

Country Cooperation Strategy for WHO and Egypt 2010–2014

Egypt



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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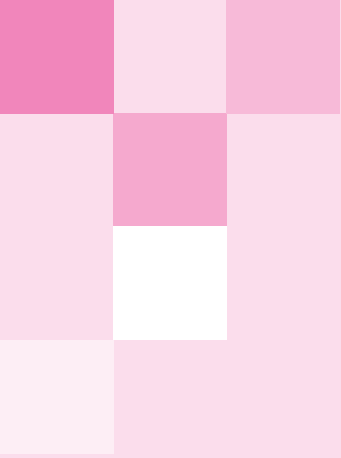
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❖ Abbreviations

AIDS	Acquired immunodeficiency syndrome
CCA	Common country assessment
CCS	Country cooperation strategy
CAPMAS	Central Agency for Public Mobilization and Statistics
GDP	Gross domestic product
GNP	Gross national product
HIV	Human immunodeficiency virus
HIO	Health Insurance Organization
IHR	International Health Regulations (2005)
ILO	International Labour Organisation
IMCI	Integrated management of childhood illness
IOM	International Organization for Migration
JPRM	Joint Programme Review and Planning Mission
MDGs	Millennium Development Goals
MOHE	Ministry of Higher Education
MOH	Ministry of Health
NAMRU-3	(U.S.) Naval Medical Research Unit No. 3
TRIPS	Agreement on Trade-Related Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United States Educational, Scientific and Cultural Organization
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization
WTO	World Trade Organization



Section

1



Introduction



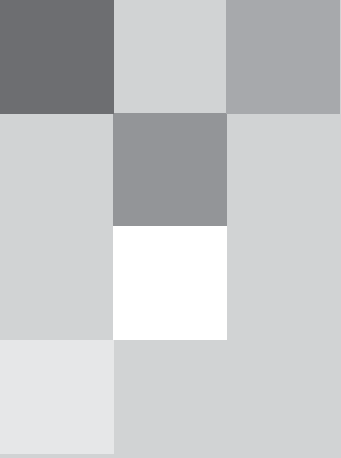
Section 1. Introduction

The Country Cooperation Strategy (CCS) reflects a medium-term vision of WHO for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS process, in consideration of global and regional health priorities, has the objective of bringing the strength of WHO support at country, Regional Office and headquarters levels together in a coherent manner to address the country's health priorities and challenges. The CCS, in the spirit of Health for All and primary health care, examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, the determinants of health and upstream national policies and strategies that have a major bearing on health.

The exercise aims to identify the health priorities in the country and place WHO support within a framework of 5 years in order to have stronger impact on health policy and health system development, strengthening the linkages between health and cross-cutting issues at the country level. This medium-term strategy does not preclude response to other specific technical and managerial areas in which the country may require WHO assistance.

The CCS takes into consideration the work of all other partners and stakeholders in health and health-related areas. The process is sensitive to evolutions in policy or strategic exercises that have been undertaken by the national health sector and other related partners. The overall purpose is to provide a foundation and strategic basis for planning as well as to improve WHO's contribution to the Member States for achieving the Millennium Development Goals (MDGs).

The CCS for Egypt is the result of analysis of the health and development situation and of WHO's current programme of activities. During its preparation key officials within the Ministry of Health as well as officials from various other government authorities, United Nations agencies, nongovernmental organizations and private institutions were consulted. The critical challenges for health development were identified. Based on the health priorities of the country, a strategic agenda for WHO collaboration was developed.



Section

2



**Country Health and
Development Challenges**



Section 2. Country Health and Development Challenges

2.1 Macroeconomic, political and social context

2.1.1 Population

Egypt is the second most populous country in the WHO Eastern Mediterranean Region. Its population at the end of 2007 was 73.4 million, of which 1.9 million were working/living abroad. Of the 71.5 million Egyptians living in the country, 37.5 million (51.2%) are male and 35.9 million (48.8%) female; 49.5% of the population are below 15 years of age and 3.4% are 60 years and above.

Over the past several decades Egypt has experienced a rapid transition to lower fertility. Since the late 1970s the total fertility rate has decline by more than 40%, from 5.3 as reported in the 1979–1980 Egyptian Fertility Survey to 3.0 in the 2008 Egyptian Demographic and Health Survey (Table 1).

Nearly 40% of the population lives in urban areas, with much of the population living in crowded conditions. In some areas of Cairo and Alexandria, the number of persons per square kilometre exceeds 100 000. There are approximately 16 million people who live in Egypt's 1105 slum areas which represent approximately 30% of residential areas. The availability of utilities, health and social services are severely limited in the slum areas.

2.1.2 Poverty

Egypt is a lower middle-income country. Its economy relies on four principal sources of income: tourism, remittances from Egyptians working abroad, revenues from the Suez Canal and oil. It has managed to improve its macroeconomic performance throughout most of the past decade in the areas of fiscal policy, monetary and structural reform. Recognizing the role of the private sector in development, the government has made job creation and creating an improved

Table 1. Demographic indicators, 2007

Total population (in thousands)	73 400
Percentage aged 0–14 (youth index)	49.5
Percentage aged 60+ (ageing index)	3.4
Total fertility rate (per woman)	3.0
Contraceptive prevalence rate (%)	60.3
Crude birth rate (per 1000 population)	25.3
Crude death rate (per 1000 population)	6.2
Annual population growth rate (%)	1.9
Life expectancy at birth (years)	71

Source: Egyptian Demographic and Health Survey 2008

Table 2. Socioeconomic indicators 2007

GNI per capita in US\$	1350
Human development index, 2006	0.716
Population below income poverty line (%)	16.7
Human poverty index rank	48
Human poverty index value	20

Source: UNDP Human Development Report 2008; World Bank report 2007; Egypt Human Development Report, 2008

climate for investment and private sector development specific priorities.

Gross domestic product (GDP) is estimated to be US\$ 89.4 billion (2005). Average growth fell from 4.6% in 1997–1998 to 3.0% in 2001–2002. GDP per capita in 2005 was US\$ 1207. Agriculture accounts for 14% of GDP, industry 30% and services 56%. The major export is petroleum and petroleum products (28.7%).

Poverty has declined over the past few decades with the Millennium Development Goal Second Country Report for Egypt suggesting that as a national average the MDG commitment to halve poverty by 2015 will be realized. A World Bank-supported Poverty Alleviation Study carried out in 2002 showed that poverty incidence fell from 19.4% in 1995–1996 to 16.7% in 1999–2000.

Although poverty in Egypt had been characterized by its rural nature, it recently has become a predominantly Upper Egypt phenomenon, with poverty increasing in rural and urban areas in Upper Egypt governorates. The MDG Second Country Report noted that between 1995 and 2000, poverty in Upper Egypt increased from 29% to 34% in rural areas and from 11% to 19% in urban areas. During the same period Lower Egypt experienced significant

reductions in poverty, from 13% to 5% in urban metropolitan centres and from 22% to 12% in rural areas (Table 2).

2.2 Health status of the population

2.2.1 Health indicators

Egypt has recorded major achievements in improving the health status of its population as reflected in the marked reductions in the 2007 crude death rate (6.2 per 1000 live births in 2007); infant mortality rate (19.2 per 1000 live births); under-5 death rate (23.3 per 1000 live births); and maternal mortality rate (44.6 per 100 000 live births).

2.2.2 Burden of disease

Egypt, like many other developing countries faces a dual disease burden: a persistent though much diminished communicable disease burden and a large and rapidly growing noncommunicable disease burden including mental health-related diseases (Table 3). Lifestyle factors and risk-taking behaviours such as smoking, substance abuse, lack of exercise, overconsumption of fatty and salty foods, non-use of seat belts and nonobservance of traffic rules contribute to a significant proportion of the overall mortality and morbidity.

