

# HIGH LEVEL MEETING ON BUILDING RESILIENT SYSTEMS FOR HEALTH IN EBOLA-AFFECTED COUNTRIES

10-11 DECEMBER 2014  
GENEVA, SWITZERLAND



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## BACKGROUND TO THE MEETING

As of 10 December 2014, nearly 18 000 people have been infected with the Ebola virus and 6388 have been reported to have died. More than 99% of cases have occurred in three adjacent West African countries: Guinea, Liberia, and Sierra Leone. Part of the reason that the virus has progressed to epidemic levels in these countries is that their health systems were already weak following years of civil conflict that left health infrastructures badly damaged or destroyed.

Since the outbreak started, existing public health services – which were already quite limited – have been diverted to Ebola. In addition, many health workers have become ill and died from the virus. The net result is that people have encountered significant barriers in accessing needed care. In some areas, all forms of essential care, whether for malaria treatment or safe childbirth, have ceased to function. Progress made in moving towards the health-related Millennium Development Goals has been reversed.

Given the importance of these issues, the African Development Bank, the West African Health Organization, the World Bank, and the World Health Organization convened a High Level Meeting on Building Resilient Health Systems in Ebola-affected Countries from 10-11 December 2014 in Geneva, Switzerland.

Ministers of Health and Finance of Ebola-affected countries, international organizations and development partners discussed the current state of the health systems in Guinea, Liberia and Sierra Leone. They also considered what needs to be done to rebuild and strengthen essential health services in these countries.

Specific objectives of the meeting were to:

- Identify the main constraints and challenges faced by countries in rebuilding and developing more resilient health systems;
- Identify medium- to long-term solutions on how best to build and invest in national and sub-national systems that deliver good-quality essential health services and also have the capacity to respond adequately to future emergencies and crises;
- Discuss the roles and responsibilities of different stakeholder groups (governments, non-state actors, donors and international technical agencies) in assisting countries to build resilient health systems.

## CURRENT SITUATION AND KEY HEALTH SYSTEM CHALLENGES

Meeting participants discussed the situation around the current Ebola epidemic in the most-affected countries. They considered the factors that contributed to the rapid spread of the epidemic, as well as the main obstacles to an effective response. Participants also discussed the effects on non-Ebola health services and on the countries' economies.

### HEALTH SYSTEMS PRE-EBOLA

**Prior to the Ebola outbreak, Guinea, Liberia, and Sierra Leone had different forms of decentralized service delivery systems.**

- Guinea has a highly decentralized health-care network with significant rural-urban disparities.
- Liberia's organization of health services is under reform, transitioning towards a decentralized delivery system divided into 15 counties. Service delivery is pluralistic with a mix of public and private providers.
- Sierra Leone has 19 local councils that are responsible for managing the delivery of primary and secondary health-care services. Like Liberia, service delivery is pluralistic with a mix of public and private providers.

**All countries had national plans prior to the outbreak.**

- Guinea's national health plan ended in 2012 but a new Politique Nationale de Santé 2015-2024 is under development. The new policy will cover disease and emergency management and control, promoting health across the life course, and overall strengthening of the national health system. Its health services are organized in a decentralized context, which is aimed at increasing community participation and intersectoral cooperation.
- Liberia has a National Health and Social Welfare Policy for 2011 to 2021, which calls for basic health services close to communities, expanding the essential package of health services and increasing human resources for health.
- Sierra Leone also has a National Health Sector Strategic Plan for 2010 to 2015. The plan is aimed at health system strengthening and moving progressively towards universal health coverage.

**Pervasive health system weaknesses challenged all countries.**

Prior to the Ebola outbreak, weaknesses existed throughout the three countries' health systems. All lacked adequate numbers of qualified health workers, most prominently in rural areas. Laboratories were few in number and concentrated in cities. Many large referral hospitals had no electricity and running water or were made unsafe by electrical fires and floods. Health information, surveillance, governance and drug supply systems were weak.

- Guinea had severe shortages of health workers (see table below), especially in rural areas, and a limited availability of health facilities. Its health management information systems were weak and fragmented into sub-national sub-systems. The procurement and supply of medicines and medical products were weak but improving, thanks to strong efforts from national-level management.

