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Report on the

Twenty-second meeting of the Regional Director with WHO Representatives and Regional Office staff

Cairo, Egypt
5–8 February 2007

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1. INTRODUCTION

The twenty-second meeting of the Regional Director with WHO Representatives (WRs) and Regional Office staff was held in Cairo, Egypt from 5 to 8 February 2007.

2. OPENING SESSION

(Agenda item 1)

Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean, welcomed the WHO Representatives and Regional Office staff, along with colleagues from UNRWA, the Centre for Environmental Health Activities (CEHA) and WHO headquarters. He expressed his appreciation for the confidence and trust Member States had placed in WHO, which was made possible through the efforts and good work of WHO's staff and representatives. The Regional Office would work to continue to build this trust by delivering more, by responding more effectively and by ensuring transparency in interactions with Member States.

He drew attention to the Director-General's stated commitment to integrated primary health care. This would require more focus on issues such as equitable access to health services, health care financing, a balanced and skilled health workforce, and better organization and management of health systems and services. In addition, promotion of community ownership through community-based initiatives, and working together with other sectors and partners would underpin work to address the social determinants of health.

Most countries in the Region, he noted, had multiple challenges in their health systems. WHO needed to improve governance of the ministries of health; support capacity development in policy formulation and development of strategies for balanced human resources, and for generating fair and adequate financing of the health system; support development of health promotion programmes; promote government commitment to addressing the social determinants of health through community-based initiatives; collaborate in building cost-effective interventions that target major health problems; and help protect and maintain health in emergencies. Above all, WHO must work with Member States to ensure that solid scientific evidence was produced to inform policies, strategies and operations on the ground.

Communicable diseases remained a priority in many of countries of the Region. He emphasized the Region's collective vision of disease elimination or eradication wherever feasible, and of disease-free areas where this was not feasible; of delivering a safe vaccine to every child for every childhood vaccine-preventable disease; and of having in place surveillance and rapid response to epidemic-prone emerging infections. The risk of pandemic influenza continued to be serious. The Regional Office would strengthen its collaboration with Member States and other agencies. Tuberculosis, malaria, HIV/AIDS and other diseases of poverty continued to burden the low and middle income countries. More focus was also needed on neglected tropical diseases, such as leishmaniasis, viral haemorrhagic fevers and schistosomiasis. Polio eradication was in the final, but very critical stage. External factors, including insecurity, hindered work. It was clear that renewed commitment and involvement of everyone as well as innovative actions would be needed.

While substantial gains had been made to prevent and control communicable diseases, there was a steady and consistent increase in the burden of chronic noncommunicable diseases, of mental health problems including substance abuse, and of injuries particularly as a result of road traffic accidents. Poverty and chronic noncommunicable diseases were interlinked in a vicious cycle. Although chronic noncommunicable diseases occurred in all countries, the majority of deaths and disabilities due to chronic diseases and injuries occurred in low and middle-income countries, where a double burden of diseases was obvious. Without proper action, the burden would seriously weaken the existing health infrastructures. Member States would need to rethink their health systems to plan and implement the necessary integrated approaches. This meant not only integrating management and care into primary health care services, but establishing health promotion initiatives and strategies, capacity-building in policy development, strategic planning and programme implementation, and establishing a health promotion research agenda so that evidence on the effectiveness of health promotion in reducing the burden of diseases could be collected and effectively disseminated.

He drew attention to the subject of security, a key social determinant of health in the Region. The Regional Office would be preparing for the Commission on Social Determinants on Health a review paper on countries in conflict and crisis. It would continue to address the health consequences of all emergencies regardless of their cause. Efforts were needed to build local and national capacity to ensure coping mechanisms, to sustain the achievements and to respond to future emergencies. This meant investing more resources and energy in risk reduction measures; ensuring resilient health infrastructures; engaging communities in planning and response processes; and ensuring access to basic health services in emergencies to prevent excess death and disability.

He referred to a decentralized management system as a source of WHO's strength. True decentralization meant taking decisions at the lowest possible level, and would be achieved only if responsibility to deliver the expected results was aligned with an appropriate delegation of authority and full accountability against the authority delegated. He would continue this policy and ensure that all necessary measures were taken to make it a success. Efforts would also continue in order to strengthen WHO programme management through joint programming, the development of unified management tools and guidelines supported by modern technology, and enhancing communication at the three levels of the organization.

Concerted efforts would continue to be made to strengthen the mechanisms and systems governing resource mobilization and allocation. All related information would be shared in a transparent way. Efforts would continue towards ensuring that the decision to spend 75% of WHO funds in the regions and countries was implemented.

In response to the changing environment, Country Cooperation Strategies, now used in all countries of the Region, would be a key instrument to align work with national priorities and harmonize country programmes with the UN system and other development partners. They would be the main tool to inform the preparation of the country workplans as well as the global and regional programme budgets, and to implement country focus policy, generate resources and develop partnerships. The 11th General Programme of Work (GPW) and 6-year

medium-term strategic plan (MTSP) provided a long-term vision on determinants and trends in health and clear directions of action to be taken in and with Member States.

The Regional Office had already prepared the draft programme budget for 2008–2009, with an estimated cost of US$ 468 million. It was an integrated proposed budget and included assessed and voluntary contributions in the one budget. Implementation of the proposal would require more work with partners and donors to align voluntary contributions with the programme budget to meet the set targets in the medium-term strategic plan and ensure resources were equitably available across the Organization.

It had been agreed at the recent meeting of the Director-General and the Regional Directors to hold regular meetings on policy directions and management issues of the Organization. This would enable them to coordinate and harmonize actions by the three levels of WHO, and would result in transparency and collective leadership.

In closing, he noted that the meeting had a challenging task ahead. The interactions were expected to provide some answers to the many questions on health systems, and to guide WHO in designing feasible strategies to address them. Concrete measurable action points were also expected that could be taken forward into the Joint Programme Planning and Review Missions. He noted the strength of the regional collaborative planning model, which had been adopted by other regions, and suggested that emerging priorities, including emergencies, should be taken into consideration during collaborative planning.

3. ELECTION OF OFFICERS

Dr Mohamed Abdurrab, WHO Representative for Sudan, was elected Chair, Dr Mohamed Assai, Regional Adviser, Community Based Initiatives, was elected Rapporteur.

4. ADOPTION OF THE AGENDA AND PROGRAMME

The draft agenda and programme were adopted. The agenda, programme and list of participants are given in annexes 1, 2 and 3 respectively. Results of an evaluation of the meeting are included as Annex 4.

5. TECHNICAL DISCUSSIONS

5.1 Health system issues in the Eastern Mediterranean Region

5.1.1 Introduction and objectives

Dr B. Sabri, Director, Health Systems and Services Development

A one and a half day programme prepared by the Division of Health System and Services Development aims to highlight challenges that face the health systems of Member States, identify strategies for tackling these issues, and better delineate the role and

contribution of WHO, especially the country offices, in assisting Member States in redressing these.

The objectives are to:

- highlight key issues and themes related to the health system and its development in countries of the Region;
- share the work of the Division of Health Systems and Services Development in order to seek better synergy with technical programmes and country offices;
- develop and discuss strategies for effective support to health system strengthening in member states

It is expected that the program will help acquire a common understanding of the key issues and challenges in the area of health systems and in mounting a unified response in tackling these. This effort will also help create better coordination and coherence between country office, Regional Office and headquarters staff in confronting health system issues. The programme has been developed to promote greater interaction based on contribution from the regional and country office participants, experience sharing, and two-way learning.

The expected outputs will be a shared understanding of key health system issues and challenges; and recommendations to support strengthening of health systems.

5.1.2 WHO global health system strengthening strategy

Dr T. Evans, Evidence and Information for policy, WHO headquarters

A WHO strategy on strengthening health systems is being developed to guide WHO's institutional response to the priority given to health systems by Member States, as reflected in the GPW and MTSP. The strategy will be grounded in the values of Health for All, primary health care and WHO's commitments on human rights and gender. The strategy is being shaped through a consultative process taking place through a series of meetings, including most recently a brainstorming meeting held in Miami in October 2006 with representation from all regions.

