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Report of the Intercountry Workshop on Child Health Policy Development

Damascus, Syrian Arab Republic, 26–29 July 2004

World Health Organization
Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The Regional Office for the Eastern Mediterranean (EMRO) of the World Health Organization (WHO) held an intercountry workshop on child health policy development in Damascus, Syrian Arab Republic, from 26 to 29 July 2004.

The workshop was organized for the five countries in the Region which had joined the Child Health Policy Initiative (CHPI), namely Egypt, Morocco, Sudan, Syrian Arab Republic and Tunisia. The objectives of the workshop were to review the progress in the development of a national child health policy in the CHPI countries and to develop an outline of a six-month plan of action for the national child health policy development process for the same countries. The agenda and programme of the workshop are given in Annexes 1 and 2, respectively.

The workshop was inaugurated by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean and H.E. Dr Mohamed Eyad Chatty, Minister of Health, Syrian Arab Republic. A total of 29 participants attended the workshop, including 20 representatives of five countries at the level of undersecretary of health, primary health care directors, coordinators and members of the Integrated Management of Child Health (IMCI) national team, staff at sub-national level and the president of the Sudanese Association of Paediatricians; two staff from two UNICEF country offices; a representative of the Agha Khan Development Network in the Syrian Arab Republic; and five WHO technical staff from WHO headquarters, the Regional Office and country Offices (Annex 3).

2. OBJECTIVES AND METHODOLOGY

2.1 Background

The Regional Office launched the Child Health Policy Initiative (CHPI) in October 2003. The aim of the CHPI is to assist countries in bringing together in one document all the main policy elements and issues related to child care, including illness and healthy growth and development, to establish a legal framework that gives clear long-term directions and support to improve the health status of our children. At a time when all Member States have pledged to achieve the Millennium Development Goals (MDGs), a national child health policy will enable countries to "institutionalize" this commitment and translate it into stronger action. The CHPI comprises three phases: situation analysis; policy document development; and official adoption of the policy document. As the foundation of a policy should lie in an in-depth review of the current situation, much emphasis has been given to the first phase of the process, the situation analysis. Since its launching, five countries in the Region have formally joined the initiative, namely Egypt, Morocco, Sudan, Syrian Arab Republic and Tunisia. These countries have embarked on a detailed situation analysis that should lead to the identification of policy issues to be addressed in the policy document. The Regional Office has been collaborating very closely with these five countries in this undertaking and the workshop was organized to review progress in the country situation analysis, share experiences between countries at this stage, and develop a plan of action to complete the first phase.

2.2 Rationale

About 1.5 million children under 5 years of age continue to die each year in the Region. The under-five mortality rate remain high in 7 countries in the Region, at a level above 100 deaths per 1000 live births, while only 4 countries have rates below 20 deaths per 1000 live births, the rest having rates within this range. Fewer than two children in three are immunized against measles in 6 countries, and malnutrition remains common in 4 countries, with 35% of children under 5 being low weight-for-age (< 2 SD from median weight for age of reference population). As emphasized by the Regional Director in his address to the workshop, if current trends in the Region continue, the Millennium Development Goal 4 of reducing by two-thirds the mortality in children under 5 years old by 2015 will remain a theoretical goal, both at global and regional level, despite the Millennium Declaration. Most of these deaths are preventable and effective interventions to avert them are available, but country commitment to the MDGs needs yet to be translated into strong, intensive and effective action to expand the coverage of interventions and reach those who are at highest risk and need them most. Competing health priorities, inadequate investments in health, and underutilized partnerships are but a few examples of factors limiting progress. Furthermore, most countries lack national child health policies and solid data to inform policies and enable sound planning. National child health policies, endorsed at the highest possible level, can help translate the high-level commitment into a more concrete direction and a driving force for action, maximize the use of resources for the long-term, and serve as a reference to harmonize partner actions. The policy document is expected to provide a holistic and comprehensive approach to child health in a country, identifying priorities, strategies and interventions to ensure equitable access to health care for everyone, including the most disadvantaged families, whose children often pay the highest toll. High appreciation of the importance of the CHPI was expressed during the inauguration of the workshop by the Minister of Health of the Syrian Arab Republic as a means of bringing child health to the top of the public health priorities in the country and providing long-term directions.

2.3 Methodology

Based on the positive experience gained with previous workshops, the time allocated to presentations was limited in general to 15 minutes each, in order to reserve much more time for discussions in plenary sessions and groups. The main purpose of the presentations was to provide input to the main sessions of the workshop. The workshop was articulated in the following main parts:

- review of the regional Child Health Policy Initiative (CHPI), with information on the process and expected outcome;
- country presentations on the steps carried out to date as part of the CHPI;
- country presentations on selected sections of the child health policy situation analysis, followed by individual review of the relevant country report chapters and plenary discussion with all country teams;
- group work by country teams to develop country plans of action on the CHPI first phase (the situation analysis) up to the finalization of the report, and presentation and discussion in plenary sessions;
- group work on advocacy for the whole process
- conclusions and recommendations of the workshop.

Annex 4 summarizes the progress made in these five countries in the situation analysis. The table shows the important role that the intensive preparatory work for this workshop and WHO close collaboration have played to enable countries to complete the first draft of the situation analysis report and revise it before the workshop, with much of this work concentrated in the weeks preceding the workshop itself. The topic of the presentations to be made by countries was selected based on the review of the draft country reports. The presentations were reviewed by the Regional Office, then revised by country teams based on the WHO comments, reviewed again by the Regional Office and country teams several times through intensive work, by e-mail and telephone conferences, to ensure that the presentations were clear, followed a standard format, covered and summarised the main points, and trigger discussion on practical issues. This approach was very demanding but the results—the presentations and discussions which followed—were highly appreciated by the participants and served their intended purpose. Also, it should be noted that through this preparatory work, many issues on the CHPI process were discussed and clarified with the country teams. The workshop, therefore, also through its effort-intensive preparation, represented a key step in the situation analysis and, more generally, in the CHPI process.

3. THE TERM "POLICY"

Definitions are important and of practical value to use a consistent language which facilitates the comprehension of topics by the target audience. They help promote and guide exchange of ideas with and within the audience. The workshop therefore was started off by a presentation in which WHO staff clarified the term "policy". It was observed that this term is often used to refer to ministerial statements and speeches, technical guidelines such as those contained in training materials, planning documents, decrees, directives and circulars, that influence public health activities in the health sector, at health facility and community levels. The term may also be used simply to refer to established, prevailing practices in a specific domain. The term "policy" in the Child Health Policy Initiative refers specifically to a written policy document which:

- Sets long-term, outcome-oriented directions and priorities ('what to do') for child health, in line with the resources that a country can mobilize, and identifies main strategies ('how to do it');
- Reflects system views, going beyond individuals;
- Ensures commitment and continuity over time, and promotes standardization;
- Formalizes decisions already made, legitimizes existing guidelines, and institutionalizes strategies and interventions;
- Commits financial and human resources;
- Helps in strategic thinking and planning;
- Brings together all (child health) elements in one document which ensures consistency and maximizes the use of available resources;

- Will be granted due importance and credibility, ensuring greater compliance, and reduces chances of misinterpretation;

- Clarifies roles and responsibilities of staff, defines lines of communication and identifies coordination mechanisms and structures;

- Serves as a reference for all partners, and establishes directions for their involvement.

A written policy document can guarantee greater continuity over time than verbal statements. Such a document should allow for flexibility, to respond to changing needs over time.

