RDO/WP/12.5

Restricted

High Level Expert Meeting on Health Priorities in the Eastern Mediterranean Region

1–2 March 2012

Health systems in the Eastern Mediterranean Region:

situation, challenges and gaps, priorities and WHO contribution

World Health Organization

Regional Office for the Eastern Mediterranean

Contents

Summary

Introduction

1. WHO's Regional Office of the Eastern Mediterranean is preparing to reinvigorate itself to better serve its Member States. This follows the change of leadership in the Regional Office as of 1 February 2012. The renewed effort proposes to focus on several regional priorities of which one is strengthening national health systems.
2. The purpose of this paper is to present an overview of health systems in the Eastern Mediterranean Region, highlight the challenges and gaps, identify priorities, and present WHO's current and future contribution to support Member States in improving their health system performance.

Situation analysis

3. The Eastern Mediterranean Region is a politically volatile region and during the last 10 years at least 10 countries have been or continue to be in a state of occupation, internal conflict or complex emergency. The recent economic recession has further exacerbated the situation and many governments have had to cut the real per capita budget for social services, including health. The recent turn of events in what has been called the 'Arab Spring' is likely to influence health policies, programmes and population health in the Region.
4. The median life expectancy in the Region increased by over 12 years during the period 1980–2007, however, glaring disparities continue to exist across the Eastern Mediterranean Region. The regional burden of disease is estimated at almost 300 DALYs per 1000 population and is second after the African region. Over 50% of the regional disease burden is due to noncommunicable diseases. The infant mortality rate in all low-income countries is unacceptably high, largely due to high neonatal mortality. The maternal mortality ratio was estimated at 220 per 100 000 live births in 2010. Tuberculosis, malaria and HIV/AIDS, are responsible for the major burden of disease due to communicable diseases. The regional average immunization coverage for vaccine-preventable diseases is around 90% for children under 1 year of age. Despite significant progress in poliomyelitis eradication, transmission of the wild virus continues in two remaining endemic countries.

Challenges and gaps in the Region

5. In presenting these challenges, the paper acknowledges that considerable progress has been made by countries in improving the performance of many, if not all, aspects of their national health systems.
6. Leadership and governance in health. The capacities of ministries of health to develop and implement evidence based health policies and strategic plans; formulate legislation and

enforce regulations; efficiently contract out to non-state sector; coordinate/lead on inter-sectoral action; or engage with ministries of finance and planning are limited in many countries. Most national policies have a narrow health care, rather than the wider population health perspective. Few countries are promoting health in all policies. Donor coordination and aid effectiveness is a challenge in low-income and conflict-affected countries. Many ministries of health are not undertaking the 11 essential public health functions.

7. Universal coverage and financial risk protection. There is an absence of national strategic directions for health care financing in many countries; high rates of out-of-pocket payment exist despite efforts by governments to reduce it; there are difficulties of extending social health protection in countries with large informal sector; and wastage of scarce resources occurs due inappropriate priorities, inadequate use of technology to improve system efficiency and poor accountability and transparency. It is difficult to implement social health protection schemes in countries in complex emergencies.
8. Ensuring a well performing health workforce. *Governance, policy and planning*: Multiplicity of stakeholders outside the bounds of the health system and their independent actions are a governance challenge; there is absence of long-term perspective for health workforce planning; health workforce ratios are skewed in many countries; nursing structures in ministries of health need strengthening. *Production and training*: Curricula for different cadres need to be competency based; training programmes for family practitioners need to be harmonized; continuing development of health professionals is not institutionalized; wide variation in the quality of medical graduates necessitates speeding the progress towards establishing national accreditation systems. *Workforce management*: Staff absenteeism is a problem in many countries; task shifting and evolutions of roles for some cadre is lagging in the Region; unplanned and unregulated internal (within) external (outside country) migration remains unaddressed; and regulatory mechanisms and incentive systems are not in place to rationalize dual practice.
9. Universal coverage and service provision. Access to basic health services is a problem in the least developing countries and in countries in complex emergencies; countries have not adequately configured primary health care services to address the double burden of disease due to noncommunicable diseases; quality and safety of health services is an issue in all countries; implementation of family practice as a mode for primary health care service delivery is patchy with no clear progress; and lack of programmatic approach to the emerging issue of the care for the elderly. Key issues related to hospitals are to: improve overall efficiency, avoid user fees and protect the poor, provide effective referral and support to primary health care, and function effectively as autonomous institutions. Patients from some low-income countries spend large sums on medical tourism to seek

treatment abroad. Decentralization of health services has remained ineffective, largely due to inadequately functioning sub-national health systems. Emergency health services are disrupted, especially in countries in complex emergencies.

10. Health technologies. *Medicines*: public sector procurement prices are higher in some countries than the international reference prices; most countries do not have fully functional drug regulatory authorities; irrational drug prescribing, dispensing and self-medication continue to be a problem; procurement of counterfeit medicines is a problem in some countries. *Vaccines*: weak national regulatory authority capacities, low government commitment, lack of funding, absence of long-term strategy for the national production of vaccines, and lack of access to advanced necessary technologies are key challenges. *Medical devices*: major challenges are irrational procurement; inadequate funds for preventive maintenance and repair; sup-optimal use of equipment due to insufficient expertise or non-availability of consumables; and lack of policies and regulations. *Clinical technologies*: laboratory networks and blood transfusion services need rehabilitation, especially in countries emerging from disaster situations.
11. Better information for better decisions. There are weaknesses in health information systems in terms of quality of reporting and timeliness. There is shortage of trained human resources in health information and inadequate investment in technologies. Not all countries have credible registration of births and deaths. Health information systems need to monitor indicators of resources, coverage and health-related Millennium Development Goals and provide disaggregated information to monitor measures of equity. There is a need to invest in institutional capacity development for health systems research, and communication skills of researchers, and to induce demand among policy-makers for more evidence and information.
12. Health systems – barrier or benefit to public health programmes and initiatives? Countries eligible for the support of the GAVI Alliance and Global Fund to Fight AIDS, Tuberculosis and Malaria have not adequately exploited the opportunity to strengthen health systems despite the availability of funds. Health system expertise should be fully involved during transition from early response to recovery and reconstruction in post-emergency situations.

Priorities for the Region

The Regional Office will support countries to strengthen national health systems in the following priority areas:

- moving towards universal health coverage
- ensuring an effective health workforce
- improving efficiency of hospitals

- effective management of technologies
- enabling health systems to be more responsive in emergencies and disasters
- building comprehensive and integrated PHC health services which address population priority health needs
- health system support to public health programmes
- expansion and scaling-up of family practice programmes and development of regional models in family practice.
- access to essential technologies
- strengthening national health information systems
- empowering health systems to tackle social determinants
- improving leadership and governance

WHO Contribution

The Regional Office, led by the Division of Health Systems and Services Development, has been responding to health system challenges in the Region. This was endorsed in 2009 by an independent evaluation report, which acknowledged that the Division has spearheaded important issues, such as trade in health services, contracting, governance, health financing and social health insurance, medical technology, and role of the private sector. The Regional Office has trained nationals in applying analytical tools, such as the national health accounts, burden of disease assessment and health expenditure surveys. Many countries in the Region have a strong tradition of primary health care and by having provided active support and direction, the Regional Office is well positioned and technically prepared to strengthen health systems based on primary health care principles and values. The main constraint is current capacity. The Division is already stretched and it will not be able to meet the increasing demand unless the Organization mobilizes more resources.

The future work of WHO in health systems will continue to be guided by primary health care values and principles. The strategic directions include: unequivocal commitment by the leadership and senior management in the Regional Office to support health system strengthening; establishment of a regional advisory group to advise on health system priorities for the Region; a roadmap to enhance technical capabilities, organizational configuration and financial viability as the premier hub for health system development in the Region; country offices with staff dedicated to effectively support of Member States in the broad scope of challenges related to health system strengthening; more consistent coordination between the three levels of the Organization to streamline and enforce support to health systems in the Region; building of partnerships at the regional and country levels to promote health systems development; and development of a resource mobilization strategy to support health system strengthening in countries as part of an overall resource mobilization strategy.

1. Introduction

WHO's Regional Office of the Eastern Mediterranean is preparing to reinvigorate itself to better serve its Member States. This follows the change of leadership in WHO EMRO as of February 1, 2012. The renewed effort proposes to focus on five regional priorities of immediate concern. These are (i) tackling the burden of noncommunicable diseases; (ii) addressing existing and emerging communicable diseases; (iii) preparing and responding expeditiously during emergencies; (iv) making progress in maternal and child health; and (v) improving the performance of national health systems.

The purpose of this paper is to present an overview of status of health systems in the Eastern Mediterranean Region, highlight the challenges and gaps, identify priorities, and present WHO's current and future contribution to support Member States in improving their health system performance. The paper recognizes that health systems cannot function in isolation, rather they are meant to serve as a foundation for public health programmes and to be resilient and responsive in the face of public health emergencies.

