EM/WR/024/R/E

Report on the

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

Cairo, Egypt
22–25 February 2009

World Health Organization
Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The twenty-fourth meeting of the Regional Director with WHO Representatives (WRs) and Regional Office staff was held in Cairo, Egypt from 22 to 25 February 2009.

2. OPENING SESSION

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, welcomed WHO Representatives and Regional Office staff, as well as colleagues from UNRWA, the Centre for Environmental Health Activities (CEHA) and WHO headquarters. Referring to the recent Israeli aggression in the Gaza Strip, he acknowledged the excellent work of WHO staff in the Gaza Strip and throughout Palestine, as well as the efforts the emergency and communication units and all concerned staff in the Gaza crisis.

Turning to the theme of the meeting—enabling environments—he noted that the selection of this theme emanated primarily from the forthcoming introduction and application in the Region of the Global Management System (GSM), as well as a number of other important and challenging human resources and financial management, security and administrative issues. The concurrent development of the Global Management System and the establishment of a global service centre were major undertakings, with profound impact on organizational structure, working methods, work flows, processes and procedures. The Secretariat was committed to moving forward with these reforms to improve efficiency and effectiveness at all levels and to modernize its systems. Management reform could not be implemented without the commitment of staff.

A decentralized management system would be a strength but would be achieved only if responsibility to deliver the expected results was aligned with an appropriate delegation of authority and full accountability against the authority delegated. WHO programme management would continue to be strengthened through joint programming, the development of unified management tools and guidelines supported by modern technology, and enhancing communication at the three levels of the Organization.

Concerted efforts would continue to be made to strengthen the mechanisms and systems governing resource mobilization and allocation, with all related information shared in a transparent way. Country Cooperation Strategies (CCS) would be a key instrument to align WHO's work with national priorities and harmonize country programmes with the UN system and other development partners. The nature of global health had changed dramatically in the past two decades, bringing in many actors with a unified approach to expand responses to global health needs. Global health partnerships had been established to raise visibility and provide common platforms for working together by combining the strengths of public and non-state organizations and civil society.

The renewal of primary health care was now well under way at the global level. The Regional Director noted the successful meeting in Qatar in November 2008 and the importance of the Qatar Declaration on Primary Health Care. The importance of social determinants of health and partnership had not yet pervaded the work and practices of many

health partners, and forceful advocacy for health promotion and protection in relation to health and environment, nutrition, basic housing and poverty reduction were not on their main agenda. The demography of countries had changed. In high-income and middle-income countries the demand for better quality health care had increased, putting a huge burden on government. At the same time, basic health care in the least developed countries was still inadequate. The renewal of primary health care provided WHO Representatives with an exciting technical, institutional and managerial challenge to broker a workable national vision.

The difficult task of taking forward this and other agendas, and maintaining the quality and standards of our work, was against the backdrop of the dire financial crisis affecting the entire world. The challenge would be to assist the countries of the Region to minimize the negative impacts on national health development. In countries that relied heavily on external assistance, it would be important to support or initiate an assessment process for projecting the potential reduction of external support to the health sector, in collaboration with our UN partners, and also to help ministries of health to do the same for assessing the deficit from internal, and particularly government, allocations.

The programme of health promotion and protection, he said was not receiving the rigour and priority that it deserved in a number of countries. This was particularly crucial for primary health care renewal. Communicable diseases remained a priority in many countries and the risk of pandemic influenza continued to be serious. The Regional Office would strengthen collaboration with Member States and other agencies in developing national preparedness plans, in highlighting the shared responsibilities and in tackling key issues. Tuberculosis, malaria, HIV/AIDS and other diseases of poverty continued to burden the low- and middle-income countries, the main challenge being how to strengthen health systems in order to develop the necessary integrated approach and cross-cutting activities. Focus on neglected tropical diseases needed to be increased. The final stage of polio eradication was critical. External factors, including security, had hindered work. It was clear that success would require renewed commitment and the involvement of everyone, as well as innovative actions to address the remaining obstacles.

The Regional Director concluded by noting the challenging task ahead and the aim of meeting the increasing demand for a stronger WHO leadership and coordination role for the health sector, as well as for closer collaboration with all sister agencies and stakeholders to fulfil its mandate.

3. ELECTION OF OFFICERS

Dr Houssain Abou Zeid was elected Chair and Dr Ghulam Popal, Vice-Chair. Dr Sameen Siddiqi, Mr Hatem El Khodary and Mr Peter Graaff were elected rapporteurs. The Vice-Chair and the rapporteurs were requested to follow up and report back at the next meeting on implementation of the recommendations.

4. ADOPTION OF THE AGENDA AND PROGRAMME

The draft agenda and programme were adopted. The agenda, programme and list of participants are given in annexes 1, 2 and 3, respectively.

5. FOLLOW-UP ON RECOMMENDATIONS OF THE LAST MEETING

The report on the follow-up of the recommendations of the previous meeting was introduced and WRs were requested to provide the secretariat with comments (if any) on the report during the next few days.

6. ENABLING FUNCTIONS

6.1 Introduction on the theme of the twenty-fourth meeting: "Enabling functions"

Dr Abdallah Assae'di, Assistant Regional Director

The theme of the meeting was "Enabling functions". Dr Assaedi noted that the global health context within which WHO operates continues to change. The 11th General Programme of Work of the Organization reflects upon the most important forces affecting health now and for the next 10 years, highlighting areas for collective action to address the challenges these represent. Acting as the directing and coordinating authority on international health work, WHO focuses its work around six core functions.

The core functions are not carried out to the same extent at all levels of the Organization, or across all programmes. The political and development context in which each office works varies. Technical programmes are also of a differing nature, ranging from those that contribute to health outcomes, those that are linked to determinants of health, those that aim to strengthen health policies and systems, and those that enable the Organization to effectively deliver its programmes. WHO's governance mechanisms and organizational structure aim to harness this diversity, making it truly "one" Organization. WHO's operating model is based on the premise that managerial and administrative functions serve to enable the optimum delivery of technical health programmes, in support of Member States.

Increasing effectiveness and efficiency is also about doing things "in the right place". This requires better articulating the roles of the different levels of the Organization and constantly reinforcing the need for the three levels of the Organization to work effectively together, i.e. countries, regional offices and headquarters. More concretely, there is a strong drive in the Organization today to bring resources closer to where programmes are being implemented. This translates into a significant shift of the Organization's resources to countries in order to strengthen WHO's capacity to support countries.

Since 2000, WHO has been implementing a results-based management approach. The Results-Based Management Framework (RBMF) is a logical and structured approach to define what the Organization will do and aims to achieve, how it will do it and what resources are required to achieve those results. As such, it encompasses planning, budgeting, monitoring

and evaluation, and is a key instrument for advancing the process of change and reform in WHO. Results-based management enables the Organization to better demonstrate results and exhibit a greater focus within and across programmes; to improve the targeting of resources and the integration of all sources of funds; and to demonstrate greater transparency and accountability of programme management.

Being a knowledge-based Organization, WHO's greatest asset is its staff. To maintain its leadership role in the public health field, WHO needs to attract and retain talented women and men from all countries. It must thus be both a competitive and socially responsible employer, which mirrors its own principles and standards in the workplace. WHO needs to be effective in a variety of settings and must have a versatile, productive and motivated workforce, dedicated to the Organization's ideals.

Human resource policies, systems and services aim to reflect the Organization's strategic objectives and be responsive to evolving needs, particularly at the regional and country level. It also strives to provide a supportive and enabling environment for staff to deliver WHO's programmes across the world.

WHO has a commitment to provide a work environment in which: staff are able to maintain a healthy work–life balance; efficient and fair mechanisms are in place to address staff concerns; efforts are made to manage stress effectively; harassment is not tolerated; and staff management relations are based on mutual respect and consistency of approach across the Organization. A supportive workplace is not just an ethical requirement; it makes good business sense as it positions WHO as an employer of choice and helps the Organization to attract and retain the talent it needs to deliver its commitments to Member States. Managers are key in ensuring these directions are adhered to.

