WHO-EM/CAH/180/E

Report on the

Second Intercountry Workshop on the Child Health Policy Initiative (CHPI)

Cairo, Egypt
13–16 November 2005

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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Contents

1 INTRODUCTION

The World Health Organization (WHO) Regional Office for the Eastern Mediterranean (EMRO) held the Second Intercountry Workshop on the Child Health Policy Initiative in Cairo, Egypt, from 13 to 16 November 2005.

The workshop had the following objectives:

o For the five countries which had joined the Regional Office's Child Health Policy Initiative (CHPI), namely Egypt, Morocco, Sudan, Syrian Arab Republic and Tunisia:

- to review and discuss the latest steps undertaken by the countries, in order to finalize the first phase of the initiative concerning the child health situation analysis;
- to endorse the child health situation analysis report;
- to discuss the steps of the second phase of the CHPI on the development of the policy document; and
- to develop a plan of action to finalize the child policy document.

o For four new countries interested in the Initiative, namely Iraq, Jordan, Oman, and Pakistan:

- to share the experience with them.

A total of 29 participants attended the workshop, including 19 national and subnational representatives of 8 countries in the Region, two staff from two UNICEF country offices, and eight staff from WHO headquarters, the Regional Office for the Eastern Mediterranean and four country offices. Countries represented in the workshop included the five countries which had joined the CHPI since its launch (Egypt, Morocco, Sudan, Syrian Arab Republic and Tunisia), and three countries that had recently expressed interest in the Initiative (Iraq, Jordan and Oman). For another country, Pakistan, the WHO country office Medical Officer responsible for Child and Adolescent Health (CAH) attended, while the national counterparts—who were interested in the CHPI—were eventually unable to participate. The agenda and programme of the workshop are shown in Annexes 1 and 2, respectively; the list of participants is given in Annex 3.

The workshop followed intensive collaborative work between countries and the Regional Office, including also a workshop held in Damascus, in July 2004, in which progress in the first phase of the CHPI had been reviewed with the initial five countries. The CHPI was launched by the Regional Office in October 2003. The Initiative aims at supporting interested countries in the Region to develop national child health policy documents which bring together into one document all key policy elements and issues related to child

health in a country. Such policies are believed to provide mid- and long-term directions and commitments and identify priorities for policy actions, as emphasized in the inaugural message of Dr H. Gezairy, WHO Regional Director for the Eastern Mediterranean. This is critical to harmonizing partners' actions and creating a supportive environment for child care in a country. The need for a comprehensive policy becomes even more relevant at a time when Member States have pledged to achieve the Millennium Development Goals (MDGs), including the reduction of under-five mortality. The Regional Office support to the CHPI was reiterated by Dr Gezairy in his message; additional resources had been made available to sustain the first phase to date.

This second workshop was part of a logical plan to present country experience of the situation analysis and share it with other interested countries, develop plans for the next CHPI phase and discuss the policy document structure.

2 CHILD HEALTH POLICY INITIATIVE: OVERALL PROGRESS

While child health is being re-stated as a global priority and the Millennium Development Goal 4 specifically relates to reduction of under-five mortality, the child health situation in the Region remains cause for concern, with about 1.5 million under-five deaths, mostly preventable, estimated to occur yearly. Unless intensified efforts and unprecedented political commitment is provided to child health, it is unlikely that MDG4 will be met on a regional scale. For commitments to be fulfilled, they need to be translated into clear, comprehensive, action-oriented policies.

The Regional Office recommends a child health policy development process which consists of three phases: 1) the situation analysis; 2) the development of the policy document; and 3) the official adoption of the policy document itself. The situation analysis, a 10-step process, represents a key stage in developing country-specific policies. It has been recommended that the initial focus be on children under-five, as they are a priority and highly vulnerable age group, information is more readily available than for other age groups, much public health experience has been gained over the years on under five-related issues, and addressing specific issues for this age group through policies is expected to have a major impact. This phase aims to describe and critically analyze the child health situation in a country, reviewing facilitating factors and constraints to change, and identifying and summarizing

issues having major policy implications. The situation analysis report is typically composed of 8 main sections, covering: an introduction (supportive environment and rationale for a child health policy); general context (geographical, political, administrative, demographic and socioeconomic); health system elements; health care financing; human resources (management, production and capacity-building) including pre-service education; public child health issues, including trends of key indicators over the years; child health-related programmes and the extent to which they have been able to address those issues; and partners. To assist countries in this task, the Regional Office prepared a document in 2004, Development of national child health policy. Phase 1: the situation analysis, made available in English, Arabic and French[1]. Four of the five countries which initially joined the initiative, namely Egypt, Morocco, Sudan and Tunisia, completed the first phase and finalized the situation analysis report, which was endorsed and signed by the minister of health in each country.

