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Report on the

Regional consultation on strengthening service provision through the family practice approach

Cairo, Egypt
18–20 November 2014

World Health Organization
Regional Office for the Eastern Mediterranean

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EXECUTIVE SUMMARY

The regional consultation on service provision through family practice (family practice) was held by the WHO Regional Office for the Eastern Mediterranean in Cairo, Egypt from 18 to 20 November 2014 in collaboration with the World Organization of Family Doctors (WONCA). Participants included international and regional experts on health system strengthening. The consultation also involved representatives from ministries of health, academia and health care delivery professionals from 20 countries of the Eastern Mediterranean Region as well as selected health system focal points from WHO country offices.

The objectives of the consultation were to: present the current status of family practice in the Eastern Mediterranean Region highlighting challenges, opportunities and priorities for moving towards universal health coverage; share regional and global good practices in implementing family practice programmes including aspects related to the integration of services, quality and safety of care, essential package of health services and alternative options to complement family practice approach and develop a road map and action framework for improved service provision as part of the commitments towards universal health coverage that is compatible for the three groups of countries of the Region.

The regional consultation was facilitated by WHO staff from the Regional Office and attended by regional experts from Afghanistan, Bahrain, Islamic Republic of Iran, Jordan, Lebanon, Pakistan, Palestine, Saudi Arabia and Somalia as well as international experts in family practice from Australia, Denmark, Malaysia, United Kingdom, Spain and Thailand. Participants discussed and presented family practice road map in support of universal health coverage for four groups of countries. Each group presented short term action plan and the WHO requested technical support for six main areas; governance and regulations (system absorption capacity); scaling up of family practice training programme; financing (strategic purchasing); vertical and horizontal integration of services; quality and accreditation process; community empowerment (demand, marketing and participation).

At the end of the consultation, the participants welcomed the scaling up of family practice programmes for moving towards universal health coverage and recognized the diversity in family practice implementation among the three groups of countries of the Region. During the working groups the participants discussed the challenges in accelerating family practice and came out with proposed actions to scale up implementation of family practice within countries the Region (see table below). They also emphasized the essential role that WHO can play in advocating family practice and guiding countries in adapting it as an overarching strategy for health care delivery.

Proposed family practice roadmap for universal health coverage in the Region

Major area	Short-term actions (2-year term)	WHO technical support
Governance/ regulations (system absorption capacity)	Advocate with policy-makers to adopt strengthening of family practice as a national health goal for universal health coverage Incorporate family practice as an overarching strategy for service provision within framework of universal health coverage (including projection of future needs for family physicians and other family practice team members) Establish public private partnership through contracting out mechanism with defined catchment population and defined package of services Establish/ strengthen a national high-level multisectoral commission for universal health coverage that sets goals, develop roadmap and oversee progress in scaling up family practice Assign and provide resources to the appropriate unit in the Ministry of Health to take responsibility for coordinating family practice activities Define/adapt the elements of family practice and identify family practice team members that suit the national context Update laws/ regulations for supporting implementation and expansion of family practice programme Establish standards for regulation of family practice programme (whether implemented through the public or private sector) Develop a health information and reporting system (manual/electronic) to monitor health facility (risk factors, health status, system) performance	Present an evidence informed case for family practice with policy-makers in high level forums, including the Regional Committee Assist in making rational projections for production of family physicians and family practice team members Provide terms of reference/roles and functions of the family practice unit within the Ministry of Health Frame a generic public health law/legislation in support of family practice, covering training and delivery aspects for adaption by countries Develop essential standards for family practice for adaptation by countries Build capacity in family practice facilities to report on core indicators agreed by Member States
Scaling up of family practice training programmes	Advocate with university presidents/chancellors and deans of Faculties of Medicine to establish, strengthen and expand family medicine departments and increase intake of family medicine trainees Develop and implement competency based short courses to orient general practitioners, nurses and allied health workers on principles and elements of family practice Introduce incentives for physicians to be enrolled in postgraduate family medicine programmes based on work experience in rural areas and primary health care services Develop continuous professional development programmes for recertification in family medicine Harmonize curricula, evaluation and standards of family medicine board certified programmes in countries of the Region Establish departments of family medicine in all medical schools and integrate a family medicine teaching programme into medical and nursing curricula	Prepare policy briefs and present before deans and chancellors of medical institutions the need to strengthen family medicine departments Collaborate with WONCA to develop short courses for orientation of general practitioners and nurses in family practice Develop a policy paper on options for incentives for health care professionals to participate in family practice training programmes Establish a group of regional experts to review and harmonize family medicine training programmes across the Region
Financing (strategic purchasing)	Introduce family practice financing as integral part of the national health financing strategy in a manner to ensure sufficient and sustainable funding for implementing expanding family practice Engage in strategic purchasing for family practice from	Update tools and guidelines for design and costing of essential health services packages and provide training in their use and implementation Synthesize and disseminate country experiences in financing family practice under

Major area	Short-term actions (2-year term)	WHO technical support
	public and private providers to achieve pre-set goals Design and cost essential health services packages to be implemented through family practice and identify target population to be covered Agree on implementation modalities of essential health services packages delivered by public, not-for-profit or for-profit private health care providers Build capacity to undertake contracting for family practice including outsourcing of services provision Decide and pilot provider payment modalities, e.g. capitation, case payment and necessary performance-based payment or their combinations	different health financing systems and provided related technical support to Member States Share and disseminate evidence on the advantages and limitations of different modalities of contracting (including outsourcing) and organize related capacity building activities Disseminate WHO guidelines as well as a organize a regional consultation on strategic purchasing and provider payment methods Provide evidence-based programme budgeting for financial sustainability
Vertical/ horizontal integration of services	Undertake an assessment of service delivery to review status of integration of priority programmes Develop and pilot a prototype referral system between primary, secondary and tertiary level including feedback and follow up (includes policies and procedures, instruments and staff training) Introduce functional integration of health services (preventive, curative, others) by multi-tasking and refresher training of staff Implement integration in all programmes in certain areas: training, supervision, health promotion, health information systems, drug supply and laboratories	Develop and update WHO guidelines, tools and policy papers on integration of health services Continue to share best practices and exchange experiences of successful integration of programmes within primary care Develop “integrated district health system based on family practice approach” assessment tool
Quality and safety/ standards/ accreditation process	Develop quality standards and indicators for family practice (inputs, process, outputs and outcomes) Develop training and continuous professional development programmes for primary health care workers on improving the quality of service delivery Strengthen supervision and monitoring functions including through interventions to improve the quality of care Introduce/institutionalize accreditation programmes to support higher primary health care performance Enforcing the accreditation of primary health care facilities	Develop framework for quality standards for primary care including those for family practice Pilot and validate assessment framework in countries Organize a regional consultation/workshop to develop consensus and build capacity in the use of framework Support countries in the monitoring quality of care using the endorsed framework Guide for set up monitoring tool to measure progress in family practice implementation with list of indicators
Community empowerment (demand, marketing and participation)	Establish a community health board to oversee the establishment of family practice Launch a community-wide campaign to encourage populations to register with reformed health facilities in the catchment population (including civil registration and vital statistics) Strengthen/initiate and support training of community health workers/outreach teams in scaling up home health care as integral part of the family practice approach Encourage the health volunteer approach as a bridge between households and health care facilities and train volunteers in the use of WHO manuals Organize orientation training for staff of health facilities on communication skills Develop multimedia educational campaigns	Update tools and guides for community engagement in family practice Provide technical support in developing a communication strategy for family practice programmes Exchange successful experiences of community volunteer programmes in support of family practice Provide technical support to increase access to primary health care services through community health workers, outreach teams and home health care strategies