Successfully financing the Organization is about ensuring the Organization's needs, priorities and gaps are met with the appropriate resources. It is as much about having sound financial principles and policies, as it is about having the capacity to mobilize resources and efficiently channelling these resources to where they are most needed. As voluntary contributions become an increasingly important share of our budget, and as the global health landscape increases in complexity, a more strategic and coordinated approach is required to ensure WHO's Programme Budget is effectively financed.

Although overall resource requirements are approved by the World Health Assembly, resources reach the Organization at different times, with varying degrees of specificity, and must be considered within an existing programmatic and financial implementation context.

The effective management of financial resources on a day-to-day basis is the responsibility of all managers that have responsibility over budget lines and associated work plans. They must monitor the resources they have been delegated, how they are being spent and are accountable for achieving the results. Areas of Work networks, under the overall coordination of a global focal point, can facilitate this by ensuring a continuous link between programme implementation, needs and required resources across different levels of the Organization. Efforts made in recent years to improve administrative and managerial

efficiency have been limited by the existing computerized information systems for administration and management. The Global Management System aims to facilitate the transformation of WHO's vision for more efficient and effective ways of working across the Organization into reality. It will replace the existing fragmented computerized information systems with an integrated system for global management and administration.

Infrastructure and logistics support are the invisible backbone of the Organization, equally essential to the support of programme delivery. Staff security is critical to the functioning of the Organization and is a key priority of WHO. All staff in all WHO offices must be able to work in a secure environment. WHO actively participates in the United Nations Security Management System, including contributing to the development of policies and procedures and overseeing their implementation and compliance.

Accountability and oversight are essential elements of any well functioning organization. This becomes even more critical in an organization working in a results-based environment, which is performance bound rather than an administrative culture in which work is rule bound. The accountability framework sets the scene in terms of the authority, responsibility and accountability of all staff; and the oversight framework operates as a control mechanism. Accountability operates at a collective and individual level. The Secretariat is collectively accountable to a number of different stakeholders outside the Secretariat, in particular Member States in their capacity as the World Health Assembly who approve the Programme Budget that gives the Secretariat direction as to what is to be done, i.e. expected results; and in their capacity as the beneficiaries of the work of the Secretariat, in other words, the achievement of the Secretariat's responsibility; and Member States and other providers of funds for the proper use of those funds according to the approved Programme Budget. Accountability means being liable to be called to account. For example, staff have a responsibility to respect and follow internal policies and procedures as much as those mandated by the governing bodies. There is in addition, a more general accountability that all staff have as international civil servants, as well as that which is inherent in their status as a staff member who is required to follow the direction of the Director General.

6.2 GSM: status, transition and the way forward

Mr Martin Peter Catterall, Director, Information Technology and Telecommunications and *Mr Martin Valois, GSM Project Management Office*

Mr M. Catterall reviewed the current status of implementation of the GSM in headquarters and the Western Pacific Region. He noted that operationalization of the system was approaching normality but was not there yet. He outlined the stability criteria for further regional rollout, most important of which related to the readiness of the Region, especially in relation to data and training, as well as stability of the system itself.

Discussion

It was noted that the system had been more than five years in the making so far. It represents a serious change for any organization and although serious delays have been experienced this is not unusual for a project of this kind. Other UN agencies have instituted

similar systems and the UN itself was in the process of planning such a change. Although the company contracted to integrate the Oracle product into the system (Satyam) has faced major difficulties following the resignation of its chief executive on fraud charges, the staff have continued their commitment to the project with no change in productivity, and the government of India is backing the company. The project consequently is not in jeopardy. The Executive Board has expressed its satisfaction with the transparency of the system.

A lot of preparatory work is still needed at regional level. Project plans include steps that have to be taken in order for the work to take place. The Region will have to assess its own readiness. The original cost provision for global rollout of GSM of US$ 55 million includes the Region; the funds have been rolled over from biennium to biennium. It was acknowledged that the transition solution is not working well, partly because it was not originally envisaged that this would be required beyond a short period of time. It was also acknowledged that work at country level has been impeded by the difficulties faced by implementation at headquarter's level. However, once the system is rolled out in the Region it is expected that many of the problems will have been solved. Once testing is complete, use of CAMS will be discontinued and there will be no fallback system.

Among the lessons learnt from rollout in WPRO and the problems that had to be overcome were: the importance of data cleansing; the need to learn new processes; the perceived erosion of delegated authority; the need to understand new business processes and accommodate them to the demands of work at regional and country level; and inclusion of fellowships. Procurement and travel functions are now working well but there are still problems in the human resources function. Once the workflow processes are defined it is not possible to change them and therefore it is essential to understand these well and also to train staff well.

It was noted that the regional plan and the regional readiness plan are in place, and are revised as the rollout is delayed further. Regional staff will be consulted for their input when the time is right. Once the rollout timing is known staff will receive initial training and then further training on implementation.

6.3 Delegation of authority updates

Dr Hichem Lafif, Director of Administration and Finance

Ms S. Hammoud outlined the changes in the delegation of authority to WRs. She noted that GSM was intended to enhance the delegation process, not hinder it, and this process was built into the GSM hierarchy. She recommended review of the delegation checklists that had been developed by SEARO.

Discussion

In reply to some general questions, it was noted that WRS have the full right to negotiate voluntary contributions at country level. The country office share of core voluntary contributions is decided through the network of strategic objective facilitators. However, so

far this biennium only one tranche has so far been received and so the amount of money involved is small.

Unannounced arrival of staff within the country ("parachuting") has been reduced and should be reported in order for management to address any violations. At any rate, the security system should alert WRs to such arrivals.

The perception of loss of delegated authority as a result of the GSM is only perception. WRs are still able to use obligation references at country office level; it is necessary to enter the references into CAMS for information purposes only. National training activities were replaced in 2006 by direct financial cooperation agreements. Delegation of appointment of STCs has not been anticipated but could be looked at.

Delegation of authority is intended to enhance implementation of workplans and the Regional Director will review any further suggestions favourably. At the same time there are aspects of the delegation that WRs are not using to their full potential.

6.4 Human resource management

Ms Sonia Mulvany, Personnel Officer, Ms Elizabeth Heraldsdottir-Thomas, Director, Global Learning and Performance Management, headquarters and *Ms Jutta Nopper, Regional Personnel Officer*

SSA contracts

The terms and conditions of SSA are unsatisfactory for long durations, as non-staff contracts are not intended for WHO core activities; an SSA may be issued for work of a technical or administrative nature. An individual should not be recruited on a SSA contract unless it is funded and approved in the human resource plan although this plan is a living document and can be modified with the approval of the Regional Director. The revised policy and procedures for SSAs, which became effective in July 2008, outline a number of changes to the current contract of SSAs, which include: total renumeration should not exceed that applicable to UN local salary scales; renumeration may incorporate dependants' allowances if these are in national legislation; WHO will meet the cost of continuing fund/life insurance commitment contributions for SSA holders for the duration of their agreement; the fee scale which is applicable to SSAs in each country must be reported to the Human Resources Department in headquarters and revisions reflected in GSM; annual, sick and maternity leave provisions should be the same as those applicable to government civil servants associated with the project or other activities; and 50% of unused annual leave can be paid in cash. Country offices and divisions must review all functions being performed by SSA holders and determine functions for WHO type work versus those being performed on behalf of governments, and the Human Resources Department will work with country offices to establish scales and benefits for SSAs in each country.

PMDS

A recurring theme has been the perception of the PMDS as a judgemental tool although it is in everyone's interest for the form to work and for staff members and supervisors to adopt a positive stance as the form is now mandatory. Training needs assessment needs to be conducted. As the PMDS is an internal regional arrangement changes can be made in the evaluation of SSAs, although there is a question mark over the Organization's commitment to the development of SSAs.