The strategy proposes to base WHO's response on four pillars: clear building blocks for health systems; effective working relationships between health programmes and systems; an effective WHO role in health systems at country level; and an effective WHO role in health systems at international level. In defining its strategy, WHO must address how to support the building blocks of health systems without creating more vertical programmes and identify ways to achieve better integration between health systems and existing programmes. The strategy must also identify ways to enhance the effectiveness of WHO's role in the context of dynamic change at country and international level. Among the recommendations of the brainstorming meeting in Miami were to make greater use of existing health systems resources within WHO, estimated at approximately 500 staff and US$ 50 million for the 2006–2007 biennium, to re-focus partnerships towards strengthening health systems and to adopt more inclusive approaches to resource mobilization and allocation.

The next steps in developing the strategy will be to revise the draft strategy document and continue the consultative process. The revised draft document will also be posted on the headquarters intranet for review and comments.

5.1.3 Discussion

It was stressed that country context must be taken into consideration in planning for health systems development. There is wide variety in country situations within the Region, and this variety is reflected in country priorities for developing their health systems. WHO must be able to respond to changing priorities and deliver the necessary technical expertise, and must develop new modalities accordingly. The health workforce must also be responsive to these changes. The major advantage of WHO is that it can bring actual experiences from the field—both successes and failures. These should be documented. Member States should study both positive and negative experiences, such as the example of successful polio eradication in Egypt. The participants discussed the need for a stronger focus on primary health care systems as being pivotal to health systems strengthening. Also the participants felt that the strategy document should be widely shared with countries, stakeholders and partners.

Among the most critical factors in health system development is the strength of the governance function within each country. The challenge is to find ways to enhance this function, to raise awareness of governments of their role in health and to strengthen national commitment and ownership of the health system. Close collaboration and partnership is vital with all actors in health at national level, including donors and players outside the health sector, in order to avoid duplication of efforts and systems and ensure that national health leadership is supported, rather than fragmented.

Joint activities and collaboration in health systems development should maintain core WHO values, such as equity, universal access and the preservation of public services. In some instances, WHO's role includes promoting behaviour and policy change among partners and donors. WHO is collecting evidence to help identify health policies that affect equity in health systems. As equitable health systems do not occur naturally, "pro-poor" policies are needed, along with planning for equity, setting targets and monitoring and evaluating the extent to which poor and marginalized populations are being reached by health services.

More resources are needed, particularly in the form of dedicated human resources at country level that can take a leadership role in health systems. One of the recommendations of the health systems meeting in Miami in October was for a pan-institutional workforce assessment, to be undertaken as an Organization-wide responsibility. It was noted that although considerable financial resources are available for health systems strengthening, this availability is not readily reflected in planning tools at present.

Better integration of health systems and health programmes is critical, but challenging. More work is needed to define the role of individual programmes within the health system, including specific ways in which programmes could contribute to health system strengthening. While emergency situations present considerable challenges to health systems,

reconstruction efforts present a unique opportunity to strengthen systems. This should be addressed in more detail in the global health system strengthening strategy.

5.1.4 Eastern Mediterranean Regional Health System Observatory

Dr S. Siddiqi, Regional Adviser, Health Policy and Planning

The Eastern Mediterranean Regional Health Systems Observatory is a regional initiative of the Division of Health Systems and Services Development and is coordinated by the Health Policy and Planning Unit. The purpose of the observatory is to promote evidence-based health policy-making by providing relevant and comparative information about health systems and reforms and to assist policy-makers in development of health systems in their countries. The aim is to contribute to improvement of health system performance and outcomes in the countries of the Region. Specific objectives of the observatory include developing health system profiles of all the countries in the Region; establishing a database for information on health systems; documenting and monitoring research on key health system issues and publishing and sharing the findings with all stakeholders; and setting up a Region-wide network of researchers and policy analysts. The observatory will fulfil five closely interrelated functions: 1) a descriptive function that provides for an easy access to profiles and database; 2) an analytical function that draws on lessons from successes and failures; 3) a prescriptive function that provides recommendations to policy-makers; 4) a monitoring function that focuses on aspects that can be improved; and 5) a capacity-building function that aims to develop partnerships and share knowledge across the Region.

One of the major undertakings of the observatory was to develop health system profiles for all the countries in the Region. So far 21 profiles have been developed based on a common template using a glossary of terms and guidelines. After editing and filling in the gaps, the profiles were sent back to the countries for their feedback, endorsement and approval. Technically all the profiles have been approved. In addition, an independent review of the profiles was also undertaken. The other main output of the observatory was to develop a database on selected health system indicators that allows comparison over time and to make comparison across countries. The database contains data starting from 1990 to 2005 for all 22 countries although there are a few gaps that need to be filled. It also has selected data disaggregated by rural/urban and by sex. The main source for the database is the yearly publication "Demographic, social and health indicators for countries of the Eastern Mediterranean" which is endorsed and approved by countries. For health care financing indicators the source is The World Health Report 2006. A small working group has been formulated to systematically review the data for any discrepancies. Another major task of the observatory is to provide a platform for dissemination of research on health system functions and performance. Work is in progress to develop a searchable database for all the health systems research in the Region, such as country and regional studies.

The concept of an observatory is not new. Two other WHO regions, the Americas and Europe, have established similar observatories. The American initiative is named The Latin America and Caribbean Regional Health Sector Reform Initiative (LACHSR), established with financial support from USAID. It uses a participatory approach, working with key decision-makers to build capacity to address health sector problems and to design, implement

and monitor reforms. The European Observatory is established in partnership with European governments and a number of different organizations. In addition to producing health systems in transition country profiles, they are conducting research and producing publications on important topics of public health interest. These initiatives are well supported by Member States both technically as well as financially.

The enabling factors in this initiative include commitment and support by senior management, collaboration between units and interest of ministries of health in health system profiles and desire to establish national observatories. The challenges include reliability, validity and timeliness of information; need for continuous IT support; establishment of national observatories and need for resources to sustain the initiative.

Discussion

In addition to its primary purpose as promoting evidence-based health policy-making through the provision of information about health systems and reforms, the regional health system observatory will facilitate comparisons between countries. It will assist policy-makers in the development of health systems in countries and contribute to improvement of health system performance and outcomes in countries of the Region. By enabling the efficiency of health systems to be monitored and evaluated over time and across systems, the observatory will allow policy-makers to build an evidence base on the relationship between the design of a health system and its performance.

Greater stratification and expansion within the system is desirable, in order to provide data on areas such as the prevalence of communicable diseases. Such expansion would represent a huge undertaking and significant additional resources. Greater resources are needed not only to expand and improve the database, but also to maintain and update information.

Whatever the initial cost, the observatory will prove to be cost-effective in the long term. It was suggested that all regional databases, such as the communicable and noncommunicable diseases databases, could be combined and a global observatory created. It was also suggested that the regional observatory could be expanded to include subnational data. The geographical information system (GIS) component of the observatory is operational.

5.1.5 Enhancing the visibility of health systems in countries

Dr S. Siddiqi, Regional Adviser, Health Policy and Planning

In order to raise health systems on the policy agenda of countries, in-depth health system reviews took place in five countries. These reviews also led to policy dialogue in health system strengthening in those countries. The exercise included reviewing the function of health system building blocks, assessing the support of the health system to priority public health programmes, reviewing health status and fair financing and proposing strategic directions. The reviews were implemented in the Islamic Republic of Iran, Jordan, Bahrain, Sudan and Afghanistan in 2006. The exercise is planned to be carried out in Pakistan, Yemen and Somalia in 2007.

Islamic Republic of Iran

Two reviews of the health system were undertaken in the Islamic Republic of Iran (in 2002 and 2006) which identified critical issues and gaps. The results of each review have been translated into World Bank-supported projects. The reviews relied on secondary data sources, and as there was no one single source of data the question of the validity of data has been raised. Future reviews will also consult primary sources of data. An important lesson learnt from the reviews was that the information gained from the exercise needs to be shared between countries, particularly between countries sharing similar characteristics.

Iraq

Countries in the Region experiencing complex emergencies require country-specific solutions to the problems they are facing. The lesson learnt from the needs assessment exercise conducted in Iraq was that there was a direction to move away from a centralized approach to the primary health care approach. The need for consistency was highlighted as a critical element in the policy dialogue taking place for health development, and despite the initial difficulties of coordination, the UN cluster system in the country has proved to be very effective.

Pakistan

Pakistan is engaged in a robust policy dialogue on health system reform and is looking for demonstration areas, such as GAVI, for evidence of successes to implement changes to the current system. Within the policy dialogue currently taking place, the Ministry of Health in Pakistan has identified outsourcing as a major issue from among the five main areas selected for reform within the health system.