1. INTRODUCTION

Improving access to quality health care services is one of the seven priorities for health system strengthening in the Eastern Mediterranean Region. WHO for the Eastern Mediterranean Region is committed to assist its Member States in improving access to quality, comprehensive and affordable health care services through implementation of the family practice approach. This was reiterated during the 60th session of the Regional Committee held in October 2013 that urged Member States and WHO to expand the provision of integrated health services that address the major burden of ill-health and are based on primary health care.

Despite gaps in information, the key challenges facing family practice in the Region include: lack of political commitment, limited number of good practices in the Region, insufficient number of family medicine specialists, limited number and capacity of family physician training programmes, absence of bridging programmes for general practitioners, and limited engagement of the private sector in the delivery of family practice programmes.

In order to share experiences from within and outside the Region, a regional consultation on strengthening service provision through family practice approach: towards universal health coverage took place in Cairo, Egypt from 18–20 November 2014. Representatives of Member States, academia, United Nations agencies, the World Organization of Family Doctors (WONCA) and nongovernmental organizations participated in the consultation and shared experiences on family practice from within and outside the Region. The objectives of the consultation were to:

- present the current status of family practice in the Region highlighting challenges, opportunities and priorities for moving towards universal health coverage;
- share regional and global good practices in implementing family practice programmes including aspects related to the integration of services, quality and safety of care, essential package of health services and alternative options to complement family practice approach; and
- develop a roadmap and action framework for improved service provision as part of the commitments towards universal health coverage that is compatible for the three groups of countries of the Region.

The consultation was opened by Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, who noted the challenges facing implementation of the family practice programme in the Region and encouraged participants to look critically at the major issues and how to overcome the challenges, recognizing that the expansion of family practice in the Region required innovative ideas and solutions. He expressed hope that the consultation would result in a clear regional roadmap for scaling up implementation of the family practice programme to help countries move towards universal health coverage.

2. OVERVIEW OF FAMILY PRACTICE IN THE REGION

2.1 Family practice assessment

WHO assessment of the implementation of family practice has shown that 16 countries (72%) of the Region have included family practice in their national health policy and plans and established a unit or appointed a focal point to be responsible for family practice. Thirteen have expansion plans for family practice. The proportion of primary health care facilities fully implementing family practice and the number of family physicians varies tremendously between the three groups of countries and even between countries within each group.

In Group 1, primary health care facilities fully implementing family practice range between 100% in Bahrain and Qatar and 14% in Oman. The density of family physicians varies from 2.12 per 10 000 population in Bahrain to 0.04 in the United Arab Emirates. The density in Group 2 countries varies between 0.18 per 10 000 population in Lebanon to 0.01 in Palestine. Despite reasonably good political support for family practice in Egypt, the Islamic Republic of Iran and Iraq, the density of family physicians is less than 0.08 per 10 000 population.

Patient registration exists in 10 out of the 22 countries while only two countries, Bahrain and the Islamic Republic of Iran, assign physicians for a specific number of families. In the other eight Group 2 countries, families may see a different physician on each visit.

All the countries in the Region have developed an essential health services package, although full implementation exists in only 14 countries (63%); in the other eight (31%) implementation is partial or non-existent. All have also developed an essential drug list. Seventeen countries (77%) have reported the availability of these drugs in primary health care facilities, however, full availability at all times in all primary health care facilities in these 17 countries need to be further assessed.

Ten countries (45%) reported staff availability in primary health care facilities sufficient to deliver the essential health services package, while the remainder experience shortages and disparities between rural and urban areas. Most of the physicians working in primary health care facilities are general practitioners, not family physicians, who are certified to work without further specialist training after graduating from medical school.

Despite the existence of several academic institutes with family medicine departments in 13 countries (59%), all countries, without exception, still face major difficulties because of a shortage of specialist family physicians. To improve their technical capacities, 11 countries have developed short-term training programmes over the past decade. The duration of the programmes varies from country to country: Kuwait and Saudi Arabia have established 24-day programmes, followed by 16 days in Oman, 50 hours in Bahrain, and five days in Jordan. The Islamic Republic of Iran has developed distance training programmes through user-friendly multimedia comprising PowerPoint slides, audios, videos and text files.

Referral guidelines are available in 15 countries (68%), but functioning in only five (23%). Non-emergency patients are allowed to approach hospitals directly in 14 countries (63%). The assessment shows that 17 countries (77%) do not have a functioning referral system despite the availability of guidelines.

Family/individual health folders are available in 14 countries (64%), however the huge variations between and within countries should be noted. Primary health care facilities in 18 countries (81%) have information on morbidity and mortality, which is used for planning in 14 countries (63%). Feedback to the primary care level from a higher level occurs in 12 countries (54%). An electronic information system in primary health care facilities is fully implemented in three countries, and partially in eight. Disaggregated data at primary health care level are available in 13 countries (59%). Table 1 shows the main findings from assessment of family practice in 22 countries of the Region.