Table 3. Leading causes of death in adults, 1987–1988 and 1999–2000

1987–1988		1999–2000
1	Lower respiratory infections	Fibrosis and cirrhosis of liver
2	Cerebrovascular disease	Essential (primary) hypertension
3	Hypertensive disease	Hepatic failure, not elsewhere classified
4	Other digestive diseases	Respiratory failure, not elsewhere classified
5	Ischaemic heart disease	Atherosclerosis
6	Nephritis and nephrosis	Cerebral infarction
7	Diarrhoeal diseases	Acute myocardial infarction
8	Cirrhosis of the liver	Arterial embolism and thrombosis
9	Asthma	Elevated blood glucose level
10	Other respiratory diseases	Others

Source: National burden of disease study

Overall, the age-adjusted mortality burden in Egypt declined by more than 10% in the ten years between 1990 and 1999. There was a substantial decline in the contribution of infectious diseases and an increase in the mortality burden for cardiovascular diseases, respiratory infections and other digestive diseases.

Regarding the burden of disability, neuro-psychiatric and digestive disorders are the leading causes of disability accounting for 19.8% and 11.5% respectively of the non-fatal burden, followed by chronic respiratory diseases (6.9%), injuries (6.7%) and cardiovascular diseases (5.6%). In terms of specific conditions, osteoarthritis, injuries and asthmatic bronchitis are the leading causes of disability.

The total burden of disease and injury in Egypt in 1999 amounts to 172 disability-adjusted life years (DALYs) lost per 1000 population. The disease groups contributing

most to the burden of disease are: cardiovascular disease (19.5%); digestive diseases (10%); neuro-psychiatric disorders (9.9%), injuries (8%); and chronic respiratory diseases (6.6%).

2.2.3 Communicable diseases

Communicable diseases have largely been controlled in Egypt; however diarrhoeal diseases, acute respiratory infections and hepatitis are still reported from health facilities. With high coverage rates for routine immunization, vaccine-preventable diseases have shown a remarkable decline in the past decade. Egypt experienced in 2007 a nationwide measles and rubella outbreak. This was the result of accumulation of susceptibility to those two diseases. When the needed financial resources had been available, the Ministry of Health developed an action plan to conduct a massive national vaccination campaign for measles and rubella in two phases for the target age

group of 1–20 year olds. The first phase, which targeted the age group of 10–20 year olds, was successfully implemented in 2008 as indicated in the international monitors' reports, while the second phase will take place in 2010. Egypt joined the regional rotavirus surveillance network and launched the national rotavirus surveillance programme in 2006; the incidence rate of rotavirus in children under five years old is 36.4 % and the case fatality rate is zero. With regard to meningitis due to *Haemophilus influenzae* type B, the Ministry of Health conducted surveillance in sentinel sites in Egypt during period 1999–2004 in collaboration with NAMRU-3, in which an estimated 300–500 cases of meningitis were registered annually due to *Haemophilus influenzae* type B. The Ministry of Health will plan another survey to determine the prevalence rate of *Haemophilus influenzae* type B.

Egypt has been polio free since 2006. The neonatal tetanus incidence rate is 0.06 per 1000 births. There were no reported cases of diphtheria. The incidence rate for typhoid and meningococcal meningitis was 10 and 0.26, respectively, per 100 000 population. Prevalence of *Schistosoma mansoni* infection decreased from 14.5% in 1995 to 0.9% in 2007, and the prevalence of *Schistosoma hematobium* infection decreased from 5.4% in 1995 to 0.6% in 2007.

Hepatitis B and C continue to be a public health problem in Egypt with data suggesting their incidence, particularly hepatitis C, may be increasing. A 1996–1997 survey of individuals aged two years or older indicated the overall prevalence of anti-HCV and HBsAg was 18.9% and 4.5%, respectively.

In 2003, a sample of 200 000 persons seeking work abroad were screened and the prevalence of hepatitis B infection was found to be 1.25% and hepatitis C, 6.5%.

Tuberculosis is considered to be the third most important communicable disease problem after schistosomiasis and hepatitis C. Egypt ranks among countries with mid/low level of tuberculosis incidence. It is estimated that 11 cases per 100 000 population are developing active pulmonary smear positive tuberculosis and 24 per 100 000 are developing all types of tuberculosis annually. The case detection rate for smear positive tuberculosis was 59% in 2006, while treatment success rate is 79% for cases registered in 2005. The population standardized average age for tuberculosis is 38 years with most cases in the age group of 35–64 years.

The Ministry of Health indicates a total of 2393 cases of HIV/AIDS from 1986 up to the end of August 2008 (1534 HIV infections + 859 AIDS cases), with 1059 deaths up to the end of August 2008. The prevalence of HIV/AIDS among 15–49 year-olds is approximately 0.03%. According to UNAIDS, Egypt appears to be at a low epidemic level. The primary mode of HIV transmission is through sexual contact. Mother-to-child transmission is thought to be negligible. Epizootic outbreaks of avian influenza were reported in Egypt with 20 human cases and 5 related deaths confirmed in 2007. Most human cases of influenza A/H5N1 in Egypt had exposure to backyard poultry.

2.2.4 Chronic noncommunicable diseases

The prevalence of hypertension and diabetes mellitus in the adult population

is around 26% and 9%, respectively. A survey for detection of pre-diabetes in the governorates of Cairo, Menoufia and Sohag found the prevalence to be 11%, 7% and 18%, respectively. Around 1.0% of the population are blind, mainly due to cataracts; a high prevalence of trachoma is reported in some governorates. The incidence of cancer is approximately 110–120 cases per 100 000 population. The four commonest cancers in the country are breast, liver, bladder and lymph node.

The major challenges facing the area of noncommunicable diseases include: the need for better surveillance and inclusion of noncommunicable diseases in the national surveillance and reporting system; improvement in early detection; integrated service delivery; lack of a reliable referral system; and the need for a more rational use of drugs for treating this group of diseases.

2.3 Socioeconomic and environmental determinants of health

2.3.1 Education

Since the early 1990s Egypt has demonstrated a strong commitment to education as a key development tool, embarking on an ambitious and comprehensive programme of educational reform. Adult literacy rates (age 15 and older) have improved significantly from 44.4% in the period 1985–1995 to 71.4% in the period 1995–2005. The youth literacy rate (age 15–44), an MDG indicator, has increased over the period 1996–2007, from 73.2% to 86.2%.

As a result of concerted efforts to promote gender equality in the field of education, the disparity between women and men has been reduced, with the ratio of literate women to men and 15–44 years increasing from 0.85 to 0.91 during the same period.

2.3.2 Nutrition and food security

Egypt's national nutrition strategy formulated in the 1990s provided for several initiatives designed to improve nutrition and control micronutrient deficiencies such as iron and vitamin A. Although indicators of child health have improved, malnutrition still constitutes a serious problem, especially in rural areas.

The trends in nutritional status during the period 1992 and 2008 as reported in the preliminary 2008 Egyptian Demographic and Health Survey indicate a recent deterioration in the nutritional status of children. Data on height-for-age indicate that approximately 25% of Egyptian children under age five have chronic malnutrition, with rural children slightly more likely to be stunted than their urban counterparts (26% and 23% respectively). The weight-for-height index which provides a measure of wasting or acute malnutrition indicates approximately 7% of Egyptian children under age five suffer from acute malnutrition, with the highest levels of wasting observed in the urban governorates (8%). A third measure of nutritional status, weight-for-age which is a composite of height-for-weight and weight for height, reflects effects of both chronic and short-term malnutrition. 8% of children under the age of five years are underweight for their age. The highest proportion of underweight children are in Upper Egypt.

The high level of stunting seen in Upper Egypt appears to be due to insufficient household food security, inadequate feeding and caring practices, and high infection rates. As noted in the MDG Second Country Report, girls in poor families show a higher prevalence of all types of under-nutrition as well as higher infant and child mortality rates, a result of gender discrimination in the family.

As indicated in the UN Common Country Assessment 2005 (CCA), approximately 75% of the population benefit from food subsidy programmes to fulfil their basic food needs. These programmes provide basic supplies including bread, sugar, oil, rice, lentils and tea at less than a quarter of market price.

