Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

Mali Mission Report
10–13 October 2017

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IOAC Mali Mission Report

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1. Introduction

1.1 Background

Mali has been facing a complex crisis since January 2012 when rebel groups began armed attacks against the Malian government with the aim of gaining independence for northern Mali. As a result of the escalating conflict, more than 470 000 people out of a total population of 15 million were displaced. Despite a peace agreement signed in 2015, the situation in Mali has continued to deteriorate into a protracted crisis.

As of August 2017, about 140 000 refugees remain displaced in neighbouring countries, where they struggle to access essential services such as food, water and health care. People who have returned to their communities have no means of maintaining livelihoods and suffer from chronic food insecurity and malnutrition. The declining immunization rates in certain areas and the weakened surveillance system are serious concerns, since these communities are exposed to a high risk of resurgence of epidemics including cholera, haemorrhagic fevers, meningitis, measles, malaria and polio. In some parts of northern and central Mali where the Government is absent, humanitarian actors are the sole providers of essential services. Yet a high level of insecurity characterized by armed conflict, terrorism, civil unrest and kidnapping has led to a substantial reduction in both humanitarian space and capacity.

1.2 Mission objectives and activities carried out

The Independent Oversight and Advisory Committee (IOAC) mission was tasked with reviewing the WHO Health Emergencies (WHE) Programme in Mali and its link with WHO's role in humanitarian crisis settings. The IOAC was provided in advance with a selected set of key documents including the Mali Humanitarian Response Plan 2017, the terms of reference for the health cluster, and the mission report on the Joint External Evaluation of Mali's International Health Regulations (IHR) core capacities. The IOAC visit programme included:

- Meeting with the Government, UN agencies, non-governmental organizations (NGOs) and other implementing partners and donors to review how WHO is perceived on the ground, what role these partners expect from WHO in humanitarian crisis settings, to what extent they are aware of the WHE Programme, and whether they have benefited from it
- Meeting with WHO staff to review how much progress has been made with WHE Programme implementation, namely the WHO Country Office's (WCO's) structure, human resources, funding, emergency business processes, partnerships, and security and staff protection; to what extent these changes have enabled staff to perform in outbreaks and emergencies; and whether the new Programme has influenced the WCO's approach to the humanitarian crisis

See Annex 1 for a detailed programme of the visit

2. Specific findings and recommendations

2.1 WHO Country Office in Mali and the WHE Programme

2.1.1 WCO in Mali

Mali is a WHE Programme priority 1 country and the WHO Representative (WR) has been leading implementation of the Programme at the country level with a clear vision and great dedication. The successful roll-out of the WHE Programme is attributable to the leadership and commitment of the Regional Director.

The WCO is located in Bamako; there is no subregional office. A Country Business Model has been agreed upon across the three levels of the Organization and a country functional review exercise led by the Africa Regional Office (AFRO) will further optimize human resource (HR) planning. For the biennium of 2016–17, the WCO has a planned cost of $20 million, is operating on a total budget of $18 million, and has four international staff and 21 national staff who are based in Bamako. Staff costs represent about 18% of the overall expenditure. There is an existing plan to recruit three additional international staff and three national staff, but the positions are yet to be approved by AFRO and may change after the country functional review.

As of October 2017, the overall implementation rate had reached 93% and covered a wide range of essential services. The largest proportion of the WCO budget is dedicated to polio eradication. In the current biennium, about 45% of the total activity cost has been allocated to polio programme activities. Mali was certified polio-free in October 2008 and phase two of the polio transition plan will be carried out during 2018–19. Currently there is only one dedicated fixed-term national staff member for polio, but a significant number of polio workers have been absorbed into the Ministry of Health or are being deployed by the WCO as field medical officers on a contract of Special Service Agreements.

The WCO relies on funds provided by HQ or AFRO, and the in-country donor base for health is limited. The IOAC recommends that HQ/AFRO funding be regarded as seed money and used as a catalyst for boosting donors' confidence. The IOAC also considers that the WCO's current HR capacity and funding are inadequate considering the enormous need for health service delivery, particularly in the northern part of Mali.

2.1.2 Implementation of the WHE Programme

About $1.9 million (11% of the total budget) is allocated to the WHE Programme, which covers the management of outbreaks and emergencies, emergency operation preparedness and health information management. Traditionally the WCO has had a budget component for "outbreaks and crises", with $1.15 million allocated for the current biennium, but an additional $784 000 has been budgeted for implementing the WHE Programme at the country level. Additional key positions for the WHE Programme have already been identified through a consultative process across three levels of the Organization. The WCO staff members are aware of these changes but have a limited understanding of WHO's strategic direction in emergencies, the objective of the Programme and the scope of its work.