Table 1. Number of the countries implementing key elements of family practice

Key elements	Group 1	Group 2	Group 3
Family practice as part of the national health programme	All	8	2
Partial engagement of private sectors in family practice	3	2	2
Registering over 80% of the catchment area of primary health care facilities	4	1	1
General practitioners responsible for specific number of families	3	6	1
Availability and delivery of essential health services package in primary health care facilities	All	4	4
Treatment protocol developed and available at all primary health care facilities	4	6	2
Essential drug list available in all primary health care facilities	All	9	2
Sufficient staff available at primary health care facilities to deliver essential health services package	All	3	1
Primary health care facility equipped with approved standard list of medical equipment	All	7	4
Short-term training for general practitioners to provide services based on family practice	5	8	3
Referral system is functional between primary health care facilities and hospital level	2	2	1
Facility information used in planning process of family practice/primary health care	4	7	3
A system for quality assessment of primary health care facilities in place	6	7	3
Community has a role in local health decision-making and implementation of health programmes	6	7	All

2.2 Panel discussion on the current status of family practice

It was suggested that the focus should be on the 13 elements of family practice, particularly for identifying elements which are the most feasible to be scaled up in the short-term. Following are 13 elements of family practice:

1. Registration of catchment population and development of family folder
2. Development family physician roster
3. Community engagement
4. Essential health services package
5. Essential drug list
6. Staff pattern based on family practice with updated job descriptions
7. Standard set of medical equipment and furniture
8. Training programmes based on the new job descriptions
9. On-the-job training for general practitioners and other supportive staff
10. Availability of updated treatment protocols
11. Functional referral system
12. Health care information system
13. Quality and accreditation programme

Family practice approach is a model that is not limited to only physicians but requires a team. Therefore, a clear vision is required for all the health workers when implementing a family practice approach.

Although it has been more than 30 years since Alma-Ata and all ministries of health in the Region are committed to universal health coverage, it was noted that the family practice approach is not yet part of the health system in many countries of the Region. Several participants called for their countries to demonstrate real commitment to integrated primary health care. They recognized that it is critical to link family practice to universal health coverage as well as quality of care. A key difficult in integrating family practice into primary health care is due to the weak structure or limited support within some countries of the Region. WHO recent study shows that 33% family medicine key informants reported low level of readiness of the Region health systems to absorb family physicians. Thus, it was recognized that the health system may need to be strengthened/reshaped to absorb the family practice approach.

Community involvement was raised by several participants. Some noted that although the family practice approach is people-centred, the delivery system often does not meet community demands. It was suggested that a clearer understanding is required regarding what is meant by community involvement. At the same time, it was proposed that a mechanism is needed to make family practice more responsive to the community needs and demands. This may involve assessing community needs and demands, orienting the community on the needs for a family practice approach and marketing family practice.

Countries of the Region have come a long way in building the health workforce and many medical schools in the Region do not have a family medicine department. Out of 290

medical schools, only 59 have family medicine departments. Extensive discussions explored how to upgrade the current workforce, particularly training medical school graduates (some of whom may have worked for many years) in the field of family medicine as well as the training for all health and social workers to be part of the family practice team. Understanding what motivates students to enrol in specialty programmes needs to be further explored to meet WONCA goals of 50% of physicians being family practitioners. There was general agreement that any training programme may need to be accompanied by incentives and regulations to ensure the adoption of the family practice approach in achieving universal health coverage in the Region. Decentralized budget, development of key performance indicators and incentive schemes such as capitation for outcome measures are some ways to make family practitioners accountable.

Measuring quality and safety of care was also a concern raised by participants. It was noted that many indicators are available to measure input and process; however, further clarity is required regarding output to build an evidence base on the impact of integrating family practice in countries of the Region. It was suggested that a checklist of input, process and outcome indicators for quality and safety of service delivery may be useful. Given the importance of gathering data, it was suggested that an automated system through the use of information technology (e-health and mobile apps) should be better integrated into the system.

2.3 Family medicine training programmes

A recent WHO study on family medicine education and training programmes in the Region presented in the inaugural session that has shown lack of family medicine departments in medical schools of many countries of the Region is resulting in lack of exposure of medical students to this specialty. A need has been identified to establish family medicine departments in all medical schools, in order to expose and sensitize medical students to this specialty. Global evidence shows that more medical students select family medicine as their future career when they are exposed to the specialty at undergraduate level. In addition, the study identified a number of reasons for students not selecting the family medicine specialty: less attractive compared to other specialties; not well known; less salary; the present health system doesn’t fully support family medicine, nor are there any positions for family physician at primary health care facilities (health system structure based constraints); no role models for medical students in family medicine; and inadequate training capacity in all medical schools.

According to a report published in 2011, 31 family medicine residency programmes existed in 13 countries across the Region, graduating approximately 182 residents per year. This was up from an earlier reported 20 programmes graduating 150 residents each year in the Arab world in 2007. To date, there has been limited information about undergraduate education in family medicine. Moreover, there are no reliable estimates regarding postgraduate training programmes in the field.

Postgraduate training programme availability is variable and lacking in several countries of the Region. Numbers of trainees inducted and graduates from postgraduate training programmes are insufficient to meet the health care needs of the countries in the Region. Issues related to curriculum, assessment and accreditation have been identified and require

urgent attention. On-the-job training in family medicine and building the capacities of general practitioners for delivery of quality primary health care services exist and are growing. They vary in duration from three months to two-year training and aim to improve knowledge and skills of the general practitioners in management of diseases, based on local needs. Availability of continuing medical education programmes for family physicians in the Region is variable and far from satisfactory. Continuing medical education is not a mandatory requirement and not linked to either licensing, credentialing or recertification.

According to an assessment conducted by WHO in collaboration with partners in 2014, countries of the Region are divided into 4 groups in terms of performance in family medicine training. Group 1 (highly performing countries) comprise Bahrain, Kuwait, Oman, Qatar and United Arab Emirates. Group 2 (moderately performing countries) are Egypt, Jordan, Lebanon and Saudi Arabia. Group 3 (countries with challenges) consist of Iraq, Pakistan, Somalia, Syrian Arab Republic, Sudan and Tunisia. Group 4 (countries with no family medicine training) are Djibouti, Libya, Morocco, Palestine and Yemen.

2.4 Panel discussion on family medicine

During the discussion a few participants raised some queries regarding the two presentations including clarification on the gender distribution of family practitioners and community involvement. Participants also raised queries regarding the terminology particularly for family medicine and family practice.

Family medicine is: a medical specialty concerned with providing comprehensive care to individuals and families and integrating biomedical, behavioural and social sciences; an academic medical discipline that includes comprehensive health care services, education and research; known as general practice in some countries. Health care services in family practice are provided by family doctors and often supported by a multidisciplinary team. Family practice is characterized by comprehensive, continuous, coordinated, collaborative, personal, family- and community-oriented services and comprehensive medical care with a particular emphasis on the family unit.

3. TECHNICAL SESSIONS

3.1 Establishing family practice programmes

The technical sessions were organized under 7 themes. Under the first theme, presentations and discussions focused on the role of family practice in providing integrated people-centred health care services from the global perspective.

Lessons from global experiences

The first presentation provided a brief on the global strategy for people-centred and integrated health services that is in line with family practice approach and common challenges that have been faced in relation to human resource management, quality of care, service

provision management, needs based-financing misconceptions about family practice, artificial confrontation between general practice and hospital specialized care.