The regional situation analysis has been developed based on the contribution of the staff from the Division of Health Systems and Services Development in the Regional Office. It relies on the review of documents on health systems prepared and presented to Regional Committees over the last 10 years, regional policy papers, meeting reports and review of published literature.

2. Situation analysis of health systems in the Region

2.1 Geopolitical and socioeconomic context

The Eastern Mediterranean Region comprises 22 countries in addition to the occupied Palestinian territory and is estimated to have a population of over 550 million. Despite the geographic continuity, cultural compatibility and common historical background, the Region exhibits a high degree of diversity when it comes to macroeconomic and developmental profiles of its countries which invariably reflects on the status of population health and health systems in the different Member States. A three tier system is being adopted according to socioeconomic status, expenditure on health and health outcomes. (Annex 1) Thus the countries in the upper tier include the GCC plus Libya (oil economies), the middle tier includes Egypt, Tunisia, Morocco, Islamic Republic of Iran, Syrian Arab Republic, Iraq and occupied Palestinian territory while the lower tier includes Pakistan, Afghanistan, Yemen, Sudan, South Sudan, Somalia and Djibouti.

The Eastern Mediterranean Region has been a politically volatile region for over several decades. During the last 10 years at least ten countries have been or continue to be in a state of

occupation, internal conflict or complex emergency.[1] This puts additional demands on already fragile health systems to respond to such challenging situations.

The economic growth rate of countries of the Region has been modest over the past decade and the recent economic recession has further exacerbated the situation, especially in non-oil producing countries. Many governments have had to cut the real per capita budget for social services, including health. In order to maintain the integrity of the public health system, policy-makers have introduced cost containment and cost recovery strategies, thereby jeopardizing the goal of fair financing and risk protection in health.

The recent turn of events in what has been called the 'Arab Spring' in several countries of the Region is likely to influence health policies, programmes and ultimately population health as countries embark on an arduous transition from prolonged periods of dictatorship to become nascent democracies.

2.2 Overview of population health in the Region

The median life expectancy in the Region increased by over 12 years during the period 1980–2007 (Figure 1). Life expectancy in Egypt, Libya, Oman and Yemen has increased by more than 15 years. Countries that recorded the least increase during this period are those that have been or continue to be involved in prolonged conflicts. Despite overall improvements in the health status, glaring disparities exist across the Region. The global burden of disease estimates show that the Eastern Mediterranean Region is second after the African region in the density of the disease burden per 1000 population (Figure 2).

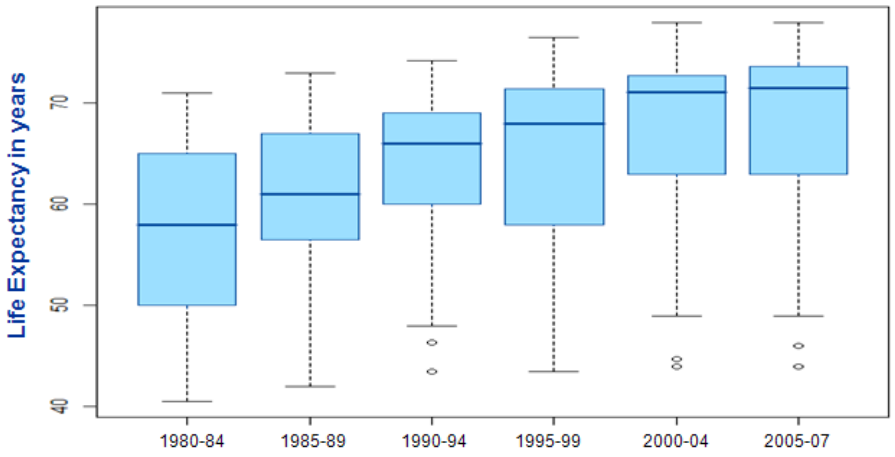
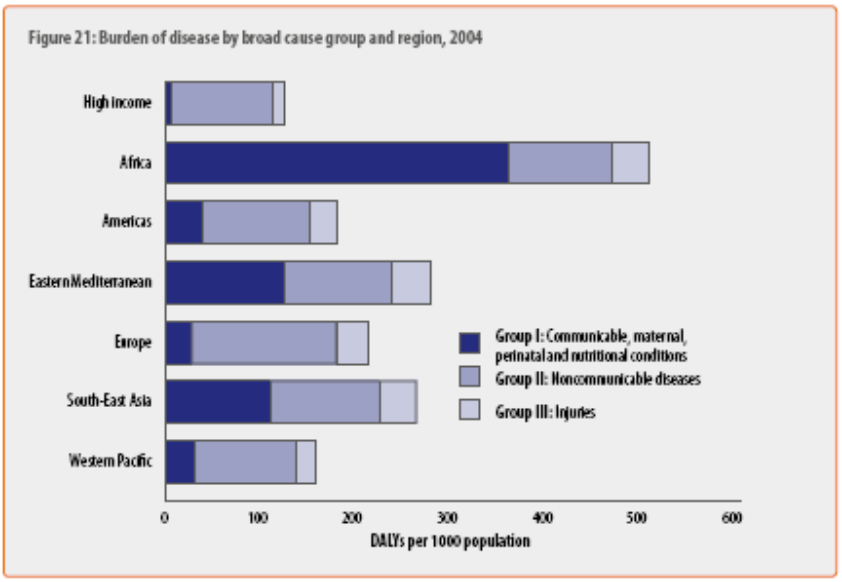


Fig 1 Regional trend in life expectancy in the Eastern Mediterranean Region, 1980–2007

[1] These include - Afghanistan, Iraq, Lebanon, Libya, occupied Palestinian territory, Pakistan, Somalia, South Sudan, Sudan, Syrian Arab Republic, Yemen;

Demographic and epidemiological transition is rapidly impacting on the morbidity profile of the Region. Currently, over 50% of the regional disease burden is due to noncommunicable diseases, and this is expected to increase further by 2020.(*1*) In some countries almost 60% of premature deaths (<60 years) can be attributed to noncommunicable diseases. Cardiovascular diseases and cancer are the leading cause of mortality and morbidity (Table 1). An increasing burden of mental ill health is caused by high levels of stress, particularly in countries in complex emergency situations. Injury and violence prevention has yet to be sufficiently studied and the increasing incidence of road traffic injuries poses a major challenge.



Source: The Global Burden of Disease 2004 Update, WHO Geneva

Fig 2 Burden of disease by broad cause groups and region, 2004

Infant and child mortality has declined significantly in the Region since 1980.(*2*) Despite this reduction, the infant mortality rate in all low-income countries remains unacceptably high. Evidence has shown that a major contributor to the high infant mortality is neonatal mortality or deaths occurring in the first four weeks after birth.(*3*) Growth retardation is a serious nutritional problem in all low and some middle-income countries, and is linked to unsatisfactory infant and young child feeding practices. On the other hand many middle and high income countries have recorded an increased prevalence of overweight and obesity among children.

Despite the reduction in maternal mortality in many high- and middle-income countries, it is unacceptable in the Region as a whole. The regional estimate for maternal mortality ratio was estimated to be 320 per 100 000 live births in 2008.(*4*) More recent estimates show it to be 220 in 2010.(*5*) Maternal mortality in Somalia, South Sudan and Afghanistan continues to be among the highest in the world. The maternal mortality ratio in all low-income, and some middle-income countries of the Region such as Egypt, Iraq and Morocco, is still high.

Table 1. Age-standardized mortality rate for noncommunicable diseases (per 100 000 population)

Country name	All noncommunicable diseases		Country name	All noncommunicable diseases	
	Males	Females		Males	Females
Afghanistan	1285.0	952.7	Oman	757.8	494.2
Bahrain	641.9	551.8	Pakistan	746.9	637.8
Djibouti	878.1	748.9	Qatar	367.5	433.7
Egypt	829.7	660.0	Saudi Arabia	753.1	510.0
Iran (Islamic Republic of)	661.2	506.7	Somalia	996.6	932.9
Iraq	779.5	592.9	Sudan	920.3	859.8
Jordan	817.8	568.4	Syrian Arab Republic	730.4	503.5
Kuwait	395.0	393.6	Tunisia	505.4	404.2
Lebanon	717.4	465.0	United Arab Emirates	448.0	340.0
Libya	743.5	525.9	Yemen	886.8	721.3
Morocco	665.2	523.6			

Source: Global Status Report on Non-communicable Diseases 2010

Tuberculosis, malaria and HIV/AIDS, and hepatitis in some countries, are responsible for the major burden of disease due to communicable diseases. The regional average immunization reported coverage for vaccine-preventable diseases is around 90% for children less than 1 year of age. Despite significant progress in poliomyelitis eradication, transmission of the wild virus continues in the remaining endemic countries (Afghanistan and Pakistan) due to system barriers and security challenges. In addition, the Region remains at high risk for introduction of emerging and other infectious diseases such as dengue fever, H5N1 and cholera outbreaks.