Reporting lines within the WCO are clear and there seems to be a good level of coordination and communication with AFRO and HQ.

Only 30% of the total request for funds for the Humanitarian Response Plan has been granted over the past 2 years. In 2017, the WCO received $ 338 331 from the Central Emergency Response Fund (CERF), which is a modest amount given the magnitude of the crisis. In an effort to build resource mobilization capacity and raise the profile of health in the humanitarian response, the positions of partnership and resource mobilization coordinator and of health cluster coordinator were planned. However, the health cluster coordinator position has been vacant for over a year and a senior staff member at the WCO is currently filling the gap. This prolonged delay indicates that the current recruitment process is not adequate to support this priority country dealing with a humanitarian emergency. The recruitment of international staff is jointly handled by HQ and AFRO: collaboration should be further improved in responding to the HR need at the country level.

A similar delay in procuring emergency medical kits has severely eroded the confidence of humanitarian partners in WHO's ability to provide operational field support in a timely manner. The WCO placed an order 5 months prior to the IOAC's visit, but had still not received the medical kits, partly due to a long lead time by the manufacturer. It is critically important for WHO to keep emergency medical stock for ensuring a timely response in emergencies.

HQ and AFRO have made significant efforts to improve accountability by clarifying responsibilities, adjusting the level of authority and streamlining business processes. The Regional Director has recently issued a revised delegation of authority and business processes in the African region after careful examination by a specific working group. Putting the new policy into practice will require a close follow-up and periodic staff training across the three levels of the Organization.

2.2 WHE's work in Mali: health emergencies and health in emergencies

2.2.1 Health emergencies

The Government and humanitarian actors in Mali recognize WHO as a reliable partner with a permanent presence on the ground. It was noted that the WCO is one of the first responders to emergencies.

WHO is delivering a wide range of essential services and the 2014 Ebola outbreak highlighted WHO's main functions including: coordination, technical support, surveillance and information management, operational and financial support and provision of critical medical supplies.

Mali's success in ending the outbreak was based on the Government's ownership and strong political commitment. This was well supported by WHO and partners who promptly provided technical and operational assistance in a coordinated manner. The country has made a significant effort to apply the lessons learnt from the Ebola outbreak to other epidemics and maintain its infrastructural legacy. This includes the Emergency Operational Centre, standard operating procedures, national laboratory capacity, medical stock for emergencies, community engagement and information sharing and interactions with other departments

within the government. Hygiene and other good health behaviours are practised among the population.

In November 2016 the Ministry of Health conducted a simulation exercise with support from WHO and partners. The critical need to enhance surveillance networks and operational capacities for early detection and rapid response was emphasized. In collaboration with the US CDC, WHO has supported the country to developed an Integrated Disease Surveillance and Response Strategic plan and revised the existing surveillance guidelines and other tools. In 2017, 100 health workers have been trained for emergencies and nine Rapid Response Teams have been formed. However, the IOAC noted that the WCO's current capacity to perform the key functions of the Emergency Response Framework is limited. To address this issue, the WCO has recruited 30 Malian medical doctors from the polio HR database using the funds allocated to the WHE and deployed them from 1st October 2017 as Focal Medical Officers to all ten regions except in Bamako. This plan was welcomed by both the Government and other partners, since it has the potential to improve health information management, sub-cluster coordination and health emergency operations.

2.2.2 Health in emergencies

During the 2014 Ebola outbreak, WHO proved itself to be a reliable operational partner and a strong convener. In view of the WHE Programme, WHO is increasingly engaged with emergency responses in the volatile environment of Mali. WHO's expanded role in the humanitarian crisis is welcomed by partners and its work has started building the trust of partners on the ground.

The epidemic response in the humanitarian crisis setting has proved complex and costly because of persistent security threats, logistical difficulties, the weak governance, a lack of fully functional health facilities and limited capacity in the affected areas. In some areas in the northern part of the country, health services are mostly provided by NGOs as government services are absent.
The Ministry of Health is in the process of developing a plan to deliver essential health services in these areas, but an innovative approach is required to address health needs in the long term.

The 2016 Rift Valley Fever outbreak in Menaka was successfully managed in collaboration with FAO and the UN peacekeeping mission MINUSMA and involving 80 UN military personnel, ten armoured vehicles and two helicopters. During the 2017 terrorist attack in Gao that killed 77 people and injured more than 200 people, WHO played a role in facilitating evacuations in addition to emergency medical kits and supplies. To date WHO has supported 16 humanitarian operations, delivering critical health services and interventions directly to the affected population in need. The WCO is also assisting NGOs in running mobile clinics in the northern parts of the country.

