

WHO-EM/HMS/058/E

Report on the
**Subregional workshop for G5
countries on health systems
strengthening**

Islamabad, Pakistan
19–20 November 2013



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The first subregional workshop for G5 countries (Afghanistan, Islamic Republic of Iran, Iraq and Pakistan) on health system strengthening was hosted by the Ministry of National Health Services, Regulations and Coordination of Pakistan on 19–20 November 2013 in Islamabad, Pakistan with the support and close collaboration of the World Health Organization

The overall objectives of the workshop were to:

- Share experience among G5 countries in setting up multisectoral mechanisms for achieving universal health coverage and addressing main elements of health system blocks;
- Review progress towards universal health coverage from the perspectives of financing, service provision and workforce;
- Look at options of how the G5 countries can support one another in specific areas;
- Seek possibilities and options to build subregional cooperation in promoting global health initiatives and health system strengthening; and
- Identify areas for future collaboration in other areas related to priority public health problems such as noncommunicable diseases, communicable diseases and maternal child health.

The opening session commenced with the recitation of the Holy Quran followed by a message from Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean delivered by Dr Sameen Siddiqi, Director, Health System Development. In his message, the Regional Director noted that the Islamic Republic of Iran had initiated the establishment of the G5 in 2005 to promote subregional cooperation in health among the group of four countries – Afghanistan, Islamic Republic of Iran, Iraq and Pakistan – plus the World Health Organization as the fifth member of this group to provide technical support in improving this collaboration. Several activities have already been taken under this initiative, with the Islamic Republic of Iran taking responsibility for serving as its secretariat.

The next speaker, Dr Mohammad H. Nicknam, Adviser to H.E. Minister of Health for International Affairs, commented that the G5 was a good example of subregional collaboration in the Eastern Mediterranean Region. The event provided a unique opportunity to discuss common challenges, share experiences and work collectively to address some of the issues commonly faced by all four countries. In particular, the workshop deliberations would support the efforts to strengthen health systems and ensure meaningful progress towards universal health coverage. Dr Nicknam also expressed appreciation for the personal commitment of Dr Ala Alwan to provide the technical support necessary to ensure the success of the subregional initiative.

He referred the workshop's theme of universal health coverage, including the synthesis of lessons learnt in promoting social health protection, published in the World Health Report 2010: Health systems financing – the path to universal coverage. He acknowledged that reforming the financing system alone would not be sufficient to advance and achieve the goal

of universal health coverage, since other components of the health system are all of critical importance. Hence, he said, the emphasis for progress towards universal health coverage should be on the development of a vision, strategy and a roadmap, irrespective of the income status of any country and access to resources.

Dwelling on the workshop agenda for the two days, he said that the workshop would provide the opportunity to share experiences related to health system strengthening between the four neighbouring countries, and to discuss how the global health initiatives could more effectively support progress towards universal health coverage, particularly as some of the challenges are common among the four countries and the G5 initiative provided a real opportunity to learn from one another and build South–South collaboration in health system strengthening. The workshop would help to build consensus on the modalities to further enhance subregional cooperation and collaboration among the four countries on health system strengthening and in other areas as well. He encouraged all country teams and participants to organize a similar meeting at the national level, as would be done in Pakistan immediately after the workshop.

Her Excellency Mrs Saira Afzal Tarar, Minister of State, Ministry of National Health Services, Regulations and Coordination, welcomed the delegates to the workshop, which would help to cement collaboration in the most critical areas that commonly affected the lives and well-being of their peoples. Owing to the similarity in challenges, there was shared concern and scope for the four countries in furthering the development agenda and ensuring equity in the delivery of basic services including health care to those who needed it the most.

She expressed appreciation to WHO for convening and providing a common platform to brainstorm, deliberate, share best practices and experiences. Together the workshop participants would help chart a course for provision of quality health services to people through a responsive and pro-poor health system that catered to an ever-growing population and increasing pressure on the existing health infrastructure. She closed by noting that Pakistan had been a strong advocate of regional collaboration in the area of health care and continued to work closely with the WHO Regional Office in contributing meaningfully to regional dialogue and cooperation in the field of public health.