5.1.6 Primary health care: the driving force for developing national health systems in the Eastern Mediterranean Region

Dr A. Abdellatif, Regional Adviser, Health Care Delivery

Since Alma-Ata, valuable lessons have been learnt. The primary health care approach encouraged new thinking of systematic reform. It introduced essential care and technology as a package. It focused on the first line of care and gate keeping. It generated interest in the values and concepts of community involvement, intersectorality and voluntary work. It also introduced decentralization and continuity of care through district health system. The agenda of integrated primary health care in the Region is to review current policies for the health system, secure adequate political and financing commitment, work in low and middle-income countries and settings, and provide opportunity for a credible primary care service. The future challenge is to focus on social determinants of health and redesign the working system at country level towards one country programme.

Discussion

It was noted that the world has changed substantially since the goal of health for all through the primary health care approach was proposed in Alma-Ata, and since the approach itself was reappraised and revised in the 1980s. Globalization and neoliberal macroeconomic thinking had dramatic impact on approaches to public health in the past 20 years, while urbanization and population growth, among other things, have affected the public health landscape. It is necessary to move away from a dogmatic approach to the original primary health concept, though without losing sight of the ideal and the need to make essential care accessible to all. Intersectoral partnership and community participation are key elements and need greater focus. The reality of the role of the private sector in the Region needs to be taken into account and addressed.

New tools and approaches are needed to measure and monitor primary health care, including quality standards. A major shift in public health thinking in the Region is needed to convince governments of the benefits of a health care system based on primary health care, with all programmes and specialties integrated. Up to 85% of health needs can be delivered at primary health care level. At the same time there is an increasing trend of referral to the tertiary level, which needs to be assessed and addressed. Assessment of the effectiveness of primary and secondary prevention programmes in the health care system is also necessary.

The opportunity is available to revisit and revitalize the primary health care approach and this should be taken. The work conducted on renewing the health for all strategy for the 21st century and in applying the district health system should be reviewed and made use of. At the same time, a health system approach needs to be taken to see how best to operationalize primary health care for each country. This means developing and applying tools that are appropriate for different settings. Primary health care can no longer be marketed as a cheap option for poor countries and WHO can no longer advocate the approach without the appropriate costing. An in depth review of the primary health care approach over the past 29 years and its cost-effectiveness is needed together with study of how a health systems approach can be used.

Since 1978 WHO has itself not followed a consistent strategy on primary health care and has sent conflicting messages. WHO still does not have a coordinated approach, whether inhouse or in promoting its strategies to countries. The MTSP will go some way towards addressing this but is only a beginning and coordination and integration within WHO will remain a challenge. Regional input to the two task forces on primary health care established by the Director-General is essential.

5.1.7 GAVI Health System Strengthening Window in support of EPI

Dr A. Mahghoub, Regional Adviser, Health Management Support

GAVI emerged in 1999 in response to stagnating immunization rates and widening global disparities in access to vaccines. Eligible countries through support of GAVI achieved remarkable results in immunization services, new vaccine introduction and injection safety. But coverage reached a plateau around 80%. There is a realization that institutional weakness of health systems is hampering the utilization of available resources. Unless these weaknesses are addressed, improving coverage to above 90% will be very costly. In line with commitments to achieve the MDG, GAVI support for health system strengthening to eligible countries is worth US$ 90 million. Steps were undertaken to manage this window of opportunity for resource mobilization including briefings to delegations during the Regional Committee, dissemination of guidelines, regional working group meeting and interaction with GAVI secretariat on the procedures. The way forward is briefing of national teams, development of proposals and formal submission, implementation of a one-year plan of action, and monitoring and evaluation. It is crucial to take advantage of this opportunity and promote synergy between the health system and technical programmes. WRs should play a proactive role by leading this exercise.

5.1.8 Panel discussion on health system strengthening in the Eastern Mediterranean Region

Discussion centred around three areas: how to strengthen country offices' support and response to Member States in the area of health systems; how to improve collaboration and synergy within the Regional Office; and how these might be achieved. It was noted that WHO has a unique advantage in its collaborative work with Member States which is its technical expertise and capacity, backed up by a constitutional mandate. However WHO also has a duty to ensure that this mandate is preserved for the benefit of all and that it continues to work for the countries. WHO has comparative advantage in its strong country presence however country offices do not have the capacity to be able to respond to Member States needs in the area of health systems.

The ultimate goal of WHO is the health of populations, health for all. All WHO programmes ultimately are working towards this goal, regardless of how they may be set up. Collaboration between the technical divisions and individual units therefore needs to be institutionalized, and the managerial support processes reviewed to take this into account. Primary health care is an obvious example in this regard. Regular interdivisional meetings to discuss issues and share experience would contribute to promoting a spirit of cooperation, a sense of community and unified thinking. Greater collaboration is needed also between technical and health systems officers to discuss and clarify systems issues. There are mechanisms available for greater information sharing in the Regional Office that are not being used optimally.

Providing country offices with the capacity would require competencies in health systems literacy, policy, financing and human resources. There is an imbalance in availability of such competencies at an organizational level and more equity in distribution is essential.

Core competencies should align with the core functions of WHO. With regard to strengthening health systems, WHO needs to work more closely with its partners and this also means strengthening capacity. The best people should be at the community level or close to it.

5.1.9 Draft approach paper for community-based initiatives, lessons learnt and way forward

Dr Mubashar R. Sheikh, WHO Representative, Islamic Republic of Iran

During the past decades, the health sector has proved its catalytic role for health promotion, setting off appropriate initiatives for improving health and quality of life of the communities. This effort was promoted by the Regional Office through community-based initiatives (CBI), which provided opportunities to integrate health interventions in local development processes. The CBI approach addresses the major determinants of health within a broad perspective of development and creates access to the essential social services for optimum level of equity at the grassroots level through active involvement of the community and intersectoral collaboration. The evidence and outcomes of these initiatives have shown that health is a human right, and investment in promoting comprehensive development capitalizes the improved quality of life and well-being of the communities.

CBI cover a population of 18 054 316 in 17 countries of the Region. Evaluations have been carried out in Jordan, Pakistan, Sudan, Djibouti, Yemen, Syrian Arab Republic and Islamic Republic of Iran. The overall objective of these evaluations was to assess the inputs, processes, and outputs of the CBI, aiming at reviewing the implementation strategies for further programme expansion. Although the CBI in these countries had considerable effect in improving health, social and economic indicators including literacy, access to water and sanitation and income of the direct beneficiaries in the implementing areas, health is not receiving the required attention. Community participation is the main strength of the programme and has created a move among the communities to achieve self-reliance, self-sufficiency and solidarity. Acceptance of the programme is wide among the communities, governments, UN organizations and civil societies but government commitment and support vary. Intersectoral and intrasectoral collaboration is not institutionalized in many countries. Partnership development is taking place in varying degrees. Linkages with national development plans are limited, as only in a few countries are CBI part of the annual budgetary plan. Management of CBI is centralized in a majority of countries. Supervision, monitoring and evaluation needs reinforcement as the monitoring is usually not structured and organized and programme expansion has not reached the intended levels.

Despite the number of remarkable achievements accomplished over the past two decades of CBI experience, it could not be expanded to the level intended at the beginning. Since the CBI provide resources, there have always been high expectations among the communities and at local level for continuous and enhanced support. From the initial stage, due to certain weaknesses in the implementation and undertaking of the processes, some false expectations have put CBI sustainability at risk. Therefore it is essential to review the progress made and align it with the original vision and approach of health and development, demarcating the roles of health and other sectors during the model and expansion phases. In order to initiate creative thinking on the future shape of CBI, the document presents the

following modalities which can assist in overcoming the weaknesses identified in various evaluation reports, making the CBI more able to achieve targets and goals:

1. institutionalizing CBI within the health system;
2. organizing intrasectoral coordination for comprehensive health care;
3. formalizing intersectoral collaboration mechanisms;
4. implementing local health and development through empowered communities;
5. scaling up CBI expansion, promoting partnerships and linking with ongoing development activities like MDGs, PRSPs, etc;
6. streamlining programme management and monitoring systems;
7. introducing a disaster management component in the CBI areas.

