WORLD HEALTH ORGANIZATION
Regional Office
for the Eastern Mediterranean
ORGANISATION MONDIALE DE LA SANTE
Bureau regional de la Méditerranée orientale

منظمة الصحة العالمية
المكتب الإقليمي
لشرق البحر المتوسط

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

Thirty-seventh Session

Agenda item 13

EM/RC37/Tech.Disc/1
July 1990

Original: ENGLISH

TECHNICAL DISCUSSIONS

PROGRAMMES IN SUPPORT OF HEALTH FOR ALL

CONTENTS

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PROGRAMMES IN SUPPORT OF HEALTH FOR ALL

Very few public health concepts, approaches or events have received so much universal support--if not universal implementation--in such a short time as have the concepts of Health for All/Primary Health Care (HFA/PHC). It is imperative, therefore, that we should consider the definition, philosophy, mission and targets of this approach. There are two basic reasons why the HFA/PHC approach has received such wide acceptance: one philosophical, addressing equity and social justice, and the other, that it would seem to be the best and most practical way of availing health and health care to the masses who have, thus far, been deprived of their right to health.

In this paper, an attempt is made to look at the concepts of health for all/primary health care from both the philosophical and practical points of view, and to describe some of the *innovative* programmes that support these concepts. The Technical Discussion is expected to define ways and means to further promote innovative programmes and assist in solving and overcoming constraints and problems hampering the implementation of health-for-all strategies. Although the premises of these innovative programmes in support of health for all/primary health care are not that new, as some of them have been known and accepted for several years, they will all become clearer when seen within the context of health for all/primary health care, which itself cannot be separated from other activities that promote human development and quality of life.

1. Health

Until the early 1940s, many people used to believe that *more* doctors and *more* hospitals would result in *better* health. This idea had stemmed from the belief that health meant the absence of disease or infirmity.

At the Thirtieth World Health Assembly (1977), WHO Member States adopted a resolution setting a humanitarian target for all governments, WHO and the world community, such that "all citizens in the world should attain by the year 2000, a level of health that will permit them to lead a socially and economically productive life".

In 1978, the Alma-Ata Conference defined health as the "... state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity ...". The Conference stated clearly that health "... is a fundamental right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector". This complies well with the WHO Constitution in whose preamble it is stated that "The enjoyment of the highest standard of health is one of the fundamental rights of every human being".

1.1. Health for All

The definition of "health for all" implies that health is a social need and is to be brought within the reach of every citizen, in every country, wherever he/she lives or works. The concept "health" and "health for all", as defined above, is a *holistic* one, which sees health as part and parcel of

socioeconomic development (i.e., there is no development without healthy people). In view of this, "health for all" calls for efforts and multi-disciplinary actions to improve agriculture, industry, housing, environmental quality and sanitation, and other aspects of socioeconomic development, just as much as medicine and public health. Medical care alone cannot bring health to hungry people living marginally in hovels and shanty towns. Health for such people requires a new strategy that will bring about a whole new way of life, and fresh opportunities to people to provide themselves with a better standard of living. These include, among other things, good nutrition, adequate supply of safe water, a healthy environment, hygienic housing, and a healthy life-style. Therefore, "health" and "health for all" should be considered an objective of socioeconomic development.

1.2. How to attain the goal of health for all

1.2.1. Primary health care

Primary health care (PHC) was asserted by the Alma-Ata Conference as the primary conduit to reach the humanitarian health-for-all goal. PHC has been defined as:

> ... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of development in the spirit of social justice, self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of the individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health-care process.

1.2.2. Health-for-all status

We are now more than halfway to the target date of "health for all by the year 2000", which was collectively decided at the Alma-Ata Conference in 1978. The concepts and principles of health for all/PHC have provided the world with moral, political, social and technical guidance, which has enabled countries to deal forthrightly not only with the ill health of their populations, but with problems of inequity in health care. Many countries have made considerable progress in improving the equity and effectiveness of their health services and the health and well-being of their populations, thus affirming the validity and strategies of the health-for-all goal. The following are global examples that refer to improvement of coverage, effectiveness and quality of health programmes:

- Immunization rates in most countries of the world have increased from about 5% of children in developing countries in 1970, to more than 50% in the late 1980s;
- Decreasing infant, children (under five) and maternal mortality rates; in many countries, under-five mortality rates have decreased by more than 50% since 1950;
- Increase in the coverage of the population with water supply; and

Many countries have based their national health policies on the health-for-all concept, emphasizing health promotion, including improvements in life-style, and decentralizing initiatives to districts and local communities. Many EMR countries have attained similar achievements (see Tables 1-5). However, despite widespread progress, the gains have not been uniform, either among countries or within them.

However, a number of the least-developed countries (LDCs), some of which are in this Region, have made only very limited progress; their infant, young child and maternal mortality rates and related morbidities remain unacceptably high. Projections of current trends to the year 2000 indicate that these morbidity rates will persist at tragically high levels for many of these countries. Health problems are still increasing seriously in large rural populations steeped in poverty.

Therefore, this Region is faced with variable progress in the pursuit of the health-for-all/primary-health-care goal: remarkable gains by some countries, and, for a few, relatively little progress at all. To address the range of persisting problems and to be prepared for problems that will emerge in the future, some innovative programmes and activities have been started by EMRO to support the health-for-all/primary-health-care movement. Some of these are briefly mentioned in the following sections.

2. Leadership for Health-for-All/Primary-Health-Care Development

Recognizing that the health-for-all goal through primary health care cannot be achieved by the health sector alone, and that coordinated efforts will be required from other social and economic sectors responsible for overall national development, as well as from communities and individuals, it was felt that creating collective leadership for the acceleration of the implementation of health for all/primary health care should be developed. In January 1985, in response to the call for "leadership development", the Director-General of WHO launched a WHO initiative called "Health for All Leadership Development". This was followed by the formation of a task force in headquarters, for the purpose and organization of three international colloquia in different WHO regions. EMRO participated in a number of colloquia that discussed the issue and defined the best ways and procedures to implement the approach in WHO Member States. As a result, the "WHO Medium-Term Programme Document" (1990-95) was issued to advocate and call on all Member States to promote health-for-all leadership development.