- Liberia also had severe workforce shortages and limited availability of health facilities, especially in rural areas. In addition, it had inadequate management capacity at sub-national levels. Its health management information system did not cover the largest hospital or most of the smaller facilities in rural areas. Sub-standard, counterfeited medicines were a pervasive problem.
- Sierra Leone's workforce shortages were similar to that of Guinea and Liberia, with slightly greater availability of health facilities. The country had developed a district-level health information system but monitoring was still weak. Procurement was decentralized for basic essential medicines but their availability was limited and variable.

### Health system capacity pre-Ebola

	Guinea	Liberia	Sierra Leone
Number of physicians per 10 000 population	1.37	0.3	0.3
Number of health facilities per 10 000 population	1.6	1.7	2.2

In terms of disease surveillance, none of the three affected countries attained the minimum IHR (2005) core capacities requirements by 2012. The Integrated Disease Surveillance and Response (IDSR) guidelines were implemented in Guinea, but only adapted for Liberia, and did not start implementation in Sierra Leone. Substantial support is required to strengthen preparedness and implement core capacities requirements under IHR (2005) in these countries, as well as many other countries in the region.

### Despite these weaknesses, all countries were making progress.

Before Ebola, the countries had made significant improvements in key areas, particularly those related to the Millennium Development Goals (MDGs). Under-five mortality was declining and all countries had expanded coverage of basic interventions into sub-national rural districts. Skilled birth attendance was increasing and maternal mortality was declining.

- Guinea had improved its rates of skilled birth attendance and immunization coverage from 1999 to 2013 (see table below). At the same time, both child mortality and maternal mortality had declined significantly.
- Liberia had improved family planning coverage, skilled birth attendance and immunization coverage from 2007 to 2013. Child mortality had declined beyond MDG 2015 target levels and maternal mortality had nearly halved between 1990 and 2013.
- Sierra Leone had made good progress on family planning coverage, skilled birth attendance, and immunization coverage between 2000 and 2013. Child mortality and maternal mortality had declined significantly, although they were still the highest among the three countries in 2013.

### Key health indicators pre-Ebola (2013)

	Guinea	Liberia	Sierra Leone
Child mortality per 1000 live births, 2013	96.8	81.8	160.6
Maternal mortality per 100 000 live births, 2013	690	680	1100

## Resources for health were rising but still limited overall.

Health expenditures were rising in all countries, but still overall at low levels and directed mainly at HIV/AIDS, tuberculosis, and malaria. So while major investments were being made in battling specific diseases and health issues, the countries' overall health systems remained fragmented and unable to cope with unexpected challenges.

- Guinea's total general government expenditure for health, including Official Development Assistance (ODA), fell well below the Abuja target of 15%, as well as the estimated USD \$86 per capita that would be needed for a basic benefit package (see table below). Out-of-pocket expenditures were high, at 67% of all expenditures per capita, suggesting households suffered from financial hardship when using services and also that government expenditures were relatively low.
- Liberia's total general government expenditure for health exceeded the Abuja target, but still fell short of the amount needed to fund a basic benefit package. Out-of-pocket expenditures were 21%; this relatively low percentage might be due to the population's limited ability to access services.
- Sierra Leone's general government expenditure for health did not meet the Abuja target and its out-of-pocket expenditures were 76%, meaning that many people were unprotected from the financial consequences of ill health.

## Key financial indicators pre-Ebola

	Guinea	Liberia	Sierra Leone
Official Development Assistance disbursed, 2011-2012	USD \$95 million	USD \$198 million	USD\$ 142 million
Total general government expenditure for health, including ODA, 2012	7% (USD \$9 per capita)	19% (USD \$20 per capita)	12% (USD \$20 per capita)

## FROM OUTBREAK TO EPIDEMIC

**Ebola spread from its initial outbreak to crisis and epidemic levels in Guinea, Liberia, and Sierra Leone in large part because of the countries' weak health and surveillance systems, coupled with socio-cultural factors. Several health-system functions that are considered essential were not performing well, and this hampered information sharing and the development of a suitable and timely response to the outbreak.**

The first known case of Ebola was a young boy who died in Guinea, close to borders with Liberia and Sierra Leone, on 28 December 2013. From that single case, the virus spread, undetected, for more than three months, in multiple chains of transmission involving urban as well as rural areas. The virus entered the capital city of Guinea, Conakry, at the beginning of February. The disease was misdiagnosed twice as cholera and later thought to be Lassa fever. As late as mid-March, when the government raised its first alert, cases of sudden death, reported around the country, were thought to be independent outbreaks caused by different diseases. By the time Ebola was identified as the causative agent, on 21 March 2014, the virus was firmly entrenched in Guinea. This was largely the result of a significantly under-resourced and unprepared health system. The epidemic also unveiled a very important trust issue between communities and the health system. Communities in these three countries are deeply distrustful of Western medicine and foreign medical teams. Many prefer to seek care from traditional healers, who in rural areas are often the only option.