Discussion

The legitimacy of community-based initiatives as a community-based approach to alleviating poverty and improving health was highlighted. Despite the initial costs of implementing the programme in countries, programme success stories have proved the initiatives to be both cost-effective and equitable. Three important requirements were highlighted: the need for the integration of the initiatives into national programmes, in particular, social welfare programmes; the need for governments to adopt an integrated approach to development; and the need for community interventions, with health as an essential component. Clear monitoring indicators are a crucial element for institutionalization of the initiatives. The initiatives can also be integrated into joint national programmes if linkages between programmes are promoted at country level. Strong, solid data, such as the evidence being collected on the initiatives by the Commission on the Social Determinants of Health, are critical for the successful translation of the programme into national policy. The support of universities and institutions should be sought in further supporting and documenting evidence of the health, social and economic benefits of the programme. More advocacy tools and resources are needed at national level.

Ownership of the initiatives remains a key issue. Rigorous external evaluation is critical to the issue of community ownership, and there is also need for the involvement of a greater number of partners in the programme. In terms of exit strategies in countries, participants expressed a desire to see the delegation of resources to ministries but expressed concern about the potential failure of the programme if exit strategies in countries were initiated prematurely.

5.1.10 Recommendations and next steps on health system strengthening in the Region

- The health system is built around six building blocks and provides the necessary platform for efficient and integrated implementation of priority health programmes.
- Health system strengthening is "everybody's business", and cannot be strengthened without such spirit of "working together".
- WRs expect more concrete support from health system colleagues at Regional Office offered in more practical terms to all countries.

- The Region, which represents 15% of the global population, has only 5% of the human resources and 5% of budget allocated to health system development and strengthening by WHO globally.

5.2 Planning, implementation and monitoring of Medium Term Strategic Plan 2008–2013

Ms Namita Pradhan, Director/PRP, WHO headquarters, Dr Sussan Bassiri, Regional Adviser, Programme Planning, Monitoring and Evaluation

Discussion

In relation to the expected results for headquarters it was noted that this is reflected in the MTSP at the same level as the regional expected results. It was acknowledged that country needs will drive planning at country level, not organization-wide expected results. Nevertheless WHO collaboration with countries is expected to be largely in line with organization-wide expected results.

With regard to allocation of funds from 'other sources' it was noted that this should be discussed with the coordinator for the area of work concerned. There are also now raised expectations in regard to transparency, both in terms of the source of all financial resources and the destination. It is expected that the GSM will address and reflect this expectation.

A presentation made by WR Islamic Republic of Iran, on behalf of WRs Islamic Republic of Iran, Sudan and Tunisia, elaborated on the fact that currently EMRO follows a biennial results-based planning cycle at the country level with an optional mid-term reprogramming. The programme planning and reprogramming is primarily output based, therefore the outcome/impact of the WHO programs of collaboration are not measured. The CCS documents, although providing very useful strategic direction for the WHO collaborative programmes at the country level, do not contain any mechanisms for measuring impact. Also, as the linkages between the OWERS and RER are not robust, achievements measured against delivery of WHO core functions are not computable.

In order to respond effectively to the priority health needs of the Member States two scenarios are proposed. In either case the CCS should be updated on a regular basis and aligned with the UNDAF and linked with WHO GPW and MTSP, as well as the regional strategies. The CCS should contain well defined indicators (qualitative and quantitative) to make monitoring and evaluation possible. It should be used by WHO and countries to build the programme of collaboration. Similarly, the development of the programme of collaboration should be a country office-led exercise, while the Regional Office and headquarters should review and add the relevant activities to make it a one-country plan. The country plan should have a certain percentage of regular budget as "untied" to address emergency needs. The mid-term review should focus on assessment of the expected results achieved, along with identification of possible areas of reprogramming. Alternatively, to bridge the gap between the CCS and the JPRM, a country strategic action plan needs to be developed and translated into operational plans consistent with the CCS and UNDAF. This

plan should encompass the indicators for outcome/impact evaluation at the end of the CCS cycle.

5.3 New global and regional tools to strengthen WHO country presence

5.3.1 Global country support unit-network portal

Dr Marie-Andree Diouf, Director, Cooperation and Country Focus, WHO headquarters

The CSU-N "Country Support Unit Network" was established in 2003. It includes the CSU in each Regional Office and CCO (Department of Cooperation and Country Focus) in headquarters. In the Network meeting in Santa-Domingo (June 2005), it was agreed to develop a virtual environment, or e-community, that should enable the network members, country offices, and staff in regional offices and headquarters to have access to the same "electronic office" where strategic information relevant to the country focus policy can be retrieved. This virtual environment was expressed in a "Portal", and the CSU-N assigned the project of portal development to PME in EMRO. The project now is in its final phase, with the soft launch in December 2006, and it was expected that the official launch of the CSU-Network Portal could take place during the forthcoming Senior Staff Meeting, that was planned to be held in headquarters during March 2007 (postponed to the end of 2007).

The CSU-N portal is a global platform for sharing information, and can be utilized to collectively engaging in discussions on various work processes, such as the development of CCS in a specific country. The portal was developed by PME and belongs to the Network of Country Support Unit. It has 7 administrators (focal points): one per region and one for headquarters.

5.3.2 Country activity management system (progress of work and lessons learnt)

Mr Jaffar Jaffal, Technical Officer, Programme Monitoring

The country activity management system (CAMS) is an application that has been developed to assist country offices in the administration and management of their work and monitor the implementation of WHO collaborative programmes. Through CAMS, country offices are provided with up to date information on implementation of programmes and activities for their country. CAMS provides staff in the country office with access to data in various information systems running in the Regional Office from a single integrated user-friendly environment.

CAMS has been instrumental in preparing staff, particularly in the country offices, for introduction of Global Management System. Also, as a solid platform, it is considered a promising system which can help to fill the gap in other systems in the future. Lessons learnt so far include need for extensive training of staff in country offices and the Regional Office on a continuous basis, particularly in those locations with high staff turnover. Good progress in familiarizing staff with the electronic work environment was made. Workflow and tracking of requests and exchange of comments is the most appreciated part of CAMS while monitoring of JPRM implementation has also become simpler. Until the Global Management

System is in place, CAMS will continue to serve as the main vehicle for two-way data transportation between regional applications and country offices.

5.4 Update on emergency preparedness and response including pandemics and outbreaks

Dr M.H. Wahdan, Special Adviser (Poliomyelitis), Dr Hassan El Bushra, Regional Adviser, Emerging Diseases, Mr Altaf Musani, Regional Adviser, Emergency and Humanitarian Action

The presentation on polio focused on lessons learned and Regional Office initiatives. Among the lessons learned, importation cannot be prevented until global eradication; however, the outcomes can be controlled, essentially by ensuring high levels of routine immunization. Preparedness means that the programme should be ahead of the virus and not run after it. This necessitates regular monitoring of the global situation and alerting countries about the risk of importation and advising and helping them on how to be ready to address the situation. Several examples were given on the great value of this policy. A regional initiative in this regard is the regular issue of the Weekly Polio Fax for over eight years. Another monitoring element is to monitor population immunity through analysis of the vaccination status of children, which will help in deciding the need for preventive campaigns. Early detection of any unusual situation depends on good surveillance and hence no delay in fighting the disease before it establishes itself. With regard to rapid and timely response, at present, the standard set for polio is to conduct the investigation within 72 hours and conduct the response within four weeks. Continuing control efforts with full power until the job is done will guard against conversion to endemicity. Finally, eradication is a global effort. All countries should make the effort together and finish together. It is a joint responsibility of each and every country. The Regional Director has been extending support to countries in need, not only in the Region, but in other regions and helping to resolve obstacles facing their efforts, e.g. addressing rumours. The importance of coordinating between neighbouring countries (Afghanistan and Pakistan, Horn of Africa, etc.) was highlighted.

5.5 Meeting of the Regional Director with WRs, senior advisers and MDC members, Desk Officers and Director of CEHA and UNRWA

Discussion focused on several issues.

The three Regions which have eradicated polio are assisting countries still experiencing transmission. It was noted that countries ceasing the administration of the oral poliovaccine, against the advice of WHO and UNICEF, had found the injectable vaccine ineffective. The recommendation to countries is that individuals should receive as many doses of the vaccine as necessary.