2.1. What is leadership?

There are differences between the terms "management" and "leadership". Managing and leading are not equivalent. "Managing" means bringing about, accomplishing, while "leading" entails influencing, guiding in direction, course of actions. The distinction is both fundamental and crucial. *While good managers do things right, leaders do the right things.*

Effective managers are often good leaders. Leadership is an essential part of "good managing". It grows in importance as the "human side of the enterprise" becomes that much more significant. The two qualities often become congruous when the managers have the responsibility for the basic purpose and general direction of an organization or an enterprise, in other words, when he/she becomes an executive leader. Emphasis is then on "leading others in managing themselves".

Table 1. Some Regional Averages of Socioeconomic and General Health Indicators, Based on Reporting Countries (data available as of date given)

Indicator	1982	1985	1988
Adult literacy rate	(%)	(%)	(%)
Both sexes	35	38	45
Males	47	49	56
Females	22	26	32
Per capita (US$)			
GNP	$1 504	$1 375	$1 131
GDP	$1 616	$1 645	$1 560
% of GNP spent on health	3%	...	4.9%
% of national health expenditure devoted to local health care	31%	50%	53%
% population covered with safe drinking water	(%)	(%)	(%)
Total	53	61	63 (20-100)
Urban	78	85	90 (38-100)
Rural	36	45	43 (17-100)
% population covered with adequate excreta-disposal facilities	(%)	(%)	(%)
Total	41	41	45 (0-100)
Urban	63	73	79 (2-100)
Rural	22	23	22 (0-100)

(Range given in parentheses).

Table 2. EMR Regional Average: Maternal Mortality Rate (MMR) per 10 000 Live Births

MMR	1982	1985	1988
	C	C	L
No data	9	3	8%
<5	8	7	5%
5-9		2	16%
10+	5	11	71%

C = Number of countries.
L = % of regions live births therein.

Table 3. EMR Regional Average: Infant Mortality Rate (IMR) per 1 000 Live Births

Area	1982	1985	1988
Total	111	97	81 (12-187)
Urban	(31-145)	(41-146)	(14-200)
Rural	(39-189)	(67-189)	(10-189)

(Range given in parentheses).

Table 4. EMR Regional Average: Immunization Coverage

Type	1982		1985		1987		1989	
	C	Average	C	Average	C	Average	C	Average
DPT-3	22	24%	20	45%	23	65%	23	75%
Polio-3	22	28%	20	45%	23	65%	23	75%
Measles	21	22%	20	39%	23	61%	23	70%
BCG	18	22%	16	51%	18	67%	18	78%
TT2/Bst	17	4%	16	9%	17	20%	19	28%

C = Number of reporting countries.

Table 5. Percentage of the Population Covered with Local Health Care within One-Hour's Walk or Travel in the EMR

Area	1982	1985	1988
Total	69%	73%	79% (20-100)
Urban		94%	96% (20-100)
Rural		62%	64% (50-100)

(Range given in parentheses).

Leadership is a word covering the human dimension of activities that initiates and fosters the process of *change*. The subject is both challenging and complex. It includes issues such as the nature and cultivation of the vision and values, and the development of leadership skills of individuals who are in a position to mobilize others.

2.2. Functions of effective health-for-all leadership

- Changing oneself;
- Projecting vision in own context;
- Conceptualizing/understanding the health-for-all vision;
- Initiating/guiding change;
- Mobilizing commitment and support for change and motivating relevant sectors to follow that;
- Managing change - resolving conflicts and issues;
- Building sustainability - developing others.

An important issue in leadership development for "health for all" is the involvement of other sectors in a true spirit of cooperation and partnership. There is abundant evidence that much action has taken place to clarify the role of other sectors in contributing towards health. It is now widely recognized that education, food, agriculture and environment sectors have important roles to undertake towards health. Yet we must ask whether leadership in the health sector has successfully mobilized the support of this sector? For example, have the ministries of health fought for the education of women, because of what we know about the education of the mother as a decisive factor for the health of her children and her family? And what role has the health leadership played in the food and agriculture policies that have such an important bearing on health? When governments have had to cope with the economic crisis brought about by increasing foreign debt burdens (as well as man-made and natural disasters) and had to adopt adjustment policies, has the health leadership been strong enough to protect the poorest and most vulnerable? And what about the leadership of educational institutions that prepare and guide the leaders of tomorrow?

Almost everyone agrees that current medical and health personnel education does not respond to the needs and challenges of "health for all", and that drastic changes are needed. Yet these changes are only halfhearted. Has the educational leadership responded affirmatively and with conviction to the challenge? Have they sought, initiated and pursued mechanisms of effective cooperation with governments, communities and service agencies? Are they supporting political leadership as well as taking the initiative to effect change? Have they started to move out of their traditional realms of academic accomplishment to work with the uncharted and unpredictable political and social forces in society? Are they sensitive to emerging problems in society in order to expand their roles? Of course there are many barriers, but that is where leadership is challenged to the utmost. Ways have to be found to overcome these barriers and to turn them into opportunities.

2.3. Leadership responsibilities at different levels of the health system

The many and complex changes implied in health-for-all strategies are directed at all levels of the health system as well as related systems. Therefore, health-for-all leadership is needed for every single unit, at every level that comprises the health system and throughout the spectrum of a national structure (i.e., in the community, health professions, political

organizations, health sector, institutions, universities, research establishments and nongovernmental organizations or NGOs).

At each level of the health system, different leadership functions evolve according to the responsibilities of the leadership position and the nature of the change sought.

At the central level, leadership usually rests with political leaders such as ministers of health or ministries of relevant sectors, heads of research and professional associations at the national level. Their key leadership responsibilities involve directing and guiding policies, evaluating and orienting change, influencing other top-level leaders, mobilizing support for change from critical influencing groups, resolving central policy issues, mobilizing and directing resources in support of change and motivating others.

At the intermediate level, usually the technocrats assume leadership roles. These are the national and professional-level administrators in health and other relevant sectors, senior officials of NGOs, political and other elected or appointed leaders at provincial or district levels, and senior representatives of educational institutions. Their leadership responsibilities include providing managerial directions for the implementation of policy, monitoring and evaluating, motivating others, mobilizing support of influential and pressure groups, resolving implementation issues and problems and participating in policy-making, including allocation of resources. At this level, leadership functions become an integral part of management functions, and effective managers are therefore characterized by their leadership qualities.

