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PROCEEDINGS OF THE SEVENTH MEETING OF WHO REPRESENTATIVES

Alexandria, 4-8 June 1989

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN
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INTRODUCTORY ADDRESS

Dr Hussein A. Gezairy, the Regional Director, after a general welcome to the WHO Representatives (WRs), extended a special welcome to new WRs and to the UNDP representative and bade an early farewell to those WRs who may not be attending the next meeting.

New approaches are continually, and successfully, being introduced to strengthen efforts to achieve the goal of HFA/2000: the Basic Minimum Needs (BMN) is one such approach. Others are the Interagency Programme on the School Health Curriculum and a Consultation on Development of Healthy Life-styles to be held in Amman, Jordan, in two weeks time which will be linked with a Regional Committee Meeting.

The Leadership Development Programme (LDP) being conducted in EMRO at present for seven potential leaders is progressing well and this meeting will be used for an exposé of the programme.

AIDS remains a problem, although fortunately not at present a big one in this Region. The only way in which it can be kept low, however, is to treat the subject as one of high priority. WHO is now moving into the development of national medium term programmes.

Since last year there have been developments in CEHA in Jordan and full use should be made of this facility by all countries.

Also, since last year there has been further improvement in EPI coverage, which at the moment is about 71% overall for the Region. By the application of only a little extra effort, in a few countries, it would be possible to increase this figure significantly.

Whilst there are many areas of successful achievement in the Region, there are also some problem areas. Malaria poses such a problem which by its intractability lowers the morale of workers in this field. The parasites are becoming more resistant to chemotherapy and the insects are showing increased resistance to insecticides: DDT is no longer a permissible insecticide.

The economic situation in many countries of the Region shows little improvement on last year. Conflict remains between countries, oil prices are yet not stable and the Organization still faces problems caused by the non-payment of contributions by Member States. However, the single most important issue affecting the financial situation of WHO arose at the 42nd session of the World Health Assembly. This concerned the application of Palestine for membership of WHO and the possibility of the US withholding its contribution from the Organization. Whilst the problem was overcome this year, it was only postponed and will arise again next year. The result of the situation has been a freeze on half of all unobligated funds; the matter has not yet been resolved.

An invitation was extended to Executive Board members to attend our WR meetings, but none has so far been able to do so.

Following the Regional Director's address, Dr J. Jirous, was elected as chairman of the meeting and Dr M.A. Barzgar and Dr A.M. Rahmani were elected as rapporteurs. The agenda and the list of participants are included as Annex I and II respectively.

AGENDA ITEM 1. FOLLOW-UP OF RECOMMENDATIONS OF PREVIOUS MEETING

1. WRs should follow up on any previous recommendations that have not yet been implemented. Subsequent meetings should start by reviewing the recommendations of the last meeting and should make their own recommendations during the discussion sessions.

- This has been included in the agenda and would be included in future meetings.

2. WRs should help countries to develop the type of plan necessary to implement decisions and resolutions of governing bodies which are applicable to it, and report on a six-monthly basis to the Regional office.

- Many of the WRs have succeeded in initiating some mechanism to hold discussions with the national health authorities after their return from the governing bodies. However, many have found the authorities to be reluctant or uncooperative. WRs are asking for the support of the RD by his mentioning the need for these meetings to the national authorities when they meet during the Regional Committee.

3. A national intersectoral HFA coordination committee should be formed in those countries which have not yet done so and efforts made to make this committee functional. Similar committees may be formed at various levels of administration.

- Many WRs found that the HFA intersectoral coordination committee is not workable at the central level but they reported that these committees are much more easily formed, and are completely effective, at the provincial level.

4. WRs are requested to promote understanding and use of the Regional Programme Budget Policy by nationals. In so doing, translation of the document into local languages should be made whenever necessary. Workshops and seminars should be conducted to orient nationals to the content of the document. The Regional Office will translate it into French.

- WRs reported that they have done their utmost to help the nationals to understand and use the Regional Programme Budget Policy and in many cases, have succeeded.

5. WRs should initiate implementation of a plan of work as soon as it has been approved and sticker numbers should then be attributed as soon as possible.

6. Technical divisions should continue to keep WRs informed of short training courses available, especially in the Region, which do not appear in the Directory of Education and Training Programmes of Health Personnel as a regular entry.