The virus quickly spread into Liberia and Sierra Leone via their land borders with Guinea. The countries did their best to respond yet were unable to contain the virus due to weak surveillance systems, widespread fear in communities, insufficient hospital beds, and the loss of many health workers due to the virus. The total number of deaths due to Ebola in each of these countries is now larger than the total number of Ebola deaths in Guinea.

**When the outbreak started, the countries had no reserve capacity to mount an effective and timely response, particularly without compromising essential health services for other conditions. In this sense, their health systems lacked resilience.**

## THE DIRECT AND INDIRECT EFFECTS OF THE EPIDEMIC

**Ebola has devastated the already-weak health systems of Guinea, Liberia, and Sierra Leone.**

Recent reports from Guinea, Liberia, and Sierra Leone indicate that basic essential (non-Ebola) health services have been severely disrupted. When the outbreak started, all existing public capacity was diverted to fighting the virus, and other basic health services were largely suspended. Health worker deaths combined with widespread community fears about visiting health facilities have further complicated the situation in the ensuing months.

As of 7 December 2014, 642 health workers have been infected with the Ebola virus in these three countries and 342 have died (see table below). The absence of these health workers is on top of pre-existing dire shortages in the numbers of qualified health workers.

### Health-care workers with Ebola, as of 7 December 2014

	Guinea	Liberia	Sierra Leone
Cases	121	363	138
Deaths	62	174	106

Health facilities have also been affected. In Liberia, 62% of health facilities have been closed since the outbreak started. Those facilities that have remained open have experienced significant declines in visits and admissions. Guinea has experienced a 58% drop in outpatient visits and a 54% drop in hospital admissions. Institutional deliveries have declined to 11% in Guinea, 23% in Sierra Leone and 50% in Liberia.

**The impact of the Ebola outbreak spans well beyond health: economies have been affected, food is becoming scarce, and development has stalled.**

Prior to the outbreak, Guinea, Liberia, and Sierra Leone were among the poorest countries in the world, yet were experiencing high rates of economic growth. Major economic sectors included mining, agriculture, and services.

Since the outbreak began, the economic picture has changed dramatically. Ebola has affected the economy through two main channels: the direct impact of the epidemic, and the risk aversion behaviour of the rest of the population. Many flights have been suspended, cross-border trade has been hampered, and multinational corporations have left the area. Tourism to all of Africa has been affected. The World Bank estimates that in 2015, the three affected countries will forego two billion USD due to the virus, while the broader region of West Africa will forego 30 billion. Major sources of employment – in the

mining, agriculture, and service sectors – have been hit hard; the impact on poverty is large and growing. The social and economic gains of the past decade are now at risk for the three countries, and indeed for the entire sub-region.

In Guinea, the Ebola epidemic has been an economic shock. Projected 2014 economic growth has declined to 0.5% (versus 4.5% before the crisis). Agricultural and manufacturing exports to neighbouring countries have come to a standstill; and projects involving expatriate workers, including mining, have slowed or stopped.

Liberia was among the fastest-growing economies in Africa prior to the outbreak, with an annual growth rate of 11.3%. As of August, it had declined to 4%. Meanwhile, inflation has risen from 7% to 10.4%, and is expected to be at 14% by year's end. Farms have been left unattended in Ebola-affected areas, which has affected employment, agricultural output, and food supply. Mining, which has been a driver of growth in country, has been largely disrupted.

Since the outbreak, Sierra Leone's economic growth rate has declined from 9.5% to 1%, while total revenues are down by 16% and expenditures are increased. Food production, mining, and the service sector have been adversely affected.