4. THE CHILD HEALTH POLICY INITIATIVE

Task force

Any process requiring input and coordination from a variety of programmes, partners and sectors, such as a policy development process, benefits from a management and coordinating structure set up for this specific purpose, which should be given high visibility and political support to pursue its tasks: the "Child Health Policy (CHP) Task Force". All five countries joining the CHPI in the Region and participating in the workshop had established a national CHP task force or committee. Egypt had also set up a high-level Steering Committee to support the process. In Morocco, where a major initiative on children is under way, the CHPI has been integrated in this process, making use of the available management structures created for the children's initiative; a CHP Task Force has been created as a core group of the large child health committee established for the children initiative. Tasks to be carried out by these ad hoc committees include:

- collecting and reviewing all relevant documents and information;
- analysing the information critically and summarizing conclusions and policy issues;
- preparing the report on the situation analysis;
- identifying components of the policy document based on the situation analysis;
- identifying members of the technical committees for the development of the various sections of the policy document;
- coordinating all activities related to the process;
- advocating for child health policy throughout the process.

The early experience of the five countries implementing the child health policy initiative supports the essential role that the CHP task force plays in the process since the beginning, representing a prerequisite for any country embarking on the CHPI. The composition of the task forces set up in the five participating countries is shown in Annex 5. Country experience has shown that it is preferable for the core team of the task force to be small (6–7 permanent members) in order to be functional and carry out its work effectively. For example, the composition of the task force in the Syrian Arab Republic originally included many members. Based on the experience gained and especially on the difficulties for a large group to meet frequently, the composition was being re-considered in favour of a smaller task force, re-designating some of the original members as resource persons. In some cases, the task force work has been divided by thematic areas (e.g.

Egypt), with the focal point compiling all the work, then revised by the task force; in others these areas have been assigned to working groups (e.g. Sudan) or members of the task force assisted by resource persons (e.g. Tunisia). Members should represent key departments or programmes of the ministry of health, and partners, and should be appointed according to their position, to ensure continuity in the flow of work. The task force should be chaired by a senior chairperson and have an active focal point responsible to coordinate and facilitate the work of the various members of the task force or technical committees, ensure good communication between them and with programmes and partners, and disseminate information. A number of resource persons could be identified to be consulted as needed (from health insurance, teaching institutions, national council of childhood, nongovernmental organizations, private sector, medical syndicate, international organizations, etc.), thus expanding the range of expertise on which to draw during the process.

Three phases

The policy development process advocated by the CHPI consists of 3 main phases: the situation analysis, the development of the policy document and the official adoption of the document itself. Throughout the process, advocacy plays a crucial role in bringing it forward, drawing the necessary support from the highest political level possible and all sectors involved, and giving full ownership of process and outcome to the country itself. Joint orientation and planning meetings held by the WHO Regional Office and Ministries of Health of individual countries (e.g. Egypt, January 2004; Syrian Arab Republic, February 2004; Sudan and Tunisia, March 2004) have also contributed to promoting the initiative and eliciting further interest and support.

The situation analysis

The situation analysis is a key step in the policy document development process, to which adequate time and human resources should be devoted. Annex 6 shows the recommended steps of the situation analysis phase. It requires collection of documents and information related to public child health on existing policies, strategies, national development plans, management structures at different levels, health systems and human resources, partners including the community, programs and interventions, and other main factors influencing child health. A variety of key documents were reviewed by the task forces in the five countries, as shown in Annex 7. The information collected is used to describe the current situation of child health care within the political, socioeconomic, demographic, educational and health system context of the country. It is also analysed critically in order to identify strengths and weaknesses, and identify as an outcome policy priority issues to be addressed in the child health policy document.

Commitment to child health

All the five countries had expressed their commitment to children and child health, as shown by the ratification of the United Nations Convention on the Rights of the Child, commitment to the World Summit goals and, more recently, the Millennium Development Goals. Translation of these commitments into actions and progress, however, varied from country to country. A unique initiative on children was being undertaken in Morocco, in which a 10-year (2005–2015) national plan of action for children was being developed by a committee headed by the Prime Minister. Health was one of the three priorities identified during the congress on Convention on the Rights of the Child in

May 2004, together with education and child protection. The national child health policy initiative had therefore been made an integral part of this plan of action in Morocco. Another interesting undertaking was the one reported by the Tunisian team. At the beginning of the past decade, a national plan of action for children was developed with the contribution of the various ministries (health, youth, and child and family). While the document comprises directions with objectives, a strategic plan to implement them was not included. The need was felt by the participants to institutionalize child health strategies and interventions, and improve coordination among the existing child-related programmes and initiatives; the lack of a comprehensive child health policy document was noted in all countries.

Challenges

Four main challenges were identified by the country teams in the process of carrying out the situation analysis at country level.

- Inadequate cooperation of partners—both internal and external to the ministry of health—with the task force in some cases, which calls for stronger advocacy.

- The lack of availability of certain information, documentation or reliable data, and the substantial difficulty in accessing some information when available or the need to access multiple sources.

- Programme managers' tendency just to describe the activities which have been carried out, and their difficulty in analysing the information critically to 'extract' policy issues.

- Limited time availability of the task force members, formally in charge of many other responsibilities other than the CHPI, and difficulty in maintaining the 'initial momentum' and time commitment.

These challenges confirm the importance of formalizing all steps in the process, with high-level support, from the establishment of the task force to setting up meetings and interview appointments with concerned partners to gather and review information.

5. SITUATION ANALYSIS: COUNTRY EXPERIENCES

5.1 Overview

Each country presented the results of its review of a specific aspect of the complete situation analysis that they had carried out. This was done first by summarizing the major findings by a power point presentation, then having the whole group of participants review the relevant section of the draft situation analysis report of that country individually, and finally discussing it in a plenary session. This method enabled dynamic interaction between country teams, with the presenting country benefiting from the other participants' comments, and the other country teams gaining additional ideas from the discussion to review their own work on the same subject area. The main sources of information used for the situation analysis in each country are attached as Annex 7.

5.2 Egypt: Trends of child health indicators and assessment of child health programmes

The indicators selected for review followed the child health-related indicators included in the Millennium Development Goals. Downward trends for the past 10 years were reported for child mortality (under-five, infant and neonatal mortality), diarrhoeal and acute respiratory infections (ARI), specific mortality rates and severity (percentage of pneumonia and severely dehydrated cases among all reported ARI and diarrhoea cases, respectively) and child nutritional status showing progress. At the same time, the data highlighted the persistence of traditional disparities between Upper and Lower Egypt, and urban versus rural areas, which called for more action and targeted approaches. Improvement in measles vaccination coverage and decrease in measles incidence for the past five years were also presented. Among other achievements described were maintaining the annual immunization coverage above 90%, having brought the vitamin A supplementation coverage to 97% in children and 84% in mothers (2003), having made iodized salt available at 94% of commercial outlets and present in 79% of households.

Child health related programme areas taken into consideration for the situation analysis by the Egyptian team included healthy child (neonatal care, growth and development, neonatal screening of congenital hypothyroidism), nutrition (breastfeeding, complementary feeding, micronutrient supplementation), child illness and injury (diarrhoeal disease control programme, acute respiratory infections programme, IMCI, tuberculosis control, injury protection), and children with special needs (disabilities, separated newborns, street children).

Data on IMCI implementation confirmed an accelerated pace of expansion, reaching almost 40% of all health facilities and districts in about two-thirds of governorates in the country (Figure 1). IMCI implementation was accompanied by improved quality of care (provider performance, health facility support elements, caretaker satisfaction), as assessed through pre- and post-intervention assessments, IMCI follow-up visits and an IMCI health facility survey carried out in 2002.