Non-monetary reward system

The Regional Office's non-monetary reward system, which is currently a policy framework, recognizes outstanding services of staff members and will be operated by supervisors and peers. It is not always directly linked to performance but the way in which activities are conducted. There are two types of recognition which will be used in the Regional Office: the Immediate Recognition Reward and the Yearly Recognition Reward. At the moment the reward system is a pilot project and can, therefore, be modified at any time, if deemed necessary. The Immediate Recognition Reward will promote staff members who have demonstrated an extraordinary performance/contribution in a special event, and the reward can be offered at any time during the year, preferably as soon as possible after the event has taken place. The Yearly Recognition Reward will be provided to staff members who have demonstrated exceptional performance over the last year. The reward should be applicable either to individuals or teams. In selecting candidates for the award, a maximum of six can be selected: three from the Regional Office and three from country offices.

Conflict management resolution

Conflict management systems in place at headquarters and the Regional Office aim to promote the prevention and resolution of conflicts involving disagreements among individuals or group of individuals or employment-related disputes. The ombudsperson dealing with complaints, although appointed by the Regional Director, works independently and provides conflict resolution services to staff who have difficulties with colleagues or a supervisor but does not make decisions for staff members or create or change rules or policies. Human Resource's role is to guide the staff member to the resource that is best suited to handle the staff member's concern or problem. The Grievance Panel is responsible for examining a formal complaint of harassment that is submitted by a person who feels being harassed by an individual or a group of individuals. The Regional Board of Appeal is responsible for examining appeals filed by staff members against a final administrative action or decision affecting their appointment status.

New approaches to identification and development of WRs

The new selection and reassignment policy of WHO Representatives, based on recommendations discussed during the WRs meeting with the Director-General and Regional Directors in November 2007, involves the establishment of a global roster for WHO Representatives. In the first screening, the Global Roster Screening Committee selects a list of

applicants who meet the minimum qualifications for the position. On 2 March, headquarters will forward the CVs of all applicants to all regions for screening. Regional Directors will send back their list of suitable candidates to headquarters by 16 March. Headquarters and Regional Directors will review all lists to create a single list. This exercise has to be completed by the beginning of April 2009. This list will be then forwarded to the Global Roster Assessment Committee whose main role is to agree on a list of eligible candidates. The Global Assessment Committee is the most important element in the process and comprises DPMs/DRDs, DGO and CCO. Once the list is approved, it will be forwarded to the Assessment Centre. The Assessment Centre will then assess applicants by testing their technical knowledge, as well as their skills in management, communication, negotiation and diplomacy. At the end of the assessment, only successful candidates are put on the global roster. The Assessment Centre is expected to open in late April and the global roster will be ready by the end of summer 2009.

Staff development and learning update and plan

Staff development and learning (SDL) workplans were prepared in 2007 and 2008. Some activities have been conducted but not all of those which had been planned. Implementation of workplans was affected by implementation of the GSM and the perceived need for training on GSM. The review of SDL activities held in 2008 identified the need for a decentralized approach which envisioned a strengthened role for local and regional SDL committees. It identified the need for measurable outcomes in the normative work of local, regional and global learning committees and the recording of improved individual performance as a result of SDL activities. The six learning principles which have been reaffirmed are: core competencies; management and leadership; induction of staff; managerial and administrative skills; technical skills; and learning excellence, and focus should be on country staff to increase equity in access. Requests for individual training, however, cannot be granted.

Medical services

Staff members are often unaware of stress management facilities as WHO does not have the same structures in place as other agencies to protect the health of staff and for crisis management. Other agencies have regional counsellors. Stress management should be included as a training topic for WHO Representatives. WHO has been keen to promote tobacco-free workplaces but needs also to promote occupational health as an important area and ensure the adequacy of staff workstations. WHO guidelines on occupational health need strengthening. There are missed opportunities within the Organization to protect women’s health in terms of screening (breast screening) and for vaccination (HPV virus vaccination).

Participants suggested the creation of a hotline when dealing with problems in the evacuation of medical emergencies. The functionality of the UN medical emergency team was discussed briefly. The team received funding and was trained with the Army in Sweden although was not deployed during the recent conflict in the Gaza Strip.

6.5 Financial management

Ms Susanne Hammoud, Budget and Finance Officer and *Mr Robert Chelminski, Assistant Budget and Finance Officer*

Discussion

Among the key points emerging from the discussions was the importance of providing timely information to the Regional Office: if programme obligations are set up from the beginning, they will be reported. The Regional Office will support country offices in finding ways to ensure that bureaucratic processes do not result in added risks to staff or delays in implementation of necessary activities. Funds may be allocated on the basis of pledges, for example, and obligations can also be shifted to ensure funds are not lost due to lack of timely implementation. A number of alternatives can be considered on the basis of country context. A risk-based perspective should play a more prominent role in the management system; in this regard training is needed on risk assessment and management.

The Director of Administration and Finance needs to clear all partnership agreements; use of the standard agreement form will help avoid delays in obtaining clearance. Certified financial reports are available only from headquarters, often with considerable delay. The Regional Office can provide interim financial reports which are satisfactory for most reporting purposes. Committing to additional reports in donor agreements places undue burden on country staff.

It is important to clarify for donors and partners that programme support costs are indirect costs that cover the Organization's enabling functions and are pooled at global level. This must also be well understood by staff at country level. Where direct technical support costs need to be covered, they can be factored into donor agreements. Programme support costs are 13% except in the areas of humanitarian response, poliomyelitis eradication and UN reform (7%). However, for WHO the real cost of implementing voluntary funds is estimated at around 25%.

The Central Emergency Response Fund (CERF) is an attractive mechanism for countries to obtain funds quickly in a crisis situation. However, the criteria for use of the funds must be considered carefully. Only "life-saving" activities can be funded, and liquidation within the specified time-frame (3 months) is often a challenge. The Regional Office can provide support in this regard, including templates for contractual agreements with partners. Draft standard operating procedures have been developed for emergency situations. They are currently being finalized in accordance with revised delegation of authority and GSM processes and will be introduced in the Region in 2009.

6.6 Partnership

Dr Namita Pradhan, Assistant Director-General for Partnerships and UN Reform

In order to advance global public health WHO engages in a large number of broad and diverse relationships, ranging from informal arrangements to formal engagement in partnerships.

Such relationships play an increasingly prominent role in WHO's work, and account for a considerable amount (50%) of the Organization's financial resources.

Draft policy guidelines on global health partnerships and collaborative arrangements have been developed by the WHO Secretariat and will be discussed at the Health Assembly in May. The guidelines form a framework for WHO to engage in different types of informal and formal health partnerships and to assess those partnerships; they also provide specific parameters to be applied in cases where WHO is asked, and agrees, to host a formal partnership.

The proliferation of new players in the global public health arena has created new ways of working in which WHO is sometimes constrained or marginalized. Serious effort is needed to examine the current and potential roles of WHO and the ways in which it needs to adapt its working methods to the changing public health landscape. In particular, careful consideration is needed to identify the optimal role of WHO in partnerships at country level.

It is important that partnerships have well defined—and complementary—roles and responsibilities for each partner, as well as a clear mechanism for collaboration. Existing partnerships should be assessed in terms of usefulness and cost–effectiveness. Relationships should also be explored with new types of partners, such as municipalities and local governments, that can offer more flexibility in ways of work than traditional bilateral partners.

A list of regional partners is currently being assembled, and the draft regional strategy for resource mobilization is being finalized and will cover all partnerships in the Region. These and the draft policy guidelines on global health partnerships and collaborative arrangements to be presented to the Health Assembly will be useful tools for staff in country offices.

