autonomous entity. It seemed more helpful to support NPHIs developing an investment plan on resources needed (human, financial, material) and how they can be mobilised.

In DRC the evaluation of the RIPSEC programme mentioned that through careful management of the programme and continuous dialogue with Government authorities, significant results were achieved with little funding.

The mobilisation of sufficient funding needed to ensure the sustainability of all achievements was a major challenge

EU experience of collaboration with Africa CDC

The EU is a strategic partner of Africa CDC. The partnership has been expanding over the recent years reflecting the ever-growing importance and role of Africa CDC in ensuring the health security of the continent. The partnership that started with the ECDC for -Africa CDC capacity building project and the support to the continental response to COVID-19, the initiative on local manufacturing of vaccines and medicines, the strengthening of pandemic preparedness and response, digital health, research and scientific collaboration and health workforce development is now being further developed with the initiative to support public health institutes

Throughout the engagement so far, the underlying challenge has been the lack of adequate capacities in Africa CDC structures causing implementation delays and low absorption of funds. To mitigate these challenges different implementation modalities are being used including third party implementing partners.

Given the expanded mandate and the new institutional status of Africa CDC, there is a recognition of the need to engage Africa CDC not only as a technical partner, but also at political level, since it will have a key role in facilitating the dialogue with Member States and other regional organisations. Joint strategic dialogue platforms between AU/Africa CDC and EU to follow up on the delivery of health-related commitments of the AU-EU Summit are being set up. The first meeting of the High-Level Steering Structure took place in Addis Ababa on June 29th, 2023.

An internal preliminary mapping of ongoing support identified various EU-funded Public Health Institutes projects across African countries. Furthermore, other important technical and financial partners are supporting core functions and strengthening public health institutes in Africa. While all existing projects are of high value on their own, they also contribute to the fragmented support to Public Health Institutes. This initiative strives to achieve a higher

efficiency of European programming by coordinating programmes and promoting synergies, reducing duplications and gaps, and increasing value for money for all involved members. It also seeks to enhance coordination with other key stakeholders (duty bearers), notably international organisations.

3.5 The Intervention Logic

The Overall Objective of this action is to contribute to the population's health and wellbeing (SDG 3) via the provision of essential public health services by NPHIs. The action will focus thematically on reducing inequities in addressing the double burden of disease and addressing public health priorities linked to integrated holistic health systems. However, in case of a health emergency of international concern or a serious epidemic, becoming then a public health priority, the thematic focus of this action can be adapted to address the emergency. For this the action intends to support NPHIs to provide evidence-based policy advice and to organise a structured policy dialogue under the leadership of Government Authorities. A structured and effective policy dialogue should lead to a coordinated and collective action and effective implementation of formulated policies and strategies.

Specific Objective 1: Establish/enhance regional and international links and capacity among African and European NPHIs for public health research, knowledge and information gathering that drive evidence-based policy advice, workforce training, and advocacy

For this first component the underlying intervention logic for this action is that increased collaboration among NPHIs at regional level (peer-to-peer collaboration, South-South collaboration) and collaboration between African and European/international NPHIs (North South collaboration) will facilitate enhanced capacity of NPHIs to provide the core public health functions (CF) and formulate evidence-based policy advice. This will drive progress towards the achievement of set targets for key health indicators and ultimately towards universal health coverage (UHC), in turn contributing to the population's health and wellbeing (SDG 3). Africa CDC, mandated to coordinate African NPHIs, and IANPHI will be supported through this action, to link NPHIs to work together on specific identified public health priorities. This collaboration of NPHIs, amongst others on research projects, the reciprocal exchange of information and evidence, the pooling and sharing of resources and expertise, etc.. will facilitate enhanced capacity of NPHIs to deliver the CFs. The action will both use existing networks and establish new network activities, when needed, to organise regional networking events and conferences, fora, workshops, think tanks, research dissemination workshops (ensuring the equal participation of women and persons with disabilities), etc; on priority public health themes. This will enhance knowledge sharing, initiate joint activities, strengthen regional agenda setting, development of guidance and practice documents, regional strategy and policy formulation.