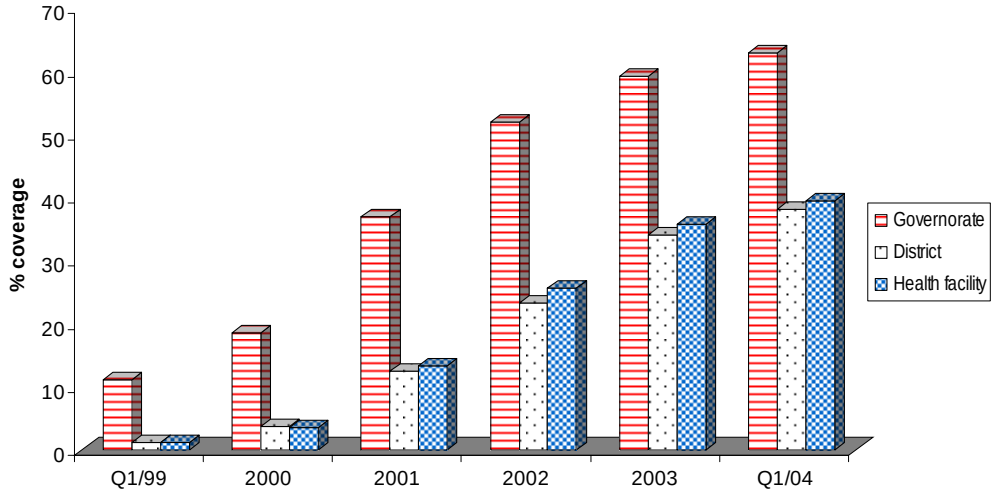

Figure 1. IMCI cumulative coverage by year, Egypt, 1999–2004

The rapid scaling up of implementation of the IMCI strategy in the country in the past few years, associated with the documented improvement in the quality of child health services provided by health facilities implementing IMCI, represents a major achievement and a step forward towards achieving the Millennium Development Goals.

Elements of supportive environment include high political support to child care, especially child health care; increasing attention to emerging child health problems (e.g. injuries and disabilities); high access to health services (estimated as 95% of the population) and presence of an extensive and well staffed health infrastructure; successful past experiences in programme management and implementation (e.g. with the diarrhoeal disease control programme) and management structures at all levels, introduction of various payment schemes (free, increasing insurance coverage, or different levels of fee-for-service); and high coverage of communication channels.

A number of challenges were identified which include: a worsening performance of breastfeeding indicators, according to the demographic and health survey conducted in 2003 compared with the previous one of 2000, ascribed at least in part to a reduced emphasis on breastfeeding promotion in recent years; the high morbidity rate in young children; the persisting, high prevalence of anaemia in children 6–59 months old and mothers; the disparities between geographical areas; and inequable distribution of resources. Health system issues include a complex health system with limited coordination between programmes on policy, management and implementation, and the ministry's organizational structure of child health; lack of standard protocols by some programmes; limitation in availability and access to reliable information and its use; inadequate supply of drugs coupled with extensive overuse, especially antibiotics; a firmly established, traditional concept of supervision without emphasis on its supportive role; rapid turnover of primary health care providers; potential consequences of the health sector reform fee policy if parents decide not to opt to have child insurance; lack of a specific government budget line for programme activities; and sustainability concerns with projects supported through external funding.

5.3 Morocco: Health system and health expenditure

Health care providers in the country

Three main "sectors" were described for the delivery of health care services: public (e.g. government hospitals and primary health care network, institutes, army health services); non-profit private (e.g. national organizations', leagues' and Red Crescent's hospitals and health centres, health insurance facilities); and for-profit private sectors (e.g. private hospitals and clinics, private practitioners, pharmacies). The review highlighted the existence of disparities in the availability of health care services at all levels of care, e.g. staffing, with a primary health care facility to population ratio ranging from 1:4930 down to 1:36 800 population, and hospital bed to population ratio ranging from 1:2049 down to 1:5005 people, with rural areas being more disadvantaged. Their more limited access to health primary health care facilities was explained by many factors, including a more dispersed population and the geographical nature of terrain (e.g. mountainous areas).

Health service coverage

The majority of the population (58%) is covered by mobile services and 40% by health facilities, while the remaining 2% has very difficult access to health services (1996 data). The proportion of the population utilizing public health services increased from 37% in 1990–1991 to 48% in 1998–1999; this was ascribed to worsening economic factors. The estimated service utilization was 0.4 contacts per person per year. Preventive services are provided free of charge and delivered mostly by the public sector.

Human resources

With a general practitioner to population ratio of 2.5:10 000 people in 2003 and an estimated need for 16 500 practitioners by 2020, the estimated production requirement is an average of 539 general practitioners per year. A similar need was estimated for specialists, while it went up to 3200 for nurses and technicians per year.

Health information

As in any other country, there are weaknesses in the health information system: the same unit may report the same information to different services; university, private and military sectors are not included in the system; and the quality of the information reported is inadequate, with limited and delayed analysis and utilization for problem-solving and planning.

Drug management

The national pharmaceutical industry appears well developed, following international quality standards—with quality control undertaken by the national laboratory—and capable of meeting 80% of the country needs. The country has a national essential drug list. However, the cost of drugs is high. This limits purchase by the public and results in limited drug availability at health facilities, which adversely affects service utilization.

Health expenditure

National health accounts and other information related to health financing for the period 1997–1998 were presented. Difficulties in obtaining more recent data were cited.

- Total health expenditure in 1997–1998 represented 4.5% of the gross domestic product (GDP), equivalent to a per capita health expenditure of US$ 56 at the 1997–1998 exchange rate level (or US$ 135 PPP);

- The budget allocated to the Ministry of Health in the same period was 5% of the total government budget (compared with 7% in the 1960s), representing 1% of the gross domestic product (compared with 1.7% in the 1960s).

- Almost half (47%) of the Ministry of Health budget was spent for hospitals, while 38% went to primary health care. A large part of the financial resources was spent on drugs.

- The distribution of funding sources showed households contributing to more than half (54%), tax revenues to 26%, health insurance to 16% and other sources, including local communities and international cooperation, to the remainder.

- Coverage by health insurance was low, 16.4% of the population.

The review found that government was committed to the health of the population, service coverage was expanding, and there was awareness of the need to accelerate reforms of the health system and implement an obligatory health insurance scheme (AMO) and social funds for the needy people (RAMED).

In conclusion, many challenges were identified. Management and coordination are inadequate. There is a substantial lack of medical personnel, both doctors and paramedical staff, and a need to update the 'national health map'. Disparities remain in the access to health services. Financing of the health sector is inadequate and inequitable, households bear more than half of total health expenditure as a result of it, and drug costs represent a large proportion of the total health expenses.

5.4 Sudan: Human resources and pre-service education

Policy

- A policy for human resources development, including those related to child health, is lacking.
- A coordinating body, the "National Higher Council for Human Resources Development", between the Ministry of Higher Education, Ministry of Health and academic institutes, although not fully functioning, is being revitalized.

Management

- At state level, Ministry of Health's planning units of human resources for health have not been established or lack capacity.
- An inequitable distribution of health cadres exists among and within the states (e.g. rural versus urban).
- There is a lack of tools for integrated routine supervision.
- There is a lack of leadership development in this area.
- Doctors' career pathway, although developed, is not fully implemented.

Planning

- Planning is not always based on country priorities.
- The "Service Target Approach" has recently been introduced, to be used for all health service institutions. According to it, human resources' needs are calculated. However, the approach is not yet operational.