At the community level, leadership devolves on a wide range of people, including health workers, locally elected community leaders, religious leaders, representatives of voluntary agencies or NGOs, representatives of other sectors, such as school teachers, or even in the private sector (e.g., shopkeepers, tribal leaders, and village volunteers, etc.). Their leadership responsibilities embrace mobilizing and coordinating community action for health, including resources; setting community-level targets and monitoring them; and influencing those at higher levels for support towards community health programmes. At this level (implementation level), the actual resolution of health problems takes place.

2.4. Developing and mobilizing health-for-all leadership

There is a paradox about leadership. Formally trained and experienced leadership is in short supply, and often over-used. At the same time, there are vast numbers with leadership potential who are untrained and inexperienced. Those already in leadership roles, often too few in number, need support, while at the same time, training and experimental opportunities need to be created for others. Incentives need to be developed to help sustain those in leadership roles.

Areas critical to the development of health-for-all leadership include: (i) intersectoral dimension of health; (ii) health policy and strategy development based on health-for-all principles; (iii) mobilizing commitments; and (iv) initiating leadership development.

Besides these issues, leaders must have:

- Clear understanding of Health for All Strategy and its broad principles;
- Commitment to guide national policy decisions towards social equity;
- Comprehension of the health aspects of policies of other sectors in order to argue for health in an intersectoral setting;
- Capability to identify critical issues affecting the implementation of health-for-all strategies;
- Confidence stemming from the knowledge of having the relevant skills and experience; and
- Capacity to motivate others and to mobilize commitment.

2.5. The implementation gap between health for all and leadership

As the year 2000 draws near, less and less time remains for achieving "health for all by the year 2000"; it is also recognized that the health-for-all movement is widely accepted and that there is evidence of real progress towards the goal. However, there is still a substantial gap between what is said and what is done. People in the political arena are committed to health for all. Bureaucrats and technocrats are willing and able to develop plans and programmes. Managers exist to carry them out, and people at all levels have enormous potential to contribute and participate. With so much *potential*, what then is the problem? Why do these gaps exist?

- Is the vision not understood?
- Are the goals unclear?
- Are the people not enabled to play their part?
- Is change initiated but not sustained?
- Are the values and principles of the primary-health-care approach still not understood?
- Who will take the leadership responsibility to address these gaps?

Probably the establishment and development of leadership may answer all these questions.

2.6. What can leadership do for health?

How do leaders affect change? How do they construe their own roles? What concerns become the focus of their leadership responsibilities? How do they involve and infuse others with the same sense of purpose towards a common goal? What obstacles do they encounter, and how do they deal with them? How do they ensure that the process of change is sustainable after they move on?

Answers to these questions emerge with certain common themes regarding leadership responsibility, irrespective of the level at which they are involved. These include:

- Conceptualizing/understanding the vision of health for all;
- Projecting the vision, clarifying the principles;
- Initiating/guiding change, introducing policies, innovation, complementary strategies;
- Mobilizing commitment and support for change, enhancing commitment and achieving consensus;
- Managing change, resolving conflicts and critical issues; and
- Building sustainability, enabling and developing others.

In essence, it is the development of health-for-all group leadership or collective leadership that is of central concern. This is a shift from a single charismatic to the symbiotic leadership of many, working towards a common goal.

2.7. Role of EMRO in health-for-all leadership development

To facilitate and sustain the health-for-all movement in the Region, EMRO began a programme of health-for-all leadership development. To start the programme, intercountry colloquia were organized in 1987 and 1988, in Thailand. These intercountry colloquia drew on the experiences of three previous international colloquia organized by WHO/HQ. The EMRO intercountry colloquia exposed groups of multidisciplinary high-ranked officials, from various countries as well as staff members from regional and country levels, to the Thailand experience of collective leadership. As a continuation of that, it was decided to organize four intercountry workshops on health-for-all leadership development for "facilitators" during this biennium. These workshops are meant to be organized in EMR countries and aim at developing effective multidisciplinary resource persons to facilitate health-for-all leadership development in their own countries; and train others through conducting similar country workshops. Participants are meant to be exposed to their own countries' experience in health-for-all leadership.

The first workshop was organized in Sana'a, Yemen (6-16 May 1990), and participants from five countries (from various sectors) were exposed to the Yemeni experience in health-for-all/PHC development and health-for-all leadership.

Another pioneering area that EMRO embarked upon for health-for-all leadership development is the nine-month course called **Leadership Development in International Health (LDP)**. The Regional Committee, in resolution EM/RC33/R.5 in 1986, approved the suggestion of the Regional Consultative Committee that 10% of the country general fellowship allocation "be used to recruit nationals for the purpose of providing them with on-the-job training in international health work and the planning and implementation of various technical programmes. The aim of the LDP has been to develop mid-career potential leaders of the national health systems. These potential leaders are exposed to detailed knowledge of international health

organizations, first and foremost of WHO, and they are able to develop nationally appropriate and relevant cooperative programmes and, in general, use most effectively and efficiently international collaboration for enhancing national health development towards health for all.

This aim is clearly twofold. Nationals of EMR countries with leadership potential should learn (i) how to lead, plan and manage their national health systems, including the planning and implementation of various technical programmes to enhance national health development; and (ii) how to harness international health collaboration to speed up national health development towards health for all. Seven nationals from different levels of their national health systems in different countries attended this session. The course itself was assessed twice by an External Review Committee (ERC). The second ERC, at the end of the course, recommended that since the first session of this training course proved to be successful in fulfilling its objectives, a second round should start in 1991, and that networks of supporting institutions, at country level, should be started and promoted. The ERC also recommended that facilitators should devote more time to transferring capabilities to local resource people and to preparing learning materials that can be based in local languages in countries for similar courses and for subsequent intercountry courses. They also recommended increasing the number of participants for the second session.

Another example of EMRO's overall efforts for health-for-all leadership development includes the use of joint government/WHO programme review missions (JPRMs) in all countries of the Region in odd-numbered years, which are usually followed by visits of senior officials from the ministries of health to EMRO with WHO representatives (WRs) to continue the dialogue of health-for-all/PHC development through the collaborative programmes in even-numbered years. It also includes other forms of technical cooperation among developing countries (TCDC) through networking, dissemination and exchange of technical information, technical working groups, etc.

Finally, it is felt that more effort is needed from WHO and EMR Member States in health-for-all leadership development to accelerate the process of health-for-all/PHC implementation to make sure that countries:

- Maintain and reaffirm health for all as a permanent goal;
- Avoid the major gaps in the process of achievements of the health-for-all goal;
- Use strategies and approaches to mobilize commitment, at all levels, for health-for-all leadership development.