WONCA's presentation focused on its potential role and support in promoting family practice. The presentation emphasized the importance of building strong family practice teams to improve the health of individuals, families and communities. In the Eastern Mediterranean Region, WONCA calls for every family to have a physician whom the members of that family can trust for medical care and advice. The presentation also underlined the need for working with medical schools in each country to develop greater clarity around how to educate future family medicine workforce to ensure meeting the future health care needs of the population. In addition, postgraduate family medicine training must be based in primary care and communities.

Exchange of experiences was among the key elements of this session as different family practice experiences from outside the Region had been discussed such as Latin American countries, Malaysia and the United Kingdom.

The lessons learnt from the global experiences to support implementing the family practice approach highlight the importance of the following: strong primary health care; developing the primary care professionals' skills to address the complexity of the health–disease process (bio-psychosocial model); and integrating family practice into medical curricula.

Based on the presentations of global experience, the speakers were requested to identify lessons learnt from their experiences. It was noted that integration is fundamental to family practice and political commitment is required throughout this process. Linking it with universal health coverage, working in a phased approach and allocating resources for the transformation of the health care system are important points to be considered. Regarding the family medicine specialist, all speakers recognized that the training needs to be at par with other specialties and countries need to explore their own pathways in determining how to unskilled the current workforce whether it is formal postgraduate training, grandfathering, online educational opportunities or other continuing professional development programmes. Updating the regulatory function of primary health care facilities may also be required.

Lessons from regional experiences

Family practice experiences of some countries of the Region were discussed in terms of challenges, success stories and lesson learnt. Country experiences including the Islamic Republic of Iran, GCC countries and UNRWA were presented during this session.

The issue of a clearer definition of family practice and the terminology on the role of family physicians as "gatekeepers", "gate facilitators" or "first contact" continued in the afternoon sessions. The discussions regarding the training of family physicians continued from the morning session. It was noted that there is no global standard for training. It was agreed that it should be a decision based on the country context that ensures physicians have the knowledge and skills needed for a family practice approach and that the clinical training

should include placement in both hospitals and model health centres. The strategy for integration of family practice needs to be developed with the inclusion of stakeholders (i.e. financial and public health experts).

The issue of catchment area definition and registry was also raised. Although many participants appreciated the need for a health system that involves registration to a health centre, family practice team and/or physician, difficulties were raised for some countries such as Afghanistan which has not done a census nor has a vital registration system. At the same time, it was proposed that for those countries that have not yet established a family practice approach to ensuring universal health coverage, a roadmap or 10-point checklist should be developed to guide them in the process.

Many countries are struggling with conflict and have a double burden of health system challenges on top of the issue of insecurity. Although it was noted that implementing the family practice approach may be difficult, UNRWA provided a good example of how primary health care reform including the integration of a family practice approach could improve quality of care and patient satisfaction under difficult situations.

The issue of the private sector, although mentioned in the morning session, was discussed more fully in the afternoon. It was noted that for many countries the private health care sector is growing; they are an important resource to be considered but they currently do not follow standards. It was noted this issue needs to be examined further, particularly the financial implications; but one possible way to work with the private sector is for the government to contract them to provide a clear package of services. Another may involve better coordination with health insurance organizations.

The WHO Regional Committee for the Eastern Mediterranean in 2014 endorsed a framework for action on advancing universal health coverage in the Region. The framework includes key actions for countries to expand the coverage of needed health services, along with supportive actions by WHO.

The participants found that the countries in the Region are very diverse and face different challenges. For some countries, universal health coverage may require a major reform of the health system which would also require a significant amount of resources. It was therefore suggested that integrating a family practice approach into service delivery should be a goal for every Member State; and then each country identifies how this goal can be achieved both in the short-term and long-term. For example, in some countries it may involve making more use of allied health professionals in the short-term rather than a dramatic increase in the number of family physicians. Piloting will help to identify priorities and develop models for each country in line with the existing infrastructure and national needs.

An extensive discussion was held on building the human resource capacity for family practice with a focus on competency-based training. For example, big gaps between training of physicians and practice in the field exist. It was noted that scaling up requires training of different cadres of health workers, not just physicians. It was emphasized that training programmes should

be well-structured; building model training programmes within country could then be scaled up, as needed. This would require reviewing the curricula of medical and nursing schools.

Suggestions were made to include the information system, referral system and availability of medicines in the framework of action. It was stressed that the information system should incorporate reporting on health outcomes since regional evidence on the impact on family practice is very limited. Outcome indicators would also help identify model countries in the Region. It was suggested that “twinning” could encourage closer collaboration between countries.

Challenges and opportunities and the role of family practice

Day two started with a presentation by Dr Sameen Siddiqi in which he covered the main dimensions of universal health coverage and the current status of universal health coverage in the Region in terms of direct cost, share of out-of-pocket payment in total health expenditure, service coverage for communicable and noncommunicable diseases and reproductive health in addition to health workforce. The presentation also discussed the main challenges and opportunities in relation to moving towards universal health coverage and what is the role of family practice in attaining universal health coverage.

The brief discussion following this presentation focused on how to meet universal health coverage through family practice. Concern was raised about the ability for some countries to improve service provision through family practice approach. However, it was noted that most of the countries have some positive experience on service provision. It was recognized that having a family practice approach should not just involve the integration of family medicine specialties but involves all health workers as part of the family practice team. It was also recognized that family practice involves 13 elements and it is not realistic for countries to implement all elements at the same time. Rather they should focus on scaling upthose that are the most feasible and then expand to include the others.

Concern was raised about meeting universal health coverage in Group 1 countries which have a high proportion of migrant workers. Their access to health care is unclear but has been raised internationally.

The issue of addressing wastage was discussed briefly as one way to improve efficiency. Oman’s “lean thinking” project was given as an example of addressing wastage in ambulatory care. It was recognized that more information on wastage in the Region is needed. It was also recognized that this is a sensitive area of governance. WHO would welcome the opportunity to work closely with countries interested in addressing this issue.

Finally, concern was raised about the most vulnerable groups. It was recognized that countries have social protection and policies and insurance schemes that can assist in ensuring universal health coverage.

3.2 Scaling up training of family physicians in the Region

The second theme focused on the main challenges in implementing the family practice approach in terms of the shortage of family physician specialists and the insufficient post graduate training programmes and deployment of family physicians for primary health care facilities. In this regard, Dr Faisal Al Nasir, professor of Arabian Gulf University, Bahrain made a presentation in which he highlighted that although many efforts have been made in the Arab countries to implement family medicine, the expected goals have not been reached. Many Arab countries have not yet implemented family medicine while the few others that have introduced it are still struggling with a shortage of qualified family doctors.