Training and production

- Basic (pre-service) training
  - Ministry of Higher Education and Ministry of Health orientation of pre-service training is towards public health.
  - There is a shortage in all categories of health cadres working in child health.
  - While child health is well covered as a topic in medical and health science school curricula, focusing on programmes guidelines, its practical aspects are insufficiently addressed.
  - A comprehensive child health training approach based on the IMCI outpatient approach has started in seven medical schools and is in the process of being introduced also in the medical assistant schools.
  - An accreditation system for medical and health science schools is being set by the Ministry of Higher Education to ensure quality production.
- In-service training
  - Nongovernmental organizations do not always follow Ministry of Health guidelines.
  - A lack of coordination and communication exists between federal and state ministries of Health in relation to the number and categories of human resources to be trained and their geographical distribution.

Main achievements in this area were: the formulation of a plan for capacity-building in Federal and State Ministries of Health and the joint Ministry of Higher Education and Federal Ministry of Health 10-year plan for human resource production, using the "service target approach"; the career pathway designed for doctors; the "Sudan Declaration for Nursing and Allied Health Personnel Educational Reform"; the package for quality supervision developed by IMCI and EPI; the implementation of the IMCI outpatient approach in the teaching of seven medical schools and its introduction in Medical Assistant schools.

Issues requiring attention concerned the shortage of medical and paramedical staff, the rather unbalanced production of medical doctors compared with other health staff categories, the uneven distribution of health personnel by geographical areas and by health care level (with much concentration at central level, and differences in urban versus rural and primary health care versus hospital care distribution), and the absence of a human resources performance appraisal system.

5.5 Syrian Arab Republic: Commitment to children; socioeconomic indicators; partners

Commitment to children

Children were reported to enjoy the highest level of political commitment in the country, with the Constitution and legislation considering child care through all stages of development of the child, including its embryonic period. As with other countries, the Syrian Arab Republic has adopted the Millennium Development Goals and ratified the United Nations Convention on the Rights of the Child. At national level, a Steering Committee for Childhood was set up in January 1999, chaired by the Prime Minister, with representatives of concerned partners.

Preventive and curative health care are provided free. The Ministry of Health established a wide network of primary health care services and child related programmes, and launched the Healthy Villages initiative in 1995 and the district health system to foster community participation. Recently, the Ministry has taken important decisions to improve the quality of child care by:

- ensuring provision all necessary drugs for child health care at primary healthy care level, by a ministerial decree;
- requiring that staff trained in IMCI should remain assigned to the same facility for a period of one year, to reduce the effects of staff turnover;
- developing a national health strategy supporting areas in greater need.

Socioeconomic indicators

- Development expenditure showed an increase from 39% of total government expenditure in 1990 to 48% in 2000, an increase in gross domestic income per capita to over US$ 1000, and an increase in the Ministry of Health budget up to SYP 16 billion in 2004.

- Two-thirds (65.4%) of the total population is literate. Disparities in literacy rate exist between sexes (87.2% for males versus 67.9% for females) and residence location (87.7% in urban areas versus 77.7% in rural areas).

- Population growth showed a significant decrease in the past decade, from an average of 3.3% in the period 1981–1994 to an estimated 2.4% for the period 2001–2005. This was ascribed to many factors, such as the decrease in infant and under-five mortality, which helped change family beliefs, increases in education level in both males and females (and better women empowerment), improved services in urban and rural areas, increased age of marriage by 5 years in the 20-year period 1981–2000, and enhanced family planning programme activity.

- No official information was available on the poverty level in the country, but a number of initiatives are being conducted to address the issue by government organizations, such as a poverty alleviation project, rural women development, healthy village programme, Bedouin health service programme, health insurance project, and by charity (*ferdous*) and nongovernmental organizations.

Partners

In addition to ministries (e.g. education, high education, interior, agriculture, etc.) and international multilateral organizations (e.g. WHO, UNICEF), partners in health are community and nongovernmental organizations, private sector and professional organizations.

Some of the constraints identified by the Syrian team are the lack of some information, coordination between partners and use of resources. Future priorities include support to the population policy to reduce population growth, poverty alleviation and focus on governorates and areas with special needs, improvement of quality of some services, and women’s education.

5.6 Tunisia: Health systems, including health expenditure

Health care providers in the country

Three main "sectors" could be identified: the public, 'semi-public' (health facilities of the ministry of interior, military, health insurance system, companies) and private sectors. The review showed that the State remains the main health care provider in the country. The public health system is decentralized and organized in three levels: 1) central (responsible for strategic planning, guidelines, coordination at national level, training, and supervision of lower levels); 2) provincial (coordination at provincial level, development of operational plans, training, supervision of implementation of national guidelines); and 3) peripheral (guidelines and programme implementation in the field). In addition, the private sector is growing fast. While a link exists between these two sectors, such as when patients are referred from private to public sector facilities, the review showed lack of coordination between the two.

Provision of child health services

The Primary Health Care directorate (implementation of national child health programmes and services at district hospitals and primary health care centres), School and University Medicine directorate (schools) and Hospitals directorate (university and provincial hospitals) all deliver child health services. There is good coordination between these three structures in strategic planning and training; however, coordination of implementation is weak.

Access to services

There is good overall access to health services, with 95% of the population living within 4 km of a provider, but with some disparities in some areas. Access to services by the most needy social categories has been facilitated by providing free care for the underprivileged and establishing a national solidarity fund.

Health expenditure

The review showed that while per capita and public health expenditure had increased over the years, there was also an increase in the proportion of health expenditure borne by households and by the health insurance between 1985 and 2000, with a corresponding decrease in the State participation (Figure 2). While the budget allocated to health had been increasing, the budget for child health was considered insufficient to fully support prevention activities. The reporting system is a well developed and performing system, supporting planning, but missing data from university health facilities.

Supervision

Experience in integrated supervision of child health programmes is being gained with the expansion of the health district development programme, quality assurance system and IMCI strategy. Weak areas include a more administrative than technical emphasis, and an increasing shortage of transportation means, human resources and motivation for supervision.

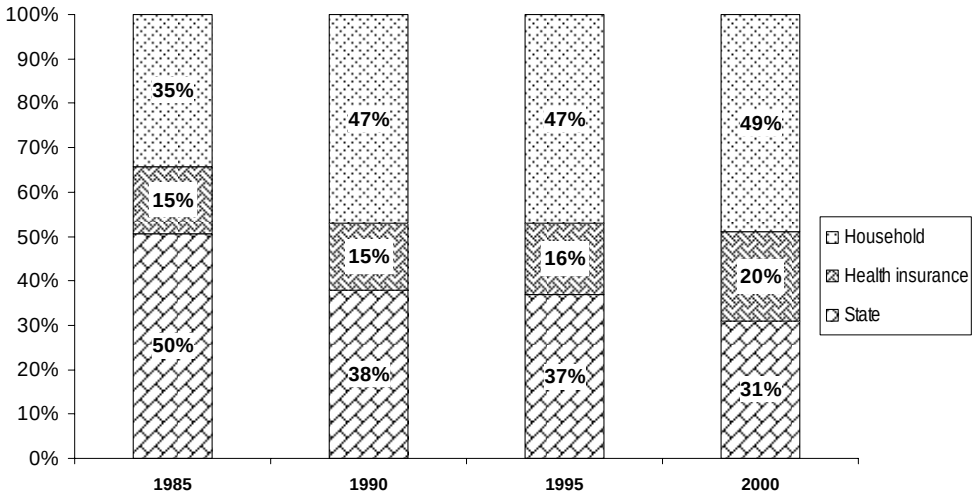

Figure 2. Proportional contribution to health expenditure, Tunisia, 1985–2000

Referral system

As with the supervisory system, the referral system—currently with a weak feedback component—may also benefit from the implementation of the health district development programme, quality assurance and IMCI strategy.