6.7 Procurement of goods and inventory

Mr Isam Asadi, Logistics Support Officer and *Mr Hatem El Khodary, Administrative Services Officer*

It is paramount to exercise adequate control techniques over the Organization's assets to safeguard it against possible misuse and loss and to provide an appropriate basis for its valuation and reporting into the Organization's financial statement. Accordingly, appropriate coordinated efforts with country offices is vital to ensure adequate preventative measures are in place and to ensure adequate corrective actions are taken in case of discrepancies. Moreover, and before the launching of GSM, coordinated efforts should ensure that assets are adequately recorded and verified and hence, adequate and successful conversion into GSM is carried out and that adequate transition is guaranteed.

Discussion

It was emphasized that the procurement process should be started early on in the planning cycle, preferably at the beginning of the biennium for regular requirements. Urgent requests provide little time for processing and result in higher cost because of the need to deliver by air. Urgent requests should be reserved for genuine emergency situations and all

other needs anticipated in good time. Use of the WHO and UN IAPSO catalogues facilitates turnaround since catalogue items are covered by supplier agreements.

Ministries lack capacity in procurement and their systems are often inadequate. Training can be provided for WHO and ministry staff and if this was followed up by further on-the-job training, outcomes would be improved. The UN is currently looking at using a single procurement model in order to standardize and harmonize its purchasing; WHO might consider the same.

WRs have the right to make use of other UN procurement schemes at local level. For emergency health kits global agreements with two vendors have been made, together with agreements with regional suppliers, for prelocation at the World Food Programme (WFP) warehouse in Dubai, where storage is provided free of charge. There is a need to build up and maintain this stock. Emergencies can often benefit from exceptional waiving of some of the rules governing procurement but this is not usual.

With regard to the delegation of authority, it was pointed out that copies of purchase orders are needed for information purposes only. These should be submitted through CAMS and there is no need to wait for further approval from the Regional Office. For vehicles where duty free resale has been agreed at country level, it is preferable not to hold on to the vehicle much beyond the permitted sale period, both because of depreciation in value and because resale at this point can often result in a major saving on new purchases.

With regard to inventory tracking of small items it was noted that the GSM will facilitate this, being designed to capture and report at all levels. Finally it was requested to issue a circular concerning the delegation of authority in order to raise awareness of it among staff.

6.8 Security challenges

Mr Patrick Beaufour, Coordinator, Security Services, headquarters

Mr Beaufour highlighted the serious security incidents that had occurred in the Region in 2008, noting that these accounted for all such incidents for WHO. He paid tribute to those who had died and indicated that acknowledgement of such sacrifice should be drawn to the attention of the World Health Assembly with a view to recognition. He said that clearer policy guidance may be needed on designation of UN vehicles so that those of the development agencies were not confused with others. It is important to gather evidence about how the UN is perceived in countries and whether identification of individual agencies reflects the different perceptions as this might have a bearing on how security challenges are addressed. He noted some shortcomings in the UN DSS, with WHO paying for services that it did not receive. He noted also that WHO's own security apparatus is not commensurate with WHO's presence in many challenging environments compared with other agencies, and investment is needed. The World Health Assembly will be requested to consider additional funding for security. He also highlighted recent and upcoming changes in UN security policy that take into account the need for flexibility according to different country situations.

Discussion

The gap between DSS and WHO on security thinking was emphasized by a number of WRs. Others noted a positive experience. This reflects the variation across the UN and the scarcity of professional and expert security officers who are sensitive to, and knowledgeable of, WHO and other agencies' work. Security officers need to be able to speak the language of the environment in which they operate, and should not be spokespersons on behalf of individual agencies. Fixed-term posts are needed to attract the right competencies. WHO needs to review this and possibly consider a low profile travel policy where the security situation warrants this, with maintenance of close contact with people on the ground and en route. DSS security analysis should be based on evidence and should conclude with clear recommendations to the SMT on action that can be taken. DSS currently makes recommendations that do not take into account the cost to agencies and the feasibility of implementing high cost changes.

There has been an over-reliance on static building security that does take into account the nature of the work of individual agencies in the field. WHO's traditional location within ministries of health is perceived to be more secure overall; however, discretion needs to be exercised to ensure adequate security for WHO staff and assets in these premises to avoid becoming a soft target. No UN building in the world is 100% MOSS compliant. This has implications for building and staff insurance. At the same time, applying MOSS can hinder operations, has major cost implications and requires the agreement of landlords, which if not forthcoming, necessitates removal to other premises. Even where buildings are MOSS compliant this does not guarantee complete protection.

In addition to recognizing those who lose their lives in service, WHO should recognize all staff who work and carry out their humanitarian duties under difficult circumstances.

With regard to transport, it was noted that use of armoured cars in high security situations, as required by MOSS, may portray an image at odds with the humanitarian mission. In countries where carjackings are a problem, WHO should consider switching to less desirable, but effective, models. Use of low profile vehicles might also affect insurance and this has to be taken into account.

With regard to the security phases, the proposed changes and flexibilities were welcomed. It was noted that the phases are currently applied differentially at global level. Several WRs reported differences in opinion between the SMT and DSS as to which phase was locally appropriate and found the SMT overruled. Decisions about raising the security phase/level should be made based on evidence.

WHO headquarters should be copied on all queries and incidents regarding security in the Region in order to be able to advise and support fully. Headquarters is also ready to undertake consultant missions to countries to assess and provide reasonable advice on security Where MOSS cannot be implemented WRs need to ensure alternative measures are in place. Headquarters is looking at further capacity-building through adaptation of a UNHCR course to WHO specificities. WRs were requested to provide headquarters with full information

regarding the cost of upgrading their security to meet current policy in order for the facts to be presented to the World Health Assembly.

In conclusion, it was noted that a balance needed to be struck between the need for good security for staff and the humanitarian and field needs. WHO staff should not be prevented from carrying out their mandate in humanitarian crises. Better risk assessment is needed within countries according to specific situations with guidance on how to deal with risk. WHO needs to maintain the philosophy and momentum behind the One UN concept, while adjusting its own policy to suit the reality of specific countries and working for change from within the UN system. The humanitarian mandate of the UN is already being challenged on the ground and isolation on the basis of security would isolate it further. Money spent on security needs to be rational and justified, so that neither staff nor programmes are compromised.

6.9 Conclusions on "Enabling functions"

1. GSM: Coordinated efforts will be exchanged to brief country offices on the development of GSM and to prepare country offices and the Regional Office for an effective transition through training and structural changes.

2. Delegation of authority: Updated delegation of authority will be provided immediately to country offices with appropriate guidelines to ensure full implementation with the fewest administrative limitations.

3. Human resource management: Guidelines on SSA reforms need to be established with emphasis on modified benefits and standardized compensation among existing UN agencies.

4. Human resource management: The appraisal process should be simplified and comprehensive to ensure effectiveness. Approaches should be in place to link PMDS to tangible rewards to elevate motivation and retain competent resources.

5. Staff development and training: Guidelines should be established and provided to allow effective preparation of a comprehensive plan including all types of contractual staff.

6. Staff development and training: Once plans are prepared, action should be provided to ensure timely implementation of the plan.

7. Staff development and training: Consider approaches to institutionalize the SDL activity through the establishment of a unit that will ensure organizational-wide continuing professional education.

8. Medical services: The need to establish norms and practices on staff occupational health which promote healthy lifestyles and support staff's need in crisis and emergency situations.

9. Partnerships: A global policy on partnership needs to be drafted considering an up-to-date database of partners and highlighting a clear role for WHO as a leading technical agency in fostering such partnerships.

10. Financial management: The aim and stress of our presentations today were to highlight the importance of financial accuracy and monitoring. Efficiency of turnaround time for journalization of imprest returns is critical in reflecting early and accurate implementation. Compliance with donor agreement requirements ensures smoothness in operations, implementation and final reporting.