3 SITUATION ANALYSIS: COUNTRY EXPERIENCES AND LESSONS LEARNT

3.1 Management structure

Task forces were established in all countries to coordinate CHPI work. These structures, aided by resource persons, usually include staff from both within the ministry of health and outside (Annex 4). In Egypt, a higher level committee, the Steering Committee, was established in addition to the Task Force (Annex 4). In general, the terms of reference of the national task forces were similar in the various countries, aiming to coordinate work with partners to collect information and undertake the child health situation analysis, identify policy issues and develop the policy document. In Tunisia, the task force was also given the responsibility for contributing to the monitoring of the implementation of the child health policy once formally established (Annex 4).

[1] Development of national child health policy. Phase I: the situation analysis. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2004 (WHO-EM/CAH/014/E). Available on the Regional Office CAH website at http://www.emro.who.int/cah/Reports.htm#Section1.

3.2 Approach to the process

Key tasks and steps in the policy development process followed in the participating countries are shown in Annex 5. To develop the situation analysis report, task force members were usually assisted by resource persons outside the task force, especially to collect information on specific areas. In Sudan, the task force and resource persons formed small teams or sub-committees responsible for collecting information and documents on a few specific areas, reviewing them and drafting relevant sections of the report. These sections were compiled in one report by the task force rapporteur, for review by the task force. The draft report was shared with partners and went through three to four revisions to incorporate comments received each time. Each country conducted various advocacy activities, briefing partners within and outside the ministry of health about the CHPI and its process in order to obtain support for it. In the case of Sudan, this resulted in the establishment of a child health directorate. Of particular interest was the Egyptian experience with a steering committee, established by the Minister of Health and Population in addition to the task force. Although the committee met formally only once, it represented key decision-makers in various institutions, who facilitated the process of data collection from those institutions and, as a committee, were a strong support to the initiative. Furthermore, the task force shared the outcome of its work each time with the steering committee members in addition to the formal meeting, thus making it possible to keep the committee members fully aware and updated on every development. This approach was more convenient for them than finding the time for meetings of the whole committee. It was observed that such a high-level and policy-making committee was likely to play a determinant role in the next phase, the policy development phase. Reasons for delays in the process reported in the workshop included: difficulties in collecting information and documents from many different sources; inconsistencies of data; the limited time availability of partners and the other main responsibilities and competing priorities of those involved; turnover of task force members in some cases and limited experience in critically reviewing information. However, the task forces were able to overcome most of these constraints over time. It was noted that the private sector, an important source of services and information in some countries, had been inadequately informed and involved, and approaches were being considered to address this issue. The first draft report of the situation analysis was usually developed within four to six months, while the process to circulate it for comments, revise it and identify policy issues took much longer. All in all, from the establishment of the task forces (between January and March 2004 in all participating countries) to the written endorsement of the situation analysis report by the minister of health and printing of the document (November 2005), the process took 20 to 22 months. As countries were piloting this initiative for the first time, they learnt lessons that will benefit other countries and contribute to substantially reducing the time required for the first phase (see Section 3.4 below). Also, the Regional

Office guidelines[1], published in the 3rd quarter of 2004, and the experiences shared by the participating countries in the workshop in Damascus in July 2004, including the situation analysis country reports, helped to clarify many issues and to standardize and advance the process. It is expected that the process will be much shorter in countries subsequently undertaking this initiative. The extra cost of the first phase was mostly limited to financial support for workshops, meetings, advocacy initiatives and reproduction of the report, ranging from US$ 7000 in Egypt, to US$ 10 000 in Sudan and about US$ 17 500 in Tunisia.