Monitoring and evaluation

Information for monitoring and evaluation purposes comes from monthly and annual reports of child health programmes, IMCI follow-up visits, in-depth programme reviews (including IMCI) and surveys (e.g. Multiple Indicator Cluster Surveys or MICS, to evaluate World Summit goals for children).

Management and availability of drugs

Strengths are the quality of drugs available—with local drug manufacturing capacity—and the essential drug list; however, occasional problems with procurement lead to shortages from time to time. Of concern is the overuse of drugs; in this regard, implementation of strategies such as IMCI is helping to rationalize prescribing.

The good progress in child mortality reduction over the years, together with efforts undertaken by the Ministry of Public Health to further develop the health system and improve access for the most needy population, are the main achievements. Current emphasis has shifted to improving quality of life and quality of care for children, through the IMCI strategy and quality assurance, with the public sector remaining the major source of services. Drug management, programme

implementation and evaluation, and development of the health information system are seen as accomplishments of the current health system.

Areas needing more attention include: disparities of urban versus rural and eastern versus western areas in terms of resources and performance; partners' coordination on human resource development and coordination mechanisms with the private sector (including in-service training and programme implementation); lack of human resources at provincial level in a decentralized system; need to collect health information also from university health facilities and to consider also the rapidly growing private sector; the weakening and mostly administrative supervisory system; weak standardization and feedback component of the referral system; and overuse of drugs.

6. PREPARATION OF PLANS OF ACTION

Each country team prepared a plan of action for the next six months, detailing steps and responsibilities to finalize the situation analysis report (See Annex 8). The Tunisian team expected to complete the process in just four more months, by the end of November 2004. Country plans included: re-formulation of the national CHP task force (e.g. Morocco and Syrian Arab Republic) in line with WHO's recommendation for a small size and more functional body; identification of technical committees; revision of the draft situation analysis report based on the workshop comments and input; sharing of the revised draft report with WHO and partners, and further revision; identification of policy issues, to be addressed in the policy document; formal endorsement of the report; and designing of the policy document itself. The identification of the policy issues was seen as the key outcome of the situation analysis, and the most challenging task to most if not all teams. Overall, the plans were rather ambitious, considering that the task forces' members had also other routine responsibilities than those related to child health policy development. Overall, finalized country situation analysis reports were expected for all countries by the end of the first quarter of 2005.

7. GROUP WORK: ADVOCACY

Group work was carried out to review how to advocate for the CHPI in order to obtain the highest level of endorsement possible for the policy in each country. As enabling factors for the process, the teams emphasized the importance of establishing task forces formally through the direct involvement of the minister of health, and the involvement of different partners—both within and outside the ministry of health, and in the public and private sectors—from an early stage, coordinated by the undersecretary of health. The need was stressed by the participants to obtain high-level support also for data collection to access various sources. Official contacts between WHO and Member States and international events, including formal letters to the ministers, Regional Committee meetings and World Health Day, also play an important role in creating a supportive environment for policy development, while WHO technical support was reported as essential in this process. Referring to existing high-level commitments to children and child health (ratification of the UN Convention on the Rights of the Child, country endorsement of the Millennium Development Goals, etc) is also critical to help support the initiative, showing that it was consistent with and would help keep up to country commitments. Advocacy has to target all levels, international, regional, national and subnational, use key opportunities and instruments (e.g., mother

and child health days, scientific meetings, appropriate briefing notes to decision-makers such as ministerial council meetings, parliamentary health committee, governors, etc.).

Participants identified the following as key moments in the process to intensify advocacy efforts for the child health policy: when preparing the report on the situation analysis and during the process of selection of the policy options (main outcome of phase 1 of the CHPI), policy development (phase 2) and endorsement of the police document (phase 3).

8. CONCLUSIONS

- Under-five mortality and morbidity rates in the Region are still unacceptably high, despite the efforts made during in recent decades.

- Not all children are being reached by the life saving interventions, because of geographical and socioeconomic inequities.

- IMCI is the strategy promoted in the Eastern Mediterranean Region to improve quality of life of children in Member States and thus increase child survival.

- While there exist child health policy-related elements scattered in different documents, a comprehensive national child health policy document is not available in most countries. This document would bring together all child health related elements and would provide long term directions to improve their quality of life.

- A child health policy document, by including clear indicators and a plan to monitor its implementation, would assist countries in translating their commitment to internationally agreed goals into action.

- A critical situation analysis is a key step in the process of child health policy development to which adequate time and effort should be devoted. This step is meant to lead to the identification of policy issues to be addressed in the final policy document.

- There is usually much information available in countries; however, problems with its accessibility, quality and analytical component are frequently a major constraint.

- Advocacy is essential throughout the process.

- Availability of task force members and resource persons as well as high level commitment are essential for the success of the process.

9. RECOMMENDATIONS

1. All the steps of the child health policy development process should be adopted formally at national level, including the country plans of action developed during the workshop.

2. National political commitment should be translated into the active participation of task force members and resource persons and allocation of financial resources within the country.

3. The policy issues should be identified very specifically and the policies proposed to address them should be prioritized according to their feasibility.

4. Key partners should be fully involved throughout the development of the policy document; they should endorse it and support its implementation.

5. WHO should continue to provide required technical and financial support throughout the process of developing the child health policy document.

6. WHO should provide guidelines for data analysis and presentation.

7. Mechanisms and opportunities should be identified to advocate for and solidify commitment to the process, including forums such as annual meetings of the Regional Committee for the Eastern Mediterranean and events such as World Health Day.

8. Following the completion of the child health policy development process in the five countries, the initiative should be expanded to other countries in the Region.

9. The child health policy development process should be documented at all levels (regional and national), to serve as guidance for other Member States.

Annex 1

AGENDA

1. Inauguration of the intercountry workshop

2. Regional overview on national child health policy

3. Global update on national child health policy

4. Situation analysis: country experience
- Outline of the section of the situation analysis report
- Sudan
- Tunisia
- Egypt
- Syrian
- Morocco
- Group work: Development of country 6-month plans of action on national child health policy development

5. Advocacy: Towards obtaining the highest level of political commitment and endorsement
- Regional experience
- Group work

6. Conclusions and recommendations of the workshop

7. Closing session

Annex 2

PROGRAMME

Monday, 26 July 2004
Chairperson: Professor Zein A. Karrar
Rapporteurs: Dr Sumaia Al Fadil and Dr Ahmed Nagaty

08:00–09:00	Registration
09:00–11:00	Opening session Address by Dr Hussein A. Gezairy, Regional Director, WHO/EMRO Message from the Minister of Health, Syrian Arab Republic Introduction of participants Adoption of Agenda National Child Health Policy: Rationale, Process and Status, Dr Suzanne Farhoud
11:00–12:00	Regional overview: national child health policy–the process in detail, Dr Sergio Pièche Global update: National child health policy: global perspective, Dr Jose Martines
12:00–12:30	Discussion
12:30–15:00	The process of National Child Health Policy Development Presentation by each country (Egypt, Morocco, Sudan, Syrian Arab Republic, Tunisia) Plenary discussion and conclusions on the process of national child health policy development
15:00–17:00	Situation analysis: Sudan Presentation on the outline of the section of the situation analysis report: Human resources, including pre-service education Review of the relevant section of the country situation analysis report Plenary discussion Conclusions on Sudan experience
17:00–18:00	Individual county meetings: Egypt