The expanded role for health in humanitarian crisis settings is welcomed by partners and increasingly required. However, unpredictability of funding does not allow the WCO to have a clear perspective in WHO's response to the humanitarian situation. This is affecting WHO's credibility in the eyes of partners.

Despite the challenges, hundreds of humanitarian actors, including WHO, are delivering aid to the most vulnerable people in northern and central Mali, but capacity on the front line

should be strengthened and civil protection and incentives need to be considered for both health workers and the affected communities, and sustainability of service delivery merits further discussion.
The experience and lessons learned from the Joint External Evaluations (27–30 June 3017), which brought different sectors and players together, could be utilized to address the health of affected communities. Development of the National Action Plan for security could be an opportunity for filling the gap through one health approach.

2.3 Security and staff protection

Multiple terrorist attacks have occurred throughout Mali over the past 12 months and the potential for terrorist attacks in Bamako is high. Despite the presence of a UN peacekeeping mission (MINUSMA), the situation remains tense. In addition there have been incidents of armed robbery, car-jacking and kidnap in northern Mali. Such criminal acts and terrorism pose significant threats to civilians and humanitarian actors, leading to substantial shortages of humanitarian aid, especially in the northern parts of the country.

According to the UN Department of Safety and Security (UNDSS) classification, Bamako is a non-family duty station and currently the security level is 4 out of 5. There is no full-time WHO field security officer, one clerk is playing the role of security assistant. MINUSMA and UNDSS are working closely together in line with the Memorandum of Understanding for integrated resources, and coordinated services by different UN entities are providing security. In Mali there is a good level of coordination between UN agencies and the Government force. WHO receives a good service from MINUSMA and UNDSS in terms of security updates, alerts, support to essential field missions, mitigation measures, the warden system and evacuation planning. OCHA-MINUSMA developed a template for requesting security for field missions and deployments and in case of multiple demands a priority is defined during coordination meetings of heads of UN agencies.

It is challenging but not impossible to carry out health interventions in such a volatile insecure environment, given that health is at the centre of any crisis and access to health care is a basic need. General acceptance and tolerance towards child and maternal health care workers in the field could facilitate access to the hard-to-reach areas and provide civil protection. Provision of health services could open dialogue with the community and contribute to building trust and social capital within the affected communities.

2.4 Coordination and partnerships

WHO’s presence on the ground and the WR’s leadership have been recognized by the Government and partners. Partners are fully aware of the importance of health in the protracted crisis and acknowledge WHO’s critical role. The WCO works closely with the UN country team members and had unique experience working with UNDSS and MINUSMA in the response to the Rift Valley Fever outbreak. US CDC is one of the most important partners for the Global Health Security Agenda and IHR implementation.

Partners acknowledged WHO as a health cluster co-lead with the International Medical Corps. WHO is perceived to be in the best position to facilitate relationships between individual

NGOs and the Government. The WCO was successful in accessing the CERF and in supporting NGOs in implementing the field operations.

The health cluster was established in 2012 at the beginning of the northern Mali conflict and currently has 35 members (12 UN agencies and 17 NGOs). A monthly meeting is held to review the epidemiological situation, response activities in the affected areas and emerging issues, reporting against the Humanitarian Response Plan. The health cluster members acknowledged that the current level of response to health needs is low and emphasized the urgent need for health indicators and reliable baseline data in the conflict-affected areas.

WHO's role in providing information and baseline data, including mapping of health care facilities, current functionality and need estimation, is very important. Such actions are urgently needed, not only for coordination of the health cluster but also for initiating inter-clusters dialogue.

Out of the $305 million total budget requirement for the Mali Humanitarian Response Plan 2017, the health sector requirement is less than 4%—i.e. $11.9 million, including the WHO funding requirement of $1.27 million. Considering that access to health care remains limited overall in the country, that there are increasing reports of epidemics from the conflict-affected areas, and that the population is vulnerable to epidemics and other natural disasters, the requested amount is too modest. The health component of the Humanitarian Response Plan should be increased and advocacy for repositioning health as basic service in humanitarian crises should be encouraged. The WCO should lead strategic engagement among partners on the ground to influence donors. This could be supported by the senior leadership of AFRO and HQ.

Throughout the Ebola response, WHO played a key role in liaising with the Government and coordinating partners and providing strong support for the field operations from surveillance to procurement of personal protection equipment. WHO managed to bring the different actors to work together under a common platform with clear responsibilities and open communication. According to the interviews with the health cluster members, this good practice has not been fully maintained.