11. Procurement: There is a need to enhance the capacity of our counterparts in the Ministry of Health through institutional procurement training and allow for effective local procurement.

12. An early annual procurement forecast will allow for effective regional procurement support and avoid unnecessary procurement delays.

13. Inventory: Coordinated effort between the regional and country offices to ensure complete recording and adequate verification. This will allow for an accurate and smooth conversion to GSM.

14. Despite current MOSS requirements, there is a need to keep a balance between the standards and the reality on the ground. Each country is operating based on certain specificities. Further intelligence analysis is required and keeping a low profile with minimum affordable security measures in place would be a solution.

7. STRATEGIC CHALLENGES FACED BY HEALTH SYSTEMS AND SERVICES DEVELOPMENT, ISSUES AND THE WAY FORWARD

Dr Belgacem Sabri, Director, Health Systems and Services Development, Dr Sameen Siddiqi, Coordinator, Health Services Development, Dr Ibrahim Adbdelrahim, WR Tunisia and *Dr Hossein Salehi, Regional Adviser, Health Economics*

The ongoing and spreading financial and economic crisis is expected to adversely affect population health in many countries in the Region. The health gains made in the past decades and towards the targets of the Millennium Development Goals (MDGs) are at risk. Measures must be taken to mitigate the potential impact of such adverse effects, especially on the most vulnerable groups.

The public health sector must be protected. The crisis will affect the health of individuals through many channels. The situation in Member States needs to be continuously monitored. WHO should provide technical assistance to ministries of health in order to secure funding and protect their population’s health when needed.

The crisis is already affecting financial resources available to WHO, and the situation could become critical if the current recession deepens. WHO should reassure Member States

and donors that the Organization is committed to reducing wasteful spending and is committed to protecting and improving population health during the crisis more than ever before.

Discussion

To ensure that primary health care is functioning effectively, it is essential to have: critical services that are available on the doorstep of the community; access to essential referral care; system financing that offers an adequate level of sustainability; a primary health care policy that generates productivity for the long-term sustainability of the system; and health protection and promotion services that are not separate components of the primary health care system. There needs to be a move away from the biomedical model of health, which is costly and resource- and labour-intensive to health protection and promotion models. To ensure the existence of a competent workforce dedicated to primary health, countries of the Region need to invest in human resource development in terms of undergraduate and postgraduate training, and career development. A greater involvement of professionals is needed at country level.

There is a tendency to be satisfied with the achievements of primary health care without looking at the challenges being faced, for example, in the Islamic Republic of Iran, the criteria for selecting *behvarz* has not been updated despite the changing demographic situation in the country in terms of higher educational levels among the general population and the need for the services of *behvarz* in urban as well as rural areas.

Social marketing of primary health care needs to be conducted to convince governments of the cost–effectiveness of primary health care, and ownership must be ensured through the provision that primary health care is tailored to the needs of countries. In Egypt, for example, this means: ensuring that the capacity and effort of government increases life expectancy among the general population and addresses inequalities; that communities are protected from avoidable hazards; there is a provision of appropriate care for all; and that the capacities of people to address their own health problems are ensured. National conferences addressing wide audiences could be held in some countries of the Region on primary health care and the social determinants of health, although these would require the involvement of all sectors and strong government commitment as part of a wider strategy.

At the country level a comprehensive practical approach is needed to primary health care, not just health system strengthening, although in terms of health system strengthening there are opportunities for Global Fund financing. A workshop could be convened to provide guidance to Regional Advisers on how to integrate programmes into primary health care.

Weak health information systems are a problem in the Region. Greater investment needs to be made in these systems as they form the basis for evidence-based decision-making. WHO needs to provide indicators and tools for countries to monitor and evaluate health systems in countries. Environmental health services need greater consideration in all countries of the Region.

Academic institutes need to provide evidence on the strengths and weaknesses of primary health care systems, although this in itself requires funding. Institutes in several countries are providing training in the implementation of community-based initiatives. More partnerships at community level need to be initiated.

8. STRATEGIC CHALLENGES FACED BY DIVISION OF HEALTH PROTECTION AND PROMOTION, ISSUES AND THE WAY FORWARD

Dr Haifa Madi, Director, Health Protection and Promotion

Dr Madi noted that an estimated 8 out of 10 deaths in the Region fell under the remit of the health protection and promotion divisional programmes. She highlighted the projected deaths by cause to 2030 and the magnitude of the problem of noncommunicable diseases, which showed a clear expectation of increase in the low-income and middle-income countries. The Region already has the second highest burden of disease of all WHO regions for noncommunicable diseases. In 2002, WHO developed a public health approach across the life course to address disease risk factors from conception onwards. However, it had since acknowledged that this did not sufficiently take health promotion into account. It was widely accepted that 25% of the global burden of disease is attributable to environmental risk factors which are modifiable. The four strategic directions of WHO's corporate strategy were a close fit with the requirements of any strategy for health protection and promotion, while the tenets of the Ottawa Charter for Health Promotion were similar to those of the declaration of Alma-Ata. The countries in the Region affected by complex emergencies include many of the MDG-priority countries. Women and children are at high risk in these countries and in the worst affected areas the MDGs are in reverse. In these countries, the funding available to emergency programmes might be used to benefit more long-term strategic goals. She highlighted the financial challenges of the past two biennia, noting in particular the reduction in allocation over three biennia to child health, a so-called priority area. The lack of staff to address the issues adequately is a serious challenge. In conclusion she posed two questions: how to mainstream health protection and promotion in the planning process at country level; and what would be the role of WRs in improving the resources available to this area?

Discussion

The need to raise awareness of the epidemiological shift within countries, and the future consequences of this, were highlighted. This requires assessment and monitoring at country level and regional level. However the tools to conduct such assessment and monitoring, including assessment of the cost of not addressing the issues, and to promote integrated action are not available currently and need to be developed. Evidence-based advocacy from WHO is a key area to focus resources on. Health promotion programmes can take many years to show positive results. This needs to be highlighted to governments within the context of advocacy. It might be more effective to focus scarce resources on those countries willing to implement health promotion. Subsequently, case studies of these countries would be a powerful tool for marketing the approach to other countries. They would also demonstrate the use of different solutions within the local context.

Health promotion activities should be built into the Joint Programme Review and Planning Mission (JPRM) and CCS, in collaboration with the national health authorities, and into national strategic planning. The WHO team members often do not help in this regard, often focusing on their own areas of expertise rather than promoting health across the range of programmes. There should be good briefing and teamwork in this regard. Even so, the amounts of money involved are often too small to be of much support to countries. There should be in-depth review of programmes at country level to determine which activities have been integrated.

It was pointed out that despite the lack of available resources, the allocation to health protection and promotion has in fact increased. It is essential to review the regional situation to see which countries have benefited from the shift in resources, and to determine if the distribution of regional resources to the various programmes is fair and appropriate.

Emergencies provide an entry point for building more sustainable health programmes, however, such funding can also distort these programmes. The pooled funding available from donors through facilities such as the Common Humanitarian Fund provided an opportunity for advocacy for health. Many disaster events in the Region are related to the environment and to environmental health. WHO's role in this has changed over recent years. It is now focused on advocacy, promotion and capacity-building for healthier environments, and has an important role in influencing public policies in other sectors that affect health. Partnerships need to be built and the context of climate change provides opportunities to establish services for prevention and impact monitoring of environmental health-related diseases. More collaboration is needed across divisional and programme boundaries to create linkages and meet the goals.

Primary health care in the Region is very largely focused on maternal and child health care, rather than on providing wider health services across the life course. Unlike other regions, primary health facilities in the Region do not link up with other community services, such as adolescent outreach and activities for older persons. Some community-based healthy lifestyle initiatives exist in the Region. These should be evaluated and the outcomes documented so that the value of such initiatives can be demonstrated.