The planned workshop discussions and formulation of modalities for regional cooperation and collaboration on health systems strengthening is in line with the growing international consensus that without urgent well-coordinated improvements in the performance of health systems, the world would fail to meet global health-related Goals. Hence, there is serious need for synergy and coordination in the efforts to achieve optimal results.

The workshop programme is attached as Annex 1. The participants included senior level professionals of the four countries drawn from relevant fields (Annex 2).

2. MOVING TOWARDS UNIVERSAL HEALTH COVERAGE

The inaugural session was followed by a session on universal health coverage. The first presentation, by Dr Sameen Siddiqi, Director Health System Development, WHO EMRO, discussed challenges, opportunities and a roadmap towards universal health coverage in countries of the Eastern Mediterranean Region.

Dr Siddiqi noted that previous efforts in the area of health systems strengthening in the Region had highlighted the crucial need to move towards universal health coverage as the overarching priority. He reviewed the situation of universal health coverage in terms of:

- What it means to countries and how it can be monitored
- Where the Region stands in terms of progress
- What challenges and opportunities exist
- Which strategic approaches and actions are needed to accelerate progress.

The current status of universal health coverage in the Region indicates that each year up to 16.5 million people face financial catastrophe and up to 7.5 million individuals become poor due to out-of-pocket payments for health, despite US\$ 125 billion being spent on health in 2011 which is 1.8% of total world health spending for around 8.7% of the world population.

The move towards universal health coverage is however, beset with challenges ranging from high level political commitment, varying and limited fiscal space with low priority to health, high out-of-pocket expenditure, inadequate provision of quality health services to wastage of resources, dearth of prepayment schemes and lack of capacity of the information systems to monitor progress towards universal health coverage.

There are however, opportunities for progress on universal health coverage owing to the global movement and focus on universal health coverage and the increased commitment of Member States. WHO and World Bank are jointly supporting the countries in this regard. The recent call of UN General Assembly called to value the contribution of universal health coverage for achieving related MDGs (December 2012) and consideration as an integral to the post-2015 sustainable development agenda, is another clear reflection of the recognition of importance of universal health coverage.

Dr Siddiqi reemphasized the need to develop a vision and strategy towards universal health coverage for provision of quality health services, reliance on prepayment arrangements, and progressive expansion to cover different population groups. In this regard, certain steps were also proposed including establishing a multisectoral national taskforce, advocacy for commitment and update legislation on universal health coverage, strengthen unit in the Ministry of Health responsible for coordinating universal health coverage to undertake situation analysis, propose evidence-based options to the national taskforce. There is also need to generate local evidence and share international experiences in universal health coverage, and develop framework with the necessary tools to monitor progress and take corrective action. In this regard, a regional taskforce of development partners with Member

States could be established, which could be convened by WHO to develop a unified approach to support countries.

In conclusion, Dr Siddiqi reiterated that there is essential need for a comprehensive vision, strategy and roadmap for progressing towards universal health coverage, which calls for reforming the entire health system. Countries that adopt a multisectoral approach are more likely to make accelerated progress, which can only be achieved if it is well monitored and measured. The gaps towards universal health coverage exist in all three groups of countries; however, every country irrespective of level of development can progress towards universal health coverage through sustained political commitment. WHO, and the development partners are committed to countries in their quest for universal health coverage.

Dr Siddiqi in response to the comment of Dr Assad Hafeez on integration of informal sector (*tibb/unani*) into mainstream health service delivery, replied that the universal health coverage definition of essential package will define how the informal sector can be incorporated.

Dr Siddiqi agreed that the governance and accountability issues raised by Dr Nisar Solangi are huge, for which all the policy-makers and programme managers should be held accountable; as accountability ensures transparency, which is also a means by which accountability can be seen. He also pointed out that even after devolution there should be one universal health coverage strategy as four strategies will widen disparities, thus enhancing provincial inequity.

Dr Mounir Farag, Acting Regional Adviser, Hospital Care Management WHO EMRO discussed current global health initiatives and how they can support the cause of universal health coverage. He emphasized the need for equity in utilization of quality service delivery and reducing the gap between need and utilization, while ensuring financial risk protection for all. There is general recognition that universal health coverage is a direction and not a destination and no country fully achieves all the coverage objectives. Dr Farag stressed that even though, it may be difficult for the poorer countries to fully achieve universal health coverage targets; however, all countries can reduce the gap between need and utilization, improve the quality of services while ensuring financial protection. Thus, moving towards universal coverage is something that every country can do; as it is relevant to countries irrespective of the levels of income. However, it needs to begin with practical orientation for policy reforms and the development of one national strategy and plan. Furthermore, the countries should work on the principles of health systems strengthening to reinforce the financing system and integrated service delivery concept; apply effective service delivery models; strengthen management information systems and data for decision-making; ensure appropriate skill mix and competency of human resource in health; and improve infrastructure and cold chain equipment with overarching focus on strengthening governance and organizational management.