- WRs reported implementation of plans of work as soon as approved and receiving information on short training courses for the technical divisions

7. WRs should apply the Regional Programme Budget Policy criteria when screening government requests for supplies and equipment, consultants etc., and indicate that this screening has occurred. In instances where these criteria cannot be satisfied and the proposal is still to be submitted, the reason for submitting it should be given.

8. Before final approval, by the Minister of Health and the Regional Director of the report of the Joint Programme Review Mission, which has been agreed upon and initialled by the head of the national team and the WR, any changes proposed by the Regional Programme Committee or by the Government should be mutually agreed by both parties.

- Also were implemented.

9. WRs will take steps for the implementation of the information framework in their offices and identify any support required from the Regional Office.

- An implementation of the information framework has been attempted in many WRs Offices.

10. The Regional Office will prepare a list of permissible levels of radiation in foods and send it to WRs.

- A booklet on this subject has been sent to WRs offices. RD suggested that this should be read before shelving.

AGENDA ITEM 2. FOURTH ROUND OF JOINT PROGRAMME REVIEW MISSIONS (JPRMs)

Dr A. Khogali, Director, Programme Management, dealt with this subject. He reported that JPRMs have been completed in all but one country, the reports have been finalized for 16 countries and the reports for the remainder are in the process of completion. He indicated that in spite of the Regional Committee's resolution, only six countries have included among their national team, representatives from sectors other than health, and in all cases this has been limited to one member. He also raised the issues of adequate preparations for the review at country level and the full time participation of the national team members in the activities and discussions of the Review Mission.

Comments and Questions from WRs

1. **Technical Guidelines** were found to be a useful tool, most of the WRs commented that these facilitated their task on the preparatory phase as well as in the preparation of the final report.

2. **Preparatory work in the Country.** Only a few WRs reported that this was done properly and on time, the majority complained about difficulties encountered vis-a-vis the project managers or senior staff of the Ministry of Health in the preparatory phase. Consequently most of the mission's time was occupied in evaluating the ongoing programmes. The importance of the preparatory work was emphasized and it was stressed that monitoring and evaluation of the programmes must be an ongoing activity, resulting in an up to date profile for each programme all the time.

3. The participation of other sectors in the JPRM was not encouraged by the Ministries of Health in spite of WRs' insistence.

4. A few WRs complained that the turnover of the national members of the JPRM is quite frequent and as a result, the new members are not wholly familiar with the procedures.

5. It was noticed that in the fourth round of JPRMs, STCs were only occasionally used; instead the professional members of EMRO helped WRs. A few WRs recommended that other WRs should be chosen as members of the visiting team.

6. Most of the WRs complained that the time allocated for the visit of the team was insufficient. It was commented in reply that had sufficient preparatory work for the evaluation of ongoing programmes been done, the time would have been ample.

7. The timing of the visit coincided in many cases with a period during which many other consultants were visiting the country. This had prevented full participation of WRs in the work of the JPRM. It was explained that the countries were given ample notice of the dates of the visit to which they agreed and therefore, it should have been possible for the necessary arrangements to be made avoiding conflicts with other activities.

8. In conclusion, the following items were emphasized:

(a) Updating of programme profiles and reports must be a part of the continuous monitoring of the progress of a programme and should be done by national managers of programmes in the Ministry of Health, under guidance and support of the WR.

(b) Briefing and training of the national officials in advance of the Mission is very important.

(c) WRs should continue to stress the importance of intersectorality of the national team, urging the Ministry of Health to appoint members from other Ministries, Universities and possibly NGOs.

(d) Invitation of other UN Agencies working in the country to the JPRMs was thought to be a useful means of coordination as well as ensuring intersectoral composition.

AGENDA ITEM 3. COUNTRY REPORTS

The WRs made short presentations on the situation in their country of assignment. Current problems, their cause and possible means of solution were outlined, achievements summarized and areas in which WHO assistance would be valuable were given.

Although the country situations are different, there were many similarities between countries and the salient points from each presentation have been combined and summarized.

1. Factors cited as impeding the progress of programmes and creating problems in many countries.

1.1. Frequent changes in senior national officials in the Ministries of Health.

1.2. Insufficient national managerial capacity, lack of any clear division of labour and weak long-term national health plans.

1.3. Allocation of only a small percentage of the budget to health and health-related activities with the result that Ministries of Health are among the weakest branches of government. This situation has been influenced and even exacerbated by the crisis caused by oil price fluctuations.

1.4. Lack of coordination between sectors was a complaint of many WRs as also was the lack of communication between the periphery and central level.