3.3 Advocacy, information and partnership

Advocacy plays a key role in the policy development process to influence policy-makers in order to create a supportive environment throughout the process leading to the desired outcome, i.e. the policy. This can be obtained directly, by targeting formal decision-makers, and indirectly, by mobilizing the support of international, national and local partners and institutions for the initiative, including those who may play a more informal role in decision-making. The child health policy development process is an intensive and long process which requires clear understanding and continuous support, and, therefore, information and advocacy throughout. This need was increasingly perceived over time in the countries which had joined the CHPI. Various approaches were followed to try and keep the momentum originated by the initiative. These included: briefings on the rationale for the policy and the child health situation in the country, and national awareness-raising meetings to sensitize policy-makers, including the ministers of health, and partners to the CHPI and the process; careful selection of members of the steering committee and task force, to ensure representation and support that cuts across sectors; involvement of partners in data collection, input in the situation analysis and revision of the draft report, through formal and informal mechanisms, to obtain ownership of the process; making use of key opportunities with large representation of sectors and partners (e.g. the national public health days in 2005 in Tunisia, the World Health Day 2005 celebration in Sudan) to further influence various sectors and build a broad base of consensus; and writing articles in Ministry of Health newsletters (Egypt). Of particular significance was the importance of providing information on the difference between policy and strategy, terms which initially caused some confusion and hesitation in some cases but were then clarified, paving the way to better understanding of the CHPI and its value within the country context.

3.4 Lessons learnt

A review of country experiences in CHPI to date, undertaken during the workshop by country teams, highlighted the following points, further presented in the conclusions of this report (see Section 7):

- CHPI is a new experience and thus requires much effort. Mastering the analytic skills and capacity for "extracting policy issues" of those involved takes time.
- While policy development is an intensive and demanding process, the persons involved in it have many main responsibilities and tasks other than CHPI.
- CHPI needs close collaboration with, and the availability of, different partners, and their strong ownership and commitment throughout the process.
- There has been some initial momentum with positive response, commitment and outcome (the first draft report). However, the importance of the situation analysis as the first step to develop a policy has been inadequately perceived by some decision-makers, eager to develop the policy as soon as possible. Their continuous involvement from the beginning and throughout the process can facilitate and accelerate the process.
- There have been some unrealistic expectations, in some cases, about the time required for the whole process, which has reduced the level of interest of some key actors in the process over time.
- Lack of information or access to it, inconsistent data and the need to contact many different partners have been major challenges in collecting and reviewing information.
- The availability of the Regional Office's guide on the process has been valued as a useful planning reference for the CHPI and in preparing the situation analysis report, in addition to the direct, intensive collaboration between the Regional Office and countries through different means, including exchange of communication, meetings and country visits. Experience-sharing through intercountry workshops has further contributed to the process and outcome.
- Of crucial importance is the timeliness of certain actions; namely, to initiate the provision of clear information to those concerned, the involvement of partners and advocacy activities very early on in the process.

4 POLICY ISSUES: IDENTIFICATION AND PRIORITIZATION

4.1 Identification

The situation analysis represents an essential step towards identifying policy issues and addressing them in the policy document. Country experience indicated that the identification of policy issues was a difficult task which required further guidance. This session aimed to propose and practise a systematic process for this task. The child health situation analysis is the basis for informing the policy and making it tailored to the country situation and needs. By describing strengths, facilitating factors, weaknesses and constraints to change, it provides the background to identifying those key issues which have policy implications. Two categories of policy issues were considered:

a) long-term policy issues, necessarily described in broad terms, to provide the context for more specific and mid-term policies; and

b) mid-term policy issues, which can be addressed more specifically in the mid term.

After identifying which issues have policy relevance, i.e. may be addressed by policies to improve the child health situation in a country, a critical approach to policy development is to analyse the potential causes of the problem, as these are those that the policy should address. The analysis should also consider whether policies already exist but are inadequately implemented (and, if so, why), whether existing policies may only partially address the issue or be partly responsible for the issue itself, or whether no specific policy currently exists that would help solve the issue. In the latter case, possible reasons for the lack of the policy should be reviewed. The process proposed in the workshop is to start with a broad issue and then attempt to define its components more specifically. For example, complex and "chronic" issues can be broken down into smaller and more specific issues considering the specific causes behind them. Each cause will have other causes behind it and so on. This process will often help to identify overlapping areas, where one cause may be responsible for more than one issue in different areas. After reviewing the relevant section of the Regional Office guidelines[1], this exercise was carried out in groups, selecting a problem in several areas (demographic and socioeconomic, health systems, human resources and child health-related programmes), analysing its potential causes and then identifying those causes which could be addressed through policies.