Tuesday, 27 July 2004
Chairperson: Dr Esmat Mansour

09:00–11:30	Situation Analysis: Tunisia Presentation on the outline of the section of the situation analysis report: Health systems, including health expenditure Review of the relevant section of the country situation analysis report Plenary discussion
11:30–12:00	Conclusions on Tunisia
12:00–15:00	Situation analysis: Egypt Presentation on the outline of the section of the situation analysis report: Trends of child health indicators and the assessment of child health related programmes Review of the selected section of the country situation analysis report Plenary discussion

15:00–15:30	Conclusions on Egypt
15:30–17:00	Individual county meetings: Morocco
17:00–18:00	Individual county meetings: Sudan

Wednesday, 28 July 2004
Chairperson: Dr Mounira Garbouj

09:00–11:30	Situation analysis: Morocco experience Presentation on the outline of the sections of the situation analysis report: Health systems and health expenditure Plenary discussion Conclusions on Morocco experience
11:30–13:00	Situation analysis: Syrian Arab Republic experience Presentation on the outline of the sections of the situation analysis report: Government commitment to children; Partners, Socioeconomic indicators Review of the relevant section of the country situation analysis report Plenary discussion Conclusions on Syrian Arab Republic experience
13:00–15:00	Group work: Development of countries' six-month plans of action on national child health policy development Introduction to the group work Country group work
15:00–17:00	Group work on plans of action
17:00–18:00	Individual county meetings Tunisia
18:00–19:00	Individual county meetings: Syrian Arab Republic

Thursday, 29 July 2004
Chairperson: Dr Hamid Chekli

09:00–11:30	Group work on plans of action
11:30–13:00	Presentation of the countries' plans of action (Egypt, Morocco, Sudan, Syrian Arab Republic, Tunisia)
13:00–15:00	Advocacy: Towards obtaining the highest level of political commitment and endorsement Regional experience Group work
15:00–16:00	Group presentations
16:00–17:00	Conclusions and recommendations of the workshop
17:00	Closing session

Annex 3

LIST OF PARTICIPANTS

EGYPT

Dr Said Madkour
Undersecretary for Central Administration for Studies and Research
Ministry of Health and Population
Cairo

Dr Esmat Mansour
Undersecretary for Primary Health Care
Ministry of Health and Population
Cairo

Dr Khaled Nasr
Director General for Maternal and Child Health
Ministry of Health and Population
Cairo

Dr Mona Ali Rakha
Director General of General Administration of Childhood Illness Programmes and Child Health Policy Initiative Focal Person
Ministry of Health and Population
Cairo

MOROCCO

Dr Hassan Akhaddam
Head of Planning
Directorate of Planning and Financial Resources
Ministry of Health
Rabat

Dr Hamid Chekli
Head, Infant Health Protection
Directorate of Population
Ministry of Health
Rabat

Dr Abdelhadi Marzak
Ministry of Health Delegate at Meknes
Meknes

Dr Aziza Lyaghfouri
IMCI Focal Point
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SUDAN
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Director General, Primary Health Care
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Federal Ministry of Health
Khartoum

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IMCI National Focal Point
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Primary Health Care
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Primary Health Care
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Ministry of Health

Damascus

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Dr Mazen Khadra
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Primary Health Care Directorate
Ministry of Health
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TUNISIA
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Director, Primary Health Care
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Primary Health Care Directorate
Ministry of Public Health
Tunis

Dr Ridha Djebeniani
IMCI National Coordinator
Ministry of Public Health
Tunis

Mr Mokhtar Dhahri
Focal Point of IMCI Family and Community Practices Working Group
Ministry of Public Health
Tunis

Dr Faten Ben Amar Ben Youssef
IMCI Training
and Head, Neonatal Component in Mother and Child Programme
Primary Health Care Directorate
Ministry of Public Health
Tunis

OTHER ORGANIZATIONS

Aga Khan Foundation
Dr Maher Abou Mayala
Director, Health Programme
Agha Khan Development Network
Damascus
SYRIAN ARAB REPUBLIC

United Nations Children's Programme
Dr Mehoundo Faton
Health/EPI Project Officer
UNICEF/Sudan
Khartoum

Dr Iman Bahnasi
Health Officer
UNICEF/Syrian Arab Republic
Damascus

WHO Secretariat

Dr Hussein A. Gezairy, Regional Director, WHO/EMRO
Dr Jose Martines, Acting Director, Department of Child and Adolescent Health and Development, WHO/HQ
Dr Suzanne Farhoud, Regional Adviser, Child and Adolescent Health and Development, WHO/EMRO
Dr Sergio Pièche, Medical Officer, Child and Adolescent Health and Development, WHO/EMRO
Dr Sumaia Al Fadil, National Programme Officer, WHO/Sudan
Dr Ahmed Nagaty, IMCI Officer, WHO/Egypt
Mr Ahmed El Arousy, Senior Technical Assistant (Network and User Support Coordinator), WHO/EMRO
Ms Suzan El Raey, Senior Administrative Clerk, WHO/EMRO
Mrs Ingi El-Manasterly, Secretary, Child and Adolescent Health and Development, WHO/EMRO

Annex 4

TIMELINE OF SELECTED EVENTS IN THE 5 COUNTRIES

Tasks	Egypt	Morocco	Sudan	Syrian Arab Republic	Tunisia
Task force established	January 2004 [Steering Committee set up in May 2004]	June 2004	February 2004	March 2004	March 2004
Orientation/planning workshop conducted	February 2004		March 2004	February 2004	April 2004
Advocacy meeting for partners	February 2004 Chair: PHC Director		March 2004 Chair: Federal Minister of Health		April 2004 Chair: PHC Director
First draft of the situation analysis report prepared	July 2004	July 2004	March 2004	June 2004	April 2004
First draft reviewed by WHO (CAH/EMRO)	July 2004	July 2004	March 2004	June 2004	April 2004
Second draft prepared	Jul 2004	July 2004	July 2004	July 2004	June 2004
Second draft reviewed by WHO (CAH/EMRO)	(just received)	(just received)	(just received)	(just received)	June 2004

PHC = Primary Health Care; CAH = Child and Adolescent Health and Development unit; EMRO = Eastern Mediterranean Regional Office

Annex 5

CHP TASK FORCE COMPOSITION IN THE 5 COUNTRIES

Egypt

Steering Committee

Chairperson of the Steering Committee

- First Undersecretary for Primary Health Care and Preventive Care sector

Members of the Steering Committee

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

Task Force

Chairperson of the Task Force

- Undersecretary for Primary Health Care

Members of the Task Force

Focal point:

- National IMCI Manager

Other members:

- Undersecretary for Research and Development (formerly IMCI manager)
- MCH director
- ARI control programme director
- Care for children with special needs programme director

International organizations

WHO

Morocco

Chairperson of the CHPI Task Force
Population Directorate Director

Members of the CHPI Task Force
Focal point:
- National IMCI focal point

Other members:
- MCH division director
- Paediatrician (medical faculty)
- National micronutrient deficiency control programme manager
- Breastfeeding promotion focal point
- National EPI Manager

Sudan

Chairperson of the Task Force
Primary Health Care director

Members of the Task Force
Focal point:
- National IMCI Manager

Other members:
- Nutrition department director
- Reproductive health directorate director and deputy director
- National Health Information Centre director
- Health planning directorate director
- EPI manager
- President of the national paediatric association and senior paediatrician of the ministry of health

International organizations
- UNICEF
- WHO

Syrian Arab Republic

Chairperson of the Task Force
Vice-Minister of Health

Members of the Child Health Committee
Ministry of Health:
- Primary Health Care Director
- Child health department manager
- Reproductive health department manager
- Nutrition department manager
- EPI manager
- IMCI manager
- Life style promotion manager
- Head of the child health department in the capital city

Ministry of Education:
- Head of the newborns department of the university paediatric hospital