In addition, this component will support Africa CDC to organize better resource coordination to enhance complementarity and synergies of actions, avoid duplication of investments and efforts at continental level. Effective coordination will support joint action of national and regional public health priorities, promote regional research agenda setting, etc.

The above activities, spearheaded by Africa CDC, will enhance the focussing on regional common priorities and promote traction and political commitment of African Union Member States to tackle these priorities. This will drive progress towards achievement of set targets for key health indicators (including gender and disability perspective) and ultimately towards UHC. The conduct of a regional gender analysis could be considered.

Moreover, this component will support NPHIs, in beneficiary countries, for example for the establishment of new NPHIs, NPHI maturity assessment, improving the organizational set-up, specifically in those countries where NPHI functions are fragmented and spread among several agencies. The regional level may also support roadmap development and activity planning to develop and promote evidence driven policy-advice, support the organisation of in-country events to present outcomes and findings, advocacy and resource mobilisation. The regional component will also specifically monitor implementation of the country-based component of this action to ensure timely identification of challenges, needs and ensure the smooth implementation of the action at country level.

In addition this component will provide secretariat support for the operationalization of the TEI on National Public Health Institutes in SSA (PHI TEI). This support will consist amongst others of: the regular updating of the TEI key documents (e.g. mapping of the PHI TEI programmes, monitoring of the PHI TEI progress based on the TEI joint intervention logic indicators, etc..), the PHI TEI reporting to the AU- EU steering structure of the GG health TEI package on the PHI TEI implementation progress, lessons learned and any challenges encountered. Support to the operationalization of the PHI TEI will ensure increased synergies, complementarity and better align–ent to AU - EU policies and strategies that will lead to more efficient and effective programmes towards the achievement of the set objectives of the PHI TEI

Specific Objective 2: To enhance NPHI capacity development to deliver Core public health functions[38] through sharing technical expertise and experience among NPHIs

For this specific objective the underlying intervention logic is that strengthening public health capacity through the provision of core public health functions will enable NPHIs to provide evidence-based policy advice. In addition, the action will foster, under the leadership of Government authorities, a coordinated and collective action to address priority public health challenges, the more complex mix of demand for curative and preventive health care, environmental and climate change issues, etc. This will in turn drive progress in the achievement of key health indicators and towards UHC. This support will mainly be provided through the collaboration with other African NPHIs and European NPHIs under the leadership of AfCDC.

The country level support will facilitate active participation and linking of the NPHIs in regional and international network events. In addition, the action will support high level academic collaboration among African and between African and European NPHIs to leverage local and international knowledge and expertise and instil ownership.

Each targeted country will address country level identified priorities. The action will focus on these identified priorities and strengthen the translation of evidence to policy to practice through feedback and learning. The support from the action may consist of amongst others the following:

- Support the building of public health workforce capacity. For this the component will support assessments on public health workforce gaps. Following analysis of these assessments, the component will support improving the offer of graduate level public health courses such as for example MSc in public Health with possibly multiple possible orientations: for example health economics, statistics, Health Care Management, Human Resources for Health, Environmental Health and Climate Change, human resources for health etc.) that respond to identified needs and gaps. This could be through in-course training but also through online or distance learning. In addition, the action may include support to improving continued health staff training and capacity building, specifically of health workforce active in health promotion and disease prevention, through responding to competency gaps and curriculum development. Furthermore, the action will promote the equal access and participation to the capacity building to women and persons with disabilities and other vulnerable groups.
- Support the NPHIs to generate robust, context, culturally and gender sensitive data, information on disease prevalence, key health indicators and health status of the population, social determinants of health and risk factors. In addition, the capacity building support to NPHIs in conducting research and studies will lead to more robust and reliable information generation.
- Support NPHIs to conduct research in by the countries identified priority areas, for example on equitable access to services, specifically of vulnerable groups women and girls, persons with disabilities, and/or on feasibility, efficacy, efficiency and impact of health interventions, and/or on environmental issues (quality of water, air, use of pesticides, on quality of food, drugs and health products.
- Support building the analytic capacity of NPHs to analyse complex data and information. This will enable NPHIs to structure and visualise data, determine relationships (correlation or causation) and consider all possible interpretations, identify biases, question data and form and test hypothesis, derive actionable conclusions, predict trends and monitor progress, identify and learn about challenges and opportunities and provide decision makers with evidence-based information. In addition, NPHIs can be supported to translate the findings into evidence-based policy advice for decision-makers. NPHIs will also be supported to communicate on generated data and dissemination of research findings through support on building a communication strategy.
- support dissemination events to present and discuss the findings at country as well as at regional level. This dissemination can take different forms: through ad hoc workshops and events, or the organisation of yearly reviews on progress in key health indicators, health status of the population, health system performance as well as on environmental, climate change issues.
- Support NPHIs to organise consultations with the population, civil society, women's rights organisations and organisations of persons with disabilities (rights-holders) and other vulnerable groups, private sector, etc.

[38] NPHIs core public health functions (CF) include i) assessment (CF1-2), Population Health and Health-Related Indicators, Public Health Laboratory and Surveillance Systems, and Emergency Preparedness and Response; ii) Policy development (CF3-5): disease prevention and health promotion, advocacy, communication and social mobilisation; Policies and Plans that Support Individual and Community Health Efforts; and iii) assurance (CF6-10) Health Protection and Support for Regulation and Enforcement, Evaluation and Promotion of Equitable Access to Services, Public Health Workforce Development; Evaluation, Prevention, and Control of Public Health Issues in Clinical Settings; and Research in Public Health

- Support the development of context adapted messaging for disease prevention, health promotion and health protection. This can be through supporting NPHIs to develop a communication strategy using mass reach health communication interventions (billboards, TV and radio broadcasts, social media and digital tools, brochures, etc.), school education, etc…
- Support NPHIs to engage in a structured policy dialogue, advocacy and coordination, under the leadership of decision makers, with key stakeholders (duty bearers) (population and communities, civil society (rights holders), private sector, technical and financial partners, etc) to influence and improve health regulation, strategies and policies regarding priority public health themes. The action intends to support the NPHIs' positioning within the broader health system context and its participation in appropriate in-country consultation platforms through effective links between the policy/political level, key stakeholders (duty bearers), health institutions and associations, civil society/non-state vulnerable groups, women's rights organisations and organisations of persons with disabilities (rights-holders) and private sector actors, relevant institutions from other sectors, etc. in the country. The action will support a structured and deliberative process where dialogue takes place around a public health question, identified as a priority by the country and NPHIs, on which key documents and national and international experts are brought together to present recent evidence, as well as relevant studies and research from countries that have faced a similar question. This process involves a round of evidence-based formal events discussions/workshops/consultations under the leadership of the national Authorities, as well as informal communication (electronic correspondence, etc among experts and stakeholders), on a particular subject, considering both technical as well as political aspects, that inform policy and result in the preparation of a clear, understandable and evidence-based policy brief.

Specific Objective 3: To support NPHIs to become digital health literate on the sustainable use and effectiveness of digital applications and to reduce the digital skills gap.

For this specific objective the underlying intervention logic is that strengthening digital public health workforce capacity in countries will contribute to closing the digital skills gap (ensuring the access of women health workforce to the capacity building). The recent proliferation and fragmented implementation of digital technologies in public health[39] has highlighted the need for NPHIs to become digital health literate. This will enable them: to advice on digital transformation and the sustainable use and effectiveness of digital applications and to promote interoperability of systems and data sharing among health care institutions and public health agencies. This will enhance information flow and coordination. This will lead to more locally adapted, effective and efficient digital applications that increase the timely availability of quality data and information. In addition NPHIs could be supported to have digital capacity and knowledge to advice on the use of digital messaging (videos, spots, etc) and applications for health education, health promotion and disease prevention; as well as for health service delivery.