4.2 Prioritization

An in-depth analysis of the child health situation is likely to identify many policy issues. It is useful to prioritize issues according to some criteria, to increase the chances of having effective policies in the mid term. Any concrete, official policy agreed and implemented will boost the process to address other issues in the future. Simple, general criteria were proposed in the workshop as examples in order to prioritize the selection of policy issues for the mid term. These included the following:

a) Importance of the policy issue. This refers to the expected, measurable impact on child health if the issue is addressed and a specific policy is developed and implemented.

b) Chain of relationships with other issues. This refers to the potential relationship that one issue may have with others, so that if properly addressed through a policy it would be likely also to have an impact on other issues.

c) Feasibility. This, for example, refers to the likelihood of policy-makers and partners reaching a consensus within a reasonable time-frame, the implications in terms of human and financial resources, legal requirements (e.g. laws and directives), feasibility of implementation, staff attitudes etc.

The above criteria were applied during the working group sessions. The process of identification and prioritization of policy issues was found to be very useful and practical, both by country teams that had joined the CHPI earlier and those that were joining the process in this workshop for the first time.

4.3 Process

The process of identification and prioritization of policy issues should involve many actors. It should, for example, include decision- and policy-makers, partners, those who should implement the policy, the potential beneficiaries and sectors potentially affected by the issue and the proposed policy.

5 SECOND PHASE: DEVELOPMENT OF A NATIONAL CHILD HEALTH POLICY DOCUMENT

5.1 Steps

Work for this phase builds on the essential step of the identification of the priority policy issues. It requires the setting up of technical committees to draft policy statements in specific areas. After that, the process is similar to the one adopted for the situation analysis: preparation of preliminary reports by the technical committees, review and compilation into one report by the task force, circulation of the draft for comments to partners, revision, presentation for final consensus and finalization. The lessons learnt in the first phase are likely to apply also to this phase:

- Thorough orientations and briefings on objectives, the process and expected output of this phase should be planned and conducted for all those concerned, including those directly involved in policy development and those who could support or influence the process.

- The CHPI task force technical committees should be established formally, with clear terms of reference, to be reflected in the members' overall responsibilities, to enable them to allocate adequate time to policy development rather than consider this as an extra, additional task. The size of the committees should be small to be fully functional, with assistance from resource persons as necessary. Major players in the specific policy subject area should be involved.

- As noted in the first phase, advocacy should continue in this phase, to influence decision-makers and those who can in turn influence them to move the process forward to the approval of the policy. Activities and approaches should be tailored to the target people, institutions and objectives, and should be well planned from the beginning of the phase rather than conducted on an ad hoc basis.

- Extensive consultations with partners should be conducted to build a broad base of consensus throughout the process, in order to facilitate the final adoption of the document, its acceptance and implementation.

5.2 The policy document

Active discussions were held to suggest some of the key elements of the policy document. It was proposed that the following key sections should be included.

a) *Introduction*. This section, expected to be concise, would summarize information on national commitment to child health, justification for a national child health policy in the country, and its initial focus on age group and areas. It would refer for more detail to the relevant section of the situation analysis report.

b) *Policy statement*. This would represent the core of the document and be very concise, providing the statement, its aim (objectives) and the issue to be addressed (rationale), while referring for more background and information to the situation analysis report. A reference to the strategic approach to indicate how the policy decisions would be implemented was also felt to be an important aspect to be included.

c) *Indicators for monitoring*. To make a difference, a policy needs to be implemented—effectively. Thus, the innovative concept was introduced of including in the policy document indicators to monitor the implementation of the policy and its effects according to the original goal of the policy itself.

d) *Annexes and supporting documents*. To keep the policy document as concise and action-oriented as possible, annexes and supportive documents could be referred to or prepared separately. One annex should contain all the existing policies related to child health in detail. If a separate document has been prepared to describe the identification and prioritization of policies, then this could be a supportive document to the policy.