Dr Inamul Haq, Lead Health Specialist, World Bank commented that the reason why the global initiatives did not deliver well was the absence of a single plan, and that health

systems strengthening was not part of the national plans. Results can only be achieved if there is a single overall plan; the support of the global health initiatives should be part and parcel of the national plan including the financing modalities. Furthermore, in future the countries should aim to have financing plan through their own resources; and the financial support through the global health initiatives should not be used to replace government funding, it should be over and above it.

Dr Mounir Farag, in response to the query from Afghanistan on the added value of the International Health Partnership (IHP+¹) in a country where donors are already working together, noted that IHP+ builds on what already exists. Dr Siddiqi added that IHP+ brings in the multilateral and multisectoral angle and thus dilutes the bilateral interface. Dr Haq stated that IHP+ provides the technical support and improves the quality aspect in identification of gaps, to access resources from multilateral partners.

Countries were given a template to present country situation including health financing, health workforce, service delivery, health technology, top five health system challenges, lessons learnt and possible areas of South–South cooperation between neighbouring countries in the context of strengthening the health systems to achieve universal health coverage.

The presentation for Pakistan was made by Dr Sabeen Afzal, Deputy Director (Technical), Ministry of National Health Services, Regulations and Coordination. The health sector situation and challenges in the context of health system building blocks were described in detail. With regard to health care financing, there is low budgetary allocation, very high out-of-pocket expenditure, a dearth of prepayment schemes and gaps in financial management. Similarly, there is lack of planning for human resources for health, issues of skill mix and competency, so-called “brain drain” and lack of career and growth opportunities and enabling environment, with inappropriate workforce production. Service delivery requires integration, addressing functionality issues, regulation of private sector, with focus on standardization and quality of care. There is need for a national health technology and medicines policy in Pakistan, availability of data on public–private split, enforcement of Good Manufacturing Practice and rational use of medicines and medical technology with establishment of a health technology assessment forum.

Lessons learnt and experience shared from the health sector of Pakistan include the success story of the lady health workers programme, which is delivering primary health care services at the doorsteps of the community, and is being replicated in Somalia. The Benazir Income Support Programme, offering social protection, is currently under replication in Punjab. There is ongoing experience with outsourcing and contracting in, as in the Peoples’ Primary Health Care Initiative and Punjab Rural Support Programme. The opportunities in the unique devolution experience in Pakistan, evident in the development of provincial health strategies, integration of service delivery (Punjab and Khyber Pakhtunkhwa), move towards multipurpose human resources (Khyber Pakhtunkhwa), establishment of health regulatory authorities and implementation of essential health services package in Khyber Pakhtunkhwa and Punjab.

Pakistan could offer support in the context of South–South cooperation in areas of human resources for health, medical education, pharmaceutical expertise, IHR and cross-border cooperation and exchange of faculty. In this regard, WHO can provide a platform for coordination, technical support, joint collaboration with and among countries, multi-centre research and setting norms and standards.

The afternoon session on universal health coverage was dedicated to group work on accelerating progress towards universal health coverage, in which groups discussed what countries need to do based on their level of development.

3. LESSONS LEARNT FROM G5 EXPERIENCES

The second day of the workshop began with a recap of day 1 proceedings by Dr M. Farag, followed by the third session on lessons learnt from G5 experiences. The first presentation, on the regional experience with family practice, was made by Dr Mohamed Assai, Coordinator, Integrated Service Delivery, WHO EMRO.

Talking in detail on the family practice programmes in countries, Dr Assai shared the outcome of family practice assessment in 22 countries undertaken by the Regional Office in early 2013. Based on the country categorization according to income, the three groups of countries included the following.

- 6 GCC countries: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates
- 10 middle-income countries: Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic, Tunisia
- 6 low-income countries: Afghanistan, Djibouti, Pakistan, Somalia, Sudan, Yemen.