Knowledge development and information collection are core to NPHIs. Producing knowledge, requires access to information and data, to health information systems, and skilled researchers. This component will support the establishment of integrated disease and health status surveillance systems which may include building capacity in developing a health enterprise architecture.

In addition, this component will support research in digital health to address the fragmentation of digital applications, for example on feasibility, cost/benefit and evaluation of applications, what works and what not, exchange of best practice and lessons learned. NPHIs could play a key role in providing evidence-based advice in the area of digital.

The action will support the translation of information and findings in digital health into policy briefs, organise a structured digital health policy dialogue as well as advocacy for more efficient and effective use of digital applications and solutions integrating the HRBA, inclusive and gender perspective.

In addition this component may focus on the development of graduate level courses on digital health, highlighting the establishment of a health enterprise architecture to ensure interoperability of health information systems that are being developed. The action may also support the establishment of digital libraries in NPHIs as well as the development of online and distant learning courses

This digital component will primarily be implemented at the country level, the gained knowledge, experience and lessons learned, will be shared at the regional level through networking activities.

[39] JMIR Public Health and Surveillance - Defining Digital Public Health and the Role of Digitization, Digitalization, and Digital Transformation: Scoping Review

3.6 Logical Framework Matrix

This indicative logframe constitutes the basis for the monitoring, reporting and evaluation of the intervention.
On the basis of this logframe matrix, a more detailed logframe (or several) may be developed at contracting stage. In case baselines and targets are not available for the action, they should be informed for each indicator at signature of the contract(s) linked to this AD, or in the first progress report at the latest. New columns may be added to set intermediary targets (milestones) for the Output and Outcome indicators whenever it is relevant.

- At inception, the first progress report should include the complete logframe (e.g. including baselines/targets).
- Progress reports should provide an updated logframe with current values for each indicator.
- The final report should enclose the logframe with baseline and final values for each indicator.

The indicative logical framework matrix may evolve during the lifetime of the action depending on the different implementation modalities of this action.
The activities, the expected Outputs and related indicators, targets and baselines included in the logframe matrix may be updated during the implementation of the action, no amendment being required to the Financing Decision.

Results	Results chain (@): Main expected results (maximum 10)	Indicators (@): (at least one indicator per expected result)	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Impact	To contribute to the population's health and wellbeing (SDG 3) via the provision of essential public health services by NPHIs.	1 2	1 2	1 2	1 2	*Not applicable*
Outcome 1	1 Established/enhanced regional and international links among African and European or international NPHIs to support public health research, knowledge and information gathering that drive evidence-based policy advice, workforce training, and advocacy	1.1 Number of NPHIs in targeted countries that disseminated their recommendations based on evidence (on robust analysis of disaggregated data, information and research) to drive regional agenda setting or strategy /policy formulation in priority public health topics in regional events through the support from this programme 1.2 Potential indic on nb of networks supported/ created through the programme	1.1 1.2	1.1 1.2	1.1 documentation of the presentations/reports Minutes, documentation of events 1.2	
Outcome 2	2 NPHI capacity is enhanced to deliver Core public health functions	2.1 Number of NPHIs having significantly improved their capacity to deliver the Core Public Health Functions 2.2	2.1 2.2	2.1 2.2	2.1 Maturity assessment reports 2.2	