1.5. General resistance on the part of ministries to accept multisectorality of health

1.6. In the majority of countries, the centralized system of management, and in some instances reliance on vertical programmes, are factors that cause serious impediments to progress.

1.7. Warfare and internal conflict in the Region have destroyed the infrastructure in several countries as well as diverting funds necessary for health to warfare, e.g. Afghanistan, Lebanon, Iran, Iraq and Sudan.

2. Factors facilitating progress in the Region are also to be found.

2.1. Increasing political commitment has been obtained, from officials at high levels in government, to the strategy of HFA/2000.

2.2. More awareness amongst political leaders, and people in general, of health and health-related matters.

2.3. The HFA leadership concept has been taken up in some countries of the Region.

2.4. Many WR's reported a general shift towards the inclusion of PHC in the curricula of the medical schools and other faculties of universities. Close cooperation between academic staff and the managerial side of the health system is growing.

2.5. In a few countries, long-term plans for health have been developed and integrated into the general development plans.

3. Encouraging achievements were reported from several countries.

3.1. Progress in the integration of health services into PHC and the abandonment of vertical programmes was reported by several WRS.

3.2. Implementation of the BMN concept has started in some countries and the full involvement of several ministries were noteworthy activities reported.

3.3. There has been considerable progress in the introduction of the action-oriented prototype school health curriculum.

3.4. Progress in the implementation of EPI and an increase in coverage were reported from several countries. Figures in excess of 90% were reported from some countries of the Region.

3.5. Decentralization of responsibility, delegation of authority to the districts in PHC, progress in health education and good coordination of the activities of WHO and UNICEF were policy changes which had greatly helped the programme implementation.

3.6. Successful implementation by WHO of community-based PHC was reported from a few countries. In one country, acceptance of the concept of PHC and its implementation was achieved under very difficult circumstances; now all the countries of the Region are committed to this concept.

4. Community participation was reported to be an increasing trend in most countries of the Region. The general population are becoming more intimately involved in the programmes and are showing an increased awareness of their health needs.

5. The intersectoral approach has not been achieved in many countries of the Region, but gradually and with the persuasions of WHO and effort on the part of WRs, there are signs that this situation will improve.

AGENDA ITEM 4. ADMINISTRATIVE MATTERS OF COMMON INTEREST

Mr R. Helmholz, Director, Support Programme, introduced new professional staff of support programme and then thanked WRs for the suggestions they had made on the content of his presentation. He said that his presentation would be of a general nature; those suggestions which were of a country specific nature could be discussed directly with support programme staff.

4.1. Financial Situation

Recent developments in the World Health Assembly (WHA) had led to HQ advising the Regional office to fix a limit of 50% to obligating the unobligated funds for the Region, with effect from 30 April 1989. As it was not known when this limit would be lifted a conservative approach was taken not involving the WRs and national authorities yet. After fixing the 50% limit, a total of approximately US$ 4 million remained to be obligated on the country programmes and it was felt that it would be possible to proceed without disrupting programmes until the end of June, at which time a more definitive decision was expected from Headquarters, when full information would be communicated to WRs. If the present restrictions were not to be lifted in June/July, the question of where cuts should be made would then have to be considered.

4.2. Contracts for local hire of nonprofessional staff

Mr Helmholz described the present situation whereby a variety of contracts (and sometimes no contract !) were covering the employment of local nonprofessional level staff. He proposed that all such staff be offered, from now on, Temporary Assistance Contracts, the salary being fixed in relation to the standard UN scale to the extent possible.

Exceptions to this level of salary, such as for personnel in location(s) outside the capital/city, could be considered on a case-by-case basis, keeping in mind the potential for solving other problems which may arise as a result of applying different rates of payment for similar kinds of work.

4.3. Financial Monitoring

Mr Helmholz regretted that due to lack of time, this subject could not be discussed, but he requested that WRs provide feedback to the appropriate support programme units concerning any improvement which could be made in computerized information currently provided for financial monitoring.

4.4. General

Mr Helmholz concluded by indicating that the Support Programme was ready to assist the Ministries of Health on administrative matters if requested, (e.g. job description, work, manuals, training etc.).

AGENDA ITEM 5. WHO PUBLIC IMAGE

The presentation concentrated mainly on the fact that there are now three annual events in which WHO can address the public, namely, World Health Day (7 April), World No-Tobacco Day (31 May) and World AIDS Day (1 December).