## TURNING CRISIS INTO OPPORTUNITY

***Meeting participants considered the potential opportunities presented by the Ebola crisis and how best to capitalize upon them.***

**Currently, the main focus of the governments of Guinea, Liberia, and Sierra Leone and their partners is to end their epidemics and to get to zero Ebola cases.**

Response activities in the three countries continue to progress in line with the United Nations Mission for Ebola Emergency Response (UNMEER) aim to isolate and treat 100% of Ebola cases and safely bury 100% of people dying from Ebola deaths by 1 January 2015. At a national level, there is now sufficient bed capacity in Ebola treatment facilities to treat and isolate all reported cases in each of the three countries, although the uneven distribution of beds and cases means there are serious shortfalls in some areas.

**Beyond Ebola, these countries need to be able to manage a broad range of health issues.**

The broader and on-going population health needs of Guinea, Liberia, and Sierra Leone are diverse and span communicable, noncommunicable, and maternal child health issues. The top three causes of death across the three countries are acute respiratory infections, cardiovascular diseases, and neonatal conditions. Malaria, the fourth-leading cause of death, is associated with more than 20 000 deaths annually – more than three times the total number of Ebola deaths to date. Meanwhile, chronic noncommunicable diseases and their underlying risk factors (including tobacco use and obesity) are becoming increasingly prevalent.

**Despite the tremendous challenges and human suffering that Ebola has caused, the crisis also presents opportunities for health systems strengthening in affected countries.**

Media interest, technical support, and financial resources have surged into Guinea, Liberia, and Sierra Leone in the wake of the Ebola crisis. The World Bank, for example, has already committed one billion USD to fighting Ebola, the International Monetary Fund (IMF) has disbursed USD \$130 million in budget support to the three countries, and the GAVI board recently decided to allocate up to USD \$90 million to support countries to introduce Ebola vaccines and to help rebuild their health systems.

This creates a window of opportunity for reinforced action on health systems strengthening. The surge of aid, combined with sudden, focused attention on the health of the population, creates unparalleled opportunities to strengthen health systems for the long term. But momentum needs to be generated at an early stage so that substantial investments will continue after the acute crisis.

This opportunity is important on two fronts: for meeting on-going and predictable health needs, and for building resilience to future health shocks that might arise.

## INNOVATIVE HEALTH SYSTEM SOLUTIONS

***Representatives from Guinea, Liberia, and Sierra Leone described actions the countries have been taking, before and during the Ebola epidemic, to strengthen their health systems at national and sub-national levels. They also considered how these innovations could be used in the future.***

**Innovative actions are already being undertaken by the three affected countries to rebuild their health systems.**

While details vary, commonalities shared among the different countries include an emphasis on strengthening sub-national systems as the primary mechanism for delivering integrated services, and engaging communities at all levels of health system planning and implementation. Key aspects of each country's plans are described below.

### GUINEA

Guinea has a plan to eradicate Ebola, as well as a broader 10-year national health plan that was in development prior to the crisis. This draft national plan will be further revised in light of the impact that the Ebola epidemic has had on the country's health system.

Community engagement and mobilization were underscored as a key strategy moving forwards. In particular, faith-based groups will be called upon to act as an interface between the community and the national authorities.

Shortages in the health workforce also need to be addressed. In the short term, Guinea is deploying new graduates to rural and remote areas.

### LIBERIA

Prior to the Ebola outbreak, many structural and functional health system reforms were underway. The Ministry of Health had been restructured and services were being decentralized into 15 administrative counties. The country also had established an Office of Financial Management and an internal audit unit.

Today, it has a pooled fund for co-mingling donor funds and aligning them with national priorities. The national level can 'contract in' by allocating funds to sub-national levels – which helps realize its goal of minimizing outsourcing of service delivery to nongovernmental organizations (NGOs) in favour of county health teams. The national government is also starting to use performance-based financing models at county levels. More recently, the government has established a health equity fund as part of its effort to increase coverage, and it is using external auditors to track the use of Ebola-related funds.

Human resources for health are viewed as a priority area for further action. The government has started to strengthen its health worker training institutions and would like to improve them further. It also is taking steps to enhance community health worker capacity.

## SIERRA LEONE

Sierra Leone has a national health plan but it is expiring in 2015. The government sees fighting the Ebola epidemic as its top priority, followed by a transition to longer-term planning for health system resiliency. Along these lines, a national consultative process is already underway. Community participation and engagement with civil society and faith-based organizations are key to this process.

The national government has limited core health functions and is committed fully to decentralization as a catalyst for recovery, but recognizes that districts must be sufficiently supported and empowered to implement this policy. Regional hubs are being developed with a full complement of professionals who can act as stopgaps in service delivery and who can help improve care quality via onsite training and supervision.