Outcome 3	3 NPHIs capacity in digital health, data and analytics is strengthened	3.1 Number of NPHIs that provided "evidence based" advice and recommendations to policy makers on use of digital health applications as part of a structured policy dialogue 3.2	3.1 3.2	3.1 3.2	3.1 documentation of the evidence documentation of the policy dialogue 3.2	
Output 1 **relating to Outcome 1**	1.1 Enhanced regional networking and bilateral South to South and North-South collaboration among NPHIs to develop and promote evidence driven policy and practice and the formulation of strategies, by sharing technical expertise and experience	1.1.1 Number of NPHIs in targeted countries that establish new or further build on existing collaboration with African and European or international NPHIs to successfully implement the activities of the programme 1.1.2 Number of NPHIs in targeted countries that presented in high level regional events (on experience and lessons learned, on findings of research, or other activities of the NPHI), supported by this programme,	1.1.1 1.1.2	1.1.1 1.1.2	1.1.1 documentation on the collaboration 1.1.2 documentation of the presentations Minutes, documentation of events	
Output 2 **relating to Outcome 1**	1.2 Enhanced donor and resource coordination of support to NPHIs, spearheaded by Africa CDC	1.2.1 A mapping of available support, resources and existing gaps/needs (with a gender and inclusive perspective) for NPHIs in SSA is available and used in stakeholder (duty bearers) coordination 1.2.2 Amount of additional resources to support NPHIs have been mobilised through enhanced coordination	1.2.1 1.2.2	1.2.1 1.2.2	1.2.1 Africa CDC approved mapping document 1.2.2 documentation of additional support/resources for NPHIs	

Output 1 **relating to Outcome 2**	2.1 NPHIs have improved public health expertise, knowledge and leadership skills to convene decision-makers and key stakeholders (duty bearers) for the provision of evidence-based and locally adapted policy advice	2.1.1 Number of graduate level courses reviewed and revised/newly established in NPHIs with the support of the programme 2.1.2 Number of NPHIs in targeted countries that have reviewed and adviced on the revision of the continued training of health professionals	2.1.1 2.1.2	2.1.1 2.1.2	2.1.1 Availability of the reviewed, new curricula Improved offer of graduate level courses in the country 2.1.2 availability of the revised continued training for health professionals	
Output 2 **relating to Outcome 2**	2.2 NPHIs have generated context, culturally and gender sensitive data, information and evidence on public health priorities to drive the policy response and formulate strategies	2.2.1 Number of NPHIs that supported building an integrated disease surveillance system and that regularly monitor and analyse the data 2.2.2 Number of NPHIs that provided “evidence based” advice and recommendations to policy makers on priority health topics as part of a structured policy dialogue	2.2.1 2.2.2	2.2.1 2.2.2	2.2.1 NPHIs reports on the data generated by an integrated disease surveillance system 2.2.2	
Output 3 **relating to Outcome 2**	2.3 NPHIs generated data, information and findings are translated into policies	2.3.1 Number of credible policies, that have been reviewed/established based on evidence and analyses by NPHIs through the support of the programme 2.3.2	2.3.1 2.3.2	2.3.1 2.3.2	2.3.1 2.3.2	

Output 1 **relating to Outcome 3**	3.1 National digital infrastructure and data systems that securely and ethically store, protect and analyse large public health data from different sources are established	3.1.1 Number of targeted countries have established a national structure that oversees large public health data management to improve interoperability, ensure its protection, secure and ethical storage as well as the analysis of these data 3.1.2 Number of NPHIs that have carried out operational research/surveys on costs and benefits of digital applications	3.1.1 3.1.2	3.1.1 3.1.2	3.1.1 3.1.2	
Output 2 **relating to Outcome 3**	3.2 NPHIs have gained digital health and data science expertise	3.2.1 Number of NPHIs in targeted countries that offer graduate level courses in digital health	3.2.1 3.2.2	3.2.1 3.2.2	3.2.1 3.2.2	

4 IMPLEMENTATION ARRANGEMENTS

4.1 Financing Agreement

In order to implement this action, it is not envisaged to conclude a financing agreement.