Three main points were raised: (1) the response to and usability of material produced by Information for these occasions: films, TV messages, kits, slides etc. (2) How to make WHD more prominent as the main event. Should it be marked over a whole week, as is the case in some countries? (3) Intersectoral cooperation and addressing other sectors directly.

The presentation also raised the question of resources and the increased burden on the WR and his staff, as a result of the institutionalization of the additional two events.

Comments were made by WRs on:

- making use of local culture and tradition in marking these events.

- relative strengths and weaknesses of WHO vis-à-vis other UN agencies in public relations activities.

- importance of input of INF/EMRO in organization of local workshops and other activities.

- importance of behaviour of staff members in keeping the image of WHO untarnished.

AGENDA ITEM 6. UNDP PROJECT FORMULATION

1. A presentation was made by Mr S. Kassum, Resident Representative, a.i., United Nations Development Programme (UNDP), Cairo, on the UNDP project cycle which included: Project Identification; Formulation; Appraisal; Approval, and Implementation

2. There was discussion on project identification. Identification in practical terms can be by the Government, UNDP, or an Executing Agency, but it should be stressed that there is no such thing as a UNDP project, only a UNDP supported project. UNDP would check with the Government the relevance of the project vis-à-vis national development priorities which are normally reflected in the country profile.

3. A critical question raised concerned the fact that the health sector operations financed by UNDP had diminished in recent years. An explanation of this situation was given: that this is not a policy of UNDP, rather than that the governments have had other priorities which have required attention, for example in Egypt the external debt and the security situation have been of prime concern so that the programme is much more production oriented and concentrated on agricultural industry. This does not mean, however, that the Government or UNDP do not take health seriously.

4. Linkages in ongoing operations at intercountry, regional and global level and agency regular programme activities as well as those of bilateral donors were clarified. The global programme tends to be mainly research oriented, i.e. aids, tropical diseases, etc. With regard to regional programmes, RBASEP is encouraging intercountry projects to be identified in the field through a mechanism of sub-regional groups of Resident Representatives. There is separate financing for each of these programmes, global and regional.

5. A general presentation was made on project design, and issues of concern to UNDP were emphasized, including alternative strategies raised specifically vis-à-vis the government institutional framework; target beneficiaries and linkages with other multilateral or bilateral operations.

6. A project formulation framework (PFF) is adequate for UNDP appraisal and approval for large scale projects on presentation of :

- field office appraisal;
- regional bureau appraisal (UNDP/HQ);
- presentation for approval to the action committee at UNDP/HQ.

7. Following this, authority is given to the RR to formulate the project document and to sign the formulation that has been made by the executing agency. In clarifying this procedure it was pointed out that a project formulation framework is not necessary. However, to speed up the process through UNDP, RRs would probably prefer to have a PFF in the first instance.

8. A clarification was provided on Preparatory Assistance and Advance Authorization. Advance Authorization is only approved when the signing of the project document is certain but delayed for some unforeseen reasons.

9. The difference between large scale and small scale projects, was explained, especially the nonfunctional parameters governing the delegation of authority to the RR.

10. The project budget is released in total on signature of the project document, or under Advance Authorization. Normally the letter of authorization is given when all the work for the formulation of the project document is being done, and it is awaiting signature.

11. A question was asked regarding the timing of the country programme formulation. It was indicated that the 5th cycle country programme will cover 1992-1997. The formulation would start in the first half of 1990.

12. A question was asked on how the executing agency is selected. The response was that executing agencies are selected on the basis of the sectorial and technical competence which is detailed in the manual.

13. UNDP/OPS (Office of Project Services) is used as an executing agency where a project is multisectoral and does not essentially fit into the field of competence of a specialized agency.

14. A question was raised about monitoring especially regarding the number of reports and revisions required. A clarification was provided that these procedures have been simplified considerably in recent years to reduce the number of tripartite reviews , reports and revisions. However, monitoring and evaluation should be regarded as an integral part of the project.

15. Finally it was emphasized by everyone that in order to enhance coordination it is necessary for all parties concerned to establish and maintain an open and supportive dialogue especially between UNDP and the executing agency.

AGENDA ITEM 7. ORGANIZATION OF NATIONAL PROGRAMMES OF MENTAL HEALTH

In his presentation Dr N. Wig, Regional Adviser, Mental Health, referred to WHO's commitment to mental health from its very inception. In the constitution of WHO adopted in 1946, "to foster activities in the field of Mental Health" is mentioned as one of the 22 functions of WHO. In the Eighth General Programme of Work the first target of WHO Mental Health programme is that "By 1995 at least half the countries of each Region will have formulated policies and programmes for mental health as part of their strategies for health for all".