Egypt depends on cereals as its most important food staple, with wheat constituting 55% of food consumption requirements. With local production wheat and coarse grains not satisfying the level of demand, Egypt depends on importing 50% of the food required to feed the population.

A further issue related to nutrition and food security has been the spread of a highly pathogenic avian influenza which moved across Asia and into the Middle East in early 2006. The poultry industry had expanded rapidly over the past 25 years with low-cost poultry meat becoming increasingly available, particularly to the poor. Each day, large numbers of live birds move between communities the length of the Nile Valley, bought by traders and slaughtered in local markets and with some kept in backyards for slaughter at home. With many of the

approximately 40 000 poultry farms lacking biosecure production systems, there is threat of a major outbreak in the country's poultry industry. With reduction in poultry intakes as part of the normal diet (poultry accounting for approximately 55% of the per capita animal protein consumption) highly pathogenic avian influenza holds the potential of becoming a serious food security issue.

2.3.3 Drinking-water

Approximately 100% of the urban population and 97% of the rural population have access to improved drinking-water supply. 99% of the urban population have piped water in their homes and 74% of the population in rural areas have a household connection; 6% drink water from public taps while the remainder drink water from covered wells.

Despite the impressive coverage rates for rural areas, the level of service still leaves room for considerable improvement. It is reported that a large percentage of the rural piped water systems perform badly. Systems sometimes supply water less than a few hours per week; the water quality in a number of systems also needs improvement.

2.3.4 Sewerage and sanitation

The percentage of population with access to improved sanitation facilities, one of the MDG indicators has seen a steady increase from 50% in 1990 to 66% in 2006¹. Coverage in urban areas increasing from 68% in 1990 to 79% in 2000 and rural areas from 37% to

¹ The UN Statistical Division's MDG indicators database reports lower figures than those in the 2007/2008 Human Development Report country fact sheet; 54 % of population having access to improved sanitation in 1990 and 70 % for 2004 (http://hdrstats.undp.org/countries/data_sheets/cty_ds_EGY.html)

47%. In terms of sewage systems, coverage is 62% in urban areas. Cairo has the best sewerage service in the country with about 97% of the buildings connected. Sewerage service rates in small rural towns average less than 11%.

2.3.5 Air pollution

Air pollution in Egypt, especially in Cairo and Alexandria, has been of concern for a number of years. Particulate matter is the most common air pollutant in urban and industrial areas. The few epidemiological studies of air pollution in Egypt have indicated a significant increase in chest problems for those exposed to high levels of particulate in the residential industrial areas. Furthermore, particulate matter and lead pollution have been recognized as the most deleterious agents to health in Cairo's environment. High levels of lead were recorded in the major Egyptian cities during the 1980s and 1990s. However, lead was completely phased out from petrol distributed in Cairo, Alexandria and most of the cities of Lower Egypt in late 1997, and consequently, lead concentration in the atmosphere of Cairo city centre and residential areas decreased markedly during the years 1997–2002 reaching less than 30% of those recorded during the early 1990s.

2.4 Health systems and services

2.4.1 Health service delivery

The health care system in Egypt is quite complex with a large number of public entities involved in management, financing and the provision of care. The Ministry of Health is responsible for overall health and population policy including the provision

of public health services as well as being the major provider of the inpatient-based curative system. The Ministry of Higher Education is responsible for medical education as well as service delivery and the Health Insurance Organization (HIO) is both an insurer/financier and provider of care to employees, students, widows, pensioners and the newborn (covering about 45% of the Egypt's population). Care also is provided by the ministries of defense, transport, aviation, electricity and interior, the Teaching Hospital Organization, Curative Care Organization, other public sector organizations, nongovernmental organizations, private hospitals and clinics.

Egypt's wide network of public, nongovernmental organization and private health facilities allow good geographic accessibility (Table 4). The public sector's health care infrastructure comprises varied types of health facilities providing a broad array of services and levels of care. The Ministry of Health primary health care facilities provide for: maternal and child health services; communicable diseases control; environmental health services; health education; parasitic and endemic diseases control; school health services; curative and emergency care (general practitioner level); family planning; and dental care.

With regard to secondary and tertiary care, there are 139 619 hospital beds in the country, of which 33 063 are in Cairo, 10 930 in Giza, and 10 092 in Alexandria. The vast majority of these beds are in the public sector which appears to have excessive capacity and low occupancy rates, less than 50%.

Table 4. Different types of health facilities for primary health care (2007)

Type of health facility	Number
Rural health units	4254
Urban health centres	298
Urban health clinics	127
Maternal and child health units	237
Health offices	401
Mobile clinics	500+

Government-owned hospitals are the only choice available to low-income groups who constitute the majority of Egypt's population. These hospitals are however, hampered by the huge demand and the government's failure to keep up with escalating costs, financial shortages, inefficient use of available resources, and ineffective management. This has led to a lack of public confidence with people turning to the private sector.

The private sector in Egypt plays an important role in delivering health care. It manages private clinics as well as specialized hospitals where people pay relatively high fees for what they consider better services. The private sector network includes general practitioners, specialists, dentists, psychiatrists, laboratories, pharmacists, etc. Competition in the private sector has induced the private hospitals to provide optimum care and over the years this sector has become highly rated in the Region.

Chemical safety

The infrastructure for dealing with chemical safety in Egypt is limited. An integrated chemical safety programme, implemented in a coordinated manner among the different responsible authorities, does not yet exist.

Existing control measures are fragmented and do not provide complete coverage for the country. There is often a lack of coordination, even within ministries and authorities.

HIV/AIDS

Although there is an active national AIDS programme, which includes voluntary testing and counselling services and the provision of antiretroviral therapy, Egypt faces a number of challenges in maintaining a low prevalence of HIV/AIDS. These include: a weak system of prevention and surveillance for sexually transmitted diseases; poor access to reproductive health information; an influx of refugees from Sudan and the neighbouring Horn of Africa; the large number of Egyptians working abroad who may return home with HIV infection; pervasive fear and stigma; and low condom demand and use.

Injury prevention and control

Mortality, morbidity and disability caused by injuries are an emerging health problem. In 1991, the Ministry of Health agreed to examine the impact of injuries on the population to evaluate the problem. Following the recommendations of this study, and to further evaluate the magnitude

of the problem, the Ministry of Health issued a decree establishing a national high committee for injury control and prevention, represented by all concerned agencies. A collaborative programme was started with WHO on the development of a national plan for safety promotion and an information system for injury surveillance. Other measures that were taken included the establishment of an injury surveillance system, supervised by the Occupational Health Department, Ministry of Health, and the convening of an interministerial working group to discuss the results of the data analysed and to make recommendations to each reporting site regarding the different types of injury.

Malaria control

Since 1998 no indigenous malaria cases have been reported by the malaria control programme anywhere in the country. However, imported cases are regularly reported mainly from sub-Saharan Africa. The main issues and constraints faced by the malaria control programme are: 1) the regular importation of the parasite by Egyptians traveling to endemic countries and by foreign visiting Egypt; 2) the loss of experience by public and private professionals in the diagnosis and treatment of malaria and the limited awareness among travelers to endemic areas; and 3) lack of coordination with related sectors. The main priorities are therefore to strengthen the malaria surveillance and information system, reinforce malaria notification and improve the capacity of health staff to diagnose and treat malaria in the public and private sectors.

Mental health services

Although efforts are being made to decentralize mental health and psychiatric services, most resources are allocated to a few large centralized psychiatric hospitals. The number of beds available for psychiatric patients is inadequate for provision of acute inpatient care, particularly as 60% of the beds are occupied by long stay patients. Progress has been made in increasing community awareness of the rights of mental patients to live in the community and the passage of new legislation organizing community psychiatric treatment.