There was, in general, agreement on the need to keep the core of the policy document, i.e. the policy statements, as concise as possible and easy to consult. Different opinions were expressed on the issue of indicators to monitor implementation of the policy and its impact on child health. This issue requires more discussion, clarifications and examples. While policy documents may traditionally state policies broadly, the CHPI aimed at action-oriented, specific policies with monitoring indicators to ensure their translation into action and, through a feedback process, enable future revisions. It was recognized that such a document is meant to be dynamic and need not be comprehensive, but should initially address the priority issues identified, as described earlier (see Section 4). Finally, it was suggested that a policy expert could assist in phrasing draft policy statements in the appropriate language.

6 PLANS

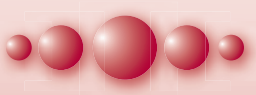
Country teams drafted an action plan for their respective countries according to the CHPI phase the country was in and the stage they had reached. For the four countries which had already developed and printed the situation analysis report, namely Egypt, Morocco, Sudan and Tunisia, the plan looked forward to the second phase, policy development. This included reformulation of the task force in the case of Morocco, and, for all: further briefings of high-level ministry of health officials; a review and further analysis of the policy issues and their prioritization according to the methodology proposed and practised in the workshop; establishment of technical committees with identification of resource persons and preparation of the various report sections; compilation and revisions of the report; partner involvement; and advocacy activities. The time-frame proposed in these plans ranged from six to twelve months, with the policy document expected to be ready in mid-2006 (Tunisia and Sudan) or by the end of 2006 (Egypt and Morocco). The plan for the Syrian Arab Republic included activities to complete work related to the situation analysis report and develop the child health policy document, expected to be finalized in July 2006. For the other countries, those joining the initiative at this stage and concerned with the first CHPI phase—i.e. the situation analysis, the plan mostly focussed on briefing meetings with decision-makers and programme managers, the establishment of the CHPI task forces with identification and orientation of key resource persons and partners, data collection for the situation analysis, and preparation and endorsement of the report. The report was expected to be ready by mid-2006 (Oman[2]) and mid-2007 (Iraq, Jordan).

7 CONCLUSIONS

- A national child health policy is an important document that provides the necessary high-level political support and sets country directions towards fulfilling national and international commitments including the MDGs. It serves as a national reference to harmonize action to improve child health.

[2] A draft, tentative plan was also prepared for Pakistan by the WHO country Medical Officer, to be discussed with the national counterparts. According to that plan, the report is expected by September 2006.

- Policy development is a highly demanding task that requires analytic, advocacy and writing skills as well as time.
- A well planned orientation for all relevant key decision-makers and stakeholders is essential to clarify the concept of policy, the need to have a policy, the need to have an initial focus of the document on children under-five and to inform and engage partners in the whole process
- The official establishment of a small-sized task force of committed and experienced members is essential to accomplish the work.
- The situation analysis is a fundamental step to the development of a child health policy document, and requires adequate time to be thoroughly undertaken.
- The analytical process used in the workshop was found to be a useful exercise to identify and analyze policy issues.
- The workshop provided country delegations with useful guidance on the steps of the second phase of the Initiative.
- Gaining access to data was identified by countries as a crucial but challenging task.
- Advocacy is essential throughout the process to create ownership, support and commitment.
- The experience of the five CHPI pioneer countries is very useful and provides good guidance to other countries which are about to embark on the initiative.
- WHO technical support during the situation analysis phase has been instrumental in finalizing the situation analysis reports.
- The active, useful participation of two UNICEF country offices in the workshop was highly appreciated by the respective country delegations.



8 RECOMMENDATIONS

To Member States

1. The development of a national child health policy document should be a priority for each country and adequate time and resources should be allocated to it by countries.

2. Key partners should be carefully identified and fully involved in the CHPI from the very beginning of the process.

3. The process of policy issues identification and analysis practised in the workshop should be replicated at country level during the national child health policy document development.

4. The work related to this Initiative should be part of the individual workplans of the people involved rather than regarded as an additional task, in order to ensure their availability and secure their time.

5. The CHPI task force should be empowered to access all relevant data required for the situation analysis.

6. Advocacy should target decision-makers at all levels and also those who can influence the policy adoption process. This requires a variety of approaches tailored to the different target groups.

7. The following should be considered in developing the policy document:
   a. the policy document should be kept as brief and clear as possible;
   b. policy statements should be the core of the document.