2.3 Health systems in the Region

The countries of the Eastern Mediterranean Region are often segregated into high-, middle- and low-tier countries as well as a sub-group of countries in complex emergencies. Despite many similarities, the form and feature of health system challenges differ according to the development and maturity of the health system. See Annex 2 for an overview of the health system challenges faced by these three groups of countries.

2.3.1. Leadership and governance in health

Governments, through ministries of health and other related ministries and agencies, play an important role in health development, through strengthening health systems and generation of human, financial and other resources. This allows health systems to achieve the goals of improving health, reducing health inequalities, securing equity in health care financing and responding to population needs.(*6*)

Ministries of health are the lead institutions and stewards of the health system in countries. The overall capacity of the ministries of health to provide the vision and direction, ensure

effective legislation, regulation, and set and enforce standards varies across the Region. The most extreme situation in this regard exists in Pakistan, where the government recently abolished the federal Ministry of Health and devolved all functions to the provinces which has led to fragmentation of essential public health functions at the federal level. Many ministries of health are not adequately fulfilling their responsibility to carry out the 11 Essential Public Health Functions as defined by PAHO.[2] A *system* for accountability in health, whether financial or performance accountability, and *transparency* whereby the decisions are made known to the beneficiaries are not well developed or valued by governments in many countries.

In general the capacity to formulate and implement evidence-based health policies and strategic plans is limited, and most national policies have a narrow health care perspective, rather than the wider population health perspective; and few countries have considered promoting health in all policies. Many countries develop 5 year national health plans and have planning units in the Ministry of Health. These units are generally engaged in infrastructure development.

Most ministries of health have not succeeded in *effective regulation* of the expanding for-profit private health sector. In many countries such as Egypt, Pakistan, Sudan and Yemen, legislation for the private sector is either non-existent or obsolete, and standards have not been updated. Many MOHs are increasingly *engaging with the non-state sector* through formal contractual arrangements. There are opportunities for improvement by ensuring that contracting is competitive, transparent, better monitored and achieves the desired results.(*7*) The Ministry of Health, Afghanistan has a Grants and Contracts Management Unit, which is well established.

Ministries of health are generally not promoting intersectoral action on multisectoral health issues such as tackling road traffic injuries or the burden of noncommunicable diseases. There is limited ability among ministries of health to engage with ministries of planning and finance. Donor coordination and aid effectiveness continues to be challenge among countries that rely on external assistance, although most have endorsed the Paris Declaration on Aid Effectiveness.

Decentralization in health has remained ineffective in several countries, Pakistan and Sudan being the prime examples. Among the many reasons are the wavering political commitment, resistance from higher tiers to redistribute authority and responsibility, unclear decision space awarded to lower tiers, and lack of training and capacity at the peripheral level.

[2] Monitoring, evaluation; Surveillance, research, and control of the risks and threats; Health promotion; Social participation in health; Development of policies and institutional capacity; Strengthening of public health regulation and enforcement capacity; Evaluation and promotion of equitable access to health services; Human resources development; Quality assurance; Research in public health; Reduction of the impact of emergencies and disasters

2.3.2. Universal coverage and financial risk protection

The total health expenditure (THE) in the Eastern Mediterranean Region is touching US$ 100 billion, which represents 1.6% of global health care spending for 8% of the world's population.(*8*) High-tier countries comprising 8% of the Region's population account for 40% of the regional THE. Low-tier countries, which account for 48% of the population are responsible for 12% of regional THE. The per capita THE is estimated at US$ 40, 180 and 830 for low-, middle-, and high-tier countries respectively.

Equity studies undertaken in some countries of the Region have shown that up to 5% of households face financial catastrophe following ill health and that half of them are pushed into poverty due to health care payments. When the level of out-of-pocket expenditure (OOP) as a proportion of THE does not exceed 20–30%, it is considered acceptable to avoid extensive financial hardship to families and for risk protection. The average share of OOP as percentage of THE in the Region is more than 40%. When disaggregated by low-, middle- and higher-tier countries it is estimated at 60% or more, 50%, and 20% or less, respectively (Figure 3).

Social health protection has witnessed erosion since 1980s in many middle-tier countries, partly due to market oriented economic reforms, increasing levels of poverty and social exclusion, and declining government commitment for investing in health. Currently, the share of general government expenditure allocated to health, in general, and to ministries of health, in particular, remains low. Two countries in the Region (Jordan and Djibouti) have achieved or come close to allocating 15% of their annual budget to health, a commitment made by countries of the African Union in the Abuja Declaration of 2001 (Figure 4).

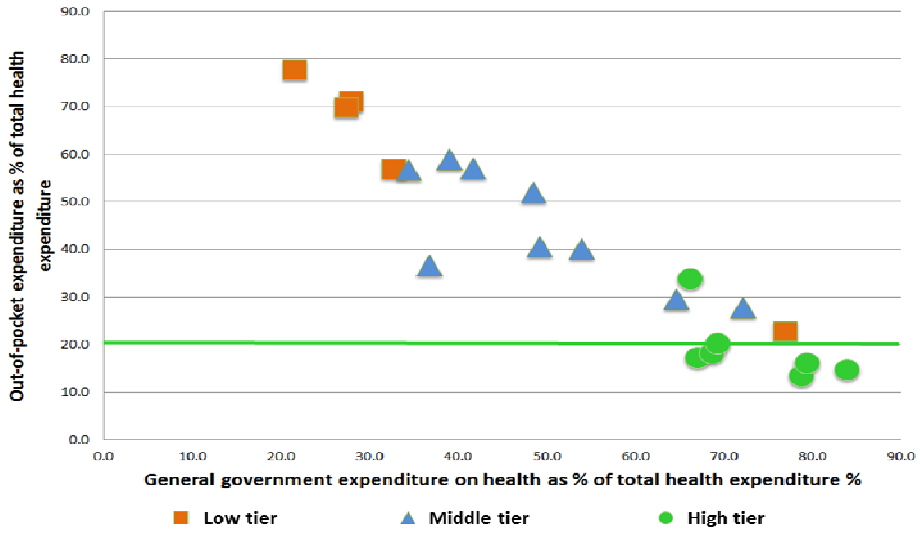


Fig 3 Correlation between OOP and general government expenditures as percentages of THE

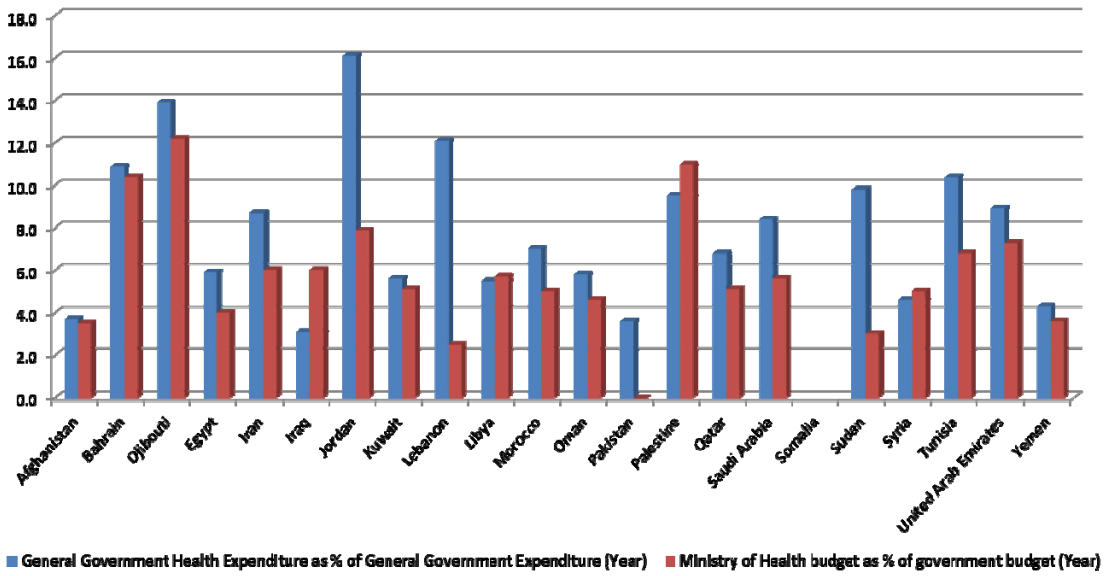


Fig 4 Percentage of general government expenditure/budget allocated to Health and to ministries of health

Following The World Health Report 2010, there has been renewed interest in social health protection globally, which is expected to be espoused by Arab countries undergoing a transition to democracy. Several countries have attempted to move towards universal health coverage and reduce the share of OOP spending by introducing and/or expanding social health insurance schemes. Given the economic profile of the Region, the presence of large informal sectors and high levels of unemployment, employer-based social insurance schemes can at best complement government financing from general revenues.