Health protection and promotion has largely neglected the area of consumer protection, an important driver in the industrialization process. Not only are consumer protection agencies absent in countries, very few countries are knowledgeable about consumer protection or acknowledge its importance, despite the existence of UN guidelines.

WRs acknowledged that resources can be mobilized at country level to support health promotion activities, and some countries have the potential and willingness to support regional action. However, WHO is currently not proactive in harnessing such potential and needs to work on advocacy to ensure all aspects of its work are equally attractive to donors. The fact that emergency and humanitarian action attracts funds in the short-term obscures the fact that health overall is losing out to other sectors. WHO needs to be proactive about documenting and publishing its successes, making itself visible to donors at country level and convincing them of the key nature of the health sector. WHO can work with UN agencies,

such as UNICEF, in collaboration towards common goals, making use of their resources while providing technical expertise. Ministries, other than the health ministry, often have more resources that can be diverted to the health sector with good advocacy. WHO can show countries how to create partnerships that meet health goals. It has a key role to play in bringing together all partners and stakeholders and facilitating the dialogue on the social determinants of health and the consequences of not addressing health issues. Country offices need capacity-building and strengthening in terms of human resources to enable them to take the lead in health promotion, mobilize resources and guide countries.

A concerted campaign is need on behalf of health promotion, both to ensure that countries' needs are met, that WHO can continue to give the necessary support and to ensure that WHO does not lose its mandate in this key area.

9. THREE EXPERIENCES AND LESSONS LEARNT BY THE DIVISION OF COMMUNICABLE DISEASES CONTROL

Dr Jaouad Mahjour, Director, Communicable Disease Control, Mr Peter Graaff, WR Afghanistan, Dr Mohamed Abdurrab, WR Sudan and *Dr Marthe Everard, WR Somalia*

Laboratory-supported surveillance in Afghanistan

Surveillance of communicable disease requires both epidemiology and laboratory components. Initial assessment of the Central Laboratory in 2006 revealed that, to run "laboratory-supported" surveillance, the Ministry of Public Health needed to build capacity of laboratory infrastructure and human resources, and, with support of WHO Regional Office, WHO Kabul recruited a Laboratory Adviser who provided standard operating procedures and training to establish good laboratory practice, improved laboratory management, quality control and laboratory safety. WHO Kabul additionally supported both the field surveillance of the Disease Early Warning System (DEWS) and the hospital-based surveillance of rotavirus and meningitis through provision of training for laboratory workers and necessary reagents and supplies.

The DEWS is laboratory-supported field surveillance which publishes a report compiled weekly from 130 sentinel sites and has responded to over 210 outbreaks this year, supported by Central Public Health Laboratory bacteriology, virology and serology to confirm disease outbreaks (cholera, shigella, typhoid, hepatitis, measles, diphtheria, pertussis, malaria, Crimean–Congo haemorrhagic fever, meningitis, influenza, brucellosis, anthrax, plague).

Lessons learned over the last two years are that a well-functioning lab network and good logistics are necessary for disease surveillance. Laboratory diagnosis can also provide added value as mentioned below:

- In outbreaks of cholera, Crimean–Congo haemorrhagic fever, measles and pertussis, early laboratory diagnosis galvanized the appropriate response by the DEWS team.
- In the outbreaks of Crimean–Congo haemorrhagic fever and cholera, the laboratory diagnosis was important in bringing partners for disease control locally and globally.

- Laboratory-based evidence of rotavirus and Hib meningitis assisted the national immunization programme to advocate for these new vaccines.
- Laboratory diagnosis is necessary for IHR implementation and provided global understanding of threats in Afghanistan, such as cholera, pertussis and influenza.

Much remains to be done to train human resources for surveillance laboratories and improve the infrastructure. Many stakeholders need to be involved to implement both the field and hospital surveillance—community, health workers, public health teams at central and peripheral levels, national vertical programmes, other ministries, nongovernmental organizations, UN agencies, development partners and donors.

Outbreak management and response within the umbrella of the International Health Regulations (IHR 2005) recent experience in Sudan

Sudan's presentation on "experience of managing outbreaks in Sudan under the umbrella of the IHR" highlights that the country continues to face a high burden of infectious diseases. In addition to high endemicity of malaria, diarrhoeal and other tropical diseases, Sudan experienced several outbreaks in recent years, including cholera, meningitis, yellow fever and Rift Valley fever. Surveillance and response capacities are severely challenged by the prevailing socioeconomic and geopolitical situation of the country. Coupled with immensely important livestock economy, outbreaks of zoonotic diseases, such as viral haemorrhagic fevers and avian influenza, increasingly pose a threat to health security. The revised IHR's main purpose is to improve health security and avoid unnecessary socioeconomic loss. Sudan has established a National Committee for IHR Core Capacity Assessment and Implementation. Although the Federal Ministry of Health is committed to following the IHR, important decisions regarding the IHR are increasingly driven by economic and political implications.

WHO Sudan's experience of managing outbreaks in the context of the IHR suggests that notification and verification of certain specific outbreaks with potential economic implications (like Rift Valley fever, cholera, etc.) have become very important and is decided at the highest level in the government. The Federal Ministry of Health is fully aware of its rights vis-à-vis obligations under the IHR, as experienced by WHO on several occasions recently but national economic interests override other priorities. For a country like Sudan, it is prudent that that coordination between animal, health and water and sanitation sectors, information-sharing between North and South Sudan, regular and official reporting to WHO, capacity-building to detect and manage outbreaks efficiently, etc. should be important priorities both for government and WHO. Experience in Sudan suggests that advocacy at the highest political level for IHR compliance and resource mobilization to support the Ministry of Health be considered as immediate action points for WHO. At the same time there is a need for WHO's exceptional support to Sudan to build its capacity for IHR compliance.

Discussion

There are many compelling reasons to support surveillance. In addition to producing effective results, good surveillance bolsters the credibility of WHO and can facilitate the

implementation of other programmes. A strong surveillance system is also prerequisite for implementation of the IHR (2005). The negotiation role of WRs is very important in this respect, and every effort must be made to encourage trust and transparency in countries and to help diminish concerns over stigmatization.

Conducting laboratory-based surveillance is not an end in itself but a means to collect data for action. Hence, a good surveillance system should enable staff to anticipate events and to take preparatory or corrective action. Post-outbreak briefings offer an opportunity to further develop the surveillance system, as the awareness and commitment of national authorities are heightened in the aftermath of an outbreak. In addition, country staff can make use of the higher levels of awareness to advocate or strengthen complementary programmes such as infection control.

The integration of various disease control interventions is important, especially for rapid response in the case of an outbreak. The infrastructure and human resources in place for polio eradication are available for delivering other interventions. Existing surveillance networks can also be used for monitoring other indicators, such as for environmental or socioeconomic conditions. As part of a new strategic approach to disease control, five subregional meetings on communicable disease control will be held in 2009 for national directors of communicable disease control. WRs and relevant country office staff are urged to attend.

10. PREPARATION FOR OPERATIONAL PLANNING 2010–2011 IN GSM TRANSITION

Dr Abdallah Assae'di, Assistant Regional Director and *Dr Sussan Bassiri, Coordinator, Programme Planning, Monitoring and Evaluation*

WHO has a global health agenda. The Mid-Term Strategic Plan outlines 13 strategic objectives which are the responsibility of both Member States and WHO. Organization-wide expected results have been developed, with 191 indicators for strategic objectives, to monitor the performance of Member States and the Secretariat. Separate indicators will be developed at country level to assess WHO's performance.

The number of programmes in countries is decreasing as increasingly greater emphasis is being placed on priority-focused areas. One of the roles of WHO Representatives is to inform the Organization of existing gaps in the provision of technical support in these areas. There are opportunities to raise funds for technical support through the Global Fund, although fewer opportunities exist through the Fund to raise funds for activities.

When ceilings are developed for the strategic objectives guidelines are needed. After ceilings have been approved, there are mechanisms for change, such as the approval of the Director-General.