There is no full-time dedicated health cluster coordinator and the persistent delay in procuring emergency medical kits for field operations has eroded partners' confidence in WHO's capacity and accountability. The participation of the cluster members is passive and information sharing or interaction among the members should be improved. WHO is expected to reinforce HR capacity and technical support to revitalize the health cluster. There are positive signs, such as deployment of 30 medical doctors, but the vacancy of the health cluster coordinator and stock-out situation must be remediated as a matter of urgency to preserve the trust gained so far from the community.

3. Conclusions

The Mali WCO has been successfully implementing the WHE Programme and progress has been noted by partners. Such progress is attributable to the strong commitment of the AFRO Regional Director and the WR's leadership at the country level. As the WHE implementation is ongoing, the AFRO country function review in Mali should be given high priority.

Despite the security challenges and limited resources, the WCO is delivering a wide range of essential services. WHO's expanded role in the humanitarian crisis setting has been recognized and partners' expectations are increasing, yet the current WCO capacity is far below what is needed to meet these new expectations. The business processes and administrative systems should be improved to support the WCO's operations. Unpredictable financing is also limiting the WCO's response. It should be given increased capacity to access CERF and OCHA pooled funds, and should reach out to locally based donors. In a volatile environment such as Mali, it is critically important to enable the WCO to deliver on its promises. Delay in the deployment of a full-time health cluster coordinator and provision of emergency medical kits should be addressed immediately.

Mali has capitalised on the assistance received from WHO and partners during the 2014 Ebola outbreak and has applied lessons learnt to other epidemics. It has retained the Emergency Operational Centre, SOPs, national laboratory capacity, and medical stock for emergencies. However, in the north of the country, where Government health services have collapsed and security concerns and logistical difficulties hamper the humanitarian response, WHO should assist the Government and partners in developing innovative ways of working. At the same time, attention should be given to the additional security issues posed to humanitarian and health workers by criminal and terrorist groups.

The health component of Mali's Humanitarian Response Plan needs to be much more ambitious. Health can contribute to building trust and social capital within communities, even those where armed groups may find other types of assistance unacceptable. WHO, at all three levels, could be proactive in engaging with partners on the ground to shift donors' focus towards the rightful place of health as a basic service.

Annex 1. Programme of the field visits in Mali by the Independent Oversight and Advisory Committee for WHO Health Emergencies Programme (IOAC)

Horaire	Thème
10 Octobre 2017	
14 h00	Arrival of the mission team and tranfer to the hotel
17h00-18h30	Briefing session by **Dr Lucien Manga**, WHO Representative to Mali
11 Octobre 2017	
08h00 – 09h30	Meeting with WHO Country Office team
09h30 - 10h30	Security briefing with UNDSS and MINUSMA **Abdoulaye Younoussou HAMADOU** Deputy Principal Security Adviser, UNDSS
10h30 - 12h30	Interview with WCO staff
13h00 – 13h45	Lunch
16h30 – 17h30	Meeting with **Ms Mbaranga GASARABWE** DSSRG/RC/HC/RR
12 Octobre 2017	
08h30-09h30	Meeting with National Health Directorate **Dr. Mama COUMARE** National Director of Health Services Direction Nationale de la Santé (DNS)
10h00-10h45	Meeting with National Institute for Research in Public Health (INRSP) **Prof. Mamadou Souncalo Traoré** Director of National Institute for Research in Public Health (INRSP) IHR (2005) Focal Point GHSA Principal Investigation
12h00-12h45	Visit to the Emergency Operations Center **Professor Adama DIAWARA** Coordinator of the Department of Health Emergencies Operations (DOUSP/CNAM) **Mr. Drissa DIARRA** Deputy Director General, National Center for Disease Control (CNAM)
12h45 – 14h00	Lunch
14h30-15h00	Meeting with US CDC and USAID **Dr. Celia WOODFILL** CDC Mali Country Director **Ms. Karen KOPRINCE** Acting Health Office Director, USAID/Mali
15h30-17h00	NGOs Round table with Health Cluster partners' representatives of: **Comité International de la Croix Rouge (CICR), ECHO, Enda Maci, Help, IEDA Relief, Internaional Medical Corps (IMC) , Save the Children, Terre des Hommes (Tdh)**
18h30-20h00	Cocktail reception in presence of **Mr Abdoulaye Diop, Minister of Foreign Affairs of Mali**
13 Octobre 2017	
10h00-12h00	Debriefing with WHO Country Office **Dr Lucien Manga,** WHO Rapresentative to Mali
12h00-14h00	Debriefing with MSHP/MoH **Pr. Samba Ousmane Sow** Minister, Minstry of Health and public hygenie
14h00-15h00	Meeting with World Food Programme **Ms Silvia Caruso**, Representative to Mali
End of the visit	