There are a number of challenges to family practice in countries, ranging from limited political commitment, shortage of family physicians and academic institutes to train family doctors and lack of coordination with academic institutes to the absence of the very concept of comprehensive family practice approach. There is lack of coordination with the private sector, inadequate community awareness and no clear family practice strategy and roadmap in the countries.

The Islamic Republic of Iran and Iraq are already implementing family practice; however, the concept needs serious attention and focus in Pakistan and Afghanistan.

Iraq shared its experience with the health sector modernization programme, which covers three sectors: health, education and water and sanitation (including solid waste management and civil registration). The programme's focus is on public administration reforms; some changes may be made in the course due to closure of the trust fund.

The major activities during the diagnostic/analytical Phase 1 comprise background scoping studies on various topics. Functional reviews with roadmaps have been approved for the three sectors (approved by Ministerial Advisory Committees) and the national statistics system. Similarly, a national action plan on e-Governance has been approved. Study tours

will be conducted on various topics. There is agreed plan on the assessment of the public administration roadmap in the Kurdistan Regional Government, with provision of support to the Public Sector Modernization Steering Committee.

The major activities in the health sector to be conducted in the Phase 2 of the Iraq modernization plan include the development of national health policy, the medium-term budget mechanism for health and finalization of future roles and functions of the central Ministry of Health, Kurdistan Regional Ministry of Health, governorate health departments and district health offices. Other activities include development of a comprehensive master plan for health facilities informed by an integrated financial and human resource planning; along with plan for appropriate number of skilled staff (physicians, nurses and midwives). Gender audit with guidelines for engendering the sector will be undertaken with the support of UN WOMEN. Training of management staff on decentralized management will be conducted.

Phase 2 activities will also include redesigning and piloting a new logistical system and procurement modalities of contraceptives with the support of UNFPA. UNICEF will provide for the development and implementation of the Communication for Development (C4D) strategy in health. Options analysis for alternative health financing mechanisms including social health insurance and private health insurance will also be undertaken.

Certain activities such as training and capacity building for implementation of the family practice model in Iraq are part of the plan as well. Review of the health information system with development of a relevant plan based on the International Classification of Diseases (ICD-10) linked to output-based budgeting will also be undertaken. Field visits and study tours to selected countries for relevant experience sharing and learning benefit for implementation in Iraq will also be undertaken.

Afghanistan shared the experience of outsourcing primary health care services to nongovernmental organizations, with the duration of contracts varying between 12 and 36 months. The package of primary health care services includes maternal, neonatal and child health, immunization, mental health, rehabilitation, communicable disease control, etc.

The coverage of primary health care services is claimed at 58–63%. So far, a total of US\$ 140 million has been spent on the initiative; which has been enhanced to US\$ 407 million for the next 5 years for contracting out under the 'sehat project'. Arrangement for procurement and monitoring and evaluation are part of the expansion plan for the next 5 years.

In conclusion, contracting should be considered among the approaches for service delivery. However, contracting alone cannot address the fundamental health sector weaknesses, its adoption implies a general restructuring of health service delivery mechanism and it may result in donor dependency.

The Islamic Republic of Iran's presentation related to the urban family practice programme and the leading reasons towards the family physician approach. The *behvarz* (front-line health workers) were unable to respond to the changing needs of the population and the need for establishing health teams. The insurance which was based on illness was changed and based on health, with the family physician responsible for the continuation of health service delivery in the three referral levels. The payment system was revised to be based on performance; provision was made for offering basic package of health services to all rural residence through increasing the accessibility of rural residence to health services. The specialist outpatient services utilization and para-clinical services costs were rationalized.

The main reason for expanding the family physician plan to the urban areas was the five successful years of experience of the family physician plan in rural areas with improved indicators of health in the village. The move was supported with the existence of definite requirements in upstream laws and regulations indicating the expansion of family physician plan to urban areas as well. Other reasons pertained to the principles and consideration for universal health coverage and quality of care with accountability and enhancing stakeholders' participation.

Certain measures for improving the impact of the family physician plan were also presented in detail. These included the formation of and relevant representation on the national and provincial executive committees for the family physician programme; intersectoral collaborative arrangements; and implementation of a population census from the provinces with entering the identification information into the Iranian electronic health services system software.