There are a number of challenges in the area of mental health and psychiatric services. In spite of the fact that mental health-related conditions constitute about 14% of the global burden of disease, the budget allocated for these diseases is far less, proportionally. The number of hours given for training in mental health in medical schools and other health training institutions is limited and does not reflect the importance of this field as a contributor to morbidity. Mental health needs to be integrated into primary health care on a nationwide basis; community awareness needs to be raised regarding the hazards of substance abuse. In addition there is an increasing need to develop services in mental health care subspecialties with child and adolescent, forensic and old age psychiatry developed as disciplines with decentralized services provided.

Reproductive and child health services

The Ministry of Health provides comprehensive services for reproductive health including maternal and child health

care, family planning clinics, and the introduction of youth-friendly and pre-marriage clinics.

Integrated management of childhood illness (IMCI) focuses on three components: 1) improvement in the quality of health services delivered to children; 2) improving the quality of the health information system, supervision, drug availability, organization of work in health facilities and strengthening of the referral system; and 3) improving family practices where progress has been slow compared with the other two components. Currently, IMCI is being implemented in 19 out of 26 governorates, in 102 out of 246 districts and in 1912 out of a total of approximately 4500 health facilities in the country. The results of evaluation activities, such as follow-up visits and an IMCI health facility survey, have shown the positive effect of IMCI on improving the performance of health providers and health facilities.

Surveillance activities and infection control

Egypt maintains a national system for surveillance of 26 communicable and endemic diseases, covering all districts in the country. A STEPwise approach for surveillance of risk factors for noncommunicable diseases is under development. The coordination of surveillance activities for communicable and noncommunicable diseases including traffic injuries lies with the Epidemiological Surveillance Unit, which was established in the Ministry of Health in 1999.

Ensuring comprehensive coverage of reported data remains a problem, as reporting by the private sector and from facilities

maintained by other organizations, such as the HIO and the armed forces, is limited. The laboratory support for surveillance needs strengthening.

The Ministry of Health has an active programme for control of infections in hospitals and other health care facilities which is in need of additional resources to cover all governorates and to provide the necessary consumable supplies of good quality to hospitals.

Tropical disease control

Egypt has achieved low endemicity of intestinal schistosomiasis and almost eliminated urinary schistosomiasis following the successful implementation of a strategy based on repeated, regular treatment with anthelmintics of school-age children, the highest risk group. Treatment is provided through the primary school health system and other ongoing health or education programmes.

In order to sustain low endemicity and to ensure the elimination of at least the urinary form of schistosomiasis, new strategies based on sensitive surveillance tools need to be adopted to prevent resurgence and recrudescence. School-based deworming campaigns need to be continued in uncovered areas, particularly in Upper Egypt.

Although regularly decreasing, the number of new leprosy cases in Egypt remain high with 887 new cases reported in 2007. To sustain the integrated approach in diagnosis and delivery of multidrug therapy to persons with leprosy, additional resources are required and the integrated referral system strengthened, especially at peripheral levels.

Prevention of disabilities and rehabilitation activities remain the main challenges in elimination of leprosy.

2.4.2 Pharmaceuticals and biologicals

Egypt produces over 90% of the pharmaceuticals it consumes. Pharmaceuticals account for just over one-third of all health spending, of which approximately 85% is private expenditure. Publicly produced medicines are heavily subsidized, which to a considerable extent accounts for their overuse. There is a great need to promote the rational use of medicines and to train health professionals in this regard. There is also a need to improve communication between pharmacists and doctors to facilitate the prescribing of generic medicines.

There are a number of problems facing the pharmaceutical services. The laws and regulations covering different aspects of the work of the Secretariat for Pharmaceutical Affairs in the Ministry of Health, such as licensing of pharmaceutical firms to produce medicines, registration of medicines and inspections are outdated and need revision. There are problems connected with storage and transportation of medicines and with maintenance of up-to-date inventories at

the various levels of the health care system. The management skills of staff need to be upgraded and an appropriate information system developed to facilitate performance monitoring and evaluation.

Concerns have been expressed regarding the expected impact of the WTO agreement on TRIPS on the national pharmaceutical industry and on access to medicines. National laws and by-laws have been updated to prepare for expected developments.

Egypt is one of the four countries in the Region that is a major producer of vaccines. The goal of the Region is to become self-sufficient in its need for quality-assured vaccine. However, only about 18% of the vaccines that are utilized in the Region are manufactured locally and none meet the WHO vaccine pre-qualification requirements of assured quality. The technical capacity of the national regulatory authority for vaccines in Egypt is still weak and needs to be strengthened to meet functional requirements.

2.4.3 Health workforce

The numbers of physicians, dentists, pharmacists and nursing and midwifery personnel are above the regional average (Table 5).

Table 5. Human resources indicators, 2009

Category	Number per 10 000 population
Physicians	28.3
Dentists	4.2
Pharmacists	16.7
Nursing and midwifery personnel	35.2

Source: The work of WHO in the Eastern Mediterranean Region. Annual report of the Regional Director 2009.

The Ministry of Higher Education is responsible for medical education. However, there does not appear to be an effective mechanism of coordination between the Ministry of Higher Education and Ministry of Health to ensure that the training and production of doctors takes into account the needs of the health system, including preventive, curative and promotive aspects. Information on human resources remains fragmented. Concerns have also been expressed about the relevance of the curriculum as well as of the quality of training imparted in medical schools.

To address these concerns, a medical education reform initiative has been undertaken between the Faculty of Medicine in Alexandria and WHO to pioneer reforms in health professions education institutes in Egypt. Among the initiative's focuses are: the adoption of national standards based on prepared regional standards; establishment a national accreditation system that will enable medical school graduates in Egypt to meet the global standards for medical education and practice; continuous quality improvement in medical education; and the preparation of guidelines and practical tools on how to plan, implement and evaluate reform interventions.

The Ministry of Health is involved in the production of technicians and nurses who staff primary health care facilities. The technical departments in the Ministry of Health indicate their requirements for various categories of technicians and nurses and the Ministry of Health then negotiates with the schools of nursing and technical institutes for their production. This mechanism provides an effective balance between the needs

for and the production of these categories of health personnel. However, there are problems with the quality of training, which needs to be more skills-oriented and less theoretical.

2.4.4 Financing

Egypt has pluralistic and complex financing mechanisms: tax-based financing; health insurance; and fee-for-service through out-of-pocket expenditures. Tax based revenues mainly support four major publicly organized and managed services: Ministry of Health facilities; university hospitals; Defence ministry hospitals; and some Health Insurance Organization services such as school health.

Egypt is a low health care spender compared to countries of similar levels of economic development. Public health expenditure, low compared to other countries in the Region, has slowly increased from 5.9% in 1997 to 7.4% of total public expenditure in 2001. Health insurance, which has existed since 1964, covers about half of the population, particularly civil servants, government retirees, students and pre-school children. Those covered with health insurance can choose to go either to private or public hospitals for services. A significant proportion of population, approximately 50%, pay out-of-pocket at the point of service in public and private health facilities.

To achieve universal coverage, Egypt is rolling out a new insurance scheme, currently being piloted in Suez Governorate, based on a 'family physician model' which will separate financing from service provision. While the Government has embarked on social health insurance as stated above, it

will be faced with a series of challenges in the near future, as a) the expenditure in health is relatively low, about 4% of GDP; b) the out-of-pocket expenditures is comparatively high, about 50%; and c) the premium in the current health insurance is considered to be too low, and has been set without any systematic actuarial studies. In addition, the United States Agency for International Development (USAID), one of the significant contributors to the health sector, will be withdrawing its assistance from the health sector in 2009 as a result of the Egypt's significant progress in improving health status; and it is unclear what will be the implications of global severe financial crisis. Government will therefore need to mobilize additional internal and external resources to invest in health if it is to ensure universal access to basic health services without the risk of severe financial consequences.

2.4.5 Governance

The governance of Egypt's complex health system requires further strengthening. Health policies and strategies often are not supported by evidence and regulatory mechanisms are not well developed. The health system remains highly centralized despite efforts being made to decentralize to governorate and district levels. Coordination within the Ministry of Health and with other related agencies and ministries remains weak.