2.3.3. Well performing health workforce

The Eastern Mediterranean Region has made advances in the development of human resources over the past 30 years. This can be demonstrated in the establishment of educational institutions, professional associations, licensing and certification bodies, continuing education programmes and fellowships, to mention just a few. The current human resources for health situation, based on disaggregation of countries by income level, reveals great discrepancy in the density of skilled workforces (Figure 5). When compared with the threshold defined by The World Health Report 2006 at 2.3 per 1000 population, it stands at less than 1 for lower tier countries and over 4 for middle tier countries.

In the lower and middle tier countries there is significant mal-distribution of human resources for health between urban and rural areas. There is also distortion of the skill mix in the production of human resources for health which favours training of physicians to other categories. The upper tier countries (GCC and Libya) have adequate density of human resources for health, although they heavily rely on expatriate workforces. National plans for increasing

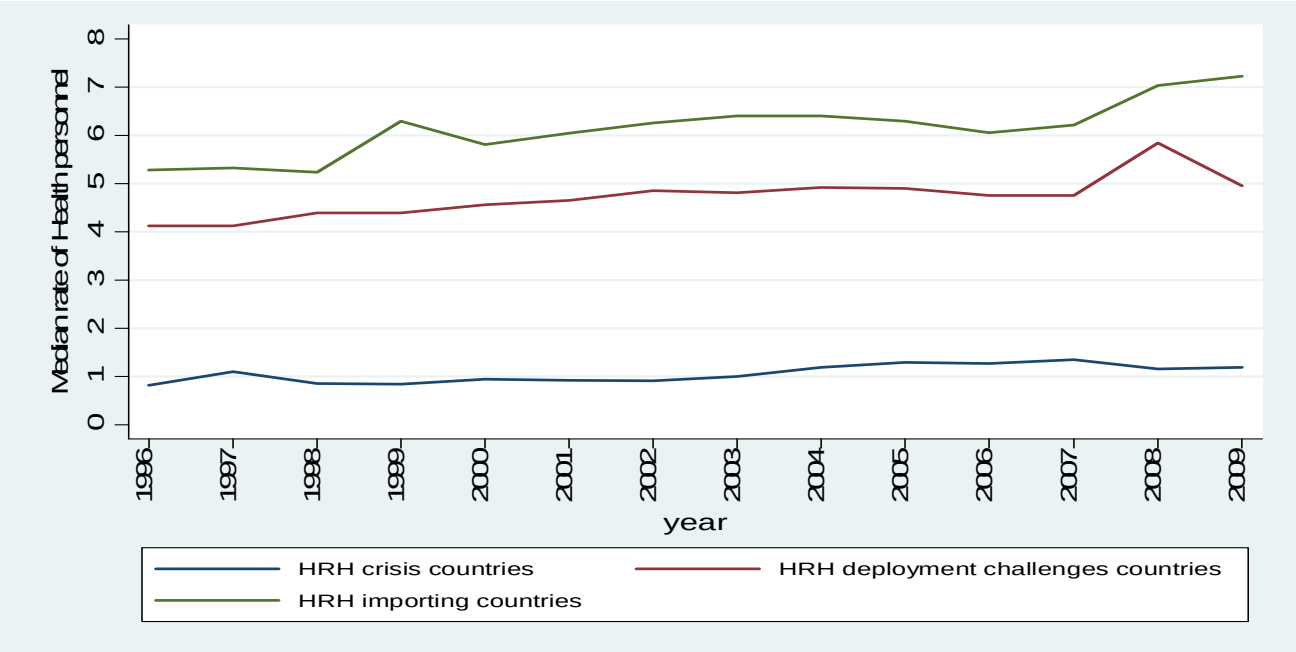


Fig 5 Human resources for health density trends in the three groups of countries, 1996-2009

the training of local human resources for health has led to varying degrees of success. The problems related to strategic planning and management capacity for human resources for health cuts across all countries.

2.3.4. Universal coverage and service provision

Member States have committed themselves to providing health services based on the values and principles of primary health care. This has been reaffirmed on several occasions in the World Health Assembly and Regional Committee resolutions (*9*) and again in 2008/09 in the form of the Qatar Declaration on Primary Health Care.(*10)*

While it is beyond the scope of this paper to provide a comprehensive situation analysis of health services in the Region, the following issues summarize the existing situation:

- Access to basic health services continues to be a problem in most least developed countries and in countries in complex emergencies due to lack or destruction of infrastructure, lack of roads (South Sudan) or security issues (Afghanistan, Iraq), absence of staff, non-availability of medicines, or inability to afford the cost of health care. The Islamic Republic of Iran and Pakistan have expanded access through a programme of community health workers. Many countries have introduced essential health packages at the level of primary health care (Afghanistan, Egypt, Iraq, Lebanon).
- Quality and safety of health services is an issue in all countries. Studies from six countries have demonstrated the prevalence of adverse events/medical errors among in-patients to be up to 18%.(*11*) Many countries have developed national accreditation programmes

(Egypt, Jordan, Lebanon) or rely on accreditation programmes from outside (GCC countries, Lebanon).

- GCC (Bahrain, Oman, Saudi Arabia) and middle-income countries (Islamic Republic of Iran, Jordan, occupied Palestinian territory, Tunisia) have adopted the family practice approach. Problems relate to the training of family physicians, which varies between 6 and 48 months across different countries.
- Population ageing has led countries to move towards home-based care for the elderly. Although some countries, especially GCC and Lebanon have made progress, overall implementation is patchy.
- The proliferation of the for-profit private health sector (Egypt, Lebanon, Islamic Republic of Iran, Pakistan, Sudan, Yemen) reflects on the quality, responsiveness and image of public health services. Large private health sectors are associated with higher out-of-pocket spending in most countries.
- Hospitals consume 60%–80% of the health budget of ministries of health. Many suffer from problems of overall efficiency, poor quality and safety of care, user fees and lack of protection for the poor, inadequate referral and support to primary health care, and insufficient institutional autonomy.
- The limited capacity of district health managers, lack of planning, monitoring and supervision, and limited involvement of communities does not support well-functioning sub-national health systems.
- Integration of care for noncommunicable diseases and mental ill health in the essential service package continues to be a challenge. Many communicable disease prevention programmes have yet to be functionally integrated at the point of service delivery.
- Trade in health services is a recently recognized phenomenon in the Region. In 2003, Yemenis spent US$ 80 million seeking medical care outside the country. In the same year, Jordan generated US$ 600 million by promoting medical tourism. If left unregulated it can have negative implications for both the importing and exporting country.(*12*)
- Emergency health services are often disrupted, especially in countries in conflict and complex emergencies. A system of immediate evacuation from the site of emergency, expeditious transportation, and prompt attention in emergency rooms does not function well in many countries, such as Afghanistan, Iraq, Pakistan, Somalia and Sudan.

2.3.5 Health technologies – medicines, vaccines, clinical technologies and medical devices

Twelve countries have adopted or are implementing national medicines policies. Commercial interests often conflict with the public health priorities for rational use, quality and safety of drugs. Policies for management of conflict of interest and mechanisms to ensure transparency and accountability are also lacking. It is estimated that 30%–50% of all medicines are wasted through irrational use. Access to controlled medicines is low when compared with per capita consumption of morphine in countries in other regions.

Eleven countries have an updated essential medicines list. The procurement prices of medicines in the public domain are high compared to international reference prices and only the GCC countries have implemented a system for bulk purchasing through regional

procurement.(*13*) The majority of countries lack fully functional drug regulatory authorities to guard the quality of imported and local products. Three countries have established autonomous medicines regulatory authorities while another eight have initiated the process. Sale of counterfeit medicines is a major problem in some countries (e.g. Pakistan).

According to sources of *vaccines*, countries can be categorized into: vaccine-producing countries (Egypt, Islamic Republic of Iran, Pakistan, Tunisia); vaccine self-procuring countries (GCC countries, Syrian Arab Republic, Jordan, Libya, Tunisia, Egypt, Islamic Republic of Iran, Pakistan); and countries for whom vaccines are procured by UNICEF and supported by the GAVI Alliance (Afghanistan, Djibouti, Pakistan, Somalia, South Sudan, Sudan and Yemen). Most countries need to establish a well-functioning vaccine regulatory system with an independent national regulatory authority (NRA). Since 2010, Egypt and Islamic Republic of Iran have functional national regulatory authorities. Jordan and Saudi Arabia have established independent Food and Drug Authorities (FDAs) on a path towards developing fully functional NRAs.

The status of *clinical services* (laboratory, blood transfusion safety and imaging) varies among countries. On the one hand, there is lack of such services at the primary and secondary levels, especially in poor and middle-income countries; on the other hand, these are over-supplied at higher levels of care in urban areas in poor and rich countries alike. This is especially the case in countries where the regulatory capacity of the ministries of health is weak and inappropriate use of technology is largely driven by the profit motive of an unregulated private sector. Most countries do not have national regulatory authorities to oversee performance in this area of work.