3. Integrated Community Development: Basic Minimum Needs/Quality of Life

Recognizing that the basic health service system of the 1960s, which was mainly curative in content, had little impact on the health of the people, the Alma-Ata Conference (1978) defined the concept of "primary health care" (PHC), promoting the provision of its eight essential elements as a minimum package of services, to be responsive to the needs of the community. The Conference asserted the importance of providing PHC services in a comprehensive manner, including health promotion, disease prevention, disease treatment and health restoration, as well as rehabilitation. The health-for-all/PHC principles include, among others, equity and social justice in

distribution of resources, community involvement in planning implementation, cost-share controlling of services, effective intersectoral collaboration in planning, management and implementation of socioeconomic development activities, including health, and the use of appropriate technology.

According to these principles and health-for-all/PHC philosophy, the whole approach cannot be the responsibility of the health sector alone. However, most countries are making the health system that responsibility. This is despite the fact that the health system is traditionally "confined" to its boundaries. The health system usually ignores the other sectors and so do the other sectors. At the same time, all forget the communities and the role that they can play in the various aspects of socioeconomic development, including health. This has isolated the health system from the community and other sectors, and has thus hampered progress in health-for-all/PHC development. Moreover, it has also degraded the priority of health in socioeconomic development, which considers the health sector a "nonproductive sector".

To change the picture, some countries have made attempts to promote community participation and intersectoral coordination. However, in some countries, these attempts have not always been successful because:

- There have been no realistic long-term plans for such participation and coordination;

- Community involvement has been related mainly to fund-raising to release governments from their financial constraints and burdens; and

- Intersectoral coordination has been traditionally related to actions during emergency situations (e.g., disease epidemics or disasters).

Therefore, although in the framework of health-for-all/PHC, certain countries have made significant progress in improving the health of their people, particularly in specific areas, the real breakthrough expected from PHC has rarely occurred. The main successes were realized in areas that health professionals and health systems were used to (i.e., curative and preventive activities), but health promotion which needs effective and active community involvement and intersectoral collaboration, was not equally developed or improved. Therefore, the two main weak areas in the process of health-for-all/PHC implementation are: *intersectoral collaboration and community involvement*. As a result of this, "bottom-up" planning methodology has been lacking in these countries.

This situation has stimulated some countries to think of innovative methods to enhance the promotion of these basic principles of the health-for-all/PHC approach. One of these methods is the **Basic Minimum Needs/ Quality of Life approach (BMN/QL)**. This method, it is believed, was first proposed in Nepal in 1979 by the government and WHO, but there was no real implementation, probably because the concerned parties were not prepared for such innovation and had still much to learn about the promotional and strategic requirements of such an approach.

A successful experiment started in Thailand in 1982-83, which included more than ten provinces. "The Village Self-managed Primary Health Care Programme" confirmed the relevance of the BMN/QL concept, including all the components of community life. The conjuncture was then practically adequate to develop an integrated common goal (i.e., improving the "quality of life"

by responding to basic minimum needs). In short, the fundamental principles of the developmental concept are as follows:

- Health services, in general, cannot solve all the people's health and health-related problems. Indeed, people cannot reach a state of health in the absence of other "basic needs" such as reasonable income, housing, food, basic education, security, etc., even if health services are well developed.

- Quality of life emphasizes the PHC philosophy by enhancing and fostering the "basic needs" of the people, and constituting the important goal of mobilizing both community and government workers of all concerned developmental sectors, intersectoral collaboration and action.

- The BMN method actually enhances and is based on the complete involvement of the community in leadership, financial support and management of its own health and health-related social affairs, within the overall sphere of socioeconomic development.

- The BMN/QL methodology includes generally such components as: water, food, habitat and environment, means of livelihood (including income generation), health education/information and sociocultural life (including security, peace, cultural and spiritual values) through active community involvement and effective intersectoral coordination. Other activities can be extended and changed according to actual community needs. These may include such components as preparedness for natural disaster, communication and transport.

- Community self-reliance and capability in decision-making, as well as provision of resources and their utilization are cornerstones of this method. BMN/QL promotes and makes use of people's self-help and self-determination, their ability to plan and manage their own community projects to meet their basic needs, their contribution to the financing of these projects (through interest-free loans) as is generally required, their spirit of responsibility, initiative, creativity, accountability and entrepreneurship.

- These actions require a real partnership between various government workers and the people. This demands mutual credibility, respect, trust and confidence, an essential transformation process or role change (i.e., from providers of services, government workers become facilitators and collaborators; from passive recipients of services, the people become actors and even initiators of projects).

- Extensive social preparation are needed to promote this method; community organization is essential and a basic prerequisite for the implementation of this method.

- The use, development and research for appropriate technologies in all disciplines needed for meeting the people's needs are keys to the success of the approach. Management itself must be an appropriate technology for the people.

- The implementation of this method starts with development of community organization; all sectors of the community should be involved. Within that organization, collective leadership is established and developed from various influential people (e.g., religious leaders, traditional tribal leaders, school teachers, etc.). This collective leadership may take the form of an executive committee accountable to the whole community. This collective leadership is exposed to training in management and development of the skills of leadership.

With the support of an intersectoral group of governmental officials, trained in social work, a community survey is conducted, followed by community diagnosis that spells out all community health and health-related problems. This is followed by priority setting of the problems that affect the majority of the people. The entire community participates in that. Indicators for evaluation of progress are then defined. Some of the activities to be undertaken by the community may be, or usually are, income-generating projects. Communities may need "seed" money to start these projects. Loans are, hence, offered by the government or any other NGO or UN agency, including WHO. Such loans are without interest. In such conditions, a social development contract between the people, the government and the funding agency is established. Such contracts, signed by the parties concerned, have a clause that at least 50%-60% of the income generated by the project must be used for social development and related activities (e.g., health, education, roads, communication, environment, etc.).

Thus, all aspects of development will be mainly self-financed by the community. Rarely do such activities require additional government funding or additional manpower, except for technical support. The people usually undertake a large proportion of community-level development activities. The people can progressively achieve self-sustained development within their own community and the adjoining communities, thus expanding self-reliance. As part of the socioeconomic development "package", PHC appears as a natural and high priority set of activities that the people are committed to and successfully carry out. Whenever there is a PHC facility, its staff will be part of the technical multidisciplinary group that supports and works with the community to reach its targets. All sectors benefit from each other, work together and interact with the community, and this will become common day-to-day practice.