The JPRM process involves the development of supported and productive operational planning at country level to reduce health priorities, although as a tool the JPRM is more effective in some countries than others. The UNDAF represents a process through which

agencies can work together. Collaborative programmes in countries will be affected enormously by the UN reforms as most funds for countries will go through the UNDAF but this represents an opportunity for WHO to use the CCS to shape the health agenda component of the UNDAF. The CCS is used to define the future strategic directions and functions for WHO in a country and assigns the relative emphasis that will be given, as well as criteria of success for each strategic direction.

In the previous biennium the Organization urged that technical units planned to obtain additional sources of funding; donors will not allocate funds without a plan, and without this planning there will be no tool for resource mobilization. Voluntary contributions will increase with greater planning on the part of WHO. It is important for WRs to explain to countries that funds are not available for all planned activities in order not to raise expectations of Member States. In the JPRM, activities for which funds have not been secured should be planned.

In GSM, countries will be able to see what is happening in country programmes because of the composite plan. The information technology unit is working with the programme planning unit in headquarters to see which enhancements are needed to the GSM system by the end of March. It is expected that the GSM rollout in all Regions, with the exception of the African Region, will take place on 1 January 2010. GSM planning should be conducted this year from April onwards. The GSM workplanner will be available for general use in April. Staff training on GSM will take place. It was also suggested that training should be conducted on results-based management for both WHO staff and ministry of health counterparts.

11. ACTION POINTS

Global Management System

- The Regional Office will finalize the roll-out plan and will provide WRs with a plan of action.
- The Regional Office will follow up with WRs to update and finalize the human resources plan for 2010–2011, including mapping of roles and responsibilities of staff in the GSM environment. [DAF, ARD, GSM focal points, GSM regional team, WRs]

Delegation of authority

- Appropriate guidelines will be developed, in line with standard operating procedures for emergency situations, to ensure full implementation of updated delegation of authority. [EMRO, DAF]
- Based on the implementation criteria outlined for emergency-related standard operating sys (activation and utilization), training and capacity development will be embarked upon in a phased manner for country offices and the Regional Office in 2009. [EHA, DAF]

Human resource management

- The Regional Office will prepare guidelines on the SSA reforms in coordination with WRs to establish remuneration consistent with that of other UN agencies; [DAF, WRs]
- Country offices will review functions performed by SSA holders and propose actions through reduction, conversion to permanent functions or suggest alternate mechanisms. [WRs, DAF]
- The Regional Office will plan to provide training/briefing sessions on performance management and PMDS preparation for regional and country office staff. [EMRO, DAF]
- Country offices will complete all outstanding PMDS for the year 2008 and the objectives for the year 2009 and submit to the Regional Office to be in compliance with the recent RD's circular. [WRs]

Staff development and learning

- Country offices will receive guidelines and/or briefing sessions on the approaches to development and learning adopted by Global Learning Committee. [HQ, PML, SDL]
- Headquarters and the Regional Office will explore institutionalization of the approach to staff career development to ensure staff needs are met. [HQ, EMRO]
- WRs will develop a comprehensive learning plan for their different categories of staff, including SSA holders, covering professional, as well as interpersonal skills training. [WRs]

Financial management

- The Regional Office will consider developing systemic applications to shift the focus from manual control to more systematic identification and management of financial risk, articulating a clear role for WRs and the Regional Office. [DAF, IT, WRs]
- The Regional Office and country offices will improve turnaround time for imprest journalization. [DAF, WRs]
- Country offices in collaboration with relevant teams in the Regional Office will include in project proposal agreements all direct costs incurred by WHO offices over and above the programme support costs. [All technical units – WRs, DAF, ARD]
- The Regional Office in collaboration with country offices will assess and determine a safe, suitable and effective means of funds transfer between WR offices and sub-offices. [DAF, WRs]
- The Regional Office will disseminate the obligation reference annually to a country office, to be used within the delegation of authority. [DAF, WRs**]**

Procurement and inventory

- Country offices will ensure compliance with the guidelines, rules and regulations, in particular RD Circular 854 addressing the local procurement of supplies and equipment. [WRs]

- Routine requests for supplies and equipment will be submitted early, avoiding end-of-biennium requests and allowing a minimum of 4-6 months of allotment validity. [WRs]
- Where possible, WHO catalogue items will be used, and a list of potential suppliers will be maintained with updated information on their performance. [WRs]
- The Regional Office will establish a training programme to enhance the procurement capacity of national counterparts in the Ministry of Health to strengthen local procurement. [DAF, RSO]
- The Regional Office swill develop and disseminate guidelines to facilitate complete recording, verification and reporting of WR's assets and to allow for an appropriate base for accurate conversion. [DAF, WRs]

Medical services

- Headquarters and the Regional Office will establish norms and practices on staff occupational health to promote healthy lifestyles in the work place and support staff counselling needs in crisis and emergency situations. [HQ, EMRO, Committee on Staff Health & Safety]
- Headquarters and the Regional Office will ensure application and dissemination of preventive care guidance for staff, especially for women. [Joint Medical Services, regional staff physician]

Partnership

- The Regional Office will update and provide a database of partners and donors in the Region and contribute to draft global policy on partnership in health, fostering adequate resources in support of countries. [ARD, PUN/HQ]
- WHO will make efforts to ensure it is the principal recipient of the health system strengthening component of GFATM grants to countries. [PUN/HQ]

Security

- The Regional Office will consolidate security cost needs in accordance with country MOSS and submit it to the World Health Assembly for establishment of a sustainable funding mechanism. [DAF, DRD, WRs]
- The security team in WHO swilld modify and disseminate WHO-specific MOSS and follow up on actions needed to ensure 100% compliance; [SEC/HQ, DAF]

Primary health care, academic institutions, financial crisis

- Mechanisms to promote south-to-south collaboration among countries of the Region will be developed and 2010–2011 declared as the biennium for primary health care. [All Divisions, WRs, Senior management]
- The Regional Office will continue to lend support to all GAVI/GF eligible countries to address challenges in developing health systems based on values and principles of primary health care. [DHS, DCD]

- The Regional Office will provide support to country offices that show interest in organizing national conferences on primary health care and primary health care reviews and national plans. [COs, DHS, TWG on PHC]
- A regional strategy on the role and contribution of academic institutions in promoting primary health care will be developed in 2009 with participation of all stakeholders. [DHS, RPC]
- Medical, nursing and allied education and primary health care will receive greater emphasis and resources during the next round of JPRMs. [DHS, PME]
- Systematic evaluation will be undertaken and operational tools developed for promoting PHC-based health systems in countries. [HSS Cluster HQ, DHS]
- The Regional Office will prepare and share with country offices a brief on the financial crisis and its effect on public health. [HEC]
- Country offices will provide the Regional Office with information that monitors adverse effects of the crisis and on governments' response to protect health. [COs]

Strategic challenges in health promotion: planning

- Planning processes will be coordinated with other divisions/units to address health protection and promotion and to find synergies with programmes having relatively larger resources. [DHP]
- Tools will be developed to contribute to building an evidence base on the cost–effectiveness of health promotion and protection interventions in order to inform policies during JPRMs and CCS and other missions. [DHP, COs, mission teams**]**
- Components of health protection and promotion will be taken into consideration when developing proposals for global partnerships. [GHI team, COs, DHP]
- Structured mechanisms/strategies will be developed to improve the involvement of health protection and promotion components in emergency operations and preparation of appeals. [DHP, EHA]
- Efforts will be made to ensure the level of attention given to health protection matches that given to health promotion, and consumer protection organizations will be engaged in expanding the scope of interventions aiming at health protection. [DHP]