## AREAS FOR FURTHER ACTION

Each of the three countries uses decentralized health systems to deliver essential services. A focus on **building resilient sub-national systems** in these countries will be a key mechanism for providing integrated, good-quality health services. Participants insisted particularly on the priorities highlighted below:

Across all countries, **the health workforce will require significant strengthening**. Investments are needed for training and retaining larger numbers of health workers. Competent health managers are also needed, particularly at sub-national levels. In the shorter-term, community health workers can be deployed into underserved communities.

**Enhancing community trust, engagement, and ownership will be key**. Partnering with communities in meaningful ways will be essential to help build health systems that are responsive to the needs and priorities of the populations. Traditional healers and faith-based organizations can serve as bridges between formal health services and communities and should be considered as integral partners in health systems strengthening.

**Strengthening core public health capacities for surveillance and response** will be essential to enabling the countries to fulfil their obligations under the International Health Regulations (IHR) (2005).

**Predictable supplies and coordinated supply chains** will need to be established, using lessons learnt and capacities from the outbreak response.

## NEXT STEPS

Overall future processes were discussed during the two-day meeting; key aspects are summarized below.

- **National governments will lead the work** on building health system resilience. All have national plans that can be used as the basis for forward planning in light of the Ebola crisis. This will include ensuring that the physical assets provided by development partners to support the response will remain in-country and be repurposed for stronger health systems. All partners can use these plans to define roles and responsibilities and to measure progress.

- **WHO will support governments to convene follow-up meetings** to review, revise, and cost national plans and to prioritize the main immediate and medium- to long-term interventions needed to build resilient health. These meetings will be country-led and will involve key **national and international partners**. One important follow-up milestone will be a **World Bank/IMF meetings** scheduled for April 2015, where Ebola will be discussed, particularly as it relates to IHR (2005) implementation, health systems strengthening, and multisectorality.
- Recognizing that the Ebola crisis spans borders and future outbreaks will have the potential to do the same, regional and international partners will consider the development of a **regional surveillance system**. It is envisioned that a regional system would be able to support countries to respond quickly to such outbreaks in the future, as well as helping them implement the IHR (2005) core capacities requirements. In addition, a regional system offers efficiencies of scale.
- Given that substantial and sustained external financing will be needed to help Guinea, Liberia and Sierra Leone recover, regional and international partners will consider the need for a “**Marshall Plan**” for building resilient health systems in the aftermath of the Ebola crisis. (The Marshall Plan was a large-scale investment initiative to rebuild Europe following World War II.)
- Any additional financial support will have to be well coordinated, in line with the **IHP+ principles**. An important element is mutual accountability between donors and recipient countries. **Budget support** and in general public financing is critically important in such crisis situations. Recognizing this, IMF has provided budget support to the affected countries and accepted the budget deficits incurred by the crisis.

An additional technical working meeting on the following day provided an opportunity for countries and key partners to reflect on pragmatic next steps. A preliminary draft process was discussed and developed at that meeting. It will be further reviewed and each country will adapt it to suit its unique structure and needs in early 2015.

## CONCLUSION

Poorly integrated and fragile health systems have contributed to the current Ebola outbreak of unprecedented dimensions. General health care in the most-affected countries of Guinea, Liberia, and Sierra Leone has largely ceased to function, and gains made in reducing morbidity and mortality from HIV/AIDS, tuberculosis, malaria, and childhood diseases are now threatened with major reversals. These countries' economies are also suffering, with decreased economic growth, food scarcity, and stalled development.

A major emergency global response has been mounted and good progress is being made. Response activities in the three continue to progress in line with UNMEER aims. Thanks to sustained and concerted national, regional, and global efforts, it seems likely that the day will arrive when Ebola will be eradicated from these countries.

Forward planning now will help ensure that the substantial assets and infrastructure developed to fight Ebola will remain in the affected countries after the disease is gone. More broadly, building resilient systems for health will help meet populations' on-going and predictable health needs, and will help ensure that future disease outbreaks and unusual health events do not result in similar devastating effects.

Ultimately, resilient health systems are not simply a concern for public health experts and authorities. As this current crisis has demonstrated, they are fundamentally tied to the economic development and security of countries, regions, and the world. Health systems strengthening should be considered as everyone's business.