The Regional Committee for the Eastern Mediterranean in its 35th session in 1988, adopted a resolution (EM/35/R-8) urging all Member States to formulate national programmes of Mental Health. After the guidelines prepared in the intercountry meetings in Amman, 1983, and Damascus, 1985, rapid progress has been made in this field. By March 1989, sixteen countries out of 23 in our Region have taken initial steps to formulate such programmes. In at least six countries it has been approved at multisectoral national workshops and adopted by Governments as part of national health plans. Significant progress has been in the field of extension of mental health care services in many rural areas which were previously completely unserved. By the end of 1988, there were over 150 primary care centres in six countries where essential mental health services were available. Over 1300 doctors and over 3000 PHC workers had received training in mental health in different countries of the Region through WHO assisted programmes.

In the field of health promotion, good progress has been made in the school mental health programme in one country in the Region. However, much more remains to be done to integrate prevention of Mental Disorders in the general health and mental health programmes.

In the subsequent discussions, there was general appreciation of the importance of Mental Health. There was consensus that these national programmes should develop as an integral part of primary health care. The importance of multisectoral collaboration was also emphasized. The need was expressed to rapidly develop appropriate manuals and other training learning material in Arabic and other local languages.

AGENDA ITEM 8. NEW INFORMATION TECHNOLOGIES AND THEIR IMPLICATIONS ON INFORMATION ACCESS AT WRs AND NATIONAL LEVELS

The paper reviewed the Compact Disks (CD-ROMs) new technology as an appropriate means for information access within the Region's settings. Certain WHO health information data bases and services, such as WHOLIS, LILACS and a number of Regional Index Medicus have also been illustrated. An outline of an information policy at the national level was also discussed, based on the availability of the new technology and services.

The discussions referred to certain issues including the present status of National Focal Point Libraries; the establishment of Ministry of Health Libraries and the focal structure at the Ministry of Health level; the coordination between the roles of the various focal points at the national level; the possibility of producing a CD-ROM containing health-related literature generated within EMR and the appropriateness of the new medium in locations where there are frequent electricity cuts. The general consensus was that the new CD-ROM technology represents a revolutionary step towards national access to valid and scientific information.

AGENDA ITEM 9. LEADERSHIP DEVELOPMENT

Leadership "Mini-workshop" discussions on the Leadership Development Programme preceded discussions. Papers on the development of the programme and on problem based learning were given. Summaries are included as Annex (III).

AGENDA ITEM 10. EMERGENCY PREPAREDNESS AND RESPONSE

Papers on the global and regional programmes of EPR were given and followed by a situation assessment. There were also papers on Training and Education and Relief Coordination. Summaries are included as Annex IV.

RECOMMENDATIONS

It was recommended that:

1. In future meetings, more time should be allowed for WRs to discuss their problems with EMR's technical units, either by allocating afternoon time to this activity or by extending the period of stay in EMRO by a few days for this purpose.

2. More time should be allocated for discussion of general problems of WRs, specially those related to their duties in the country of their assignment.

3. Time should be spent more profitably. Presentations should be of a practical nature rather than in-depth expositions of specific programmes or technical subjects which are considered to be unnecessarily time consuming and not directly related to the work of WRs.

4. WRs should try to ensure timely preparation of programme profiles through influencing the national officials to consider monitoring and evaluation of the ongoing programmes to be part of such a preparation. The technical unit should also provide the WRs with early briefing and feedback.

5. Consideration should be given to the inclusion of WRs in the JPRM for a country other than their country of assignment.

6. A one-day seminar should be held by the WR for high-level officials, in the Ministry of Health and other government departments, to brief them on resolutions and decisions of Regional Committee and World Health Assembly requiring action at national level. Attendance at the seminar could be promoted through advanced briefing by the WR for delegates to the Regional Committee and World Health Assembly meetings.

7. WRs should collaborate with other UN agencies, specially with UNDP, in identification/formulation/implementation of health and health related programmes in relation to the funds available under country, Regional and global programmes The invitation of these agencies to JPRMs and attendance at their programming activities, is considered to be a useful means of achieving collaboration.

8. EMRO should assist WRs, in individually justified cases, with training librarians; obtaining help of local information officers; training staff in use of computers; and office activities which would help to strengthen the WR's offices.