The majority of countries do not recognize management of *medical devices* as integral to health systems. It is estimated that over 90% medical devices are imported, much of which do not meet the needs of national health care systems and are not used effectively and efficiently.(*14*) Based on the findings of a global survey on medical devices done in 2010,(*3*) EMR countries fall into four groups: countries with efficient management plans (Saudi Arabia, Oman and Jordan); countries with education and training plans but lacking regulations, a system for quality and management, and procurement procedures (Morocco, Libya and Egypt); countries with written strategies, regulations and relevant experience but lacking education and training plans (Iraq, Lebanon and Pakistan); and countries with minimal planning and management (Afghanistan, Sudan and Yemen).

2.3.6. Health information for decision-making

Most countries have very weak national health information systems (NHIS) in terms of reporting quality and timely information, which reflects systemic shortages of resources, especially well trained human resources in the area of health information and statistics, and

[3] *http://whqlibdoc.who.int/hq/2011/WHO_HSS_EHT_DIM_11.01_eng.pdf. So far, 70% of countries of the Region have participated.*

inadequate use of basic technologies and analysis tools. Not all countries have credible registration of births and deaths with causes of death. There is duplication and fragmentation of data collection and lack of rigorous validation within the different programmes.

Based on the Health Metrics Network assessment tool in selected countries, most score either "not adequate at all" or "present but not adequate". Member States of the Region rely heavily on the United Nations estimated mortality figures and only a few countries have reliable national figures generated from the routine or non-routine systems. About half the countries do not produce cause-specific mortality by age and sex, and the quality of the causes of death is far from ideal.

There is need to expand the capacity of health information systems to monitor quality indicators of resources, coverage and new areas, such as social determinants of health and health system performance, and to immediately address the needs for monitoring the health-related Millennium Development Goals and noncommunicable diseases targets. Support for health sector reform in its strategic direction of decentralization will require appropriate capacity of sub-national health information systems to enable measurement of population-based health status, prioritization, planning, costing and budgeting, monitoring and evaluation of health care.

There is a need to develop country-led monitoring and evaluation strategies as part of the national health plans with clear objectives and set of indicators, and to enhance our working relationship with key international partners to ensure the standardization, international comparability and quality of health data.

2.3.7. Health systems – barrier or beneficial to public health programs and initiatives?

There is a growing recognition globally and in the Region that weak performance of national health systems is a major constraint to all programmes that target priority diseases, life-cycle interventions and the achievement of MDG goals. System-wide barriers[4] negatively affect the provision of services and reduce programme performance.

In response, many global initiatives, such as the GAVI Alliance and GFATM, have created health system strengthening (HSS) funding opportunities that cover 12 countries of the Region. In addition, new initiatives support health system building blocks more directly, such as the Global Health Workforce Alliance (GHWA), Health Metrics Network (HMN) and Providing for Health (P4H). The International Health Partnership (IHP+) helps countries develop medium-term strategic plans that would facilitate resource mobilization. Details regarding countries that have benefited from the global health initiatives and the amount of funds disbursed are reflected in Table 2.

Comprehensive national noncommunicable disease prevention and control programmes are still being developed in countries. WHO emphasizes the importance of enabling health systems

[4] System-wide barriers are factors outside the control of public health programmes, such as immunization or nutrition programmes, which affect programme performance

to respond more effectively and equitably to the health-care needs of people with noncommunicable diseases. Many countries in the Region (GCC countries, Islamic Republic of Iran, Jordan, Tunisia) have been able to partially integrate care for noncommunicable diseases and mental illnesses to in their primary health care services.

Health systems can play a critical role both in better preparedness as well as in effective management of emergencies and disasters. WHO country offices in Lebanon and Oman have been active in helping to assess hospital safety indices as a means to better preparedness in the event of an unforeseen disaster. Health systems have an equally important role during the phase of recovery and reconstruction, following the phase of emergency response in the event of disasters.

Conversely, many vertical programmes such as for HIV/AIDS, malaria, tuberculosis and EPI, have the potential to directly or indirectly contribute to HSS. This is especially true since the programmes are much better funded than health systems strengthening initiatives and is best illustrated in the GFATM assisted programmes, where HSS is embedded within disease-specific programme support. Health systems in the Region have to be more opportunistic to benefit from such initiatives.

Table 2. Countries benefiting from global health initiatives

	GAVI (separate HSS window)	GFATM (HSS tied to ATM)	HMN (health information)	GHWA (health workforce)	IHP+ (health systems)
Eligible Countries	Afghanistan Pakistan Somalia South Sudan Sudan Yemen	Afghanistan Djibouti Egypt Iran, Islamic Republic of Jordan Morocco Pakistan Somalia South Sudan Sudan Syria Arab Republic Tunisia Yemen	Afghanistan Iran, Islamic Republic of Oman Sudan Syrian Arab Republic Tunisia Yemen	Afghanistan Djibouti Iraq Morocco Pakistan Somalia Yemen	Djibouti Pakistan
Funds disbursed till end 2011	US$ 62.0 million	USD 793.2 million*	≈US$ 4.0 million	??	---

* Total disbursement for ATM including HSS support in EMR countries (Sources: GFATM, GAVI, HMN, GHWA websites, accessed Feb 2012)

3. Challenges and gaps in the Region

This section summarizes the challenges and gaps that face health systems in the Region, and which WHO should take up as a priority to support health system strengthening. In presenting these challenges, the paper acknowledges that considerable progress has been

made by countries in improving performance of many, if not all, aspects of their national health systems.

3.1 Leadership and governance in health

- The capacity to formulate and implement evidence-based health policies and strategic plans are limited in many countries. Most national policies have a narrow health care, rather than the wider population health perspective.
- The capacity of most ministries of health to formulate legislation is limited. Ministries of health need to improve their capability to regulate the for-profit private health sector.
- The capacity of ministries of health to engage with the non-state sector through formal contractual arrangements needs to be strengthened by ensuring that the process of outsourcing is competitive, transparent, better monitored and achieves the desired results.
- There is limited capacity among ministries of health to coordinate intersectoral action on multi-sectoral issues such tackling road traffic injuries or addressing noncommunicable diseases. Few countries have considered advocating for inclusion of health in all policies.
- In many countries, the political environment has not been conducive to an effective system as far as transparency and accountability is concerned.
- Donor coordination and aid effectiveness is a challenge in countries that rely on external assistance. There is limited ability among ministries of health to engage with ministries of planning and finance.
- Many ministries of health are not adequately fulfilling their responsibility to carry out the 11 Essential Public Health Functions.[5]

3.2 Universal coverage and financial risk protection

- Strategic directions for health care financing are absent in many countries.
- High rates of out-of-pocket payment persist and in some instances are increasing despite efforts by governments.
- Government expenditure on health is low, health financing is fragmented and coordination among national and international stakeholders is inadequate.
- There have been difficulties in extending social health protection to the informal sector, which constitutes a large share of the population in many countries.

[5] PAHO's EPHF - Monitoring, evaluation; Surveillance, research, and control of the risks and threats; Health promotion; Social participation in health; Development of policies and institutional capacity; Strengthening of public health regulation and enforcement capacity; Evaluation and promotion of equitable access to health services; Human resources development; Quality assurance; Research in public health; Reduction of the impact of emergencies and disasters

- Success in rationalizing use of scarce resources, including priority-setting and use of technology to improve system efficiency has been limited.
- Complex emergencies prevail in several countries, which makes it difficult to develop the long-term plans required to provide social health protection to their populations.

3.3 Ensuring a well performing health workforce

Governance, policy and planning

- Governance of human resources for health is problematic due to the multiplicity of stakeholders outside the boundaries of the health system and their tendency for independent action.
- There is no long-term perspective for health workforce planning and workforce plans are not aligned with national health plans.
- Health workforce ratios are skewed in many countries due to over-production of certain cadres (physicians, pharmacists) and under production of others (nurses, technicians).
- There is need to strengthen nursing structures in ministries of health, and develop national strategic plans for nursing and midwifery.(*15*)

Production and training

- Curricula for different cadres need to be competency-based. The training programmes for essential categories, such as family practitioners (physicians and nurses), need harmonization across the Region;
- Countries with a crisis in human resources for health need to scale up production of appropriate types of community health workers.
- A programme for continuing development of health professionals is not institutionalized in many countries.
- National systems of accreditation need to be established/strengthened to assure and improve standards of training institutions and their graduates.

Workforce management

- Staff absenteeism is a problem in many countries due to lack of supportive supervision, poor career development opportunities, and inadequate remuneration;
- Task shifting and the evolution of the roles for some categories, such as nurses, to undertake wider responsibilities such as independent practice, are slow to be implemented.

- Internal migration of health professionals from rural to the urban and from public to private sector, and external migration of deficient cadres (nurses) to countries outside the Region continue.
- Regulatory mechanisms, including incentive systems, are not in place to rationalize dual practice by public sector health professionals.