The list below is a synthesis and summary of points that were made in the course of discussions during the two days.

1. The Ebola crisis in West Africa presents **a time-limited opportunity** that should not be wasted. **Health systems strengthening and resilience building should start now.**
2. **National governments should lead the work** on building health system resilience. All have national plans that can be used as the basis for forward planning in light of the Ebola crisis. All partners can use these plans to define roles and responsibilities and to measure progress.
3. Partners should follow development effectiveness principles. Specifically, **efforts should be aligned with International Health Partnership (IHP+) principles**, including coordination under government leadership, alignment to national priorities and harmonization of (monetary and non-monetary) support among development partners.
4. Particular attention should be paid to **building core capacities to detect, report, assess and respond to public health emergencies and public health risks**, as part of countries' obligations under the **International Health Regulations (IHR) (2005)**.
5. Instead of creating yet another vertical programme for a specific health condition or to respond to a crisis, investments should be used to **build systems that are grounded in primary health care and universal health coverage principles** and capable of responding to diverse and unexpected challenges that might arise in the future. Health services should encompass disease surveillance, health promotion, prevention, diagnosis, management, rehabilitation and palliative care services, and address people's varying needs throughout their life course.
6. **Enhancing community trust, engagement, and ownership is key.** Partnering with communities in meaningful ways is essential to help build health systems that are responsive to the needs and priorities of the populations. Traditional healers and faith-based organizations can serve as bridges between formal health services and communities and should be considered as integral partners in health systems strengthening.

7. Resilient health systems need **strong cross-sectoral coordination**. Countries' infrastructure, water, sanitation, and education systems have direct and indirect impacts on health system functioning and should be considered as part of building resilience.
8. Careful thought is needed about the massive external financing currently flowing into these countries. Financing from external donors should not add to the debt burden and should be provided in the form of grants. At the same time, **countries should be given fiscal space** to expand their deficits, provided additional financing is available. Over the medium term, **financial support should be predictable and routed through government systems**. This will require capacity building so that governments can responsibly deploy these funds in accordance with their priorities and budgets.
9. In the longer term, to **move towards universal health coverage** goals, consideration is needed on how to reduce the burden of out-of-pocket health expenditures and to promote financial protection while increasing access to quality health services.
10. A strong focus on **accountability for both governments and partners** should underpin all efforts. An accountability framework can identify a core set of indicators for results and resources and explore opportunities to improve access to information.

## ANNEX 1. MEETING PROGRAMME

### High level meeting on building resilient systems for health in Ebola-affected countries

10-11 December 2014 – Geneva, Switzerland

### DAY 1: 10 DECEMBER 2014

#### DAY 1 MORNING THEMATIC AREA: CURRENT SITUATION AND KEY HEALTH SYSTEM CHALLENGES

08:00 – 09:00	Registration
09:00 – 09:30	Opening and welcome remarks
09:30 – 11:00	<b>SESSION 1 Setting the scene: Part 1 – Current Ebola outbreak, ongoing efforts to date and lessons learnt from affected countries.</b> This session will focus on countries experiences regarding the difficulties faced during the outbreak and the impact of the outbreak on the country
11:00 – 11:30	Coffee break
11:30 – 13:00	<b>SESSION 2 Setting the scene: Part 2 – Health systems issues and challenges.</b> Following a short presentation that will draw the situation in the three countries before the outbreak, this session will discuss the major health system challenges, the major lessons learnt regarding MDGs and health systems strengthening in the past decade and the urgent priorities and perspectives, including health security concerns
13:00 – 14:30	Lunch break

#### DAY 1: AFTERNOON THEMATIC AREA:

#### IDENTIFICATION OF INNOVATIVE HEALTH SYSTEM SOLUTIONS

14:30 – 16:00	<b>SESSION 3 Sub-national level: Innovative approaches for rebuilding strong local health systems.</b> The session will focus on ongoing country plans and innovative approaches to build strong, balanced and resilient sub-national health systems that provide integrated quality health services to the population. A panel of discussants will share experiences of strong sub-national systems followed by a discussion around identifying pragmatic solutions at the sub-national level
16:00 – 16:30	Coffee break
16:30 – 18:00	<b>SESSION 4 National level: Innovative approaches for strengthening essential health system functions at national level.</b> This session aims to draw out best practices and innovative approaches to ensure that the national public health functions receive the needed inputs to improve population health. It will also examine the role of surveillance and outbreak response and how they should be organized. A panel of discussants will share experiences of innovative approaches followed by a discussion around identifying pragmatic solutions at the national level