ANNEX I

AGENDA

1. Follow-up of implementation of the recommendations of the 6th WR's meeting.
2. Fourth Round of JPRMs
3. Reports of WHO Representatives
4. Administrative Matters of Common Interest
5. WHO Public Image
6. UNDP Project Formulation
7. Organization of National Programmes on Mental Health
8. New information technologies and their implications on information access at WRs' and national levels.
9. Leadership Development
10. Seminar on Emergency Preparedness and Response

ANNEX II

SEVENTH MEETING OF WHO REPRESENTATIVES

Alexandria, 4 - 8 June 1989

LIST OF PARTICIPANTS

WHO REPRESENTATIVES

Dr A.M. Abdul Hadi
WHO Representative for Jordan
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SYRIAN ARAB REPUBLIC

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Sana'a
YEMEN

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Dr N. Al Tawil
WHO Representative
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Dr A. Amini
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Dr M.A. Barzgar
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Dr N. El Gerbi
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Dr M.A. El Yafi
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Dr J. Jirous
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Dr A.M. Rahmani
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Dr D.A. Robinson
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Dr H. Wassef
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DJIBOUTI

Mr T. Zeribi
WHO Representative
Morocco
MOROCCO

WHO REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN (EMRO)

Dr Hussein A. Gezairy, Regional Director
Dr A. Khogali, Director, Programme Management
Mr R. Helmholz, Director, Support Programme
Dr M.H. Wahdan, Director, Disease Prevention and Control
Dr O.I.H. Omer, Director, Health Manpower Development and
Acting/Director, Health System Infrastructure
Dr M. H. Khayat, Director, Health Protection and Promotion
Dr M.I. Sheikh, Chief, Environmental Health Programme
Dr A.M.M. Aly, Acting Manager, Health and Biomedical Information
Dr O. Sulieman, Regional Adviser, Health Programme Development
and Health For All Strategy Coordination

All Regional Advisers and Technical Staff
Heads of Administrative Units
Administrative Assistants

WHO HEADQUARTERS GEVEVA (WHO/HQ)

Dr K. Olavi Elo, Head, Emergency Preparedness and
Response (EPR)
Dr W. Pigott, Programme Manager, Staff Development
Programme (SDP)

WHO REGIONAL OFFICE FOR THE AMERICAS (AMRO)

Dr C. de Ville de Goyet, Chief, Preparedness Emergency and
Disaster (PED)

UNITED NATIONS DEVELOPMENT PROGRAMME

Mr S. Kassum, Resident Representative, a.i., UNDP/Cairo

For Session on Emergency Preparedness:

Dr A. Calvani, Head, WHO Training Centre for Emergency
Predparedness and Response, Addis Abbaba

Dr M. Elmi, Associate Professional Officer, Emergency
Preparedness, Sudan

ANNEX III

LEADERSHIP DEVELOPMENT

In introducing the topic, it was pointed out that the focus was on Leadership Development in the context of HFA, and not on "leaders" or leadership in general. This meant a collective leadership which empowers people. A short summary was given, covering the activities of the WHO HFA Leadership Development initiative, including reference to the technical discussions held during the World Health Assembly in 1988, the background documents of which had been circulated as background reading material for this session. The three questions or issues, why leadership? What can leadership do for HFA? and How can this leadership be developed or enhanced?, which had been addressed in those technical discussions were now used to create a dialogue, with five small groups actively sharing their views and experiences. "Dialogue" had been seen to be a key component of the process of leadership development. To create such dialogue, two periods of group discussion took place, with each group giving a brief report. Their reports were collated, and discussed briefly in plenary. A short video was also shown.

Why Leadership For HFA?

The groups reported that leadership in the context of HFA is needed to motivate people's involvement in development and effect change to close the big gap between the inspiration and objectives of the people and what actually gets done; communicate the concept of HFA; ensure political commitment to a healthy society and enhance the governments ability to take responsibility; coordinate activities and involve sectors other than health; ensure continuation and sustainability, particularly in the presence of rapid turn-over of personnel; innovate; achieve broad based collective leadership; mobilize the health professions for HFA; and mobilize the international sector for HFA. One group pointed out that the term "leadership" is misleading, since it encourages people to think in terms of political leaders rather than the more important and broader issue of collective leadership at all levels in the community.

What can Leadership do in Support of HFA?