8. Technical committees should be established for addressing the identified policy issues. These committees may include external people with analytic and writing skills.

To WHO and partners

9. WHO should continue to provide technical support, guidance and advocacy throughout the CHPI process, including the development of a guide on the second phase.

10. CHPI is a good opportunity to further bring together WHO, UNICEF and other partners, and can be used by countries to build national partnership for mutual support and complementarity on child health, including joint programming.

11. WHO and UNICEF should use the successful CHPI country experiences to date to advocate with governments for this policy initiative at the highest political level.

ANNEXES

ANNEX 1

AGENDA

1. Inauguration of the intercountry workshop

2. National child health policy initiative: regional perspectives on process and lessons learnt from the situation analysis

3. Child Health Policy Initiative: country experiences and lessons learnt
   - Egypt
   - Morocco
   - Sudan
   - Tunisia
   - Conclusions

4. Policy issues
   - Demographic and socioeconomic
   - Health system
   - Human resources
   - Child health-related programmes

5. Child Health Policy Initiative 2nd phase: steps and requirements

6. Planning for the development of the child health policy document

7. Structure of the policy document

8. Would the child health policy document make a difference?

9. Conclusions and recommendations

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ANNEX 2

PROGRAMME

Day 1: Sunday, 13 November 2005

09:30–10:30	Registration
10:30–12:00	Opening session - Message of the Regional Director - Introduction of Temporary Advisers - Adoption of Agenda - National Child Health Policy Initiative (CHPI). Situation analysis phase: regional perspective on process and lessons learnt (Dr S. Farhoud)
12:00–12:30	CHPI country experience and lessons learnt: Egypt, Sudan
12:30–12:45	Discussion
12:45–13:15	CHPI country experience and lessons learnt: Tunisia, Morocco
13:15–13:45	Discussion
13:45–16:30	Group work 1. Discussions on country experiences on the CHPI first phase: situation analysis
16:30–17:30	Group presentations and discussion

Day 2: Monday, 14 November 2005

09:00–09:20	Policy issues: identification and prioritization (Dr S. Pièche)
09:20–09:30	Discussion
09:30–10:00	CHPI guide: next phases Group discussion
10:00–10:15	Policy issues: introduction on demographic and socioeconomic issues (Dr S. Farhoud)
10:15–12:15	Group work 2A. Addressing specific policy issues: demographic and socioeconomic issues
12:15–12:45	Group presentation and discussion
12:45–13:00	Policy issues: introduction on health system and human resources issues (Dr S. Farhoud)
13:00–16:00	Group work 2B. Addressing specific policy issues: health system issues
16:00–16:30	Group presentations and discussion

Day 3: Tuesday, 15 November 2005

09:00–10:45	Group work 2C. Addressing policy issues: human resources issues
10:45–11:45	Group presentations and discussion
11:45–12:00	CHPI second phase: steps and requirements (Dr S. Farhoud)
12:00–16:00	Group work 3. Planning for CHPI Group A countries: planning for the second phase Group B countries: planning for the first phase

Day 4: Wednesday, 16 November 2005

09.00–10.30	Group work 3 (continued)
10:30–11:15	Wrap-up of the planning session
11:15–15:00	Brainstorming on the structure of the policy document
15:00–16:30	Group work 4: would a child health policy document make a difference?
16.30–17.00	Group presentations and discussion
17:00–17:30	Workshop conclusions and recommendations

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ANNEX 3

LIST OF PARTICIPANTS

EGYPT

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Mr Ahmed El Arousy, National Professional Officer (Desktop and User Support), WHO/EMRO

Ms Suzan El Raey, Senior Administrative Clerk, WHO/EMRO

Mrs Manal Abdellatif, Secretary, WHO/EMRO

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ANNEX 4

NATIONAL CHPI TASK FORCES AND TERMS OF REFERENCE[3]

EGYPT

Steering Committee

Chairperson

o First Undersecretary for Primary Health Care and Preventive Care Sector Members
o Head of the Health Insurance Organization
o Secretary General of Teaching Hospitals and Institutes Organization
o Undersecretary for Primary Health Care
o First Undersecretary for Population and Family Planning sector
o Undersecretary for Pharmaceutical Affairs
o Director-General of Chest Diseases Directorate