As mentioned, BMN/QL is based on the "bottom-up" method of planning. In Thailand, this cycle of planning is strongly committed up to district and provincial levels; in some cases, it reaches central level.

Due to its success in Thailand, some other countries in South-East Asia have adapted the method and have introduced some changes to it to fit their context. In view of sociocultural differences, *inter alia*, there must be a specific national way to achieving quality of life. In the same country, there may even be local variations; therefore, each country requires considerable effort in adaptation. Implementors of BMN would be well advised to avoid simple copying of any model and use their own local experience to try and create with their communities a genuine national model.

3.1. EMRO experience

EMRO experience in the implementation of the BMN approach or method, within the context of the PHC district health system, continues to grow and

become richer. Having completed the initial step of exposing multisectoral, multidisciplinary key national staff, through colloquia and observational tours in Thailand, the introduction and implementation approach has been the next step. BMN research and development activities are being implemented, with varying degrees of success, in three countries of the Region.

Somalia, for example, has reached an advanced stage in the implementation of this approach. BMN is now covering, at various stages, 24 villages with a population of about 15 000, in Lower Shabelle region, and preparation is underway for extension to other regions. Most government officials have visited the programme area. Since the inception of the BMN programme in Lower Shabelle, the communities that became involved from the beginning were able to identify their problems and adopt valid and practical instruments to assess and put into effect needed changes, design projects and undertake their implementation, management and monitoring. Model villages that initiated the programme have started to share their experiences with other villages, resulting in active technical cooperation among developing villages (TCDV). Inasmuch as the community considered the programme its own, while addressing its priority problems rather than sectoral objectives, its financial contribution was generous. The funds for the project generated by the communities were supplemented by a loan without interest provided by the WHO Research and Development Project.

Collective effort, including the partnership of the people, the government and WHO, resulted in a dramatic change in health and socioeconomic development of the first five villages (population 2 464). After one year of implementing the BMN approach, a comparison was made with baseline data available before implementation (Table 6). Also, the community, through a self-help management PHC/BMN approach, fully immunized 100% of the children in less than one year, and provided safe drinking water for themselves and domestic and animal use, according to a target set by themselves. School attendance, especially for girls, increased dramatically. A literacy campaign was carried out. All cattle were immunized against black water diseases, *septicaemia haemorrhagiea* and rinderpest.

Table 6. Comparison of Some Health Indicators in Five Villages of Lower Shebelle, Somalia, with a Population of 2 464 Before and After One Year of BMN Implementation, 1989

Health indicators	Crude birth rate		Crude death rate		Infant mortality rate (under 1 year)		Child mortality rate (Under 5 years)		Percentage of deaths due to diarrhoea		Percentage of mal-nourished children (0-4 years)	
	No.	Per thousand	No.	Per thousand	No.	Per thousand	No.	Per thousand	No.	%	No.	%
July 1988 Before BMN	161	65.34	58	23.53	9	55.90	17	34.69	12	20.68	113	23.0
July 1989 After BMN	143	58.03	36	14.61	4	27.97	4	7.16	0	0.0	20	3.7

Note: All the differences between the rates before and after BMN were statistically significant except IMR. All rates reflect births or deaths per thousand in a given year.

Source: WR, Somalia.

Villagers were trained in animal preventive and curative care. Income-generation projects such as raising poultry, fishery, agriculture, dairy products, limestone, handicraft and pottery were planned, co-financed and implemented by the people, with technical and managerial support from the BMN team. The total cost of the above-mentioned projects in the five villages was SShs 5 721 300 of which SShs 3 360 800 was contributed by the community and SShs 2 360 000 was provided by WHO as a loan without interest. Overall, the community made SShs 21 135 600 in profit. According to the contract with the community, a part of this profit was to be spent on social services such a health and education. From this profit, the community already constructed a school, hired a teacher, established a health post and has paid the community health workers. Two villages reimbursed their loan to WHO much earlier than agreed. BMN has been introduced into another four EMR Member States (for a total of seven EMR countries) and other countries have expressed interest.

A collaborative programme involving four least-developed countries (LDCs) in the Region, namely Djibouti, Somalia, Sudan and the Republic of Yemen, is being developed and will be financially supported by the UNDP. EMRO, in preparation for more intensive efforts in this field, has already taken steps to develop its own expertise and professional capabilities to meet the increasing demand for technical assistance and support in the implementation of BMN. Four intercountry workshops on health-for-all leadership development for facilitators have been budgeted for the biennium 1990-91. These workshops expose participants to various methods and experiences in the Region in integrated community development, including BMN. The first one was organized in the Republic of Yemen (6-16 May 1990) and exposed the participants to the experiences of the Confederation of Local Development Councils that work for overall socioeconomic development of the Yemeni community. The second and the third will be organized in other EMR countries to expose participants to experiences of those countries in BMN, or in similar needed integrated community development.

In considering BMN, and its possible expansion in the countries of the Region, it is important to realize the approach does not mean a revolution of any kind; it does not mean that it is an alternative approach to the main strategy for the goal of health for all, namely PHC. On the contrary, it helps to strengthen the PHC philosophy and principles, that is:

- To see health development as an integral part of overall socioeconomic development;

- To promote a "bottom-up" methodology of planning;

- To support active and effective community involvement and actual empowering of the community for its own development; leading to self-reliance and sustainability of growth and progress;

- To strengthen intersectoral collaboration in planning and action for socioeconomic development, including health, the use of appropriate technology; and

- To promote decentralization in decision-making in day-to-day community activities, thus emphasizing the district health system approach.

Finally, although the road ahead is clear, it will not be an easy one to travel. Strong will, plus individual, group and national commitment to

achieve results will be needed if we are to have health for *all*. It is hoped that the growing and rich experiences in the Region, supplemented by international support, will make the journey, even if arduous, rewarding and satisfying.

4. District Health System

Organization of the district health system, based on primary health care, is considered one of the innovative approaches to accelerate the process of health for all/PHC. WHO's emphasis on strengthening district health systems, with support from the national level, reflects the realization by a growing number of countries that the principal obstacles to achieving health for all are weak organization and management, particularly, at the lower level of the health system.