3.4 Universal coverage and service provision

- Access to primary health care and basic health services is a problem in lower tier countries and in countries in complex emergencies due to lack or loss of infrastructure, security issues, absence of staff, non-availability of medicines, or inability to afford the cost of health care.
- Many countries have not adequately configured primary health care services to address the double burden of disease in the essential service package.
- Quality and safety of health services is an issue in all countries. The prevalence of adverse events[6] among in-patients can be as high as 18% (15).
- Despite the policy to adopt family practice, implementation is patchy in many countries due to lack of harmonized training of family physicians and nurses and inability to shift from episodic to continuous care.
- Population aging has led some countries to move towards home-based care for the elderly. Its implementation is patchy due to lack of a programmatic approach.
- The key issues related to hospitals are to: improve overall efficiency; ensure quality and safety of care; avoid user fees and protect the poor; provide effective referral and support to primary health care; and function effectively as autonomous institutions.
- Decentralization of national health systems in the Region has remained ineffective largely due to inadequately functioning sub-national health systems; limited capacity among district managers; lack of planning, monitoring and supervision; and limited involvement of communities.
- Emergency health services are often disrupted, especially in countries in conflict and complex emergencies, due to lack of a system of immediate evacuation, expeditious transportation, and prompt attention in emergency rooms.
- Patients spend large sums on medical tourism to seek treatment abroad. If left unregulated, this has negative implications for the importing and exporting country.

[6] Adverse event is defined as harm to a patient due to the care received rather than to the disease itself.

3.5 Health technologies – medicines, vaccines, clinical technologies and medical devices

Medicines

- Public sector procurement prices are high in some countries due to procurement of brand name medicines when the generic counterparts are available at lower prices.
- Most countries do not have fully functional drug and vaccine regulatory authorities to guard the quality of both imported and locally produced medicines and biologicals.
- Irrational drug prescribing, dispensing and self-medication continue to be major problems in most countries.
- Procurement of counterfeit medicines is a problem in some countries, with harmful consequences.

Vaccines

- There is low government commitment or awareness, lack of financial resources and absence of long-term strategies for national production of vaccines and acquiring the necessary technologies.
- National regulatory authority capacities are low.
- There are barriers for countries seeking to acquire advanced technology, training or get expert advice in this field.

Clinical technologies

- Laboratory networks and blood transfusion services need rehabilitation in many countries, especially those emerging from disaster situations.
- Quality management systems in laboratories are weak in many countries.

Medical devices

- Lack or ineffective application of existing medical devices strategies and policies (if any) is a serious concern in many countries.
- Technology support to service delivery is hampered by some systemic weaknesses particularly in low and middle tier countries of the region. Under-funded and weakly staffed health systems are negatively affecting the development of the health technology network.
- Problems associated with the management and use of medical devices include: irrational procurement; inadequate funds for preventive maintenance and repair; sup-optimal use of equipment due to insufficient expertise or non-availability of consumables; and lack of policies and regulations.

3.6 Better information for better decisions

- Survey tools – in the area of health examination, system responsiveness, national health accounts and facility assessments, and support for the implementation of national health surveys in terms of methodology, data processing and analysis – need to be developed;
- A common health information system platform, that integrates facility routine data collection systems with surveillance systems, needs to be deployed and supported.
- Networks of regional experts in the areas of international classification of disease (ICD), health information system assessment, research design (survey epidemiological studies and clinical trials) and data analysis are required.
- There is a lack of WHO collaborating centres to further promote the use of ICD and health research in the Region.
- The regional health observatory needs to be expanded for better dissemination and improvement of information transparency.

3.7 Health systems – barrier or benefit to public health programmes and initiatives?

- Countries eligible for support from the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria have not adequately exploited the opportunity to strengthen health systems despite the availability of funds.
- There is need for greater involvement of health system expertise during transition from early response to recovery and reconstruction in post-emergency situations.

4. Priorities for the Region

4.1 Moving towards universal health coverage

Moving towards universal health care coverage and equitable health systems is a priority for most countries, to reduce inequity in health and the relatively high share of out-of-pocket health expenditure and to lessen the exposure of households to the risk of financial catastrophe and impoverishment. This requires palpable progress in implementing social health protection in low and middle-income countries.

4.2 Strengthening health systems based on primary health care principles

National health systems need to be developed based on the principles of primary health care and the Qatar declaration (2008). This will produce comprehensive and integrated health services which address population priority health needs. The delivery of effective and quality primary health care services should be the foundation of the health system.

4.3 Providing health system support to priority public health programmes

National health systems need to effectively reinforce communicable disease, noncommunicable disease, and maternal and child health-related programmes. Weak national health systems are a constraint to programmes that target priority diseases, life-cycle interventions and the achievement of MDG goals. Overcoming system-wide barriers can enable health systems to improve programme performance with better health outcomes.

4.4 Ensuring an effective health workforce

A balanced, motivated, well distributed and well managed health workforce with the appropriate skills mix is critical for any well performing health system. This requires measures at the level of: entry – preparing the workforce through strategic investments in education and effective and ethical recruitment practices; workforce performance – enhancing worker performance through better management of workers in both the public and private sectors; and at exit – managing migration and attrition to reduce wasteful loss of human resources.

4.5 Expanding and scaling up family practice programmes

Countries should commit to and implement family practice as the principal approach for the provision of primary health care services. Many have already adopted this and are at different stages of implementation. Family practice programmes are implemented within a community context and are characterized by patient-centeredness, whole-person orientation, continuity of care, team approach, elimination of barriers to access, emphasis on quality and safety, and a commitment to provide an essential basket or package of services.

4.6 Improving efficiency of public sector hospitals

Hospitals consume 60%–80% of the budget of ministries of health. Hence, it is a priority in all countries to improve their production efficiency, quality and safety of care, referral function and support to primary health care, ability to extend protection to the poor, and institutional autonomy, to assure better performance.

4.7 Ensuring access to essential technologies

Ensuring access to essential technologies in all countries is a priority. Countries need to develop national policies, strengthen regulatory authorities, improve procurement processes, promote rational use, promote good manufacturing practices, and implement good governance initiatives.

4.8 Ensuring effective management of technologies

Countries need to build the capacities of health technology-related staff at all levels for better management of these essential resources.

4.9 Strengthening national health information systems

Strengthening national health information systems – ranging from civil registration and facility records to specialized surveys or health systems research – is a priority to ensure that

reliable, complete and timely information is available and used for public health decision-making and action, including policy making, planning, programming and monitoring. Equally important is to create demand among policy-makers and managers for decisions to be based on information and evidence.

4.10 Enable health systems to be more responsive in emergencies and disasters

Health systems should be prepared to be responsive during acute disasters and to be resilient in the face of complex and extended emergencies. Examples include ensuring the safety of hospitals or enhancing their surge capacity in the event of disasters.[7] Health systems have an increasingly important role during the phases of recovery and reconstruction that follow the phase of emergency response.

4.11 Empower health systems to be able to tackle social determinants

National health systems need to be empowered to address social determinants of health and enhance health equity at the policy level, by promoting health in all policies through intersectoral action; at programme level, by involving stakeholders in programmes that require a multisectoral approach (HIV/AIDS, noncommunicable diseases, road safety); at the delivery level, by ensuring that health services are accessible (provision and financing) for all; and at the community level, by promoting community-based initiatives that reduce poverty and improve health.

[7] The health care system's ability to rapidly expand beyond normal services to meet the increased demand for qualified personnel, medical care, and public health in the event of large-scale public health emergencies or disasters

Specific areas of technical work that the Regional Office would undertake in the priority areas identified above are illustrated in Box 1.

Box 1 Technical areas of work to support health system strengthening

- Improved analysis and documentation of health system interventions and best practices
  - Monitor health equity and social protection status and the options for achieving universal coverage
  - Update countries' health system profiles and using these dialogue with policy-makers;
  - Analyse the challenges and opportunities offered by the expanding private sector in low and middle-income countries
  - Assess the benefit of basic packages of services in countries such as Afghanistan, Iraq, Somalia and South Sudan
- Develop new tools, approaches, modalities and methodologies
  - Appraise tool for health care delivery, utilization and expenditure
  - Adapt models for people-centered primary care, such as the family practice model
  - Develop modalities for advanced nursing practice, including the nurse practitioner cadre
  - Establish an electronic platform for health information systems
  - Develop guidelines for national strategic plans, workforce plans, hospital autonomy and manuals for accreditation of educational programmes and service delivery
- Build capacity in system thinking and skills development
  - Develop a package of modular training on system thinking for WHO staff and nationals
  - Institutionalize capacity-building activities
- Advocate for the right to health and community engagement
  - Develop training and advocacy products
  - Develop capacity in policy dialogue

5. WHO contribution

5.1 WHO's response for health system strengthening in the Region

The Regional Office, led by the Division of Health Systems and Services Development has been responding to the health system challenges of the Member States. This was endorsed in 2009 by the evaluation report of the Office of the Internal Oversight Services (IOS), WHO headquarters.(*16*) The evaluation, which was based on an in-depth review of the Division, visit to three country offices and meetings with counterparts in ministries of health and development partners, positively acknowledged the relevance, effectiveness and efficiency of the contribution of the Division in supporting national health systems (Box 2).