2.5 Main national health policy orientation and priorities

2.5.1 Health sector reform programme and Healthy Egyptians 2010

The principal national health policy orientation and priorities have been articulated through the government's health sector reform programme and Healthy Egyptians 2010.

The health sector reform programme, initiated in 1997 and due to continue through 2018, reflects five guiding principles:

- Universality: covering the entire population with a basic package of priority services. Every person in the country will have the same access to and benefits from basic health care.
- Quality: improving and assuring the standards of health care and facilities, enhancing diagnostic and clinical effectiveness, and updating medical and nursing education and training. Professional and ethical treatment, public satisfaction and trust should characterize the health care system.
- Equity: financing for health care services is based on ability to pay, while the provision of services is based on need. All regions of the country and people of all income levels will have a fair share in the health system.
- Efficiency: allocating and mobilizing human and infrastructure resources for health care based on population needs and cost-effectiveness. The government and citizens will obtain the best health value for money.

- ❖ Sustainability: ensuring the continuity, self-sufficiency and lasting establishment of the health care system reforms, and services for the health and well-being of future generations.

The primary objectives and features of health sector reform are presented in Tables 6 and 7. To attain these objectives, the health sector reform programme focuses on reforms in the areas of pharmaceuticals, human resources, health care services, financing, infrastructure and institutional development.

Major challenges facing the implementation of health sector reform include: delays in infrastructure development (civil works and procurement of supplies) due to complicated procurement procedures that vary from donor to donor; limited availability of an adequate number of family physicians; absence of sustainable of financial resources for financial incentives; insufficient advocacy and marketing; and limited community participation.

Table 6. Health sector reform objectives

Universal coverage with a basic package of primary health care	Develop and implement governorate primary health care insurance systems
	Improve quality and efficiency of the governorate primary health care delivery system
	Reform public health programmes
Reform of the Health Insurance Organization (HIO)	Assure financial solvency and sustainability
	Improve management and contracting abilities
	Begin divestiture of the HIO delivery system

Table 7. Important features of health sector reform

Foundation of an efficient quality health care delivery infrastructure
Prevention and promotion-oriented
Adopting the “family doctor” concept and encouraging his/her role in serving people and communities
Expanding health insurance to cover new population groups, especially vulnerable groups, the poor and underserved rural areas
Cooperation and integration with different ministries, agencies and organizations to face the challenges related to health and the most important environmental health issues
Paying more attention to and investing in human resources development through increasing the number of doctors and nurses trained in Egyptian institutes or sent abroad to study or to be trained
Encouraging the Egyptian and Arab pharmaceutical industry, and assuring availability at affordable prices

A second input to the national health agenda, Healthy Egyptians 2010, focuses on disease prevention and health promotion priorities and includes the development of strategies aimed at behavioural change. Crafted by the Ministry of Health in collaboration with the United States Department of Health and Human Services and USAID, Healthy Egyptians 2010 programmes use evidence-based data to establish targets to measure progress over a specified time.

2.5.2 National application of the International Health Regulations (2005)

Egypt is a party to International Health Regulations 2005 (IHR) and since then several activities had been accomplished

such as; identify national official responsible for International Health Regulations, coordination and collaboration with different ministries and organizations (agriculture, airports, food safety, environment affairs, tourism, local administration, interior) to implement IHR, carry out a number of training courses and workshops for health care providers including the Quarantine staff to raise their competence, assess the capacity and surveillance preparedness in different sites in order to comply with annex A1 of IHR ,an action plan is prepared to implement surveillance and response in the governorates as well as a contingency plan according to annex A1, and modification of some regulations and legal procedures had been done in order to comply with IHR.



Section

3

Development Cooperation
and Partnerships



Section 3. Development Cooperation and Partnerships

3.1 Summary of key issues and challenges related to aid effectiveness

The health sector has benefited from the support and collaboration with Egypt's bilateral and multilateral development partners. Nonetheless there are key issues and challenges that remain to be addressed to further enhance aid effectiveness, establish greater alignment of international cooperation with the national health agenda, increase harmonization of international cooperation, and accountability for results. Specifically, there is a need to: address the diverse nature of the development partners' priorities and focuses, payment mechanisms and conditionalities of funding; and support the Ministry of Health to further strengthen its capacity to exert effective leadership within the health sector to better deal with other governmental entities, national and international development partners.

3.2 Aid environment in the country

The overall external support to the health sector constitutes approximately 2% of the total national expenditure on health. The principal providers of bilateral support to the health sector during the fiscal years 2006–2007 and 2007–2008 are the African Development Fund, the European Commission, the Japanese Development Fund, the World Bank, and USAID (Table 8). As stated earlier, USAID is reducing its assistance to the Ministry of Health and will end its support to the health sector in 2011.

The health sector also receives bilateral support from the Governments of Finland, Italy, Netherlands, Spain and Switzerland.

Among the United Nations agencies represented in Egypt, technical and modest financial support to the health sector is provided by WHO and UNFPA, which has a number of agreements with the Ministry of Health in the field of family planning and

Table 8. Principal providers of bilateral support in fiscal years 2006–2007 and 2007–2008 (in Egyptian pounds)

Provider	2006–2007	2007–2008
European Commission	404 941 079 (grant)	147 273 118 (grant)
World Bank	106 678 004 (loan)	31 708 972 (loan)
United States Agency for International Development	6 840 991 (grant)	
African Development Fund		70 156 771 (loan) 2 021 502 (grant)
Japanese Development Fund		31 708 972 (grant)

reproductive health. The Ministry also has agreements with other agencies that have an impact on health including UNICEF, which continues to support efforts to maintain Egypt's polio free status, micronutrient programme, and women and child health-related issues, as well as UNAIDS, UNDP and ILO.

3.3 National ownership

The national health agenda, the basis for bilateral and multilateral cooperation, has been articulated through the government's health sector reform programme and Healthy Egyptians 2010, both of which are government initiatives reflecting nationally perceived needs and rooted in a national policy formulation process.

3.4 Alignment of international cooperation with the national health agenda

Bilateral and multilateral agreements between the Ministry of Health and other governmental institutions and the donor community including UN agencies are reviewed by the parties prior to their signing to ensure their compliance to national policy and the long-term national health strategic plan. The agreements are reviewed and approved by the parliament.

Within the Ministry of Health, the Department of Projects coordinates all health and population projects and aid flows to the Ministry with a view towards preventing overlap and duplication and ensuring more effective mobilization and utilization of resources. The Department maintains a projects map that reflects the availability of funds supporting the long-term

strategic plan and identifies funding gaps which are brought to the attention of the donor community.

3.5 Harmonization of international cooperation

Despite the efforts to align international cooperation with the national health agenda, there remains inadequate coordination between the substantial number of programmes funded by bilateral or multilateral donors/development agencies and existing national programmes funded by the government. To address these concerns and to better harmonize international cooperation, a Donors' Advisory Group was established to serve as a coordinating body between the Government of Egypt and the donors to the various sectors.

A subgroup of the Donors' Advisory Group serves as a coordinating body between the Ministry of Health and donors that are active in the field of health. This subgroup coordinates relations between the donors and the Ministry of Health and among the donors themselves. It also supports the Ministry of Health in developing a strategic plan to demonstrate gaps in external support and to coordinate action to fill the gaps identified. The subgroup's effectiveness, as seen by some of its members, has been limited by confusion over the principles of its establishment, unclear terms of reference and a lack of leadership attributed in part to a rotating chair.

3.6 UN reform status and process

The UN country team operates within the "deliver as one" framework guided by the

UN Common Country Assessment (CCA) and UN Development Assistance Framework (UNDAF).

The CCA, seen as a planning tool to support Egypt's national development priorities, adopts a nationally owned twin-track strategy for UN system assistance. The twin-track strategy supports: 1) projects and programmes to help Egyptian citizens improve their quality of life and individual welfare through better social services, including health nutrition and education; and 2) the government and its institutions to perform their duties more adequately in the pursuit of realizing the millennium development goals and the protection of established human rights norms.