The joint programme planning and review mission (JPRM) is a very successful tool that is well accepted by Member States. However there is a need to make the planning more strategic and country-led by creating strong linkages with the respective CCS. Planning must strike a balance to ensure it is sufficiently detailed while leaving room for flexibility. Moreover, the JPRM plans should reflect activities of all three levels of the organization to

make it a one country plan. For proper monitoring and measurement of the expected results, CCS report should also include qualitative indicators. This process should be tied with the mid term review of the plans that should also focus on performance measurement rather than resource utilization. The need to recognize and address the changing priorities of countries was also stressed. Accordingly it was proposed that a certain percentage of the regular budget should be kept untied for addressing emerging priorities in the countries.

Although the Regional Office receives the least amount of extrabudgetary resources, 71% of these resources go to countries. The corporate account is intended to remove ownership of resources, although country plans can be developed for activities for which currently no funds are available and activities can be initiated when funds do become available. However, realistic projections of these funds should be made by headquarters and the Regional Office based on the trends of the recent past. Similarly the national authorities should be informed in clear terms that the availability of the voluntary contributions is not guaranteed. There is need to address the problem of not being able to carry over funds to the following biennium and of the need for WHO to inform ministries of health when other sectors within their own governments engage in partnership with WHO.

The experiences of the eight countries which have started to implement the UN reforms must be discussed. Following these discussions, the reforms will be further discussed during the global WHO Representatives meeting. He noted that the meeting will take place very late and that some offices will find it difficult to obtain timely guidance. Recognition of the need for results-based management is a major issue within the current reforms taking place. WHO will support any reform that brings benefits to Member States and which does not negatively affect WHO's mandate as a specialized agency for health.

The WTO agreement TRIPS was discussed in relation to its impact on access to medicines and to the WHA resolution urging Member States to monitor its impact, particularly in relation to drug pricing and access. The independent Commission on Intellectual Property Rights, Innovation and Public Health came out with explicit recommendations relating to medicines and patent protection which highlighted the disproportionate lack of availability of medicines for diseases affecting developing countries, how to effectively use flexibilities and safeguards in agreements and the difficulties of bilateral trade agreements. The World Health Assembly created an Intergovernmental Working Group on Intellectual Property Rights, Innovation and Public Health which included trade and industry and institutions undertaking research. The working group's mandate was to turn the 60 recommendations of the Commission into a global strategy and plan of action. The second meeting of the working group will take place in October 2007 and Member States have been urged to invite ministries of health and trade, research institutes, etc. A regional consultative meeting will also be held in August to develop a position paper and WHO Representatives are requested to submit nominations for experts and institutions to attend and to urge ministries of health to identify experts to attend to ensure the maximum effectiveness of regional participation.

Disasters, such as the earthquake in Pakistan, have demonstrated the need for national readiness and capacity-building and emergency preparedness training. A key lesson learnt has

been the need to focus to a greater extent on a systems approach to preparedness. Funds for preparedness are insufficient but the early recovery fund could be used to strengthen the emergency response. A regional trust fund for both natural and manmade emergencies and disasters would be useful in this regard. There is a need for much greater advocacy efforts in terms of emergencies, and the protection of staff needs to be linked to the health response and emergency preparedness.

There are possibilities for funds from the Economic Cooperation Organization (ECO) being used for the production, procurement and supply of pharmaceuticals in countries such as Palestine; however, capacity in countries requires strengthening. Funds to deal with mental health problems resulting from the trauma of conflict are needed, and the reorganization of health systems is necessary to strengthen mental health departments.

Health clusters are extremely important mechanisms and effective forums for country-specific guidance as donors are not currently adapting their response to the specificity of countries. Although standard security operating procedures have been developed for the Region there is a need for the further development of procedures for adaptation to countries. Country representatives expressed a desire to see the appointment of a permanent security officer in the Regional Office to assist countries which were experiencing deteriorating security situations. A set of generic tools for emergency preparedness in countries is needed. The Centre for Environmental Health Activities (CEHA) has developed several tools to assist in emergencies, such as water purification kits, and is currently developing more tools for countries.

JPRMs could be used as a platform for the development of standard emergency preparedness and response training packages to clarify the roles of staff in countries. An e-learning training course might also be useful for disaster response and preparedness. The lack of vision and data for the response to later stages of disasters and emergencies is a problem and there is need to focus to a greater extent on rehabilitation and reconstruction. Ministries in countries require much greater support in developing health and emergency preparedness and response planning, and in many countries, plans are either outdated or are not fully comprehensive. Resources are often concentrated at central level when they need to be employed locally. A plan is needed to assess health facilities. Regional hubs, such as the one in Nairobi, could be effective in assisting in emergency response situations although they require further strengthening at present.

5.6 New reforms in WHO and expected courses of action

5.6.1 Global Management System: progress of work and expected changes

Mrs E. Haraldsdottir-thomas, Director, Global Management System, WHO headquarters

The Global Management System (GSM) is a single, integrated and streamlined management system to support the delivery of health technical programmes. Once in place, the GSM will connect all offices of WHO to a single, global IT system that will replace existing systems used for programme, financial and human resources management and for

procurement. The system is designed to manage the 6-year MTSP and a results-based framework. It will enable financial and technical overviews of results and allow monitoring according to results and organizational hierarchy.

Deployment of the GSM will change many aspects of work in WHO. It will allow for greater emphasis on management, and reduce administrative workload by an estimated 11%. It will facilitate collaboration and decision-making between offices and enable accurate, up-to-date data to be available in real time. A robust training and support system will be implemented in parallel with GSM deployment. Training of trainers will be initiated in April 2007, and training for users in the Regional Office and country offices will start in the second quarter of 2008. Questions on the GSM may be referred to the regional focal point, Dr Sussan Bassiri, or to the GSM team at gsmteam@who.int (http://intranet.who.int/homes/gsm).

5.6.2 Human resource reform including staff development and learning

Ms Jutta I. Nopper, Regional Personnel Officer

A resolution contract reform was approved by the Executive Board in January 2007. Contract reform, effective July 2007, will have a significant impact on all current contractual arrangements, for contracts for non-staff members as well as staff members.

With regard to contracts for non-staff members, technical agreements (TA) and APWs for individual services can no longer be offered from 1 July 2007 onwards. APWs for companies/institutes/universities will, however, continue beyond 30 June 2007.

The special service agreements (SSA) are being reviewed during this year and, therefore, SSAs can still be issued and extended until the end of December 2007. The policy on SSAs will be reviewed in 2007 to have a more precise definition of their use, of the types of contracts and social protection that SSAs should enjoy.

Consultant contracts will be introduced on 1 July 2007 while our current short term consultant contracts (STC) will no longer exist from 1 July 2007. The difference between them is that STCs are considered as WHO staff member while the new consultant will no longer have the status of WHO staff member. The new consultant contract will replace the TAs, APWs for individual services and SSA for WHO related work.

With regard to contracts for staff members, fixed term contracts can be only extended up to a maximum period of 5 years. It is foreseen that staff members who are holding service/career appointments as of 1 July 2007 will have their appointment automatically converted into continuing appointment. Moreover, staff members with an uninterrupted service of 5 years or more on fixed term appointments as of 1 July 2007will be offered a conversion from their fixed term appointments to continuing appointment provided that their performance has been satisfactory. In the future, the process of review for conversion to a continuing appointment will normally be initiated 6 months prior to the completion of 5 years of uninterrupted service on fixed term appointments. Staff members who meet this criteria and, in addition, have satisfactory performance will be considered for continuing appointments. Staff who do not meet the performance criteria will either not be granted a

continuing appointment or their conversion will be deferred up to a maximum period of 1 year. In both cases the matter will be referred to a regional continuing appointment review committee.

The new type of temporary contract supersedes the current types of temporary appointments. As the new temporary appointment is intended to facilitate and strengthen human resource planning and monitoring of human resource needs, the temporary appointment is rooted in the basic principle that temporary functions will be allowed to continue for 2 years without interruption. After a break of service of a temporary staff and a consecutive break in service of 31 days or more the incumbent can start working again with WHO for another period of 2 years provided that the functions have changed completely or the incumbent will be working in another location (another division, country, region).

5.6.3 New financial rules and regulation

Ms Susanne Hammoud, Regional Budget and Finance Officer

Changes to financial rules and regulations were proposed by the Executive Board in January 2007 for WHA approval in May 2007 and implementation by 1 January 2008. These changes can be summarized as follows:

1. Adoption of International Public Sector Accounting Standards (IPSAS) by January 2008. This will imply a more consistent definition and reporting, among UN Agencies and Public Sector Organizations, of:

    a) Income – may be recorded and implementation started upon signing of legal donor agreement.

    b) Expenditure – to be defined and reported based on actual delivery of goods/services. Any nondelivered activities will be reflected as a footnote to the financial statements; not expenditure nor implementation.

    c) Assets – to be reported above material value and depreciated over useful life (e.g. buildings, vehicles)

    d) Liabilities – Long-term liabilities to be reported (e.g. after service health insurance, loans to WHO).