**DAY 2: 11 DECEMBER 2014****DAY 2 MORNING THEMATIC AREA: IDENTIFICATION OF RESOURCES,  
REFORMS AND ACCOUNTABILITY MECHANISMS**

09:00 – 09:30	<b>Recap of Day 1</b>
09:30 – 11:00	<b>SESSION 5 Financial landscape in the countries.</b> This session aims to portray the financing situation in the countries prior to the Ebola crisis, to explore the implications of the crisis for their macroeconomic and fiscal outlook, and to consider the national economic and sectoral financing policies needed to meet the resource needs of the health system and ensure sustained recovery. A short presentation will highlight the current financing situation in countries along with the projected need and appropriate financing policies followed by a panel discussion of the key fiscal issues and their implications. Special attention will be given to how to promote financial protection within reconstruction to advance universal health coverage goals
11:00 – 11:30	<b>Coffee break</b>
11:30 – 13:00	<b>SESSION 6 Roles and responsibilities including needed governance and accountability mechanisms.</b> Through an interactive discussion among the groups of stakeholders, this session will focus on how partners and donor mechanisms can contribute to building a robust and integrated health system and how best the different actors, based on their comparative advantage, can support the building of resilient health systems taking account of political-economy issues. It will also focus on the accountability measures that need to be put in place to ensure that the efforts are successful
13:00 – 14:30	<b>Lunch break</b>

**DAY 2 AFTERNOON THEMATIC AREA: AGENDA FOR ACTION**

14:30 – 15:30	<b>SESSION 7 Next steps and way forward.</b> This session will bring together all participants to agree on an Agenda for action, including the nomination of a working group to take the work forward
15:30 – 16:00	<b>Meeting closure.</b> Concluding remarks

## **ANNEX 2. LIST OF PARTICIPANTS**

**High-Level Meeting on  
Building Resilient Systems for Health in the Ebola-Affected Countries  
InterContinental Hotel (Geneva, Switzerland)  
10-11 December 2014**

### **Provisional List of Participants**

#### **MEMBER STATES**

##### **BELGIUM**

Dr Paul A. Cartier, Minister Counselor, Permanent Mission of Belgium to the Office of the United Nations and the other International Organizations in Geneva

##### **CANADA**

Ms Elissa Golberg, Ambassador, Permanent Representative of Canada to the United Nations Office and other International Organizations at Geneva

##### **CHINA**

Dr Ren Minghui, Director-General, Department of International Cooperation, National Health and Family Planning Commission

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Mr Yin Wang, Permanent Mission of the People's Republic of China to the United Nations Office at Geneva and other International Organizations in Switzerland

##### **CZECH REPUBLIC**

Mr Daniel Míc, Deputy Permanent Representative of the Czech Republic to the United Nations Office and other International Organizations at Geneva

##### **DENMARK**

Mr Carsten Staur, Ambassador, Permanent Representative of Denmark to the United Nations Office at Geneva

Mr Mads Filtenborg Christensen, Permanent Mission of Denmark to the United Nations Office at Geneva

##### **FINLAND**

Ms Tiina Jortikka-Laitinen, Special Envoy for Ebola, Ministry for Foreign Affairs

Dr Eero Lahtinen, Ministerial Adviser, Ministry of Social Affairs and Health

##### **FRANCE**

Professor Jean-François Delfraissy, Coordinator of International and National Operations in Response to the Ebola Crisis

Mrs Christine Fagés, Ambassador Coordinator of Ebola Task Force, Ministry of Foreign Affairs and International Development

Mr Thomas Wagner, Deputy Permanent Representative of France to the United Nations and other International Organizations in Geneva

Mrs Corinne Brunon-Meunier, Deputy Director, Development and Global Public Goods, Ministry of Foreign Affairs and International Development

Mr Marc Boisnel, Health Advisor, Permanent Mission of France to the United Nations and other International Organizations in Geneva

Mr Vincent Sciamia, Health Advisor, Permanent Mission of France to the United Nations and other International Organizations in Geneva

Mrs Juliette Daeschler, Project Officer, International Action WHO, Delegation for European and International Affairs, Ministry of Social Affairs and Health

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