Realizing that family medicine should be the foundation of health services and that 50% of the working physicians in any country should be constituted from family doctors, we can visually perceive why the health of the nation in many Arab countries are not reaching to the standard level. Such countries are not only experiencing the re-emergence of a few communicable diseases but also many suffer markedly from the consequences of the high prevalence of noncommunicable illnesses as well.

The Arab countries currently need around a quarter of a million qualified family doctors; however, statistics show that the available number does not exceed a few thousand. One of the best achievements of the Arab Health Ministers' council of the Arab League is the development of the Arab Board for Health Specialties which was founded in 1978. However, not all countries are participating in its activities. The Family and Community Council since its establishment 28 years ago (in 1986) has managed to graduate only 1567 family doctors.

Challenges in postgraduate training and deployment of family physicians based on Lebanon's experience were presented by Dr Ghassan Hamadeh, American University of Beirut. He noted that Lebanon has around 12 000 physicians, of these 2000 are general practitioners with no postgraduate training and fewer than 100 are trained certified family physicians. The challenge of the Lebanese Health Care authorities was to find means to transform general practice into family practice. Obstacles were the only 2 family practice training programmes based on the 4 year Arab Board model and lack of tutors, training sites and motivation by doctors to become family practitioners.

The turning point was in 2014 following an initiative by the past Order of Physicians president who was seeking improving patient safety and the licensing process of physicians. A law was passed allowing physicians to practice only if they have postgraduate training. He added that AUB took this opportunity to complement its numerous past family medicine advancement projects and proposed a multi-track initiative to push family medicine forward; some of the recommendations were as follows.

- Develop a course for training of general practitioners and facilitate training of existing general practitioners into family medicine post graduate
- Support the Ministry in upgrading the primary health care facilities and identify centres that can act as training centres.

- Establish a faculty development programme to train existing family practitioners interested in teaching.

Panel discussion: Can the production of family physicians be scaled up through short term training programmes for general practitioners?

Participants recognized the progress in family medicine training programmes in the Region but also recognized the challenges in having 50% of all physicians trained in family practice as part of the drive to universal health coverage. A more strategic approach is to focus on how family practice can contribute to achieving universal health coverage and not to be limited in thinking that only physicians can contribute to this task. Participants recognized the importance of family practice in supporting universal health coverage, including those from Group 3.

Although it was recognized that family practice involved a multi-disciplinary team, the focus of the discussion was on the training of physicians in family practice. It was agreed that since it is not possible for 90% of the current cadre of primary care physicians to go through a formal 3–4 year postgraduate course, a training process to upgrade the knowledge and skills of general practitioners to meet minimum criteria and be certified through assessment process is needed. This grandfathering approach (training to demonstrate competence) has been adopted by many countries including Korea, Portugal, Sri Lanka, Turkey, Viet Nam and Eastern European countries. In addition to this approach, it was suggested that undergraduate medical students should be exposed to family practice as part of their training. This requires increasing the number of clinical training centres for family medicine in countries of the Region.

3.3 Improving the quality and safety of care: gaining the trust of populations through the family practice approach

The third theme concerned different approaches to improve the quality of primary health care along with discussing different experiences from the developing world.

Accreditation of primary care facilities was among the main subjects of the theme discussing the Jordanian experiences. In addition, different challenges facing health systems in the Region was discussed along with the regional framework for improving quality of primary health care in the Region. The findings of the assessment of family practice quality in selected countries of the Region, namely Egypt, Islamic Republic of Iran, Iraq, Jordan, Morocco and Sudan, were also presented in this session. All assessed primary health care facilities showed a high percentage of breastfeeding counselling, routine growth monitoring and advising/providing pregnant mothers with iron and folic acid supplement based on national guidelines. 50% of facilities in the Islamic Republic of Iran do not have mapping of noncommunicable diseases while none of the facilities in Iraq, Morocco and Sudan has them. Screening for diabetes and hypertension for population above 40 years old is not routine in Egypt, Jordan or Morocco, while half of the facilities in the Islamic Republic of Iran conduct it. Patient satisfaction surveys are not available in the Islamic Republic of Iran, Iraq, Morocco, or Sudan. Jordan reported a high patient satisfaction and Egypt reported only 30% patient satisfaction.

Panel discussion

The participants reiterated the importance of having good family physicians even if the primary health care system is not strong. Well-trained family physicians use a holistic approach to patient management that can benefit the full primary care team as well as the community including with promoting patient safety and quality care. At the same time, it was noted that for countries with limited human resources, the population is served by medical assistants and other allied health workers. Thus, a quality strategy needs to be relevant for all contexts.

The discussion focused on quality management and accreditation. It was noted that there are numerous frameworks available to measure quality. Quality measure should include both processes as well as outcome indicators. Based on the experience in some countries of the Region, it was suggested that when developing a quality assurance programme the following should be considered: ownership of quality processes by practitioners, closing the loop (collecting data and providing feedback to the field), and the process of collecting information should ensure confidentiality. The Regional Office confirmed that the core set of 26 indicators includes both process and outcome indicators but agreed that they should cover more such as those related to the system (i.e. financing, accountability, etc.) and be linked to the health system building blocks and community engagement.

Although accreditation was seen as a good tool for quality, concern was raised regarding its sustainability and whether or not it would be appropriate for all contexts.

3.4 Strategic purchasing: the interface between provision and financing of care

The fourth theme concerned developing and implementing an essential package of health services. Different modalities for contracting out of primary care services were presented. The Afghanistan experience was discussed illustrating contracting out primary health services to non-for-profit organization that improved primary health service coverage and quality in addition to creating innovations, reform and new initiatives.

In their quest to pursue the goal of universal health coverage, countries at their various level of economic development are required to select from options available to enhance the performance of the three health financing functions of collection, pooling and purchasing. While mobilizing sufficient funds for health is the basis to promote the goals of universal health coverage, using the collected funds in an efficient manner is crucial to maximize benefits and promote sustainability. To this end, strategic purchasing has proven to be a powerful tool to promote the goal of ensuring “more health for the money” in the health sector. In the Eastern Mediterranean Region, the health sector traditionally engaged in what is typically known as passive purchasing – that is, the government/purchasers directly funds government-run/owned health facilities through paying for their inputs such as personnel, medicines, supplies and equipment. As such, it provides little incentive for the providers to improve quality or efficiency as they are not held accountable for delivering specific outputs or outcomes. Strategic purchasing involves proactive and explicit decision making of predefined outputs and outcomes based on demand and population need; and links funding to

the delivery of these pre-defined products. Results-based funding refers to the transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target. In doing so, strategic purchasing and results-based financing aim to ensure efficient allocation of scarce health resources to maximize population health and enhance financial protection. Strategic purchasing requires deliberating and answering three sets of questions: a) which services to purchase and for whom; b) from whom those services should be purchased; and c) how those services should be purchased? In addressing these questions, the way providers are paid is found to play an important role in outlining the nature of incentives provided to providers to enhance coverage, improve quality and maintain cost.