The concept of the district health system crystallized at a meeting of a WHO expert committee in 1985. This concept provides a conceptual framework for thinking about hospitals and PHC facilities in relation to the people they serve. It also involves the resources of other relevant agencies, including those not usually considered part of the health system.

Since the model of a comprehensive health system, based on the principles of primary health care, emphasizes that the effective implementation of an integrated PHC programme, at all levels of service delivery, is influenced by the functional infrastructure and by community involvement and intersectoral collaboration, the key features of a district health system have been described as follows:

- It is people-centred, emphasizing all the health-related elements of their behaviour and their environment, and their right to shape their own health care with professional help;

- It is based, whenever possible, on a discrete geographical area, within clearly delineated boundaries, and includes the entire population;

- It need not be only a government system and can be composed of many elements, for example, non-governmental institutions and traditional leaders;

- It has substantial managerial autonomy to settle priorities and problems, on a decentralized basis; and it incorporates the PHC approach as the main emphasis of its activities.

In 1987, a WHO interregional meeting in Harare, Zimbabwe, called on Member States to adopt national policies that provide for necessary support to the districts. The conference urged appropriate decentralization of financial and personnel management, to provide enough flexibility to districts to adapt national policies to respond to district needs and resources. It also called to redefine the role and functions of hospitals as an integral part of the district health system.

4.1. What is a district health system?

A district health system is a clearly defined administrative area, which commonly has a population between 50 000 to 500 000, where some form of local

government or administration takes over many of the responsibilities from central government sectors or departments, and where general hospital or referral support exists. The actual organization of a district health system depends on the specific situation in each country and each district, including the administrative structure and personalities involved. Nevertheless, the general principles for developing such systems are based on the Declaration of Alma-Ata and the Global Strategy for Health for All, and incorporates the following:

- equity
- accessibility
- emphasis on promotion and prevention
- intersectoral action
- community involvement
- decentralization
- integration of health programmes
- coordination of separate health activities

4.2. Why focus on the district?

The district is the most appropriate level for coordinating "top-down" and "bottom-up" planning, for organizing community involvement in planning and implementation, and for improving the coordination of government and private health care. It is close enough to communities to identify problems and constraints at community level and to find solutions for them. Many key development sectors are represented at this level, thus facilitating inter-sectoral cooperation and the management of services across a broad front.

Country experiences show that health workers operating within and from their health posts and health centres cannot function in a sustained and purposeful manner without support. The most appropriate level for which to organize and provide the support is the district.

4.3. Role of EMRO in strengthening district health systems

The main emphasis of the regional programme's activities has been aimed at the establishment and strengthening of the district health system based on the PHC approach. Fortunately, most of the countries of the Region have already been exposed to the concept of the district health system; they are now conversant with and supportive of it, and already possess district health structures of one form or another. However, although, in general, the Region's experience with the district health system is rich and of long duration, both Member States and the Regional Office have realized the need for:

- Introduction and strengthening of the district health system approach and methods in the establishment of an organizational structure and in maintaining the processes in smooth operation;

- Reorientation of the health system to be based on and capable of delivering quality PHC services which will ultimately realize health for all by the year 2000;

- Strengthening the managerial skills and capabilities of the health system to improve its effectiveness in delivering services and the efficient use of resources; and

- Utilization of health system research (HSR) in studying operational problems and in designing workable solutions for them, and also in seeking innovative technologies, approaches and procedures that will promote and develop the district health system.

Suitable directions and strategies to satisfy the above-mentioned needs were identified and discussed immediately after the Harare meeting (in which EMRO and some nationals from Member States participated) at an intercountry meeting organized for national PHC managers from 21 countries in the Region (held in Wad Medani, Sudan, in November 1987). This meeting reviewed countries' experiences in implementing PHC since the Alma-Ata Conference, identified constraints and suggested solutions for them, within the context of district health system development. The Declaration of the Harare Conference further helped this intercountry meeting to formulate practical recommendations in connection with district health systems based on PHC. These recommendations called for adoption of national health-for-all/PHC policies, decentralization, strengthening and promoting community involvement, development and enhancing district leadership, refinement of the role of hospitals in PHC and equity among districts.

To further assist the Member States and the Regional Office in their collaborative activities to develop district health systems based on PHC, a working group meeting of experienced senior multidisciplinary professionals from EMR Member States and WHO was held in the Regional Office in November 1988. This meeting reviewed the progress of implementation of health for all/PHC in EMR countries and advised on modification of strategies, approaches and technologies to foster and improve the implementation of PHC in district health system development. In addition, it addressed problems of financing health services within the district health system.

Furthermore, EMRO is providing technical and financial assistance to Member States to strengthen their district health systems, particularly in areas of management, including provision of supportive supervision, referral, intersectoral coordination and community involvement.

Finally, despite the good experiences of this Region in district health systems based on PHC, a lot of effort remains to be done. Many countries of the Region need either to establish and develop their district health systems, or to renovate their style already built, but destroyed by civil strife, natural disasters or financial crisis.

5. Action-Oriented School Health Curriculum (AOSHC)

In the EMR, similar to other developing areas of the world, the school-aged population compose a large percentage of the total population. School children, being the future resources and leaders of tomorrow, and being one of the most vulnerable groups in most communities, are considered to be the most critical segment of population for all actions that focus on health protection and promotion towards health for all.

Adults may be set in their behavioral patterns and life-style, making it difficult to influence them to facilitate health promotion and disease prevention. However, children are the "agents of change". They can easily acquire healthy behaviour and develop beneficial sets of values and motivation to improve physical and social conditions and opt for a better quality of life.

At the same time, school children are one of the most effective communication agents, where they can take, on a continuous and sustained basis, health messages to their homes and families. For health promotion, mass communication through the public media and other venues aim at achieving a cumulative report among those who see or hear them. It is to arouse awareness and prompt people to seek confirmation through local health workers, school teachers or other authorities with whom the audience can discuss and reassure themselves about a new health practice. Moreover, the modern mass media does not reach all segments of the population and its messages do not correspond to peoples' needs or problems, and may not be effective. Therefore, school children, who come from the majority of families of the community, and who live with their parents, can play a good, relevant and effective role as communication agents.

All these factors stimulated EMRO to develop a mechanism through which the health and health-related problems of the school population could be addressed with the aim of promoting the health of the students, the parents and the community. Thus, to develop a school health education programme based on the prototype "action-oriented school health curriculum" (AOSHC), as well as the promotion of involvement of youth in promoting health, including a healthy life-style, was developed.