Over the past two years, despite many challenges the Division has continued its efforts to support countries , including the following.

- Policy advocacy for evidence based and equitable health policies;
  - commitment to social determinants of health through intercountry meetings, country case studies, regional contribution to the political declaration on social determinants for health in Rio de Janeiro in 2011;
  - promotion of social protection policies and universal coverage through Regional Committee resolution, interregional meetings and analysis of national health accounts studies;
  - advocacy for family medicine as a strategy for quality and people-centered primary health care;
  - advocacy for innovative approaches in health professional education, including community-based education, problem-based learning and social accountability of education;
  - Quality assurance and accreditation policies for service delivery and education.
- Evidence generation and documentation
  - Annual publication of health status indicators prior to the Regional Committee
  - Updating country health system profiles through the regional health system observatory
  - Updating human resource of health profiles under the human resources observatory
  - Development of essential medicine profiles of countries
  - Studies on aid effectiveness
  - Assessment of the health system in post-conflict situations – Iraq, Saa'da (Yemen) and Libya
  - Technology assessment and development of regional technology profile

Box 2 Excerpts from the Executive Summary of Evaluation Report of DHS, 2009[16]

…"We found that DHS staff in general had high levels of competence. DHS has spearheaded important issues at the regional level, such as on trade in health services, contracting, governance, health financing and social health insurance, medical technology, and the role of the private sector. DHS has also trained Member States in applying analytical tools such as the National Health Accounts, Burden of Disease assessment, household health expenditure surveys, and assessment of health providers. Many countries in the Eastern Mediterranean Region (EMR) have a strong tradition of PHC. By having provided active support and direction to PHC in the Region, DHS is well positioned and technically prepared to build further on its achievements in HSS based on the PHC principles and values. The main constraint to the program is that its current capacity is already stretched. DHS will not be able to meet the increasing demand of Member States unless the Organization mobilized more resources, in particular to strengthen the current insufficient health system staffing capacity of WCOs.

DHS has a good vision for its work in the region. There are nine priority countries based on low income status and/or being in conflict. External factors often influence the ability of DHS to reach out extensively to these priority countries. DHS is actively involved in the formulation of the Country Cooperation Strategies (CCS) and Joint Program Review Missions (JPRM) for biennium planning. The division started carrying out Joint Health Sector Review (JHSR) missions to formulate a comprehensive analysis of countries' health system (HS) performance, and priorities for strengthening it."…

…"The main issues that require attention from senior management, DRD and RD, at EMRO and HQ, ADG/HSS, include the need to: (1) strengthen staffing capacity for HSS in priority countries; (2) have a better coordinated support from the RO and HQ, guided by the needs of the countries through, for example, strategic health system needs analyses; (3) further brief and coach WRs in their role to support HSS in countries; (4) manage synergies between the HS building blocks and the disease programs, thereby putting the PHC approach in practice; and (5) support resource mobilization."

- Capacity-building
    - Health system capacity development workshops for staff and nationals
    - Strategic planning and policy dialogue training for WHO staff in eight fast track countries
    - Short-term consultancies to provide specific health system support to countries
    - 250 fellowships organized annually
    - Guidelines for nursing curriculum, patient safety assessment
    - Accreditation standards for medical education
    - Support for national regulatory authorities for medicines and vaccines

5.2 Strategic directions for WHO contribution to strengthening health systems

5.2.1 Guiding principles for WHO's support to Member States

- Health system development in the Region will be guided by the values and principles of primary health care as reaffirmed by Member States in the Qatar Declaration on Primary Health Care (2008).
- Any effort at strengthening national health systems will be led by the Member States and WHO will provide technical support in the most expedient manner.
- WHO recognizes that it is not possible to support Member States in all areas. Hence its technical support will be strategic, based on its comparative advantages, and guided by the needs of its Member States.
- Collaboration among Member States to benefit from one another's experience and share best practices in health systems strengthening will be promoted.
- WHO's support to health systems strengthening will be an Organization wide support technically led by the Division of Health Systems in the Regional Office, with the involvement of other divisions, country offices and WHO headquarters.

5.2.2 Commitment by the leadership

The new leadership and senior management in the Regional Office will commit itself to health systems strengthening in countries by evolving a strategic vision and directions, advocating with regional policy-makers, allocating (financial and human) resources, helping to mobilize additional resources, monitoring progress and overcoming bottlenecks and constraints.

5.2.3 Regional advisory group on health systems development

A regional advisory group on health systems development will be established to give advice on health system priorities for the region, inform on new challenges and developments, and recommend options for addressing these in countries in order to advance the health systems development agenda. The group will meet annually, representing policymakers, health system and public health experts, researchers, development partners, and civil society organizations.

5.2.4. Division of Health Systems and Services Development

The Division of Health Systems and Services Development has been and will continue to provide technical leadership in advancing the health system development agenda in the Region. In continuing to do so the Division needs to better prepare itself in terms of its technical capabilities, organizational configuration and financial viability to be acknowledged by ministries of health and development partners as a the premier hub for health systems development in the Region. The following measures will help it provide more effective support to health system strengthening in countries:

- strengthen the Division by way of organizational rearrangement;
- improve the profile and ensure adequate staffing in the Division with a wide repertoire of expertise in different areas of health systems;
- expand the roster of short-term health system experts with a wide range of skills and expertise;
- improve coordination among technical units and collaboration with other divisions in WHO for more effective health system support to priority programmes;
- invest in staff development across the Organization to support health systems;
- revitalize health system and human resource observatories;
- accelerate resource mobilization for health systems development

5.2.5. Country offices with dedicated staff in health systems

Country offices are understaffed to fully and effectively support Member States in the broad scope of challenges related to health systems strengthening. Countries with large offices (Afghanistan, Iraq, Pakistan, Somalia, Sudan, South Sudan and Yemen) have one or more international staff. There are 15 such countries in the Region where the Offices are small (Djibouti, Egypt, Islamic Republic of Iran, Jordan, Libya, Lebanon, Morocco, Oman, occupied Palestinian territory, Saudi Arabia, Syrian Arab Republic, Tunisia) or there are no offices (Bahrain, Kuwait, Qatar, United Arab Emirates), and all countries face different health system challenges depending on the level of development and maturity of their respective health systems.

Every small country office should have one national professional officer dedicated to the work on health systems and a team of capable health system experts is needed who are willing to visit countries with or without country offices. In addition, the Division will have to retool itself to expeditiously respond to the demands of more mature health systems of the Region.

5.2.6. Back up and support from WHO headquarters

There is need for more consistent support from WHO headquarters to health systems in the Region. The Division evaluation report has also acknowledged the need for better collaboration between the Regional Office and headquarters to support national health systems. Joint Regional Office and headquarters missions to countries are especially important for engaging in

high level policy dialogue with national policy-makers. Headquarters needs to increasingly involve the Regional Office in its normative and global activities.