Panel discussion

The way family practice is currently financed in the Region brought to the surface a lot of questions about the nature of incentives induced by the current payment structure and its linkage with the expected outcomes. Reorganizing the purchasing of family practice-related services, taking into consideration the evoked principles of strategic purchasing, was found to be highly needed by most delegates. Defining what the package would include and specifying who is paying for what were found to be key for advancing the agenda of promoting and implementing the family practice approach in countries of the Region. Concern was expressed however with regard to the lack of full understanding and of adequate capacities in countries for implementing such new modalities of purchasing and for introducing innovative provider payment methods. Further capacity-building in the area of strategic purchasing for family practice was requested.

3.5 Integrating health services – vertical versus integrated approach

The fifth theme covered the conceptual issues on integration of priority programmes such as noncommunicable diseases and chronic care management in the primary health care in addition to sharing the Europe and the Basque country (Spain) experiences in the same area of work. The current status of integrating noncommunicable diseases in primary health care in the Region was discussed in addition to the broad outline of the regional way forward for strengthening noncommunicable disease delivery using a health system approach.

Panel discussion

An extensive discussion regarding integrating health services followed the presentations. Although integrated care is a fundamental aspect of primary care, it was recognized that health care delivery in many countries of the Region is fragmented. Concern was raised, for example, about building specialty clinics or running vertical programmes within primary care. It was also recognized that well-trained family physicians can provide comprehensive care. However, the integration of noncommunicable diseases and mental health was seen as a way to strengthen primary care and address current issues such as irrational use of medicines, under diagnosis and under treatment of noncommunicable diseases and high number of referrals. UNRWA informed that introducing an essential package of noncommunicable diseases in primary care resulted in

fewer patients referred, ensured continuity of care and may be a good way to introduce family practice into the system.

Another issued raised, was that in the literature, integrated care is not about diseases but the integration of health and social care.

3.6 Alternative service delivery options to complement family practice programme

The next theme discussed the alternative options for health care service delivery to complement the family practice programme such as introducing/scaling up community health workers and outreach services case studies of experiences from inside and outside the Region. Thailand' experience with community health workers was also presented in this session.

In addition, the need for home health care for the elderly as an integral part of primary health care services was discussed as a cost-effective approach in providing needed health services for the elderly in their homes. Home health care will help in facing the challenges of rapid rates of development and urbanization, an ageing population and the growing prevalence of noncommunicable diseases.

Panel discussion

A lively discussion on home health care and community health workers followed the presentations. Dr Tawfiq Khoja suggested the slogan "family practice in the Region: vision for the future" be used to advocate for family practice. He recognized neonatal care as one of the best buys for family practice and noted the progress happening in the GCC countries. Many participants agreed that home health care is a way to improve care for the elderly noting that some countries have started working on an elderly programme using the home health care approach. Some participants noted that this approach is useful not just for the elderly but for all people eligible for care (such as for postnatal care) to ensure continuity of care. Although it was agreed that home health care should be part of the family practice approach, some countries expressed concern about ensuring the safety of their home health care teams. Other suggestions that should be addressed when establishing a home health care programme are to ensure proper supervision and quality of care and the allocation of resources and develop certain eligibility criteria and appoint a suitable team to apply such services.

Concern was raised that home health care and health of the elderly are not well covered in undergraduate medical education. It was also noted that elderly health care needs to be strongly related to social care. Thus, such a programme should involve other stakeholders like the ministries of education, interior, religious affairs and social development. Given the great need to build capacity in this area, it was proposed that WHO should hold a separate consultation on this issue.

The participants recognized the importance of community health workers to complement the health services. Several countries, in fact, gave examples of how they have incorporated the use of community health workers in their health system. It was noted that

community health workers deliver more than just basic health care but also social care. Therefore, there is a need to work with other sectors in training community health workers.

Despite the available evidence demonstrating the achievements of community health workers, concern was raised on the quality and safety of the work they provide. It was agreed that with clear guidelines based on the local context, close supervision and monitoring, community health workers can help address common health problems in the community.

Dr Michal Kidd, President, WONCA informed the meeting that WONCA fully supports community health workers as part of the family practice team and agrees that home health care is an integral part of the service. He noted that they can help improve quality and appropriateness of care. He noted the risk of task-shifting without support/supervision and stressed that no health worker should feel obliged to work beyond their training.

The Regional Director closed the session by acknowledging the importance of home health care and community health workers. He was pleased they were included in the agenda of the meeting because it was an opportunity for WHO hear views from Member States. He acknowledged that much more work and discussion is required. He suggested that for both issues a comprehensive in-depth analysis be conducted to consolidate regional and global experience to help determine how WHO can support countries.

3.7 Roadmap for accelerating family practice in countries

To address the final theme, the participants divided into four working groups to discuss the lessons learnt from the shared experiences from the countries within and outside the Region presented on day 1. The objective was to identify challenges in accelerating family practice and drafting actions/roadmap to scale up implementation of family practice within countries of each group, focusing on key priority areas. Below is a list of the working groups.

Group 1: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates
Group 2: Egypt, Islamic Republic of Iran, Jordan and Lebanon
Group 3: Iraq, Libya, Palestine, Syrian Arab Republic, Morocco and Tunisia
Group 4: Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen

Table 2 shows proposed actions by the working groups addressing service provision in the countries of the Region.

Table 2. Proposed family practice roadmap for universal health coverage in the Region

Major area	Short-term actions (2-year term)	WHO technical support
Governance/ regulations (system absorption capacity)	Advocate with policy-makers to adopt strengthening of family practice as a national health goal for universal health coverage Incorporate family practice as an overarching strategy for service provision within framework of universal health coverage (including projection of future needs for family physicians and other family practice team members)	Present an evidence informed case for family practice with policy-makers in high level forums, including the Regional Committee Assist in making rational projections for production of family physicians and family practice team members Provide terms of reference/roles and functions of the family practice unit within