4.2 Indicative Implementation Period

The indicative operational implementation period of this action, during which the activities described in section 3 will be carried out and the corresponding contracts and agreements implemented, is 72 months from the date of adoption by the Commission of this Financing Decision.
Extensions of the implementation period may be agreed by the Commission's responsible authorising officer by amending this Financing Decision and the relevant contracts and agreements.

4.3 Implementation of the Budget Support Component

N/A

4.4 Implementation Modalities

The Commission will ensure that the EU rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures[40].

4.4.1 Indirect Management with an entrusted entity

4.4.1.1 Indirect Management with an entrusted entity

The regional component of this action may be implemented in indirect management with an entrusted entity which will be selected by the Commission's services using the following criteria:

- Demonstrated track record in active engagement with Africa CDC.
- Demonstrated track record on providing support to National Public Health Institutes in Africa.
- Prior experience implementing EU funded support in the health sector.
- Established relationships with regional and international NPHI networking organisations such as for example IANPHI.

The implementation by this entity entails the regional component Specific Objective 1 Establish/enhance regional and international links and capacity among African and European NPHIs for public health research, knowledge and information gathering that drive evidence-based policy advice, public health workforce training, and advocacy and the regional part of Specific Objective 3 To support NPHIs to become digital health literate on the sustainable use and effectiveness of digital applications and to reduce the digital skills gap) of this action.

4.4.1.2 Indirect Management with an entrusted entity

The country level components of this action will be implemented by indirect management with entrusted entities**,** which will be selected by the Commission's services using the following criteria for each of the targeted countries:

- Demonstrated track record in active engagement with National Public Health Institutes in SSA
- Prior experience implementing EU funded support in the health sector.
- To provide complementary bilateral support in the area of health systems strengthening in the targeted countries in order to increase synergies and complementarity among programmes in the health sector
- To have operational capacity on the ground in targeted countries to carry out the envisaged activities, in-country presence across most countries.

[40] www.sanctionsmap.eu. Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails.

- Track record in delivering value for money

The implementation by these entities entails the country level component of this action Specific Objective 2 To enhance NPHI capacity development to deliver Core public health functions and the country level part of Specific Objective 3 To support NPHIs to become digital health literate on the sustainable use and effectiveness of digital applications and to reduce the digital skills gap for each of the targeted countries).

4.4.2 Changes from indirect to direct management mode (and vice versa) due to exceptional circumstances (one alternative second option)

In case Indirect management with an entrusted entity cannot be implemented due to circumstances outside of the Commission's control; Specific Objective 1, Specific Objective 2 and part of Specific Objective 3 will be implementated in direct management (grants) with Non-profit organisations.

4.5. Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply, subject to the following provisions.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (Article 28(10) NDICI-Global Europe Regulation).

4.6. Indicative Budget

Indicative Budget components	**EU contribution (amount in EUR)**
Implementation modalities – cf. section 4.4	
Regional level component composed of **Specific Objective 1:** Establish/enhance regional and international links and capacity among African and European NPHIs for public health research, knowledge and information gathering that drive evidence-based policy advice, workforce training, and advocacy **Specific Objective 3:** To support NPHIs to become digital health literate on the sustainable use and effectiveness of digital applications and to reduce the digital skills gap.	7 000 000 1 000 000
Indirect management with an entrusted entity cf. section 4.4.1.1	8 000 000
County level component composed of **Specific Objective 2**: To enhance NPHI capacity development to deliver Core public health functions through sharing technical expertise and experience among NPHIs **Specific Objective 3:** To support NPHIs to become digital health literate on the sustainable use and effectiveness of digital applications and to reduce the digital skills gap.	33 000 000 9 000 000
Indirect management with entrusted entities cf. section 4.4.1.2	42 000 000
Evaluation – cf. section 5.2 **Audit** – cf. section 5.3	may be covered by another Decision
Totals	50 000 000