International organizations
- Nongovernmental organization
- UNICEF
- WHO

Tunisia

Chairperson of the Task Force
Primary Health Care Director

Members of the Task Force
Focal point
- National IMCI coordinator

Other members
- National focal point of the IMCI community component and another member of the IMCI team
- EPI manager
- Perinatal care programme manager
- Epidemiologist
- Nutritionist
- From the field: MCH and PHC focal persons from 2 different governorates, respectively

International organizations
UNICEF

Annex 6

THE 10 STEPS OF THE SITUATION ANALYSIS

1. Identify key resource persons and partners for the policy development process

⇓

2. Collect documents and information

⇓

3. Critically review the information collected

⇓

4. Prepare a draft report on the preliminary situation analysis

⇓

5. Conduct an orientation meeting on the findings of the preliminary situation analysis

⇓

6. Revise the situation analysis draft report

⇓

7. Circulate revised draft report to partners for review, further input and comments

⇓

8. Revise the second situation analysis draft report

⇓

9. Conduct consensus meeting on the situation analysis and present main sections of the policy document

⇓

10. Finalize situation analysis report

Annex 7

MAIN REFERENCES USED BY COUNTRIES

Egypt

Main documents reviewed on trends of child health indicators and assessment of child health programmes

- Achievements and future vision, Ministry of Public Health, 2004
- Egypt Demographic and Health Survey (DHS), 2000 and 2003, National Population Council, January 2004
- Baseline survey, September 1999, IMCI, June 2000
- Annual statistical report 1994-2001, Central Agency for Public Mobilization and Statistics (CAPMAS), 2002
- Annual Statistical Report series, Ministry of Public Health (1/1/2004)
- World Development Indicators Database, April 2004, Word Bank (website)
- Internal reports of MOHP departments and some other organizations

Resource persons contacted for the review on child health indicators

- Undersecretaries for Research and Development, Preventive Affairs, Dental Care
- Director General and staff of Primary Health Care sector programmes
- Director Generals of planning, information, injury prevention, tuberculosis, quality and training at pharmaceutical sector
- Training Director (liaison) at teaching hospitals and institutes organization
- Two representatives of nongovernmental organizations

Morocco

Main sources of information for the review on health system and health expenditure

Ministry of Health

- Demographic and Health Surveys (DHS): 1987, 1992, 1995 and 1997
- Report on achievements for children in the decade of the 90s, 2001
- Analysis of the child situation in Morocco, 2001
- Study of the morbidity burden in Morocco, 2000
- National health accounts, 2001
- National development Plan 2000-2004
- Child health programmes: EPI, CDD, Micronutrient deficiency and ARI
- Integrated Management of Childhood Illness strategy: progress report 1997-2003
- Survey on Causes of Child Mortality: 1988 and 1998
- Report on the Millennium Development Goals (MDGs), 2003

Other sources

- Demographic studies and Research Centre
- Ministry of Environment
- Ministry for the Economy and Planning/ Statistics department

Sudan

Main documents reviewed on human resources

Ministry of Health

A. Health planning and development directorate

- 25-Year Strategic Plan (2004–2028)
- Annual National Health Statistics Report (2002)
- Capacity Building Plan of the States Ministries of Health in Sudan (2003)
- Revision and Standardization of Health care Facilities Levels and Functions (2001–2002)
- Situation analysis of the State Ministries of Health Capacities (Report, 2003)
- Post-conflict Health System Recovery Plan (2004–2010)

B. Human resources directorate

- National Conference for Civil Service Legislation (Report 1994)
- Doctor's Career Pathway and Training Policies(2002)
- Human Resources for Health – Consultancy Report (2003)
- Ten Years Plan for Human Resources Development (2004–2013)
- Sudan Declaration for Nursing and Allied Health Personnel Educational Reform (2001–2015)

C. Primary health care directorate

- PHC Sudan In-depth Review (2001)
- Guidelines on IMCI Pre-service Training For Medical Schools (2003)

Ministry of Higher Education

- 25-years strategic plan (2004–2028)

Resource persons contacted for the review on human resources

A. Health sector

- Directors of Federal Ministry of Health directorates (Planning, Information, Human Resources)
- Director general and directors of PHC programmes (IMCI, EPI, Health Promotion, Nutrition and Reproductive Health)
- Federal Ministry of Health senior paediatrician and president of the Sudanese Association of Paediatricians
- Senior consultants in Public, Military and Police Services
- Director generals of State Ministries of Health

B. Related sectors

- Secretary general of Ministry of Higher Education
- Staff of Medical Schools and Health Sciences Institutes
- President of Medical Specialization Board.

C. United Nations agencies

- Representative from WHO country office
- Representative from UNICEF country office

Syrian Arab Republic

Main sources of information for the review on commitment to children, socioeconomic indicators, and partners

- PAP Child, 1993 (Central Statistics Office, Arab league and other concerned international organizations)
- MICS survey, 1999 (Central Statistics Office in collaboration with concerned organizations)
- Family Health Survey, 2002 (Central Statistics Office, Arab league)
- Syrian national report on the Millennium Development Goals, June 2003
- National End of Decade report on the Childhood Summit (Steering Childhood Committee, Prime Minister Office)
- Study on causes of child mortality (Central Statistics Office in collaboration with UNICEF and WHO)

Tunisia

Main documents reviewed on health systems, including health expenditure

- The situation of children in Tunisia (UNICEF, 2002)
- National Programme of Action for children for the next decade (2002–2011)
- National Report on the Millennium Development Goals
- National report on the monitoring of the global summit for children for the last decade
- Organisation chart of the Ministry of Public Health
- Report on the IMCI review

Resource persons contacted for the review on health systems

- UNICEF representative
- University paediatricians
- Key programme managers and representatives of departments involved in child health
- Representative of school and university medicine
- Nongovernmental organization representatives

Plan of action on national child health policy development: Egypt August 2004–January 2005

Step	Activities	When	By whom
1. Debriefing of Minister of Health on workshop	1.1 Preparation of memorandum	1st week of August 2004	Undersecretary
2. Review and updating of draft situation analysis report	2.1 Based on workshop input	By mid-August 2004	Task Force rapporteur
	2.2 Review of updated report by Task Force	3rd week of August to 1st week of September 2004	Focal point
	2.3 Individual meeting to incorporate corrections	2nd -3rd week of September 2004	Task Force rapporteur
3. Finalization of situation analysis report	3.1 Distribution of report for review to Task Force and Steering Committee	4th week of September – 2nd week of October 2004	Focal point
	3.2 Consensus on pre-final report by Task Force and Steering Committee (meeting)	4th week of October 2004	Undersecretary
	3.3 Sharing of report with EMRO for comments	1st week of November 2004	Focal point and Task Force rapporteur
4. Review of report by concerned partners	4.1 Circulation of report to partners	2nd to 3rd week of November 2004	Focal point
5. Identification of gaps and prioritization of policy issues	5.1 Workshop group	4th week of November 2004	Task Force with partners
6. Orientation of key persons	6.1 Preparation of executive summary for decision makers	1st to 2nd week of December 2004	Task Force rapporteur
	6.2 Individual meetings to orient key resource persons outside MOHP	3rd to 4th week of December 2004	Task Force
7. Advocacy	7.1 Preparation of materials for advocacy	3rd to 4th week of December 2004	Focal point, Task Force rapporteur and EMRO
	7.2 National workshop for decision makers and partners	1st week of January 2005	Chair of Steering Committee
8. Designing of policy document	8.1 Meeting of Task Force	2nd week of January 2005	Task Force and EMRO
9. Formulation of technical committees	9.1 Formulation of technical committees		