The programme was initially piloted in the two provinces of Fars and Mazandaran with tracking of the consequent implementation challenges through pathologic analysis to support development of corrective policies for further continuation of the programme.

Some of the various challenges encountered in family physician programme implementation include lack of shared vision and definition at different managerial levels; unbalanced geographical distribution of population and marginalization; poor participation and resistance of the small but influential private sector; unbalanced deployment of service delivery units and centres in cities with concentration in one specific area which caused difficulty of access; delivering similar services in various forms both in public and private sectors; various insurance coverage, sometimes parallel, with existence of multiple funding insurances and the problem of intersectoral coordination; ambiguity in the payment of insurance share in hospitalized time due to uncertainty on the amount of fees for various inpatient services; inappropriate use of costly medical services and technologies. The relatively low income of urban family physicians with inadequate interest of private sector doctors resulted in shortage of human resources to meet the guideline of one physician per 2500 people; shortage of skilled human resources who can implement referral plan in each province.

The unique experience and the salient aspects of 18th Amendment leading to the devolution in Health sector of Pakistan was presented by Dr Assad Hafeez, Director Health Services Academy, Islamabad. The participants were informed that prior to the constitutional amendment, particular 'subjects' having shared responsibility of federal and provincial governments were listed in Concurrent Legislative List (CLL) in the fourth schedule of the constitution of 1973. The power to function for all sectors came through Rules of Business of 1973. The 'subjects' were not delineated as health, agriculture, education etc. but there were entities that were cross-cutting and had multisectoral dimensions. The subjects in the responsibility of federal government were listed in Federal Legislative Lists (FLL) 1 and 2; whereby the FLL-2 enlisted those areas where provincial consultation was required.

Through the 18th Amendment, the CCL was completely abolished (Article 101) and some entries were shifted to the FLL. FLL-1 was extended to include; all regulatory authorities established under a federal law, national planning and national economic coordination, scientific and technological research, legal medical and other professions, international commitments and donor coordination. The FLL-2 was extended to include; policy process for national harmonization, standards and quality, and research and scientific coordination.

With the deletion of CLL, areas of: drugs and medicines, poisons and dangerous drugs, prevention and extension from one province to another of infectious/ contagious diseases or pests affecting men, animals and plants, and disease surveillance became provincial subjects. Consequently the federal government did not have powers to legislate or regulate in these areas. However considering that regulation of pharmaceutical sector requires a central coordination, the provincial assemblies passed resolutions under Article 144 of the constitution, transferring powers to the federal government to regulate drugs and medicines.

It was also noted that the federal cabinet has the powers to assign the functions to the federal ministries in respect of entries of FLL; and there is as such no delineation of roles to any particular ministries in the FLL. Currently, in addition to the functions assigned to the Ministry of National Health Services, Regulation and Coordination, various other ministries and departments at federal level, including the Economic Affairs Division, Ministry of Finance, Planning Commission of Pakistan and Cabinet Division all have important responsibilities pertaining to Pakistan's 'health' sector.

With this elaboration of constitutional context, the meeting was apprised of the challenges subsequent to devolution. There was inadequate transition time so the mechanisms, roles and responsibilities were not clearly articulated. However, through existing appropriate mechanisms some of the issues were addressed, e.g. financing of the lady health workers programme, medicines regulation and enhanced allocation of financial share to provincial governments through National Finance Commission award. There are other such challenges that still need stakeholder dialogue to develop a consensus based mechanism, and to clarify division of responsibilities between federal and provincial governments in the light of the amended constitution. Appropriate coordination mechanisms need to be defined

for issues such as national harmony and standardization, equity among provinces, disease surveillance and control etc.

Although the post-devolution period was a challenge at both the federal and provincial levels, it was recognized that the ultimate aim of the 18th amendment was to provide an opportunity to define local solutions to local problems. There is now enough international and local evidence to set the perspective right. Consensus-based decisions are required to achieve meaningful impact of devolution. It is important that both federal and provincial levels redefine roles and responsibilities to ensure stewardship, coordination, better monitoring and effective ownership.

The last session of the G5 workshop pertained to the unfinished agenda and changing burden of disease, for which presentations were made on three specific aspects of mental health, immunization and maternal, neonatal and child health. All country and technical presentations were given to all participants on external disk (soft copies of documents are available upon request).