Terms of reference

o To provide guidance and support to the task force
o To facilitate access to information
o To review, comment and endorse documents (situation analysis and policy)
o To advocate at higher political level

Task force

Chairperson

o Undersecretary for Primary Health Care Members

o Focal point
- National IMCI Director

o Other members:
- National IMCI Coordinator and Director General of the Childhood Illness Programme General Administration

[3] The original composition of the CHPI task force of the Syrian Arab Republic is available in the Report of the Intercountry Workshop on Child Health Policy Development, Damascus, Syrian Arab Republic, WHO/EMRO, Cairo, 2005, available also on the CAH/EMRO website at http://www.emro.who.int/cah/activities-meetings-syr04.htm. No update was provided in this workshop.

- MCH Director
- ARI Control Programme Director
- Care for Children with Special Needs Programme Director

International organizations
o WHO

Terms of reference
o To identify partners
o To collect documents and information
o To conduct the situation analysis
o To identify policy issues
o To review and update policies

MOROCCO

Steering Committee

Chairperson
o General Secretary of the Ministry of Health

Task force

Members
o Vice-Chairperson
- Director of Population Directorate

o Other members
- Child health and other public health programme managers
- Representatives of other Ministry of Health departments
- Representatives of medical and nursing schools
- Resource person from district level

Terms of reference
o To prepare a situation analysis of child health in Morocco
o To develop a national child policy document

SUDAN

Task force

Chairperson
o Primary Health Care Director-General

Members
o Rapporteur
- National IMCI Focal Point

o Other members
- Nutrition Department Director
- Reproductive Health Directorate Director
- Health Planning Directorate Director
- EPI Manager
- President of the National Paediatric Association and Senior Paediatrician of the Ministry of Health

International organizations
o UNICEF
o WHO

Terms of reference
o To review existing child health policies
o To review child health and development situation in the country
o To identify policy issues and gaps
o To develop the situation analysis report
o To develop child health policy statements
o To advocate for the policy document

TUNISIA

Task force

Chairperson and focal point
o Primary Health Care Director

Members
o Rapporteur
- National IMCI coordinator

o Other members
- EPI Manager
- Perinatal Care Programme Manager
- Epidemiologist
- From the field: Public health paediatrician and Head of Regional Primary Health Care Department

Terms of reference
o To advocate with partners about the importance of developing a national child health policy

o To coordinate efforts to prepare the policy document, through: a) development of a document on an in-depth situation analysis of child health in Tunisia; and b) development of a policy document on the directions, objectives, strategies and technical guidelines on child health

o To submit the national child health policy document to the highest decision-making level

o To contribute to monitoring implementation of the national child health policy

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ANNEX 5

CHPI AND DEVELOPMENT OF THE SITUATION ANALYSIS REPORT: PROCESS IN 5 COUNTRIES

Tasks / steps	Egypt	Morocco	Sudan	Syrian Arab Republic	Tunisia
Task force established	January 2004	March 2004	February 2004	March 2004	March 2004
	(Steering Committee set up in May 2004)				
Steering committee	May 2004				
Orientation/planning workshop conducted	February 2004		March 2004	February 2004	April 2004
Advocacy meeting for partners	February 2004		March 2004		April 2004
	Chair: PHC Director		Chair: Federal Minister of Health		Chair: PHC Director
First draft of the situation analysis report prepared	July 2004	July 2004	March 2004	June 2004	April 2004
First draft reviewed by WHO (CAH/EMRO)	July 2004	July 2004	March 2004	June 2004	April 2004
Second draft prepared	July 2004	July 2004	July 2004	July 2004	June 2004
Second draft reviewed by WHO (CAH/EMRO)	March 2005	May 2005	February 2005		June 2004
Third draft revised	January 2005	June 2005	February 2005		March 2005
Policy issues identified, discussed and revised	July–August 2005	October 2005	March –August 2005		April - September 2005
Fourth draft developed	September 2005	October 2005	September 2005		September 2005
Situation analysis report endorsed and signed by the Minister of Health	October 2005	November 2005	November 2005		November 2005
Situation analysis report printed	November 2005	November 2005	November 2005		November 2005

Notes: PHC = Primary health care; CAH = Child and Adolescent Health and Development Unit; EMRO = Regional Office for the Eastern Mediterranean.