The UNDAF strives to place human rights at the centre of United Nations system activities in Egypt, a key aspect of which is the country team's efforts to apply a human rights based approach to development. Flowing from the twin-track strategy, the UNDAF focuses on five cross-cutting priorities identified by the UN country team, the government and development partners:

- ❖ improving the state's performance and accountability in programming, implementing and coordinating actions, especially those that reduce exclusion, vulnerabilities and gender disparities
- ❖ reduction in unemployment and underemployment, and elimination of the worst forms of child labour
- ❖ reduction in regional human development disparities, including reducing the gender gap, and improving environmental sustainability
- ❖ improving women's participation in the workforce, political sphere and in public

life and increasingly fulfilling all their human rights

- ❖ firmly establishing democratic institutions and practices and a culture of human rights through active citizenship.

Though envisaged as cross-cutting, the UNDAF places less emphasis on health than had been suggested in the CCA. The role of WHO as the lead technical support agency in health is recognized within the UN country team. Those agencies with health-related programmes, including UNICEF, UNFPA and WFP, continue to seek out and actively engage in partnerships with WHO. In some cases, these agencies have expressed interest in making greater use of WHO's regional technical expertise.

3.7 Managing for results and mutual accountability mechanisms

The Government of Egypt employs number of mechanisms for ensuring accountability. All international cooperation between the government and the international donor community is monitored and evaluated at the political, inter-ministerial and operational levels. At the political level parliament ensures compliance with national policy and strategies; parliament reviews implementation and performance through the government's annual disbursement reports and the Central Agency for Accounting's monitoring report. At the inter-ministerial level, technical and financial monitoring and evaluation is conducted by the Central Agency for Accounting on a regular quarterly and annual basis. This is supplemented by ad hoc missions to ensure

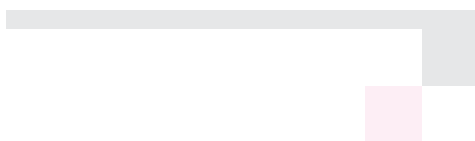
the optimal utilization of funds and their adherence to the programmes and strategic plans. Finally, at the operational level, the technical monitoring and evaluation to measure impacts within the Strategic plans is carried out by the projects themselves and the Ministry of Health programmes that host those projects.

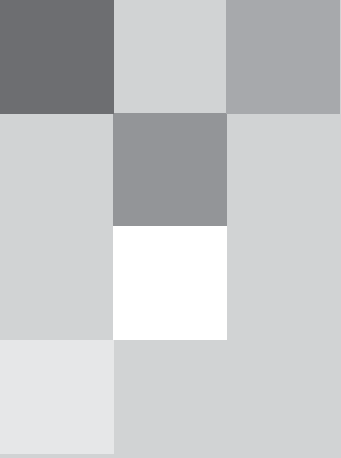
3.8 Implications of the new aid environment for WHO

The new aid environment which can be characterized by a greater consensus for supporting Egypt's national health agenda

combined with its recognized role as public health adviser to the Ministry of Health places greater demands on WHO in terms of technical support and as a voice to advocate for health.

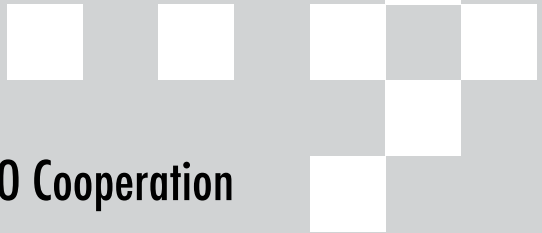
To fulfil its technical support role, WHO must develop alternative ways of working to enhance the level and scope of its technical cooperation with government and development partners. Within this new environment, the ability of the country office to draw greater support from the Regional Office and headquarters becomes critical.





Section

4



Current WHO Cooperation



Section 4. Current WHO Cooperation

4.1 Overview

4.1.1 Main areas of focus

WHO provides technical support to national health programmes and to address emerging health issues. The collaborative programme between the Government of Egypt and WHO is planned jointly every two years. The report of the Joint Programme Review and Planning Mission (JPRM) includes strategic objectives to be supported, and expected results to be achieved through defined products, activities and activity components by resources required from either the regular budget or voluntary contributions. The detailed plans of the JPRM show what is to be done, when, where, by whom and the budget allocated.

The main areas of focus of the WHO collaborative programme with Egypt are: communicable disease control; health promotion and protection; and health systems development.

In addressing these areas, emphasis has been placed on:

- Strengthening the revised epidemiological surveillance system and its laboratory support as well as operationalizing and expanding the rapid epidemic response and preparedness plans (especially towards avian and pandemic influenza);
- Supporting programmes for elimination of some tropical and communicable diseases.

- Supporting effective programmes for reducing morbidity and mortality particularly in the underprivileged population;
- Adoption of a health care package of health care benefits and public health functions with clear direction towards health promotion and protection, disease prevention, early detection, management and control, all these to be made equitably accessible to achieve universal coverage;
- Fostering healthy lifestyles by enhancing positive dimensions of health promoting environments, conditions and interventions supportive to healthy lifestyles and discouraging negative attitudes and behaviours;
- Human resources development for all levels of health care with emphasis on family health practices and quality management. In this regard a more efficient intersectoral collaboration will be developed;
- Building an integrated health information system covering all areas and levels with a capacity for informatics support at all levels;
- Operationalize the national medicine policy aimed at expanding equitable access to essential medicines and biologicals of good quality, and to rationalize use of medicines.

4.2 WHO structure and ways of working

WHO has been able to leverage its technical support to contribute more effectively to

health development in Egypt through its unique position as the public health adviser to the Ministry of Health, its role in promoting action-oriented intersectoral collaboration in health-related programmes and the use of WHO collaborating centres.

4.2.1 Advisory role

As public health adviser to the Ministry of Health, WHO has coordinated inputs to the health sector through the donor's forum on health sector reform which includes but is not limited to the World Bank, USAID, European Union. WHO has undertaken similar roles in:

- ❖ the National High Committee for Avian Influenza Control
- ❖ the tripartite alliance (with Ministry of Health and NAMRU-3) for control of emerging infectious diseases and the programme for strengthening epidemic response and infection control
- ❖ strengthening bilateral collaboration with the primary donors to ensure that their input supports the government's national strategic health approaches.

4.2.2 Coordination role

WHO continues to take an active role in fostering cooperation among UN agencies, working successfully with the UNICEF in routine immunization activities, polio eradication and IMCI expansion, with UNHCR and UNFPA in the displaced Iraqis programme, and with UNICEF, UNAIDS, UNFPA, IOM, UNESCO, UNDP and Ministry of Health in HIV/AIDS control.

WHO has been successful in initiating several activities in the area of promoting action-oriented intersectoral collaboration in health-related programmes including:

polio eradication and filarial elimination; environment-friendly schools (with the Ministry of Education); injury control and prevention (with different Ministry of Health departments, Ministries of Interior, Transport, Youth and Sports, Education and mass media); and controlling avian influenza (with the Ministry of Agriculture, FAO, NAMRU-3 and WFP).

4.2.3 WHO collaborating centres

WHO relies, in part on a network of collaborating centres to supplement its own technical expertise. Current WHO collaborating centres in Egypt are as follows.

- ❖ United States Naval Medical Research Unit No. 3 (NAMRU-3) as a centre for AIDS and emerging infectious diseases
- ❖ Faculty of Medicine, Suez Canal University, as a centre for research and development in medical education and health sciences
- ❖ Theodor Bilharz Research Institute, Ministry of Health, as a centre for schistosomiasis control
- ❖ Ain Shams University Hospitals, as a centre for training for mental health research and training
- ❖ National Nutrition Institute, Ministry of Health, as a centre for research and training on nutrition with emphasis on assessment of nutrition status and iron deficiency anaemia

4.3 Resources

The office of the WHO Representative is located on the grounds of the Ministry of Health. The WHO office consists of four rooms. The strategic health agenda outlined in the CCS places great demands on the WHO country office in providing

quality advocacy and technical support. With only two permanent technical staff, the WHO Representative and a national professional officer, the country office is stretched to meet the requirements for implementing the health agenda as well as providing the necessary visibility for the work of WHO.