Plan of action on national child health policy development: Morocco, August 2004–January 2005

Step	Activities	When	By whom
1. Official establishment of technical committee (composition and terms of reference)	1.1. Issuing and circulating a ministerial circular: - Nomination of a focal point / Population Directorate - Identification of tasks of different members	August 2004	Vice-chairperson of the committee
2. Follow up on the conclusions and recommendations of the intercountry workshop	2.1.Information meeting for the task force (limited group on « child health »)		Vice-chairperson of the committee
	2.2. Preparation and circulation of a memorandum on the meeting		Focal Point
3. Finalization of the situation analysis report and identification of child health policy issues to be included in the policy document	3.1. Development of a plan of action	September2004	Focal Point focal Member Committee
	3.2. Revision of all sections of the national report		
	3.3. Circulation of the draft report to the large committee for review and comments	October 2004	Focal Point
	3.4. Organization of validation meeting		Chairperson of the committee
4. Sharing the report with EMRO	4.1. EMRO comments	November 2004	Focal Point
	4.2. Sharing EMRO comments and recommendations with the national committee members	December 2004	Chairperson of the committee
	4.3. Writing the final report		
	4.4. Organization of orientation workshop for different concerned departments and partners	January 2005	Chairperson of the committee
5. Formal adoption of the report on the situation analysis and of main child health policy issues	5.1. Organization of a workshop to present the final situation analysis report to decision makers (MOH, other departments) and international organizations, to obtain their agreement and commitment	January 2005	Chairperson of the committee and committee members
6. Initiation of the child health policy document development process	6.1. Establishment of the technical committees (identification of terms of reference)	Starting January 2005	Vice-chairperson of the committee
	6.2. Collection of the complementary documents		

Plan of action on national child health policy development: Sudan, August 2004–January 2005

Step	Activities	When	By whom
1. Revision and finalization of the situation analysis report	1.1 Briefing for the undersecretary 1.2 Briefing for the Task Force	First week of August 2004	Task Force
	1.3 Revision of draft report on situation analysis: - Including comments made during the intercountry workshop and restructuring of the report. - including more information for specific areas (e.g. neonatal care, military & police section, private sector and NGOs, surveys underway)	Mid September 2004	Task Force (assignment of tasks to subgroups)
	1.4 Dissemination of the 3rd draft report to EMRO and partners	Mid September 2004	Chairperson
	1.5 Comments from EMRO and partners	1st week of October 2004	Chairperson
	1.6 Meeting to review comments and revising the situation analysis report	2nd week of October 2004	Task Force
	1.7 Consensus meeting (Task Force and resource persons from related sectors)	1st week of November 2004	Chairperson
	1.8 Sharing the report with EMRO for further input	Mid November 2004	Chairperson
	1.9 Finalized report	By end of the November 2004	Task Force
2. Endorsement of the report by all partners, individually	2.1 Dissemination of the report to the partners	1st week of December 2004	Undersecretary
3. Advocacy and consensus meeting	3.1 National workshop to present the final situation analysis report to a wider audience, including high level decision makers	2nd week of January 2005	Task Force, Partners (related sectors/ NGOs) and State
4. Designing of policy document	4.1 Formulation of technical committees	End of January 2005	Undersecretary in consultation with the Task Force

Plan of action on national child health policy development: Syrian Arab Republic, August 2004–January 2005

Step	Activities	When	By whom
1. Reformulation of the Task Force	1.1 Reformulation of task force by: Dr Mazen Khadra PHC Director Dr Khaled Baradie, Head, Child health department Dr Sahar Musleh, IMCI Manager Dr Hend Al-Said, responsible for IMCI Training	1st week of August 2004	PHC Director
2. Revision of the situation analysis report	2.2 Collection of workshop's recommendations and comments and distribution of tasks to the members of Task Force	1st week of August 2004	Task Force:(Dr Hind)
	2.3 Revision of the draft report according to the workshop's recommendations and comments.	1st, 2nd and 3rd weeks of August 2004	Task Force:(Dr Hind)
	2.4 Meeting of the Task Force to review individual report sections.		Task Force:(Dr Hind)
	2.5 Preparation of the 2nd draft report	4th week of August 2004	Task Force:(Dr Hind)
3. Sharing the 2nd draft report with EMRO	3.1 2nd draft report forwarded to EMRO	1st week of September 2004	PHC Directorate (Dr Khaled)
4. Circulation of the 2nd draft to concerned partners	4.1 Sharing of the report with the working team (14 members) for review and comments	1st and 2nd weeks of September 2004	Working Team (Dr Mazen)
	4.2 Meeting of the working team to discuss the report	2nd week of September 2004	Working Team (Dr Mazen)
	4.3 Revision of the report based on he working team's comments		Task Force:(Dr Hind)
	4.4 Circulation of the revised draft report to concerned partners (including the members of the High Committee for Child Health) for review and comments	3rd and 4th weeks of September 2004	PHC Directorate (Dr Khaled)
	4.5 Meeting with partners to discuss comments		PHC Directorate (Dr Khaled) Working Team
	4.6 Meeting with the High Committee for Child Health	1st week of October 2004	Minister of Health PHC Director

Plan of action on national child health policy development: Syrian Arab Republic, August 2004–January 2005 (cont.)

Step	Activities	When	By whom
	4.7 Incorporation of comments into the report	2nd week of October 2004	Task Force:(Dr Hind)
	4.8 Sharing of revised report to EMRO	3rd week of October 2004	PHC Directorate (Dr Khaled)
	4.9 Preparation of the final report	4th week of October 2004	Task Force:(Dr Hind)
5. Identification of policy document elements	5.1 "Extract" the policy issues from the report and put them as an attachment	1st and 2nd weeks of November 2004	Task Force:(Dr Hind) Working Team (Dr Mazen
6. Sharing the revised report with EMRO	6.1 Send the report to EMRO for further comments	3rd week of November 2004	PHC Directorate (Dr Khaled)
7. Finalize report	7.1 Production of final report	4th week of November 2004	PHC Directorate (Dr Khaled)
8. Endorsement of the report	8.1 Endorsement of the reports by all partners individually.	December 2004	MOH (Dr Mazen) PHC Directorate (Dr Khaled) Task Force:(Dr Hind)
9. National workshop	9.1 Preparation for the national workshop	4th quarter of 2004	PHC Directorate (Dr Mazen, Dr Khaled)
	9.2 National workshop to present the final situation analysis report to a wider audience and high-level decision makers	2nd week of January 2005	Task Force:(Dr Hind) PHC Director
10. Decide on the design of the policy document	10.1 Decide on the design of the policy document	3rd and 4th weeks of January 2005	Task Force:(Dr Hind) Working Team (Dr Mazen)
12. Establishment of technical committees	Formulation of technical committee to work on the identified, specific policy document elements	Last week of January 2005	HE Minister of Health PHC Director

Plan of action on national child health policy development: Tunisia, August–November 2004

Step	Activities	When	By whom
1. Revision of the report according to the comments collected during the intercountry workshop	1.1 Revision of the report	End of August 2004	Task Force
	1.2 Sending the final version of the report to EMRO	Beginning of September 2004	Central team
2. Endorsement of the report by all the partners individually	2.1 Sending report to partners	Beginning of September 2004	Central team
3. National workshop to present the final report to a wider audience and to key high level decision makers	3.1 Advocacy meeting on the occasion of the National Public Health days	23 September 2004	Central team
4. Decision on the design of policy document	4.1 Collection of bibliographic documents and preparation of a proposal	October 2004	Central team
	4.2 Workshop with Task Force and partners for discussion and adoption of policy design, and formulation of technical committees	November 2004	Central team