2. Revision of Financial Regulation 4.4 on Exchange rate facility to amend language to protect rather than cover exchange losses to the organization.
3. Revision of Financial Regulation 4.5 to enable carry over of regular budget funds for one year to pay for goods and services resulting from legal commitment that were made before the end of the financial period for completion the following year.
4. Elimination of financial regulation 6.5, 8.2 and Financial rule 104.2 on the Financial Incentive Scheme. The original intention of these rules was to reward and encourage member states that paid their assessments within an early time-frame (April 30). As it has proven ineffective in generating prompt payments, and the administrative burden outweighs efficiency gained, it is recommended that this be discontinued.

5.6.4 Discussion

It was noted that the GSM will include the capability to generate different types of reports to meet a variety of needs, and will also include a flexible interface for gathering business intelligence. There will be no delay in reflection of expenditure/disbursements, and the system will allow funds to be allocated as soon as they are available. Unlike management systems that have been developed for other agencies of the UN system, the GSM is being built around core business rather than financial processes. This is expected to help the Organization maintain its focus on technical and programmatic aspects of work.

In relation to the new financial rules, it was emphasized that the changes to the rules and regulations were mandated by Member States through the Health Assembly, and that donors are aware of the changes. Many of the current shortcomings in financial processes will be eliminated with the deployment of the GSM. Most planning processes will remain unchanged: staff must continue to plan activities that can be implemented within two years, and costs must be estimated as accurately as possible.

With regard to the contractual reform, the new measures will require better human resources planning in WHO, and will have a huge financial impact. A formal human resources reprofiling exercise will be conducted throughout the Organization by a team of technical experts. The induction process for new staff is being strengthened through a new orientation package currently under development. A list of frequently asked questions regarding the contractual reform will be made available by headquarters. In the area of staff development, WHO Representatives are urged to participate more actively and transparently in meetings of the Staff Development and Learning Committee, and to make use of funds available for training of country office staff.

Proposed topics for discussion at the global meeting of WHO Representatives include details on the country focus policy and strengthening country presence, clarifications on staff rotation and mobility and on UN reform, and analysis of the impact of the CCS experience on WHO's effectiveness at country level.

6. RECOMMENDED ACTIONS

Health system strengthening

1. The country offices to be strengthened with the placement of fixed term health system advisers who are backed up by support from the Regional Office and headquarters, for which resources need to be made available.
   Action: CCO HQ, Senior management EMRO, country plans as part of Joint Planning and Programming Exercise (08-09)

2. The work undertaken to establish the regional health systems observatory to be supported by necessary human and financial resources in order to sustain and expand its activity. The Regional Office to consider integrating the different databases on

communicable and noncommunicable diseases under the auspices of the regional observatory. Efforts to be made to establish national health systems observatories in selected countries.
Action: HSD, PHP, KMS, WRs

3. Efforts to promote horizontal interaction between the various divisions aimed at promoting synergy in programme analysis and development to be strengthened. Joint visits to countries bringing regional advisers from different divisions to be encouraged.
Action: All divisions and senior management

4. The policy of renewed commitment to primary health care to be pursued, with the Regional Office further consolidating its consistent policy of strengthening health systems based on the comprehensive primary health care approach.
Action: The regional perspective on PHC will be captured in a concept paper to be shared with HQ, coordinated and drafted by a four member committee HCD, PHP, WR Tunisia, WR Islamic Republic of Iran

5. The divisions of DCD and DHS to work in close collaboration with the country offices of the six low-income countries in order to benefit from the GAVI/HSS initiative to strengthen health systems and improve immunization coverage.
Action: HMS, VPI , WRs

Community-based initiatives

6. The experience with community-based initiatives in the Region to be fully incorporated in the primary health care approach and in institutionalizing of CBI within the health system supported by engaging in an active dialogue with ministries of health and other partners for adaptation of the proposed modalities.
Action: CBI, HCD, PHP, WRs

7. Strategies and tools to be designed for advocacy and promotion of the CBI approach based upon the findings and recommendations of the evaluation report.
Action: CBI, WRs

8. The revised CBI strategy to be updated and presented to the Regional Committee to obtain commitment from the highest level.
Action: CBI, DHS, ARD

Planning, implementation and monitoring of medium-term strategic plan 2008–2013

9. The existing mechanisms for the projection and distribution of voluntary contributions to be strengthened and to comply with decentralization policy with regard to delegation of authority and resource coordination and management.
Action: PME, ARD, DRD, PRP, WRs

10. Before the initiation of the planning for the next biennium, the JPRM process to be updated and modified as a result of experience, through consultation with WRs. WRs to start preparation for the JPRM early, in participation with the Ministry of Health and partners.
Acton: PME, WRs

11. WRs to closely observe developments on UN reform at country level and actively participate in negotiations with other UN agencies in this respect keeping in mind available guiding principles. WRs to provide their views to WR Pakistan who will participate in the special meeting on UN reform with DG and RDs.
Action: WRs, ARD, DRD

12. WRs to follow up on completion of the Global Tobacco Control Reports of 2007 and 2008. WRs to involve civil society and different key partners at the national level in the grant mechanism of the Bloomberg Initiative.
Action: TFI and WRs

13. The process of assessment of existing financial and human resources and infrastructure (including information and communication technology) available at the country level to be continued with a view to meeting real needs and enhancing country office performance. Action: PME, KMS, DAF, ARD, DRD, WRs

14. WRs to encourage Member States to nominate experts to participate in regional World Trade Organization meetings.
Action: WRs, EMP

Emergency preparedness and response

15. The Regional Office to ensure development of capacity to take forward the UN humanitarian reforms, in particular the health cluster leadership for future emergencies.
Action: EHA

16. The Regional Office to ensure the development and implementation of clear strategies to address procedures for a) humanitarian response, b) the transition from response into early recovery, and c) the transition from early recovery into rehabilitation, reconstruction and development, based on best practices and lessons learned.
Action: EHA, DHS

17. WHO to proactively promote investment by Member States in disaster management preparedness.
Action: EHA, WRs

Pandemics and outbreaks

18. Intensification of polio eradication activities to be continued in remaining polio endemic countries.
Action: POL, WRs

19. All polio-free countries to update their preparedness plans and put them into effect until the world is polio-free.
Action: POL, WRs

20. All polio staff and WRs to initiate fund-raising activities to ensure implementation of planned activities.
Action: POL, WRs

21. A focus group to be formed to assess the feasibility of using RASDON to manage all types of health and disease data: communicable and noncommunicable diseases, health resources and facilities.
Action: CSR, KMS, WRs

WHO reforms

22. The Regional Office to continue providing updates on progress in implementation of GSM, especially for preparation and training for WRs and technical staff.
Action: PME, ARD, DRD, WRs

23. WRs and Programme Directors with the support of Personnel, to develop human resources plans, taking into account financial implications.
Action: WRs, Programme Directors, RPO, PME

24. WRs and Programme Directors to review the list of staff in view of contract reform and transition measures, to assess the status of staff and the relevant financial implications.
Action: WRs, Programme Directors, RPO, PME

Annex 1

AGENDA

1. Opening session
2. Thematic area for the 22nd meeting of RD with WRs and RO Staff: Strengthening Health systems in countries of the Eastern Mediterranean Region
3. Planning, implementation and monitoring of Medium Term Strategic Plan 2008-2013
4. New global and regional tools to strengthen WHO country presence
5. Update on Emergency Preparedness and Response including the pandemics and outbreaks
6. Meeting of the Regional Director with WRs, senior advisers, MDC members, Desk Officers, Directors of CEHA and UNRWA
7. Meeting on procurement of psychotropic medications for Somalia and other countries in emergency conditions
8. New reforms in WHO and expected courses of action
9. Initial brainstorming on fourth global WRs meeting with DG and RDs by the end of 2007
10. Conclusions and recommendations