4.7 Organisational Set-up and Responsibilities

This action is part of the regional Team Europe initiative on supporting Public Health Institutes in Sub Saharan Africa that is the general framework to which the three specific objectives of this action contribute, particularly to to the three Strategic Objectives of the JIL, with a structured and coherent approach. Part of the third objective action contributes to the Team Europe Initiative on digital health. This action as a whole will therefore be embedded in the overarching coordination and management structure of both the PHI TEI and the digital health TEI

- The TEI Technical Working Groups (TWG) will be responsible to provide and adjust the longer-term vision of the TEI in consistency with relevant strategic orientations by TEI members and partners, and facilitate the policy dialogue with key African partners, including delivery of joint messages to support the TEI ambition, and ensure alignment of its priorities with Af CDC strategies and those of the partner regions and countries.
- The TEI Operational Management Group (OMG), composed of the TWG and African partners, responsible of the implementation, management, coordination and for the monitoring and the communication of the TEI.
- In addition, this TEI is part of the Global Gateway Health Package presented at the 6th EU-AU Summit in 2022 for which, a High-Level Steering Structure of the EU-AU Health Flagships has been established to provide high level political steer and strategic guidance of the health programmes pertaining to AU-EU relations.

Organisational set up. The programme will be implemented by entrusted entities selected by the Commission services using the criteria specified in section 4.4.1. Regarding capacity building activities, the entrusted entity will enhance collaboration among African NPHIs as well as between African and European/international NPHIs to mobilise high level academic, experienced public health expertise. This will strengthen networking and partnerships. The action focusses on strengthening NPHIs to carry out the essential public health function for the provision of evidence-based policy advice. For this data and information generation is essential, which will be obtained from research and data collection systems, but also through consultations with key stakeholder (duty bearers) that will ensure the active and meaningful participation of rights holders such as youth, women organizations and organizations representing vulnerable and marginalized groups. In addition the action will support a structured policy dialogue that will ensure involvement of the relevant key stakeholders (duty bearers), under the leadership of Africa CDC at the regional level and Government Authorities at the country level, which will enhance alignment, ownership and commitment of African partners. The action includes support and close monitoring from the regional level component of country level implementation which ensures exchange of knowledge, lessons learned and best practice.

Programme Steering Committee**.** A Steering Committee will be established with a mandate to monitor progress and ensure strategic direction. The Steering Committee will meet at least once a year and will be comprised on major stakeholders (duty bearers) including members from the participating countries, and the main implementing partners. The overall implementation, supervision and oversight of the project will be co-led by Africa CDC in cooperation with the European Union, including the European Commission and EU Delegations and national authorities in the targeted countries

Operational day-to-day management of the programme**.** The entrusted entities will be responsible for the day-to-day management of the Action in close coordination with the EU Delegations (the EUD to the AU and the EUDs in the beneficiary countries), the national authorities and Africa CDC. In this regard, it will hold responsibilities for the management of funds, delivery of results and achievement of programme outcomes. The entrusted entities will be accountable for the achievement of full value for money.

As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission may participate in the above governance structures set up for governing the implementation of the action and may sign or enter into joint declarations or statements, for the purpose of enhancing the visibility of the EU and its contribution to this action and ensuring effective coordination.

5 PERFORMANCE MEASUREMENT

5.1 Monitoring and Reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process, and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (Outputs and direct Outcomes) as measured by corresponding indicators, using as reference the logframe matrix (for project modality) and the partner's strategy, policy or reform action plan list (for budget support).

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

Roles and responsibilities for data collection, analysis and monitoring:

The EU will request implementing partners working under the same specific objective to ensure coordination in the reporting and monitoring of the action. Partners will ensure consistent reporting formats and timeframes.
The EU will request the implementing partner working under the first and part of the third specific objective (SO1 and part of SO3) to regularly monitor progress and reporting as well as identify challenges and opportunities of country level implementation (SO2 and part of SO3) and ensure support from the regional level component as outlined in the intervention logic as well as in facilitating collaboration with other African NPHIs or European NPHIs.