Strategic challenges in health promotion: resource mobilization

- Advocacy strategies will be developed based on success stories and disseminate widely among different public sector entities, donors and institutions. [DHP]
- Resources will be mobilized locally for funding of HPP-related programmes by engaging different donors. The Regional Office will back up proposal preparation and discussions with donors. [WRs, DHP]
- The increase in resource allocation (RB and CVC) for SO3, SO4, SO6, SO8 and SO9 will be pursued at the global, regional and country levels. [DHP, WRs, Senior management]
- In-depth review will be conducted of the programmes under health protection and promotion in different countries to assess the current status of the programmes vis-à-vis government ownership and resource allocation [WRs, DHP]

- Fair distribution of resources and staff will be ensured between the different Divisions at regional and country levels. [Senior management]

International Health Regulations (IHR) 2005

- Country offices, with the help of the Regional Office, will advocate the importance of key national partnership in IHR planning and implementation. [COs, EMRO]
- Country offices, with the help of the Regional Office, will support Member States in the assessment of core capacities needed for planning and implementation of IHR 2005 *(before June 2009)*. [COs, EMRO]
- Country offices, with the help of the Regional Office, will facilitate development of national plans for IHR implementation, *due in June 2009*. [COs, EMRO]
- Country offices will continue to support Member States in timely rumour verification and information sharing as per IHR requirements. [COs]

Surveillance and response

- Country offices will advocate for strengthening public health laboratories as a major component of disease early warning systems. [COs]
- Country offices, in collaboration with the Regional Office, will support countries to ensure surveillance data are immediately used for action and to anticipate disease trends. [COs, EMRO]

New strategic approach to communicable disease control

- Country offices, in collaboration with the Regional Office, will support and participate in the five DCD subregional meetings on communicable diseases control in 2009. [COs, EMRO]

Preparation of operational planning 2010–2011 in GSM transition

- Country offices will alert and organize their teams for preparation of proposed workplans for 2010–2011 based on CCS and revision of existing workplans. [WRs, ARD]
- The Regional Office will communicate with all country offices the latest proposed human resource plan 2010–2011 for their finalization. [ARD, DAF, WRs]
- The Regional Office will communicate with all country offices the required guidelines and training plans in preparation for 2010–2011 operational planning. [ARD]
- The Regional Office will seek advice and further refine the guiding principles for proper planning of Voluntary Contributions in operational plans. [PRP/HQ, DRD, ARD**]**

Role of the secretariat in preparing the meetings of governing bodies

- Country offices will engage with the Regional Office and Member States to ensure good preparedness for discussion of topics and sharing of country experiences and initiatives in Executive Board, World Health Assembly and Regional Committee**.**

UN reform: experience from Pakistan

- A successful joint UN programme requires working with UN staff to overcome their negative perceptions and build their confidence. It also requires synergy between different departments across UN agencies working in priority areas. The successful experience on UN reform in Pakistan will be disseminated to other countries in the Region as well as other regions [CCO/PUN/HQ, DRD, ARD]

Annex 1

AGENDA

1. Opening session
2. Introduction on the theme of the 24 meeting; “Enabling functions”
3. GSM: Status, transition and the way forward
4. Delegation of authority updates
5. Human resource management:
   - SSA contracts
   - PMDS
   - Non-monetary reward system
   - Conflict management resolutions
   - New approaches to identification and development of WRs
   - Implementation of the human resources component under Standard Operating Procedures for emergencies
   - Staff development and learning update and plan
6. Medical services: Stress management and critical incidents
7. Financial management
   - Imprest account
   - DFC
   - Award management
8. Procurement of goods and inventory
9. Security challenges
10. Wrap up of final discussion on actionable points on “Enabling functions”
11. Reaffirming primary health care in the Eastern Mediterranean Region: What next?
12. The role of academic institutions in promoting primary health care in the Region
13. The impact of global financial and economic crisis on population health
14. Strategic challenges faced by the Division of Health Protection and Promotion, issues and the way forward
15. Laboratory-supported surveillance in Afghanistan
16. Outbreak management and response within umbrella of the IHR (2005): recent experience in Sudan
17. Epidemiologic surveillance in complex emergencies: Experience and lessons learned
18. Preparation for operational planning 2010–2011 in GSM transition
19. Role of the Secretariat in preparation for the meetings of the governing bodies
20. Conclusions and recommendation

Annex 2

PROGRAMME

Sunday, 22 February

08:30–09:30	**Opening session**	
	Opening address	Dr H. A. Gezairy, RD
	Selection of Officers	
	Working hours and agenda	
	Follow up on recommendations of the last meeting	Dr A. Assa'edi, ARD
10:00–10:15	Introduction on the theme of the 24 meeting; "Enabling functions"	Dr H. Lafif, DAF
10:15–11:00	GSM: Status, transition and the way forward	Mr M. Catterall, Director/ITT/HQ Mr M. Valois, GSM/ITT/HQ
11:00–11:45	Delegation of Authority updates	Dr H. Lafif, DAF
11:45–12:30	Human resource management:	
	SSA contracts	Mrs S. Mulvany, PEO
	PMDS	Mrs S. Mulvany, PEO
	Non-monetary reward system	Mrs E. Haraldsdottir-Thomas,
	Conflict management resolutions	Director/PML/HQ Ms J. Nopper, RPO
13:30–15:30	Human resource management (cont')	
	New approaches to the identification and development of WRs	Mrs E. Haraldsdottir-Thomas, Director/PML/HQ
	Implementation of the HR component under standard operating procedures for emergencies	Ms J. Nopper, RPO Dr B. Sabri, DHS, Mrs E.
	Staff development and learning update and plan	Haraldsdottir-Thomas, Director/PML/HQ
15:30–16:45	Medical services	Dr P. Gilbert-Miguet,
	Stress management and critical incidents	Director/HMS/HQ Mrs N. Casalis, Staff Counselor/HMS/HQ

Monday, 23 February

08:30–09:30	Partnership in WHO	Mrs Namita Pradhan, ADG/PUN
09:30–12:00	Financial management	Mrs S. Hammoud, BFO
	Imprest account	
	DFC	
	Award management	Mr R. Chelminski, ABF
12:00–14:30	Procurement of goods and inventory	Mr I. Asadi, LSO Mr H. Elkhodary, ASO
14:30–15:30	Security challenges	Mr P. Beaufour, Coordinator/ Security Services/HQ
15:30–16:30	Wrap up final discussion on actionable points on "Enabling functions"	

Tuesday, 24 February

08:30–10:30	Strategic challenges faced by the Division of Health Protection and Promotion; issues and the way forward:	Dr B. Sabri, DHS Dr S. Siddiqi, HSD
	Reaffirming primary health care in the Eastern Mediterranean Region: What next?	Dr I. Adbdelrahim, WR/Tunisia Dr H. Salehi, HEC
	The role of academic institutions in promoting primary health care in the Region	
	The impact of global financial and economic crisis on population health	
11:00–12:30	Strategic challenges faced by the Division of Health Protection and Promotion; issues and the way forward:	Dr H. Madi, DHP
	Introduction followed by discussion	
13:30–16:00	Three experiences and lessons learned by the Division of Communicable Diseases Control:	Dr J. Mahjour, DCD Mr P. Graaff, WR/Afghanistan
	Laboratory-supported surveillance in Afghanistan	Dr M. Abdur Rab, WR/Sudan
	Outbreak management and response within umbrella of the IHR (2005): recent experience in Sudan	Dr M. Everard, WR/Somalia
	Epidemiological surveillance in complex emergencies: experience and lessons learned	

Wednesday, 25 February

08:30–10:30	Preparation for operational planning 2010–2011 in GSM transition	Dr A. Assa'edi, ARD Dr S. Bassiri, PME
11:00–12:30	Role of the Secretariat in preparation for the meetings of the governing bodies	
14:00–15:00	Conclusions and recommendations	

Annex 3

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Special Advisers to the Regional Director
Assistant Regional Director
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All technical and professional staff
Senior Administrative Assistants