5.1. The AOSHC prototype

This curriculum was originally developed by WHO/EMRO and UNICEF/MENA in 1985 with the following objectives:

- To develop positive attributes and high human qualities among children of today, parents and leaders of tomorrow;
- To identify and develop a new role for schools, making them catalysts for health development within overall socioeconomic development; and
- To "domesticate" health information messages, making them available to school children, teachers, parents, families and the community.

5.2. Strategies

5.2.1. Teaching methodologies

i) *Through discovering, analysing and learning by doing*: This implies that health facts are presented in an attractive way and health education is conducted in a stimulating manner that will involve active participation by the pupils, encourage self-discovery and promote learning by doing. Thus, children will go in groups to discover aspects and happenings in their communities that are congenial and promotive to the health issues they are studying. They will list their findings, analyse them, decide activities they should do to augment these aspects and implement these aspects, together with their teachers, families and community.

Benefits: Children, by looking for *"good things"*, first develop positive attitudes - by working together, they gain skills in team work and ability to work with their community. The process also teaches them scientific approaches and research skills and, by the actions they do, contributes to overall development and promotion of self-reliance.

ii) In the next lesson they can look into *weaknesses* and act to correct them.

Children are given home assignments: A child, along the same above approach, will make a list of factors at home that, for example, will cause, prevent and treat diarrhoea, etc., and will act with his/her family accordingly.

Benefits: Self-confidence, self and family health education, family care, good family relations, self-reliance, etc.

iii) *Health messages will be incorporated* into various subjects and school activities.

Benefits: Relevance of the education system, positive life-style, etc.

iv) *Development of mini-health projects*: School children can develop and implement mini-health programmes as offshoots of national health programmes and identify areas of implementation in their communities (e.g., malaria control programmes, environmental health programmes, income-generation programmes, etc.).

Benefits: Extra resources for health and development programmes and decentralization of these and other national programmes.

v) *Development of community schools*: By making school teachers and pupils act as health educators (thus strengthening the health role of the school), schools should use the community as an "expanded teaching ground" and class-rooms should be opened for community members to benefit from, e.g., illiteracy campaigns, discussion of aspects of village development plans, etc. Thus, when there are no health facilities, schools can play a crucial health role.

5.2.2. Implementation

The prototype has been under implementation in **Bahrain, Egypt** and Jordan; while **Morocco** and **Sudan** have just started. The prototype is presented as basic material and it can accommodate changes that suit local conditions and context. Such changes are usually encouraged.

The AOSHC is not limited to or responsive only to the needs of primary school children, but is applicable in other levels. In Jordan, it is envisaged to include it in continuing education, adult education, training of teachers and religious leaders. In Morocco, a review of AOSHC is to incorporate the innovative aspects of the prototype. Sudan has decided to interpret health messages in various subjects and transfer them in different dialects, disseminating them through the mass media, as well as through adult literacy courses.

In some countries of other regions (e.g., China, Nigeria and Sierra Leone), the AOSHC is also being adapted, adopted and/or utilized for the development of health education messages.

At the International Conference of Education for All (Bangkok, 5-9 March 1990), the AOSHC was presented as one of the basic documents to incorporate health in education.

This innovative programme has thus received wide acclamation. It has been translated into a number of languages.

Future look. Experience, so far, has indicated that the use of AOSHC, after adaptation to the context, when it is implemented, will contribute tremendously to the promotion of health-for-all/PHC activities, because it promotes active community involvement and effective intersectoral action, particularly between health and education. Where it is implemented, schools will eventually become involved in overall social and community development, including health. In other words, schools will become real social centres. Students will become an effective medium for disseminating health messages.

However, more efforts are still needed from EMR countries to translate their interest in this prototype AOSHC into practical adoption and implementation.

Evaluation. Since this curriculum has been adopted by a few countries in the Region, and interest has also been expressed by other countries to implement it, it becomes important now to define specific indicators for its evaluation. This depends on the support of Member States to provide EMRO with accurate baseline data on health and health habits against which evaluation can be made.

6. Healthy Public Policy

6.1. Definition

The cornerstones of a **healthy public policy** are an understanding of the interrelationships among the environment, economic status, personal choice and health, as well as preventive health strategies, health education, *community involvement and intersectoral planning*.

Healthy public policy is *holistic* and *ecological*, recognizing that health, in its broader sense, depends on an integrated view of people's physical, mental and social dimensions, as well as on the fact that people react to and, in turn, shape their environment.

Healthy public policy encourages politicians and policy-makers, at all levels, to become aware of the effects their decisions have on people's health. This applies whether they are building a new road or a new city; planning a new school; deciding support levels of welfare to those in need; or providing programmes for unemployed youth. It also builds on public awareness of health as an essential goal. This will be reflected in life-style, such as changes towards health foods, exercise programmes, non-smoking, etc. It promotes public concern about food contaminants, environmental and ecological issues as well as empowering consumer groups. It acknowledges that "health" is something more affirmative than the mere *absence* of disease.

Because of all these factors, healthy public policy calls for intersectoral styles of planning and more open-minded approaches to problem-solving. At the same time, to be effective, it depends on the creativity, resources and commitment of the community, which should be involved in planning, implementing and evaluating given policies, if they are to enjoy public support.

Realizing the importance of healthy public policy, EMRO has started advocating for it among its Member States, with the following objectives:

- To develop and promote healthy public policies that are in harmony with and promotive to "health for all by the year 2000"; and

- To encourage all EMR Member States to adopt this approach as a basic manoeuvre to attain health for all.

6.2. Strategies to be followed by Member States and EMRO

- Review all existing policies of various sectors and ministries, including health ministries in all Member States;

- Define, refine and readjust those policies that are contrary to and do not comply with healthy public policies;

- Develop and promote new policies that strengthen the health-for-all/PHC movement in all Member States;

- Develop public policies that specifically address and are responsive to the health and health-related problems of vulnerable groups (women, children, elderly, etc.) and deal with specific issues such as drugs, food, environment, etc.;

- Develop necessary public health legislation and incentive schemes to protect health and to ensure implementation of the developed policies;

- Advocate and promote the development of intercountry policies in relevant areas and issues such as pollution, contamination, water, industry, etc.; and

- Develop national and intercountry consultations and workshops to exchange experiences and to promote implementation of the above strategies.