All monitoring and reporting shall assess how the action is considering the principle of gender equality, a human rights-based approach and the rights of persons with disabilities including inclusion and diversity. Indicators shall be disaggregated at least by sex and age, and disability if possible.

5.2 Evaluation

Having regard to the importance and nature of the action, a mid-term and a final evaluation may be carried out for this action or its components via independent consultants contracted by the Commission.

Mid-term evaluation may be carried out for problem solving and learning purposes, in particular with respect to progress made in contribution to larger programme goals including the potential value of extending to a second phase.

Final evaluation may be carried out for accountability and learning purposes at various levels (including for policy revision), taking into account in particular the fact that this action supports addressing country level priorities (bottom up) as well as regional priorities (top down) that will meet through regional networking activities and thus may influence regional priority agenda setting and whether this leads to more coordinated and joint action.

As part of the TEI, and where practicable, evaluations jointly with contributing Member States will be the preferred option to provide an overview of the action within the larger impact of the TEI.

The Commission shall inform the implementing partner at least 2 months in advance of the dates envisaged for the evaluation missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

Evaluations shall assess to what extent the action is taking into account the human rights-based approach as well as how it contributes to gender equality and women's empowerment and disability inclusion. Expertise on human rights, disability and gender equality will be ensured in the evaluation teams.

The evaluation reports may be shared with the partners and other key stakeholders (duty bearers) following the best

practice of evaluation dissemination. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, apply the necessary adjustments.

The financing of the evaluation may be covered by another measure constituting a Financing Decision.

5.3 Audit and Verifications

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audit or verification assignments for one or several contracts or agreements.

6 STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

The 2021-2027 programming cycle will adopt a new approach to pooling, programming and deploying strategic communication and public diplomacy resources.

In line with the 2022 "Communicating and Raising EU Visibility: Guidance for External Actions", it will remain a contractual obligation for all entities implementing EU-funded external actions to inform the relevant audiences of the Union's support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the actions concerned. This obligation will continue to apply equally, regardless of whether the actions concerned are implemented by the Commission, partner countries, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU member states.

However, action documents for specific sector programmes are in principle no longer required to include a provision for communication and visibility actions promoting the programmes concerned. These resources will instead be consolidated in Cooperation Facilities established by support measure action documents, allowing Delegations to plan and execute multiannual strategic communication and public diplomacy actions with sufficient critical mass to be effective on a national scale.

Appendix 1 REPORTING IN OPSYS

A Primary Intervention (project/programme) is a coherent set of activities and results structured in a logical framework aiming at delivering development change or progress. Identifying the level of the primary intervention will allow for:

Articulating Actions or Contracts according to an expected chain of results and therefore allowing them to ensure efficient monitoring and reporting of performance;
Differentiating these Actions or Contracts from those that do not produce direct reportable development results, defined as support entities (i.e. audits, evaluations);
Having a complete and exhaustive mapping of all results-bearing Actions and Contracts.

Primary Interventions are identified during the design of each action by the responsible service (Delegation or Headquarters operational Unit).
The level of the Primary Intervention chosen can be modified (directly in OPSYS) and the modification does not constitute an amendment of the action document.

The intervention level for the present Action identifies as (tick one of the 4 following options);

Action level (i.e. Budget Support, blending)		
☐	Single action	Present action: all contracts in the present action
Group of actions level (i.e. top-up cases, different phases of a single programme)		
☐	Group of actions	Actions reference (CRIS#/OPSYS#):
Contract level		
☒	Single Contract 1	Contribution agreement with entrusted entity for SO1 and part of SO3
☒	Single Contract 2	Contribution agreements with each of the entrusted entities that cover a country (for SO2 and part of SO3)
	(…)	
Group of contracts level (i.e. series of programme estimates, cases in which an Action includes for example four contracts and two of them, a technical assistance contract and a contribution agreement, aim at the same objectives and complement each other)		
☐	Group of contracts 1	