4. RECOMMENDATIONS

The following recommendations derived out of the G5 workshop deliberations and discussions were presented by Dr Nicknam.

To countries

1. Exchange experiences on issues related to moving towards universal health coverage through establishment of a website by G5 secretariat, country visits and conducting joint meetings, seminars and workshops, in the areas of health care financing, health care delivery and health system management.
2. Develop national roadmaps and strategies for improving service delivery, population coverage and financial risk protection based on national capacities and infrastructure and using a constructive collaborative approach.
3. Assist each other in health workforce capacity development activities, health system research, national health accounts and policy development to enhance moving towards universal health coverage.
4. Develop measurable indicators related to three dimensions of universal health coverage, report progress on an annual basis and document achievements, constraints and possible local solutions.
5. Strengthen the unit in the Ministry of Health responsible for coordinating universal health coverage.
6. Assign a focal person in the Ministry of Health to work with country offices and the Regional Office on G5 collaboration.

To WHO

7. Support the development of a vision, strategy and roadmap for universal health coverage in all four countries.

8. Support and provide technical assistance in evidence generation for:
 - national health accounts analysis for strategic and policy guidance
 - utilization surveys
 - health expenditure surveys
 - OASIS.
9. Facilitate exchange of experiences and expertise within the context of country-specific needs and available national capacities in documenting and disseminating good practices related to universal health coverage.
10. Monitor progress towards universal health coverage and report annually to the Regional Committee for the Eastern Mediterranean.
11. Provide technical support for implementing the family practice programme as an overarching approach to health care delivery based on country capacities and needs and mobilization of resources for implementing universal health coverage.
12. Provide technical support for global health initiatives and health systems strengthening within one national health sector plan using the joint assessment instrument (JANS) and joint assessment reviews and adopting the IHP+ concept.

Annex 1

PROGRAMME

19 November 2013

08:00–08:30 Registration

Session 1: Opening

08:30–09:30 Message from Dr Ala Alwa, WHO Regional Director for the Eastern Mediterranean
Dr Sameen Siddiqi, Director, Health System Development
Address by H.E. Mrs Saira Afzal Tarar, Minister of State, Ministry of National Health Services, Regulations and Coordination, Pakistan
Address by the G5 Secretariat (Islamic Republic of Iran)
Dr Mohammad Hossein Nicknam, Senior Adviser for International Affairs
Objectives of workshop
Dr Mounir Farag, A/Regional Adviser, Hospital Care Management
Introduction of participants

Session 2: Universal health coverage

09:30–10:00 Moving towards universal health coverage: role of health systems
Dr Sameen Siddiqi Director Health System Development

10:30–11:30 What are global health initiatives [GAVI, GFATM, IHP⁺] and how can they support universal health coverage?
Dr Mounir Farag
Discussion

11:30–12:30 Country presentations on challenges to universal health coverage
Afghanistan, Pakistan
Discussion

13:30–14:30 Country presentations on challenges to universal health coverage
Iraq, Islamic Republic of Iran
Discussion

14:30–16:00 Group work: Accelerating progress towards universal health coverage: What countries need to do based on their level of development?

16:30–17:30 Group presentations
Discussion

20 November 2013

Session 3: Lessons learnt from G5 experiences

08:00–08:30 WHO: The regional experience with family practice
Dr Mohamed Assai

08:30–09:00 Iraq: Health sector modernization programme

09:00–09:30 Afghanistan: Outsourcing primary health care services to nongovernmental organizations

- 09:30–10:00 Islamic Republic of Iran: Urban family practice programme
- 10:00–10:30 Pakistan: Devolution in health: challenges and opportunities
- Session 4: Improving collaboration among the G5*
- 11:00–12:00 The unfinished agenda and changing burden of disease:
Noncommunicable diseases
Communicable, maternal, perinatal and nutritional conditions
- 12:00–13:00 Panel discussion: How can G5 countries collaborate with the support of WHO
- 14:00–15:30 Group work: Strengthening collaboration among G5 countries. Priority areas, strategies and action points
- 16:00–16:30 Group presentations and discussion
- 16:30–17:30 Recommendations of the workshop

Annex 2

LIST OF PARTICIPANTS

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