Annex 2

PROGRAMME

Monday, 5 February

8:30 – 9: 00	Opening session • Welcome • Opening address • Selection of Officers • Working hours and agenda • Follow up on recommendations of the last meeting	Dr H. A. Gezairy, Regional Director DRD
9:00 – 9:20	Introduction and objectives Health system issues in the Eastern Mediterranean Region and the response of the DHS/EMRO	Dr Sabri, Director/DHS
9:20 – 9:40	WHO Global Health System Strengthening Strategy	Dr T. Evans, ADG/EIP/HQ
11:00 – 11:45	Eastern Mediterranean Regional health system observatory	PHP/KMS Units
11:45 – 12:00	Introduction to group work: Case studies on health systems	Dr G. Al-Sheikh RA/HRD
13:30 – 15:30	Group work: • Using national health accounts to assess MCH services in Morocco • Health workforce: Engine of the health system • Khartoum Malaria Free Initiative • Health system approach to tackling the problem of irrational use of medicines and health technologies • Confronting the challenge of health system governance	Facilitating Units: HEC, HCD, HMS, HRD, NUR, EDT, EDB, LAB, PHP, EST, VAC, EST, PHP
15:45 – 17:00	Group presentations and discussion	

Tuesday, 6 February

8:30 – 9:10	Enhancing the visibility of health system in countries: • In-depth health system reviews • Managing policy dialogue on health systems	Dr. S. Siddiqi RA/PHP WR /Iran WR /Iraq WR/Afghanistan WR/Sudan WR/Pakistan
9:10 – 9:40	Primary health care: The driving force for developing national health systems in EMR	Dr. A. Abdellatif RA/HCD
9:40 – 10:00	GAVI health system strengthening window in support of EPI	Dr. A. Mahghoub RA/HMS
10:30 – 12:00	Panel discussion on health system strengthening in EMR	Senior Management,

	• Improved synergy and collaboration among divisions in EMRO • Strengthening country office response • Sharing resources for health systems development	Programme Directors, WRs , CCO/HQ and EIP/HQ
13:00 – 13:20	Draft approach paper for community based initiatives, lessons learnt and way forward Introduction followed by discussion	WR/Iran
13:20 – 14:00	Recommendations and next steps on health system strengthening in EMR	
14:00 – 15:30	Planning, implementation and monitoring of medium term strategic plan 2008–2013 • Monitoring of GPW 11 2006-2015 and MTSP 2008-2013 • Sharing responsibility in managing financial resources from all sources of funds: mobilization, monitoring gaps and forecasting • Operational planning for 2008-2009 as first biennium in implementation of MTSP Introductions on each topic followed by plenary discussion	PRP/HQ/DRD/PME and Country experiences from WR/Iran and WR/Tunisia
15:45 – 16:45	Planning, implementation and monitoring of Medium Term Strategic Plan 2008-2013	
Wednesday, 7 February		
8:30 – 10:00	New global and regional tools to strengthen WHO country presence • Global Country Support Unit-Network Portal (soft launch) • Country Activity Management System (progress of work and lessons learnt) Presentations for each item followed by plenary discussion	PME/ARD/DRD CCO/HQ
10:30 – 12:00	Update on Emergency Preparedness and Response including the pandemics and outbreaks	EHA, CSR and Polio
13:00 – 15:30	Meeting of the Regional Director with WRs, senior advisers and MDC members, Desk Officers and Director of CEHA and UNRW	
16:00 – 18:00	Meeting on procurement of psychotropic medications for Somalia and other countries in emergency conditions	DRD, ARD, DHP, DAF, RA/MNH, RA/EDB, RA/EHA, LSP, PME, WR/Somalia, WR/Sudan, WR/Afghanistan, WR/Djibouti WR/Iraq Head of Office/OPT

		Director of Health/UNRWA
Thursday, 8 February		
8:30 – 09:00	Update on emergency preparedness and response including the pandemics and outbreaks	EHA
09:00 – 10:00	New reforms in WHO and expected courses of action • Global Management System; progress of work and expected changes • Human resource reform including Staff Development and Learning • New financial rules and regulation	DAF, ARD, DRD, PME, PRP/HQ, GSM/HQ
11:30 – 12:30	Fourth global WRs meeting with DG and RDs by the end of 2007	DRD, ARD, CCO/HQ
13:30 – 14:30	Inauguration of SHOC room and media centre (Strategic Health Operations Center)	

Annex 3

LIST OF PARTICIPANTS

WHO REPRESENTATIVES

Dr Riyad Musa Ahmed
WHO Representative
AFGHANISTAN

Dr Jihane Tawilah
WHO Representative
DJIBOUTI

Dr Zuhair Hallaj
A/WHO Representative
EGYPT

Dr Mubashar Riaz Sheikh
WHO Representative
ISLAMIC REPUBLIC OF IRAN

Dr Naeema Al-Gasseer
WHO Representative
IRAQ

Dr Hashim Ali El-Zein El-Mousaad
WHO Representative
JORDAN

Dr Jaouad Mahjour
WHO Representative
LEBANON

Dr Ibrahim Al Hadi Sherif
National WHO Representative
LIBYAN ARAB JAMAHIRIYA

Dr Raouf Ben Ammar
WHO Representative
MOROCCO

WHO Representative
OMAN

Dr Khalif Bile Mohamud
WHO Representative
PAKISTAN

Dr Ambrogio Manenti
Head of Office
PALESTINE

Dr Awad Abuzaid Mukhtar
WHO Representative
SAUDI ARABIA

Dr Fouad H. Mujalled
WHO Representative
SOMALIA

Dr Mohammad Abdur Rab
WHO Representative
SUDAN

Dr Abdullahi Mohamed Ahmed
WHO Technical Officer
Public Health Coordinator for South Sudan
SUB-OFFICE IN SOUTH SUDAN

Dr Ibrahim Betelmal
WHO Representative
SYRIAN ARAB REPUBLIC

Dr Ibrahim Abdel Rahim
WHO Representative
TUNISIA

Dr Ghulam R. Popal
WHO Representative
REPUBLIC OF YEMEN

COUNTRY DESK OFFICERS

Dr Fariba A. Al-Darazi
BAHRAIN

Dr Oussama Khatib
KUWAIT

Dr Ahmed Abdul Latif
QATAR

Dr Said Arnaout
UNITED ARAB EMIRATES

UNITED NATIONS RELIEF AND WORKS AGENCY FOR PALESTINE REFUGEES IN THE NEAR EAST (UNRWA)

Dr Guido Sabatinelli
Special Representative and Director of Health
UNRWA Headquarters Branch
JORDAN

CENTRE FOR ENVIRONMENTAL HEALTH ACTIVITIES (CEHA)

Dr Muhammed Z.A. Khan
WHO Regional Coordinator Centre
for Environmental Health Activities
JORDAN

WHO/HEADQUARTERS

Ms Namita Pradhan, Director/PRP
Dr Marie-Andree Diouf, Director/CCO
Dr Timothy Evans, Director/EIP
Dr Abdelhay Mechbal, Director/ADGO/EIP
Mrs E. Haraldsdottir-thomas, Director/GSM
Mr Cemil Alyanak, Consultant, GSM

WHO/EMRO

Senior Policy Adviser to the RD
Special Advisers to RD
Programme Directors
All Regional Advisers
All technical and professional staff
Senior Administrative Assistants

Annex 4

RESULTS OF THE EVALUATION OF THE MEETING

Evaluation results

The purpose of this anonymous evaluation was to gain ideas and advise to improve future meetings. Throughout the questionnaire, respondents were asked for both ratings and comments; the following is a summary of the evaluation. The meeting, held 5-8 February 2007, was attended officially by 78 staff members (consisting of 8 senior management; 39 regional advisers and focal points; 24 WHO representatives, desk officers, UNWRA and CEHA representatives; 7 staff members from headquarters). Of the 78 participants who attended the meeting, 23 responded to the evaluation given.

Respondents were asked to assign rankings from 1 to 5 to a number of questions relating to their opinion of the agenda items and general issues pertaining to the logistics of the meeting. Respondents were also given the opportunity to comment on these items and issues. The results have been compiled below.