As noted previously, WHO supplements its in-country technical expertise by making use of WHO collaborative centres in Egypt. Nevertheless, WHO's effectiveness will depend on increasing its permanent in-country technical staff. Recently the country office has considered contractual arrangements with additional credible institutions to compensate for the shortage of staff. However, such arrangements require technical oversight by WHO staff to ensure quality and when necessary provide

technical advice. The use of contractual arrangements thus is an interim solution until the issue of staff shortages is resolved.

The lack of office space and shortage of technical staff have been identified as issues in the previous Egypt CCS (2004–2010). The situation has been reviewed further during the current CCS process with realistic measures proposed to resolve what has proven to be a chronic problem.

Addressing the lack of adequate space and the shortage of staff will remove significant constraints to the implementation of the strategic agenda described in section 5. However, if the current staff shortages in the WHO country office persist, it may be required to revisit the agenda for WHO support to make the necessary adjustments.



Section

5



Strategic Agenda
for WHO Cooperation



❖❖ Section 5. Strategic Agenda for WHO Cooperation

5.1 Guiding principles and policy framework for WHO work in countries

The guiding principles and overall policy framework for work of WHO as the world's health agency, are set out in the Eleventh General Programme of Work, WHO Medium-term Strategic Plan as well as statements of regional priorities.

The Eleventh General Programme of Work (2006–2015) proposes the following agenda for all stakeholders, and not just WHO.

- ❖❖ Investment in health to reduce poverty
- ❖❖ Building individual and global health security
- ❖❖ Promoting universal coverage, gender equality, and health-related human rights
- ❖❖ Tackling the determinants of health
- ❖❖ Strengthening health systems and equitable access
- ❖❖ Harnessing knowledge, science and technology
- ❖❖ Strengthening governance, leadership and accountability

In fulfilling its role in implementing the above agenda, WHO's comparative advantages lie in its neutral status and nearly universal membership, its impartiality and its strong convening power. WHO's role in tackling diseases is unparalleled. WHO has a large repertoire of global normative work. WHO promotes evidence-based debate, and has numerous formal and informal networks around the world. WHO's regionalized structure provides it

with multiple opportunities for engaging with countries.

In view of the above WHO must respond to important challenges if it is to realize its potential for effective action in the future. In health crisis, WHO has to act rapidly in order to be an effective partner among the numerous other agencies working with governments.

WHO will provide clearer understanding of health equity and health-related human rights. WHO will lead by example in mainstreaming gender equality building this into all its technical guidance and normative work. WHO will do more to focus attention and action on ensuring that countries have sufficient human resources for health, and work to keep this concern at the forefront of national and international policy. WHO will work with ministries of health to strengthen health systems and to build their understanding of what can realistically be done by working with other sectors. WHO will engage more systematically with civil society and industry, including international health care and pharmaceutical industries.

The core functions of WHO will guide the work of the Secretariat, influence approaches for achieving the strategic objectives, and provide a framework for assuring consistency and output at global, regional and country levels. The core functions of WHO are:

- ❖❖ Providing leadership on matters critical to health and engaging in partnership where joint action is needed

- ❖ Shaping the research agenda, and stimulating the generation, dissemination and application of valuable knowledge
- ❖ Setting norms and standards, and promoting and monitoring their implementation
- ❖ Articulating ethical and evidence-based policy actions
- ❖ Providing technical support, catalysing change and building sustainable institutional capacity
- ❖ Monitoring the health situation and assessing health trends.

During the six years of the Medium Term Strategic Plan 2008–2013, WHO will continue to provide leadership in matters of public health, optimizing its impartiality and near universal membership. Guidance from governments through the Regional Committees, Executive Board and Health Assembly ensures legitimacy for the work of the Organization; in turn the Secretariat's reporting to the government bodies ensures its accountability for implementation.

WHO's role in tackling diseases is without equal, whether its acts by marshalling the necessary scientific evidence, promoting global strategies for eradication, elimination or prevention, or by identifying and helping to control outbreaks.

WHO will promote evidence-based debate, analysis and framing of policy development for health through the work of the Secretariat, expert and advisory groups, collaborating centres, and the numerous formal and informal networks in which it participates.

The structure of WHO's secretariat assures involvement with countries. Headquarters

focuses on issues of global concern and technical backstopping for regions and countries. Regional offices focus on issues of regional concern and technical support and building of national capacities. WHO's presence in countries allows it to have a close relationship with ministries of health and with its partners inside and outside government. The Organization collaborated closely with bodies of the United Nations system at all its three levels and provides channels for emergency support. Through its decentralized structure and close working relations with governments, the Secretariat is able to gather health information and monitor trends over time, across countries, regions and worldwide.

WHO is operating in an increasingly complex and rapidly changing landscape. The boundaries of public health action have become less clear, extending into other sectors that influence health opportunities and outcomes. The importance of economic, social, and environmental determinants of health has grown. Demographic and epidemiological transitions now combine with nutritional and behavioural transitions, influenced by globalization and urbanization, to create unfavourable new trends.

Expected achievements over the period of the Medium-term strategic plan are reflected in the agenda for action in 13 Strategic Objectives. They provide clear and measurable expected results of the Organization. They also promote collaboration across disease-specific programmes by capturing the multiple links among the determinants of health and health outcomes, policies, systems and technologies.

5.2 Strategic agenda

The strategic agenda for WHO cooperation with Egypt clarifies the proposed roles of WHO in supporting Egypt's national health and development plans. It has been defined based on the following considerations.

- ❖ Key health and development challenges confronting the country as analysed by WHO in full consultation with the government, national stakeholders and partners at country level
- ❖ National health policy orientation and priorities of Egypt, particularly the Presidential Election Programme on Health, the national population policy, social health insurance scheme and delegation of certain powers and authorities to governorates
- ❖ Increasing role of the private sector in provision of health services
- ❖ Contributions to health development by other development partners and identified challenges and gaps in health sector cooperation, recognizing the potential adverse effects of the 2008 severe global financial crisis
- ❖ Past and current cooperation
- ❖ General Programme of Work, the strategic objectives in the medium-term strategic plan and regional orientations and priorities

The strategic agenda for WHO cooperation includes five strategic priorities for WHO technical assistance to the Government of Egypt during the period 2010–2014. The order in which the priorities are listed does not indicate a relative weight, level of effort or the importance attributed to the individual priorities.

- ❖ Building institutional capacity in the Ministry of Health for enhancing the functions of the health system
- ❖ Addressing noncommunicable diseases
- ❖ Addressing the unfinished agenda for communicable diseases
- ❖ Addressing social determinants of health
- ❖ Strengthening health sector cooperation and partnerships

Under each of the strategic priorities, a set of strategic approaches has been formulated. These approaches, which clarify the role of WHO in addressing that priority: reflect WHO's comparative advantage; are areas where the potential for impact exists; and emphasize both the convening role of WHO and WHO's role as policy adviser (rather than confining its contribution to supporting the implementation of routine public health activities in the country).

The strategic approaches reflect the way of working WHO will adopt in undertaking the actions identified under the main focus and are based on WHO's core functions. Given the cross-cutting nature and inter-relationship among strategic approaches, a strategic approach under one main focus may have positive impact on other main focuses and priorities.