5.2.7. Building partnerships to promote health systems development

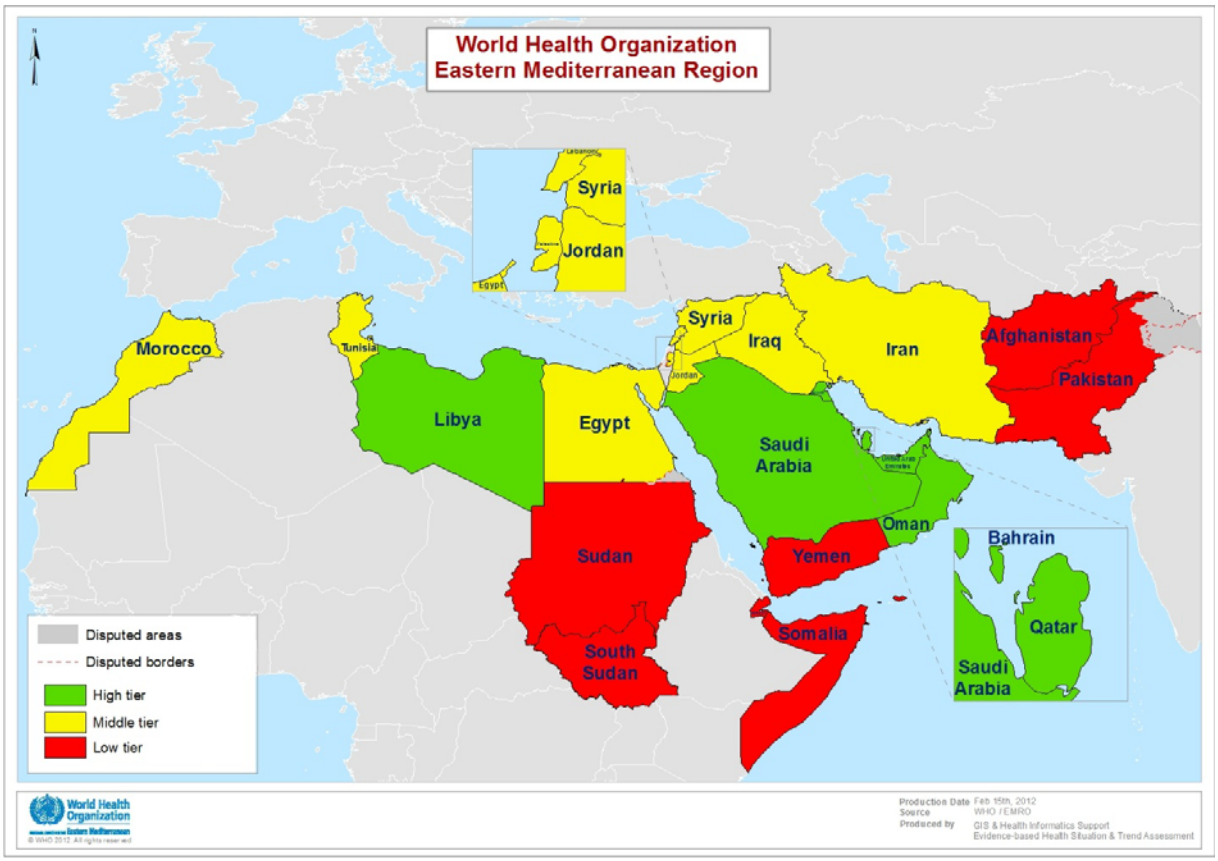
The Regional Office does not have the capacity or resources to provide technical support to countries on all aspects of health systems, hence the need to evolve and sustain partnerships at the regional and country levels. There are many opportunities with development agencies and institutions, within and outside the UN, civil society organizations and academic institutions.

One such example is the establishment of the Eastern Mediterranean Regional Academic Institutional Network (EMRAIN). This network, established with the technical assistance of the Regional Office, supports health system development and is currently hosted at the American University Beirut. A similar network of civil society organizations is envisaged in the future with the assistance of reputable nongovernmental organizations from within the Region.

5.2.8. Resource mobilization strategy to support health system development

The Regional Office will develop a resource mobilization strategy to support health system strengthening in countries by: making a strong case with WHO headquarters for securing voluntary contributions; targeting multilateral agencies such as the GAVI Alliance, Global Fund, World Bank; approaching bilateral donors; and exploring the option of mobilizing funds from within the Region. This will be part of the overall resource mobilization strategy.

Annex 1. Three tier system for classifying countries of the Eastern Mediterranean Region



Annex 2. Health system challenges, by income and crisis status in the Eastern Mediterranean Region

Building Block	Least Developed/Low-income countries	Middle-income countries	High-income countries
Governance	Limited capacity in MOHs for evidence-based policy analysis and formulation and strategic planning through better use of information Inadequate capacity to legislate, regulate and enforce rules and regulations		
Financing	Absence of universal health coverage Inadequate allocation to health to provide for basic package of services High share of out-of-pocket payment compared to pre-payment systems Absence of social protection programmes to cover the informal sector	Absence of universal health coverage High share of out-of-pocket payment compared to pre-payment systems Inefficient health protection programmes	Inadequate financing schemes aiming for universal health coverage that include nationals and expatriates
Health workforce	Poor capacity for human resource planning Inappropriate skill mix to address health problems Lack of trained health and hospital managers System of accreditation of medical institutions not functional	Poor capacity for human resources planning Inappropriate skill mix to address health problems Deficient cadre of trained health/hospital managers System of accreditation of medical institutions not fully functional	Over reliance on expatiate workforce Resources among GCC countries to produce balanced workforce not optimally shared
Service provision	Primary health care services not universally accessible, essential package of services not well implemented Weak district health systems including poorly functioning referral systems Inadequate recognition of the role of the private sector	Inadequate focus of PHC programmes on quality, utilization and responsiveness to the changing disease burden and specific needs of the aging population Escalating costs and limited capacity for cost and cost–effectiveness analysis of health services Inadequate regulation and monitoring of investment in large and complex specialized hospitals and units	
Health information	Poorly functioning or fragmented management information and disease surveillance systems Limited capacity for health system research Available information not used for decisions	Poorly functioning or fragmented management information and disease surveillance systems, Management information and disease surveillance systems need strengthening BOD and NHA not institutionalized	
	Limited capacity for health system research		
Health technologies	Most countries lack national medicines policy		
	Population does not have regular access to essential technologies Lack of appropriate and affordable technologies; Procurement of counterfeit technologies Weak vaccine regulation and weak phramacovigilance system for vaccines	Limited capacity of regulatory authorities to guard the quality, safety and efficacy of medicines, vaccines, clinical technologies and devices Public sector procurement prices are relatively high in some countries Demand for high-tech health services and inappropriate use of technology	
	Irrational procurement, inadequate funds for preventive maintenance and repair, suboptimal use of equipment		
	Irrational drug prescribing, dispensing and self-medication		

* Countries in complex emergencies are faced by additional challenges; including: (i) *Governance:* Weak institutional capacity of MOHs in post-conflict phase in policy/planning, (ii) *Financing*: Limited capacity to efficiently utilize public funds, revitalize social protection schemes; (iii) *Health workforce*: Inadequate policies to attract emigrants home, Absent human resources plan for rebuilding appropriate workforce, Need to revitalize closed or poorly functioning institutions, Over reliance on expatriate workforce, Limited MOHs capacity to coordinate donors and ensure aid effectiveness, and Lack of trained ministerial staff; (iv) *Service Provision*: Ineffective primary care and hospital-based services for handling emergencies, Inappropriate balance between health services provided by public sector and by nongovernmental organizations; (v) *Health Information*: Dysfunctional information systems; and (vi) *Health Technologies*: Lack of fast-track mechanisms for procurement and regulation of technologies for countries in complex emergencies.

References

1. World Health Organization. *Global status report on noncommunicable diseases 2010.* WHO, Geneva 2011 http://whqlibdoc.who.int/publications/2011/9789240686458_eng.pdf
2. *World health statistics*. Geneva, World Health Organization, 2007.
3. Bhutta ZA et al. Education and debate: Maternal and child health. Is South Asia ready for change? *British medical journal*, 2004, 328:816.
4. WHO, UNICEF, UNFPA and The World Bank. Maternal Mortality: 1990 to 2008. 2010, Geneva.
5. Eastern Mediterranean Regional Office, World Health Organization. *Maternal and Child Health in the Eastern Mediterranean Region*. Cairo, February, 2012
6. Eastern Mediterranean Regional Office, World Health Organization. *The role of government in health development*. EM/RC53/Tech.Disc.1, 2006.
7. Siddiqi S, Masud TI, Sabri B. Contracting but not without caution: experience with outsourcing of health services in countries of the Eastern Mediterranean Region. *Bull World Health Organ* 2006; 84: 867-75.
8. Eastern Mediterranean Regional Office, World Health Organization. *Strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015*. EM/RC57/Tech.Disc.1, 2010.
9. Eastern Mediterranean Regional Office, World Health Organization. *Health systems based on primary health care in the Eastern Mediterranean Region: How different will they be in the 21st century?* EM/RC55/INF.DOC.6(a), 2008.
10. Eastern Mediterranean Regional Office, World Health Organization. *Qatar Declaration on Primary Health Care*. Doha, 2008.
11. Wilson R, Giberd R, Michel P et al. *WHO EMRO-AFRO Adverse Event Prevalence Study Aggregated Results for 8 Countries*. Sydney, Australia: Northern Center for Health Care Improvement, 2008.
12. Siddiqi S, Shennawy A, Mirza Z, Drager N, Sabri B. Assessing trade in health services in countries of the Eastern Mediterranean from a public health perspective. *Int J Health Plann Manage*. 2010 Jul-Sep;25(3):231-50.
13. Eastern Mediterranean Regional Office, World Health Organization. *Medicine prices and access to medicines in the Eastern Mediterranean Region*. EM/RC54/Tech.Disc.1, 2007.
14. Eastern Mediterranean Regional Office, World Health Organization. *The role of medical devices and equipment in contemporary health care systems and services*. EM/RC53/Tech.Disc.2, 2006.
15. Eastern Mediterranean Regional Office, World Health Organization. *Promoting nursing and midwifery development in the Eastern Mediterranean Region*. EM/RC55/5, 2008.

Office of Internal Oversight Services, *WHO HQ. Evaluation of Health System and Services Development, EMRO*. Evaluation Report No.08/789, March 2009