Major area	Short-term actions (2-year term)	WHO technical support
	Establish public private partnership through contracting out mechanism with defined catchment population and defined package of services Establish/ strengthen a national high-level multisectoral commission for universal health coverage that sets goals, develop roadmap and oversee progress in scaling up family practice Assign and provide resources to the appropriate unit in the Ministry of Health to take responsibility for coordinating family practice activities Define/adapt the elements of family practice and identify family practice team members that suit the national context Update laws/ regulations for supporting implementation and expansion of family practice programme Establish standards for regulation of family practice programme (whether implemented through the public or private sector) Develop a health information and reporting system (manual/electronic) to monitor health facility (risk factors, health status, system) performance	the Ministry of Health Frame a generic public health law/legislation in support of family practice, covering training and delivery aspects for adaption by countries Develop essential standards for family practice for adaptation by countries Build capacity in family practice facilities to report on core indicators agreed by Member States
Scaling up of family practice training programmes	Advocate with university presidents/chancellors and deans of Faculties of Medicine to establish, strengthen and expand family medicine departments and increase intake of family medicine trainees Develop and implement competency based short courses to orient general practitioners, nurses and allied health workers on principles and elements of family practice Introduce incentives for physicians to be enrolled in postgraduate family medicine programmes based on work experience in rural areas and primary health care services Develop continuous professional development programmes for recertification in family medicine Harmonize curricula, evaluation and standards of family medicine board certified programmes in countries of the Region Establish departments of family medicine in all medical schools and integrate a family medicine teaching programme into medical and nursing curricula	Prepare policy briefs and present before deans and chancellors of medical institutions the need to strengthen family medicine departments Collaborate with WONCA to develop short courses for orientation of general practitioners and nurses in family practice Develop a policy paper on options for incentives for health care professionals to participate in family practice training programmes Establish a group of regional experts to review and harmonize family medicine training programmes across the Region
Financing (strategic purchasing)	Introduce family practice financing as integral part of the national health financing strategy in a manner to ensure sufficient and sustainable funding for implementing expanding family practice Engage in strategic purchasing for family practice from public and private providers to achieve pre-set goals Design and cost essential health services packages to be implemented through family practice and identify target population to be covered	Update tools and guidelines for design and costing of essential health services packages and provide training in their use and implementation Synthesize and disseminate country experiences in financing family practice under different health financing systems and provided related technical support to Member States Share and disseminate evidence on the

Major area	Short-term actions (2-year term)	WHO technical support
	Agree on implementation modalities of essential health services packages delivered by public, not-for-profit or for-profit private health care providers Build capacity to undertake contracting for family practice including outsourcing of services provision Decide and pilot provider payment modalities, e.g. capitation, case payment and necessary performance-based payment or their combinations	advantages and limitations of different modalities of contracting (including outsourcing) and organize related capacity building activities Disseminate WHO guidelines as well as a organize a regional consultation on strategic purchasing and provider payment methods Provide evidence-based programme budgeting for financial sustainability
Vertical/ horizontal integration of services	Undertake an assessment of service delivery to review status of integration of priority programmes Develop and pilot a prototype referral system between primary, secondary and tertiary level including feedback and follow up (includes policies and procedures, instruments and staff training) Introduce functional integration of health services (preventive, curative, others) by multi-tasking and refresher training of staff Implement integration in all programmes in certain areas: training, supervision, health promotion, health information systems, drug supply and laboratories	Develop and update WHO guidelines, tools and policy papers on integration of health services Continue to share best practices and exchange experiences of successful integration of programmes within primary care Develop “integrated district health system based on family practice approach” assessment tool
Quality and safety/ standards/ accreditation process	Develop quality standards and indicators for family practice (inputs, process, outputs and outcomes) Develop training and continuous professional development programmes for primary health care workers on improving the quality of service delivery Strengthen supervision and monitoring functions including through interventions to improve the quality of care Introduce/institutionalize accreditation programmes to support higher primary health care performance Enforcing the accreditation of primary health care facilities	Develop framework for quality standards for primary care including those for family practice Pilot and validate assessment framework in countries Organize a regional consultation/workshop to develop consensus and build capacity in the use of framework Support countries in the monitoring quality of care using the endorsed framework Guide for set up monitoring tool to measure progress in family practice implementation with list of indicators
Community empowerment (demand, marketing and participation)	Establish a community health board to oversee the establishment of family practice Launch a community-wide campaign to encourage populations to register with reformed health facilities in the catchment population (including civil registration and vital statistics) Strengthen/initiate and support training of community health workers/outreach teams in scaling up home health care as integral part of the family practice approach Encourage the health volunteer approach as a bridge between households and health care facilities and train volunteers in the use of WHO manuals Organize orientation training for staff of health facilities on communication skills Develop multimedia educational campaigns	Update tools and guides for community engagement in family practice Provide technical support in developing a communication strategy for family practice programmes Exchange successful experiences of community volunteer programmes in support of family practice Provide technical support to increase access to primary health care services through community health workers, outreach teams and home health care strategies

4. CONCLUSIONS AND CLOSING SESSION

Dr Kidd thanked WHO for the opportunity to work together on strengthening service provision through family practice. He provided a list of 8 issues on how WONCA can continue working with WHO on moving forward:

- Governments invited to demonstrate commitment by recognition of family physician as a medical specialty and reflect family practice in national health policy
- Each medical school curriculum to include training and experience in family medicine (consistent with WONCA's Singapore Statement)
- Formal postgraduate training in family medicine for those leaving medical school leading to specialist recognition as a family physician
- Organization of family physicians established in each country to work with government to support family medicine standards and education
- Opportunities for scaling up existing general practice including development of a diploma course on the principles of family medicine
- Opportunities for existing general practice to demonstrate competency and attain recognition as a family physician
- Support for the development of family practice teams
- Influence donors to fund strengthening primary care

Dr Khoja recognized that the outcome of the group work has clear action plans with a vision to integrated family practice in health systems in the Region. He emphasized the need to generate evidence from the Region. He also noted a few issues not addressed in the group work including leadership in family practice, referral system, information technology and research.

During the discussion, participants stressed the importance of the Ministry of Heath adopting a clear policy and not waiting for medical schools to establish a family medicine programme. The context and challenges of integrating family practice in health systems in the Region is complex and the challenges vary in each country. Thus, in additional to regional consultations, much dialogue is required at the country level to scale up family practice. It was noted that all countries have some level of competence which can serve as entry points in developing local models of family practice shaped by the specific needs of the country. For example, continuing medical education programmes linked to licensing can upscale current staff. Developing a regional observatory, adopting a twinning approach and joint operational research projects were identified as ways to learn the art of implementation.

It was recognized that Ministers of Health are faced with many challenges and are looking for advice on how best to ensure universal health coverage. The best way is financial support and integration can help by saving costs and directing funds to maximize their benefits. However, more concrete plans are required not only to ensure universal health coverage but to ensure quality of services.