The groups reported that leadership can communicate and clarify the strategy and the vision; enable mobilization of resources, people, energy; close gaps; help reorient people in what they are already doing; innovate; improve planning, allocation of resources, management, evaluation and intersectoral involvement; maintain sustainability and continuity and motivate people, working with them, across the spectrum. The role of

women, at all levels, was highlighted. Leadership should be appropriate to the culture and the context or situation. It requires people who are committed and informed, with skills to communicate and initiate change. As well as being caring, courageous, persistent and enabling others to do things for themselves, leaders have the ability to "tune-in" to the situation, to inspire confidence and to facilitate. They work with others and have a learning approach.

Everyone has these capacities, although they may not be at all developed. Some have inherent qualities but not all those with the capacity become leaders. Not all in leadership positions possess the qualities sought for HFA.

How can this Leadership be Developed?

The groups reported that to develop leadership capabilities, people at all levels - in leadership positions in health and in other sectors - (especially those with the potential and opportunity to use the skills and the ability to work with others) be identified. They should be exposed to those with leadership skills, given leadership opportunities, involved in community development, recognized, supported, rewarded and nurtured. This should be done individually and be appropriate to their culture, situation and context. It is a process of learning by doing, finding the strengths that already exist in the people and their environment, and building on these strengths. It requires that an example be set and that there be a shift from the idea of training in classrooms to a process of facilitating peoples' growth and development. In this process individuals are enabled and empowered to become fully involved in the community and can begin to empower others.

The environment is an important aspect and it was noted that in most settings, people moving into leadership positions need survival skills. Information, knowledge of HFA and the process of discussion and dialogue were said to be essential parts of the process.

In discussion, a challenge was raised to WRs WHO staff to look at themselves and recognize the extent to which they can practice the qualities and attributes mentioned, to provide a model and to create the environment in which others are enabled to manifest their leadership potential. A checklist proposed by the participants of the EMRO Leadership Development Programme was discussed, and it was agreed this could be useful for WHO Staff as well. A number of handouts were distributed.

EMRO LEADERSHIP DEVELOPMENT PROGRAMME

There was extensive discussion of the EMRO Leadership Development Programme following a brief review of the objectives and approach.

WRs raised a number of points covering the objectives, including the importance of looking at human resources and human potentials at the community level; the difference between development of management skills and leadership abilities; their agreement with the evolution of the

programme from international health to a stronger focus on leadership and management in health systems and an in the participants own country; their appreciation of the programme as a real pioneer effort and a exercise in HFA.

Concerning the programme, there was a suggestion that the country level experience might be extended, and used more as a starting point. There were some discussions on the situation of the programme in EMRO. Questions were raised about the age of the candidates, the length of the programmes for participants from senior positions, the evaluation of the programme and follow-up and placement of participants on their return home.

The issues of selection and follow-up were also discussed, including criteria for selection and follow-up support (WR and a national "mentor", use of participants in national level leadership development, use of the modules in country, and cultivating the role of the participants as focal points for leadership development and other activities.

In summarizing Dr Gezairy pointed out reasons for placing the programme in EMRO and the benefit of the programme for WHO staff involved and that their involvement was a real form of staff development. He also maintained that there should not be great concern about the placement of participants because the outcome would be the development of leadership skills which will be applied in whatever the situation a participant find himself.

PROBLEM BASED LEARNING - HOW TO FACILITATE THE PROGRESS

The final section was a presentation on problem based learning, which is the approach being used in the LDP. This approach reflects the shift in behaviour required for HFA which has been described as the change on the part of the health worker from the role of a provider, who delivers service to a recipient community, to the role of facilitator, with the people in the communities becoming the actors and eventually the prime movers. The learning environment must reflect this shift and problem-based learning is a tool to enable the learners to develop self-reliance as they become the key actors responsible for their own learning; and those who would help them shift this behaviour must themselves act as facilitators. Reorienting people in leadership positions or helping them to develop appropriate leadership attributes and behaviour depends more on the manner in which that is done rather than on what is done. The process is more significant than the content.

ANNEX IV

EMERGENCY PREPAREDNESS AND RESPONSE

Following the devastating effects of the disasters in Bhopal and Chernobyl, famines in Sahel, earthquakes in Mexico and Armenia, floods in Bangladesh and epidemics in West Africa, the importance of disaster preparedness and response is globally recognized.

Dr Elo introduced the WHO Global programme which, along with regional programmes is gradually increasing its involvement in the promotion of disaster preparedness in Member States, in the development of training programmes and training materials and in support of national training, in establishment of situation assessment capacity and information and communication networks, in production of guidelines and materials, in coordination of disaster activities together with other UN organizations as well as in emergency missions.