5.3 Strategic priorities

5.3.1 Building institutional capacity in the Ministry of Health for enhancing the functions of the health system

- ❖ Provide technical and policy support to develop, implement and monitor health policies, strategic plans and legislation and regulations based on the "whole-

- government” approach to health.
- ❖ Provide tools and guidelines to support the Ministry of Health in the roll-out and monitoring of the family physician model and provide lessons learnt elsewhere relevant to the content, structure and strategies for implementation of similar models.
 - ❖ Assist in development of advocacy plans and activities for the implementation of the national reproductive health strategy among other sectors, and national and international development partners.
 - ❖ Engage with research institutions and nongovernmental organizations in operational research.
 - ❖ Support the drafting of a national health insurance law and the development of a comprehensive social health insurance model with respect to the family physician model and build capacity for knowledge management in health financing and development of a national health account.
 - ❖ Provide support for the assessment and analysis of human resources for health in terms of production, composition, distribution and management.
 - ❖ Provide technical support for pre-service and in-service training of the health workforce.
 - ❖ Provide technical and policy support to strengthen routine data collection from public and private health care providers.
 - ❖ Provide technical support for establishment of integrated surveillance systems for communicable diseases and major risk factors for noncommunicable diseases, violence and injuries.

- ❖ Support the Ministry of Health in the development of health care quality assurance and patient safety, including the consolidation of ongoing initiatives, standards and protocols for diagnosis and treatment, training of health workers and establishment of a mandatory accreditation system for public and private health facilities.

5.3.2 Addressing noncommunicable disease

- ❖ Support the Ministry of Health to integrate noncommunicable diseases and mental health services into the basic health benefit package provided through the family physician model with due attention to preventive, diagnostic, treatment and rehabilitation aspects, continuity of care, self care, as well as financial and human resource implications.
- ❖ Engage in partnerships with nongovernmental organizations to pursue the global strategy on noncommunicable diseases and promote healthy lifestyles and behaviours across the life cycle at individual, family and community levels.
- ❖ Provide technical support for implementation of the WHO Framework Convention on Tobacco Convention.

5.3.3 Addressing the unfinished agenda for communicable diseases

- ❖ Support monitoring of vaccine-preventable disease programmes and assist in establishing Egypt as a pre-qualified producer of vaccines and biologicals and a regional reference laboratory for vaccine quality control.

- ❖ Assist the Ministry of Health in the implementation of the national control strategy for viral hepatitis through strong advocacy and promotion with other sectors and international partners, epidemiological research and assistance in the establishment of norms and standards for hepatitis case management.
- ❖ Support efforts to strengthen the planning and management of national disease prevention and control programmes at all levels, with emphasis on providing full coverage to poor and vulnerable sections.
- ❖ Assist the ongoing government initiatives for eradication of neglected tropical diseases such as filariasis, schistosomiasis and helminthiasis.
- ❖ Provide technical support for developing national action plans and meet the requirements of the IHR for the establishment and strengthening of alert and response systems in epidemics and other public health emergencies of international concern.

5.3.4 Addressing social determinants of health

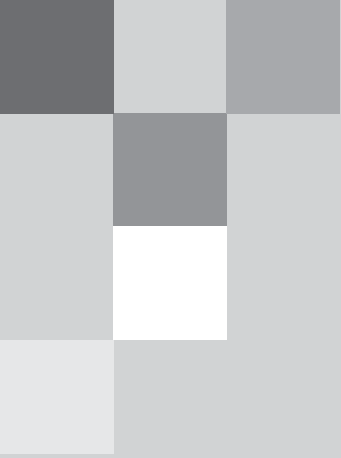
- ❖ Provide technical support in environmental risk assessment and developing mitigation strategies, giving special attention to raising awareness among children and youth through schools and setting approaches.
- ❖ In partnership with the United Nations Country Team, assist in promoting and developing multisectoral strategies

and plans for healthy diets and physical activity, based on the WHO Global Strategy on Diet, Physical Activity and Health, especially through thematic initiatives such as control of micronutrient malnutrition and reducing consumption of sugar and saturated fat.

- ❖ Support the Ministry of Health in improving monitoring and promoting community and multisectoral efforts on food safety.
- ❖ Provide norms, standards and guidelines to support the health sector in influencing policies in other sectors relating to water quality, sewage and sanitation, air quality and hazardous wastes.

5.3.5 Strengthening health sector cooperation and partnerships

- ❖ Assist the Ministry of Health by helping to build institutional capacity for leadership on partnerships for health development, and for mobilizing internal and external resources.
- ❖ Strengthen the convening role of WHO to support the government in bringing together development partners for dialogue.
- ❖ Support and engage partners in addressing health issues through more strategic and effective forums, such as the Donor Advisory Group.
- ❖ Participate actively in making health more prominent in the formulation of the UNDAF and its implementation through “delivering as one” and the development partners forum.



Section

6



**Implementing the Strategic Agenda:
Implications for WHO**



Section 6. Implementing the Strategic Agenda: Implications for WHO

Effective implementation of the CCS for Egypt will require: increasing the core capacity of the WHO country office; broadening and deepening the scope of interactions with development partners; and altering the ways of work and the support the country office receives from the Regional Office and headquarters. The implementation of CCS therefore has important implications for the WHO country office, Regional Office and headquarters. These implications are discussed below.

6.1 Implications for the country programme

6.1.1 Staff capacity

The strategic priorities outlined in section 5 give special priority to health system development and noncommunicable diseases. The capacity of the country programme therefore needs strengthening in these two areas, on a priority basis. The type of support that WHO can provide to Egypt in these and other areas can be categorized as specialized technical expert support, catalytic programme and imitative development support and facilitating partnership and networking within the country and with regional and global networks. Egypt also has a large number of specialists in medical and public health fields that could be utilized by WHO to strengthen capacity. If there are specific needs, expatriate expertise input could be provided by WHO for limited durations. The catalytic and triggering role of WHO is of crucial importance in this respect.

The country office continues to exert its health leadership role, becoming more actively engaged with other sectoral ministries and a broader set of development partners. It is important to ensure that the country office staff have the requisite skills in areas such as communications, advocacy, sectoral approaches, networking and resource mobilization.

6.1.2 Representation

There is a large number of UN, bilateral, multilateral agencies and donors present in Egypt. The Arab League is located in Cairo as well as a substantial number of other agencies have their regional offices or headquarters in Egypt. The country has a large number of medical associations and medical schools, as well as major nongovernmental organizations that are active in the field of health and development and welfare. WHO is therefore required to participate in many official events which demand significant time. As the development of partnership and resource mobilization assume more and more significance, the needs for representation must also be considered.

6.1.3 The working environment

The current space of WHO country office is severely limited and acts almost as a physical barrier for enhancing partnership. As the implementation of the CCS requires expanded engagement with the government, key stakeholders and development partners, while at the same time provision of technical

support, there is urgent need to address the severe limitations of the WHO office in the Ministry of Health. To alleviate the crowded conditions, additional office space is required to accommodate: the current staffing and the two additional full-time staff noted above; a meeting room; reception area or waiting room; a working library; archives and documentation; and general storage.

WHO needs to actively engage with the Ministry of Health to identify alternative accommodations that will provide a working environment that is more conducive to effective performance. It cannot be over-emphasized that the office space and a more appropriate alternative should be found as soon as possible.

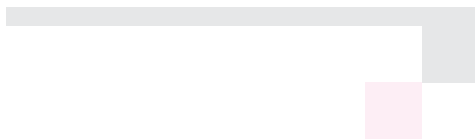
6.2 Implications for the Regional Office and headquarters

Implementation of the CCS will have significant implications for the Regional Office. As the host country of the Regional Office, Egypt has always expected to receive substantial technical support from the Regional Office. This expectation is increasing. To effectively respond to country

needs, the Regional Office should develop an interim strategic roadmap to support the country in dealing with strategic priorities outlined in section 5. The Regional Office is also expected to facilitate the networking between Egyptian health institutions and experts and the regional and global partners.

All technical collaboration from the Regional Office should be strictly channelled through the country office. This issue is vital to ensure proper coordination and partnership development with external support partners that collaborate with the country office.

The presence of so many international and external partners in Egypt provides a good opportunity to develop innovative and pioneering health development approaches. In full collaboration with the country office programme, the Regional Office and headquarters should support such initiatives. WHO headquarters is also expected to participate in the development of the roadmap mentioned above for respective programmes and to make its key technical staff available to support the national programme in Egypt.



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