The Regional Director closed the meeting. Reflecting on his experience with the International Conferences on Nutrition (he attended the opening day of the 2nd ICN), he

stressed that developing a long list of recommendations was not workable or realistic. Recommendations needed to be action-oriented, evidence-based and based on context. He noted the excellent outcome in terms of ideas, concept and concrete actions that WHO could work on. He indicated that WHO would need to continue to work with Member States, regional institutions and with WONCA and with GCC Council Ministers of health. A small working group would review the input and the recommendations and then develop a draft on the way forward covering all areas of the health system building blocks and the options for country contexts. If in 4 months' time things were ready, then efforts would be made to present it at ministerial forums including the next session of the Regional Committee. The results of the meeting would be presented at two upcoming forums in December, one of human resource strategy and the other on medical education.

Annex 1

PROGRAMME

Day 1. Tuesday, 18 November 2014

08:00–08:30	Registration	
08:30–08:45	Address by Dr Ala Alwan, Regional Director, WHO EMRO	
08:45–08:55	Objectives and expected outcomes	Dr Hassan Salah, WHO EMRO
08:55–09:15	Result of family practice assessment in 22 countries of the Region	Dr Mohammad Assai, WHO EMRO
09:15–09:30	Overall status of family medicine training programmes in the Region	Dr Waris Qidwai, Aga Khan University and Dr Magzoub Mohi ElDin, WHO EMRO
09:30–10:30	Discussion Theme 1: Establishing family practice programmes: lessons from global and regional experiences	Chair: Dr Sameen Siddiqi, Co-chair: Dr Ghassan Hamadeh
11:00–11:15	The contribution of family practice to integrated people-centred health services: a global perspective	Dr Hernan Montenegro, WHO HQ
11:15–11:30	The role of WONCA in promoting family practice	Dr Michael Kidd, Global WONCA
11:30–11:45	Experience with family practice programmes in Latin American countries	Dr Sergio Minue Lorenzo, School of Public Health, Andalucia, Spain
11:45–12:00	Experience of family practice in Malaysia	Dr Khoo Ee Ming, University of Malaya
12:00–13:00	Discussion Theme 1 (Cont.): Establishing family practice programmes: lessons from global and regional experiences	Chair: Dr Faisal Alnasir, Co-chair: Dr Mohamed Ibrahim Tarawneh
14:00–14:15	National health services in the United Kingdom	Dr Salman Rawaf, WHO Collaborative Center, Imperial College London
14:15–14:30	Family practice in the Islamic Republic of Iran	Dr Arash Rashidia, Tehran University
14:30–14:45	Implementation of family practice programme in the GCC countries	Dr Nabil Kurashi, University of Dammam, Saudi Arabia
14:45–15:00	Family health team approach: UNRWA experience	Dr Ali Khader, UNRWA
15:00–17:00	Panel discussion: Challenges, lessons learnt and priorities to enhance family practice programme in countries	Chaired by Dr Ala Alwan Regional Director WHO EMRO

Day 2. Wednesday, 19 November 2014

08:30–08:45	Towards universal health coverage: challenges and opportunities and the role of family practice	Dr Sameen Siddiqi, WHO-EMRO
08:45–09:00	Discussion	
	Theme 2: Scaling up training of family physicians in the Region	Chair: Dr Azeem Majeed, Co-chair: Dr Ahmed Abdellatif
09:00–09:15	Shortage of family physician specialists: how to approach the problem in the Arab countries?	Dr Faisal Al Nasir, Arabian Gulf University, Bahrain
09:15–09:30	Challenges in post graduate training and deployment of family physicians: Lebanon experience	Dr Ghassan Hamadeh, American University of Beirut
09:30–10:00	Panel discussion	
	Policy debate: “Can the production of family physicians be scaled through short term training programmes for general practitioners?”	Dr Michael Kidd, Dr Waris Qidwai, Dr Sergio Minue Lorenzo, Dr Salman Rawaf and Dr Sameen Siddiqi
Theme 3: Improving the quality and safety of care: Gaining the trust of populations through family practice approach		Chair: Dr Nabil Kurashi, Co-chair: Dr Khalid Mohammed
10:30–10:45	Approaches to improving the quality in primary care settings: experiences from developing worlds	Dr Per Kallestrup, Aarhus University, Denmark
10:45–11:00	Accreditation of primary care facilities: Jordanian experiences	Dr Salma Jaouni,Health Care Accreditation, Jordan
11:00–11:15	Challenges and framework for improving quality of primary health care in the Region	Dr Mondher Letaief, WHO EMRO
11:15–11:30	Assessment of quality of family practice in selected countries of the Region	Dr Hassan Salah, WHO-EMRO
11:30–12:00	Discussion	
Theme 4: Strategic purchasing: The interface between provision and financing of care		Chair: Dr Michael Kidd AM, Co-chair: Dr Mona Osman
12:00–12:15	Guide to develop and implement essential package of health services	Dr Sergio Minue Lorenzo, School of Public Health of Andalucia, Spain
12:15–12:30	Contracting out of primary care services in Afghanistan	Dr Ahmed Jan, Ministry of Public Health, Government of Afghanistan
12:30–12:45	Strategic purchasing and results-based financing in the context of family practice	Dr Awad Mataria, WHO EMRO
12:45–13:15	Discussion: what can be done to improve provider performance for better health care?	
		Chair: Dr Samer Jabbour,

Theme 5: Integrating health services – vertical versus integrated approach		Co-chair: Dr Mohammed Rassoul Al Tarawneh
14:15–14:30	Conceptual issues on integration of priority programmes in primary health care	Dr Azeem Majeed, Imperial College of London
14:30–14:45	Integrating noncommunicable diseases into primary health care	Dr Samer Jabbour and Dr Slim Slama, WHO EMRO
14:45–15:00	Integrated and chronic care management in Europe and the Basque country (Spain)	Ms Nuria Toro Polanco, WHO HQ
15:00–15:30	Discussion	
Theme 6: Roadmap for accelerating family practice in countries		
15:30	Group work: Roadmap for accelerating family practice in countries	

Day 3. Thursday, 20 November 2014

Theme 7: Alternative service delivery options to complement family practice programme		Chair: Dr Ahmed Jan Co-chair: Dr Mona Al Mudhwahi
08:30–08:45	Community health workers and outreach team: achievements, challenges, opportunities	Dr Mohammad Assai and Dr Humayun Rizwan WHO Somalia
08:45–09:00	Global/Thailand experience with community health workers – what works and what does not?	Dr Yongyuth Pongsupap, Thailand
09:00–09:15	Home health care: responding to health of the elderly	Dr Samar ElFeky, WHO Somalia
09:15–10:00	Panel discussion: improving access to care in resource poor settings	
10:30–12:00	Group presentations and discussion Roadmap for accelerating family practice in countries	Moderator Dr Sameen Siddiqi
	Closing session	
12:00–12:30	Recommendations for future action	
12:30–13:00	Closing remarks by the Regional Director	

Annex 2

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