The objectives of WHO's emergency preparedness and response programme are:

- to promote and strengthen emergency preparedness in the Member States;

- to provide timely and appropriate response to emergencies in collaboration with Member States and other organizations.

The EPR Regional programme was introduced by Dr Gebreel. The main activity of the Regional Office is to help the countries of the Region to formulate their national plans and to start training and education programmes in the Region, particularly to provide appropriate training Material and assistance to countries. In preparedness areas, not only are natural disasters included in the programme; man made disasters, like petrochemical catastrophes which are unfortunately more likely in this Region must also be taken into consideration, along with the environmental effects of these disasters. The human element arising from psychosocial effects has also been taken into account.

Included in the programme are the establishment of a Regional Collaborating Centre, a Regional Emergency Supplies Store and a data bank of relevant information.

Dr Gebreel highlighted some of the Regional activities in EPR which ranged from Regional workshops to country specific activities.

A revised version of the WHO manual in EPR for WRs was reviewed by Dr Elo.

Dr Jousela discussed Situation Assessment and Problems in Information and Communication.

The basic questions for the assessment of the situation are: the extent of the geographical area affected, the impact on housing, roads, communication and on agriculture and livestock. The characteristics of the affected population should also be assessed to find out distribution by age and sex, the physiological status and social and ethnological aspects, like taboos and mores of the affected population. Information on the present status of relief supplies and stocks and the impact of the event on the health sector should be evaluated as well.

Initial assessment should answer these questions. The existence of a pre-disaster plan will help in evaluating the situation and estimating the needs. This assessment should also include a plan for appropriate response.

The first stage assessment performed by a team consisting of health personnel, logistics specialists, engineers, water supply experts, nutritionists and/or other relevant experts, should be followed by a more detailed second stage assessment.

Communication during the initial phase of a disaster is unlikely to happen by using telephone lines, which if not damaged, tend easily to be jammed. All international communication should be sent as written records (through teleprinters, fax or computer networks) to ensure the accuracy of information. Amateurs' radio service and citizens' band radio service can be used as well, especially to collect the information from the disaster stricken area.

The proper information is then to be sent to the Regional Office and other UN agencies, not forgetting NGOs and other relief agencies. Among the relief institutions and agencies a lead agency for disaster relief should be nominated. This is necessary for appropriate and quick response.

The development of human resources is a key factor to disaster management and Preparedness Training and Public Education were dealt by Dr de Ville de Goyet.

Whilst stocks of necessary supplies for emergencies are important, the development of human resources is now a key factor for disaster management rather than further stockpiling of equipment.

In developing human resources, one of the first questions to consider concerns the identity of those having a role in the provision of essential health assistance during an emergency situation. However, the list of those to whom training should be given is long because many disciplines have to be mobilized and they must work closely with many other key sectors.

The training programmes aim to progressively broaden their audience to include:

Health professionals, almost every discipline.

Special non-health professionals, fire, police, armed forces and in particular in the mass media, where prior exposure to the realities of disaster could prevent the dissemination of myths and, as well as helping to concentrate effort effectively, could reduce ineffective uses of facilities.

Local communities, where problems must be solved before outside help arrives and where long term effects remain when the assistance has withdrawn after the acute phase has passed.

Schoolchildren and their teachers are very receptive to simple health preparedness.

WHO staff members constitute a large worldwide force from every discipline and with ideal connections in health ministries. By reorientaton of their activities they could become invaluable helpers in emergency situations.

Dr de Ville de Goyet dealt with ways of carrying out the training, but stressed that the role of WHO is to train trainers rather than provide training programmes within countries.

Reports from Sudan, Afghanistan, Somalia, and Lebanon were presented which outlined the nature of the emergency and the role adopted by WHO.

In Resolution 42/169 of 11 December 1987, the General Assembly decided to designate the 1990s as a decade in which the international community, under the auspices of the United Nations, would pay special attention to fostering international cooperation in the field of natural disaster reduction. The objective of this Decade would be to reduce, through concerted international actions, loss of life, property damage and social and economic disruption caused by natural disasters, particularly in developing countries.

Dr Elo discussed WHO's role during the International Decade for National Disaster Reduction (IDNDR): its global role as a coordinating authority on international health work, and its regional activities in support of country level action. These are given in great detail in the papers circulated during the meeting.