Agenda items

Health system issues in EMR

1. Successful choice
2. Groups need more structure and clear guidelines on group inputs. Very good exercise and purpose
3. This subject is very important. Other ad hoc meetings should be organized
4. Very good. Need more on similar lines
5. Excellent methodology -- to be replicated
6. Issues were captured in isolation as if health system operates as a vertical entity
7. Definitions of key terms were not clear
8. Too many presentations with too little discussions
9. More time should have been allotted to this important area and for proper understanding of concept
10. The subject is very important. However the dose was rather big to be assimilated easily
11. Should be one day on three types of technical and specific discussions
12. Suggestions should be more focused and practical
13. Health system research was not properly addressed
14. Nothing new, only confused concepts not well presented (apart from Drs Sabri and Siddiqi)
15. We have sacrificed other critical (managerial) issues due to the extended period given to DHS. Not recommended for the future
16. Overall interesting but confusing session. The objective of the session was not clear whether it is a training session or discussion of PHC in EMR or discussion of new theme

Planning, implementation and monitoring of Medium Term Strategic Plan 2008-2013

1. Very precise and up to the point
2. Very informative
3. Repeated -- much developed from previous versions
4. Highly important but inadequate time allocated
5. This is an area where we should have engaged the WRs more proactively in discussion
6. Discussions were not inclusive or helpful. We just felt frustration after the discussion
7. More time could have been spent on this important subject
8. Not enough time assigned. Not addressing WRs concerns and their role

New global and regional tools to strengthen WHO country presence

1. Workshops in practical applications were useful, if planned to
2. Good
3. Clearly needed more time for discussion
4. Not enough clarity because of true constraints and no possibility of WRs to group the whole aspect
5. Time was too shortened. Would have benefited from more time

Update on emergency preparedness and response including the pandemics and outbreaks

1. Excellent
2. Well presented and fruitful discussion
3. Presentations and discussions reflect good work done in these fields
4. Comprehensive and informative
5. Relevant
6. Polio was excellent
7. Again general discussions but good exchange during discussion. Unfortunately no dialogue is established
8. Excellent
9. Too many presentations
10. Lecturing epidemiology to WR was offensive
11. CSR was very long
12. This subject requires more in-depth analysis
13. Important topic, more time is needed

New reforms in WHO and expected courses of action

1. Subject is very important
2. Not enough time was allocated to understand the subjects as dissect its implications on WHO
3. Time-management is the essence of management. Presentations of GSM did not meet this management essence!!!
4. Very little time for discussion of HR reforms and staff development
5. Too little time
6. No practical specific conclusions
7. Need to be circulated and feedback to its planning not to present at this stage. No participation from Regions

8. Very important but not properly discussed
9. Needs a lot more time
10. Very relevant session

General issues

Duration

1. Appropriate
2. The "theme" focus is good but should be limited to one day of focused discussion
3. Better than previous WR's meetings
4. Ideally it should have been for five days
5. Discussions were not inclusive nor helpful. We need to control discussions and to make this meeting more productive and helpful
6. Time is more than enough if used properly
7. This meeting was the correct length, but there was a mishandling in the coverage of subjects
8. Very short compared with programme. Less subjects to discuss deeper
9. Two and half days (HS) not useful to us we would need more time for discussing managerial issues
10. It is not the duration which is important but how best we organize it. There was too much time given to HSD at the expense of other important issues
11. A better selection of priority subjects should be done
12. It is not clear why the thematic discussion on health system has taken precedence and more importance and twice from WRs over the need to discuss portfolio's of more relevance to similar meetings

Boarding, administration, catering

1. PME should be commended for excellent arrangements
2. Comfortable and friendly
3. Outstanding
4. RO staff were excluded from social activities. I would like to suggest inviting them to participate and pay for that; if they wish
5. Need to shift to healthy food
6. Need more healthy food, but overall very nice catering, and cold set up outside

Additional comments and suggestions

1. Well arranged meeting. My understanding of the meeting (having it on a thematic topic) was that it would be more clear for us how health systems provide an entry point for the programme where the other sectors are more involved than health sector -- unfortunately that outcome was not there. The meeting did provide good insight to health systems initiatives.
2. It is an occasion for reviewing the implementation and to push to reach the desired objectives
3. Theme approach is very effective
4. Although it is understandable that this meeting provides this opportunity to WRs to bring the issues they are facing at the country level, somehow it is increasingly evident that it is becoming only 'WRs"" meeting because little chance is given to the RO staff

to throw insight into these issues or respond to the queries of the WRs. This is particularly evident in the discussion sessions.

5. The RO staff is also shying away (particularly RA's) somehow to take part in the discussion and engage in active interaction
6. Some WRs were born to be WRs, others not. For every WR there are minimum skills to acquire:
    a. How to raise the rate of implementation
    b. How to improve the image of WHO
    c. How to speak in behalf of RD, DG
    d. How to cope with "real"/"not ideal" people/situation
    e. The spirit of civil servant
7. As usual some participants highjacked the time. They speak on each subject whether relevant or not. If we keep record of time taken by some participants this could be realized.
8. Suggest we keep a record of number of times the individual participant intervenes and duration of their intervention
9. Important meeting. More time needs to be spent on achieving the management aspects (the latter two days) than the technical issues (the first two days).
10. The agenda to be put earlier and distributed to all staff before 4 months finalization
11. Suggest future reports of WRs meeting are reported as summary not full report -- highlighting key discussion points, conclusion and recommendations.
12. The meeting, once again, was not well planned allowing long presentation and only very short discussions.
13. The programme was wrong, accommodating too many items in very short time.
    a. Agenda should be developed through extensive consultative process involving both ROs and COs.
    b. Should be focused on managerial issue with parallel sessions for technical issues.
    c. Greater time for discussion is required.
14. Nicely organized but time management was extremely frustrating
15. The meeting of RD with WR and EMRO staff is an opportunity of interaction to improve collaboration with the countries and EMRO. Unfortunately, there was no focus on problem solving and the limited 2 hours direct meeting with RD was clearly insufficient. There is no balance in discussions to allow addressing themes of interest: UN reform, budget, strengthening Country Offices. We are repeating expressing the problems, however no serious attempt to address the problems directly.
16. We greatly appreciate next time to allow time for the concerns of WRs in terms of management of WHO business at country level – thematic educative sessions should come later with clearer information on the objectives and product expected from the sessions.
17. (Note on the front of survey) I do appreciate the effect. It is clear that a tremendous work and efforts have been made in preparation of this meeting. Unfortunately, I do not feel I have benefited as my perception was that there are many agendas and not a harmonized agenda for this meeting – the focus should have been to improve the performance of both EMRO and WHO Offices.

Agenda items							
Health system issues in EMR	**Rating**						
Duration:	**1**	**2**	**3**	**4**	**5**	**Blanks**	**Total**
theme/subject	2	1	8	5	5	2	23
presentations	1	2	10	5	4	1	23
discussions	2	2	4	7	7	1	23
working group sessions	2	5	9	5	1	1	23
Suitability	2	2	4	5	8	2	23
Planning, implementation and monitoring of Medium Term Strategic Plan 2008-2013	**Rating**						
Duration:	**1**	**2**	**3**	**4**	**5**	**Blanks**	**Total**
theme/subject	1	2	12	7	0	1	23
presentations	1	4	12	5	1	0	23
discussions	4	5	9	2	2	1	23
Suitability	1	0	10	4	7	1	23
New global and regional tools to strengthen WHO country presence	**Rating**						
Duration:	**1**	**2**	**3**	**4**	**5**	**Blanks**	**Total**
theme/subject	1	4	11	5	1	1	23
presentations	1	4	11	5	2	0	23
discussions	3	7	10	2	1	0	23
Suitability	0	2	6	5	8	2	23
Update on emergency preparedness and response including the pandemics and outbreaks	**Rating**						
Duration:	**1**	**2**	**3**	**4**	**5**	**Blanks**	**Total**
theme/subject	0	2	10	8	2	1	23
presentations	0	2	11	8	2	0	23
discussions	0	3	9	7	4	0	23
Suitability	1	1	5	6	8	2	23
New reforms in WHO and expected courses of action	**Rating**						
Duration:	**1**	**2**	**3**	**4**	**5**	**Blanks**	**Total**
theme/subject	2	5	6	4	3	2	22
presentations	2	4	8	6	2	1	23
discussions	6	4	8	1	3	1	23
Suitability	1	3	5	4	6	4	23

General Issues							
Duration of the meeting	Rating						
	1	2	3	4	5	Blanks	Total
Duration	4	1	12	3	2	1	23
Boarding and lodging	0	0	0	7	3	13	23
Administrative support	1	1	0	5	10	6	23
Catering	2	0	2	6	6	7	23