6.3. Progress in EMR countries

So far, Iraq has decided to start this programme during the current biennium. A consultant will be recruited to assist the national authorities in the country to design and set a national healthy public policy.

EMRO is ready to assist technically other Member States to do the same. At the same time, it will make available reference materials needed and streamline the exchange of information and experiences among different Member States to enable them to formulate appropriate and relevant policies.

7. Health Promotion and Life-style Programme

Health was considered by Alma-Ata as a capacity, potential or ability to achieve goals or perform functions. These concepts emphasize health as a means to an end rather than as an end in itself.

However, in practice, the "negative" concept of health, as the absence of disease, has tended to determine decision-making, planning, expenditure and the organization of "health" services in both developed and developing

countries. In actual fact, services for sickness are named "health services", reinforcing the custom of defining health by what it is not. Thus, although PHC implementation has resulted in achieving progress towards the attainment of health for all, there is still considerable variation in the amount of progress made as regards incorporating health promotion into provision of PHC services.

7.1. Definition of life-style

The term "life-style" is taken to mean "a general way of living based on the interplay between living conditions in the wide sense and the individual pattern of behavior, as determined by sociocultural factors and personal characteristics". This simple definition means that there is a range of determinants of life-style. These include, on the one hand, personal health behaviour and, on the other hand, an individual's "ecosphere" (i.e., the family, community, culture, social structure, physical environment, financial situation, etc.). Determinants of life-style must be seen as a combination of internal and external forces, in continuous interaction. The Alma-Ata report stated that health promotion seeks to "enable" individuals and communities to increase control over determinants of health and thereby improve their health. It is therefore concerned not only with enabling the development of life-styles and individual competence to influence factors determining health, but also is concerned with environmental interventions to reinforce factors supporting a healthy life-style and/or how to change those factors preventing or prohibiting a healthy life-style.

7.2. The role of a healthy life-style in the modern concept of health

Modern medical science and technology have experienced advanced stages of development in connection with disease diagnosis and treatment, including numerous interventions to prevent many diseases have been reached. This has resulted, more and more, in the complexity of the health system and in a continuous increase in its cost, which has been accompanied by more inequity between those "favoured" who can reach the health services and those "unfavoured" residing in rural areas, as well as those living, marginally in depressed urban areas.

Thus, all of this development, witnessed in recent years, has not contributed to improvement in the health of the majority of the people, particularly in developing countries. Still, many communicable diseases and chronic and degenerative diseases, such as cardiovascular diseases, cancer, mental and neurological disorders, accidents, alcohol and drug dependance, are actually increasing and are finding a limited response from existing health services. Furthermore, health and medical care is becoming more and more modernized and mechanized and is gradually losing its "human touch".

A power alternative approach towards health, which was practised by earlier civilizations (Arabic/Islamic medicine and the Indian medical system of Ayurveda) has started again to gain prominence. This alternative approach sees health through the **"sociomedical paradigm"** rather than through the **"biomedical paradigm"**. It has now become evident that there is a clear *link* between the prevalence of health and ill-health in any given *population, and in socioeconomic and sociocultural factors involved.*

The sociomedical paradigm is well illustrated in the well-known "Lalonde Report from Canada" (1974), in which health is perceived not as something

that is confined to the individual, but as a "field of health", including (i) human biology, (ii) environment, (iii) life-style, and (iv) health organizations. It is well known that only sophisticated secondary and tertiary medical care has received attention in modern medicine, while *environmental* factors have received much less attention than they deserve in the area of life-style (i.e., personal habits and personal choices related to health have been largely neglected).

7.3. Health promotion

Health promotion is a relatively new term. Its meaning overlaps, to some extent, with the meaning of prevention. The main difference between the two seems to be one of focus rather than of overall perspective. Whereas prevention is a disease-related concept, health promotion is a health- and social-related one. Sometimes the term "health protection" is used along with "health promotion", together they refer to the balance of health. While health promotion refers to efforts to strengthen health potential, health protection refers to prevention of any imbalance of health equilibrium.

As already pointed out, health promotion (including life-style) is still an evolving concept. Some of its components that are commonly agreed upon are:

- Fostering a healthy life-style and enabling people to cope with their health and health-related problems;

- Promoting social, economic and environmental conditions conducive to good health;

- Attaining these two by raising awareness about health matters in individuals, families and communities.

Strategies include:

- Firm commitment towards this approach from health decision-makers, planners and providers;

- Promotion of the concept through analysing and informing widely the public about health and its determinants - economical and spiritual benefits of a positive life-style;

- Development of plans in selected areas and, then, disseminating these plans to the whole population; and

- Integrating the concept with community-based development programmes.

7.4. Progress achieved

- An intercountry working group meeting on The Role of PHC in Changing Life-styles was organized by WHO/EURO in Rovio, Italy (13-16 June 1989);

- An Interregional Technical Working Group on Health Promotion in Developing Countries was organized in WHO/HQ (November 1989), to develop resource persons for the purpose and to promote the approach;

- Concerned with promotion of health of EMR people, within the framework of health-for-all/PHC strategies, WHO/EMRO has started various activities aimed at developing life-style as a basic component of health promotion, e.g.:

  i) The subject was presented at the Thirty-sixth Session of the Regional Committee (October 1989) as the topic of its Technical Discussions, with the aim of promoting positive life-styles congenial to health and to counteract life-styles injurious to health of the peoples in the Region. It received good commitment from Member States.

  ii) The spiritual dimension of a positive life-style was discussed in an international conference in Amman, Jordan, when a declaration was adopted and issued (distributed at RC36).

  iii) Written materials are under print to be used as promotive material to involve local religious leaders in programme implementation.

  iv) EMRO will continue to assist countries in implementing and promoting healthy life-styles.

7.5. The future

The firm commitment of the Regional Committee towards the approach, if translated in practical activities, or if reaffirmed, will give momentum and strength to efforts in attaining the goal of health for all.

8. Self-care Programmes

Individuals, families and communities have the potential to enable them to play an active role in health promotion, protection and restoration. To make full use of this untapped potential, people have to be health-educated and informed to recognize their basic roles in health development within overall development. There are certain basic activities that individuals, families and communities can undertake to promote and protect their health, and to help prevent disease or infirmity. Adoption of healthy behaviour, healthy life-styles, measures of health protection and health restoration are examples of these activities. Health facilities and health services in general cannot provide these activities, because they start in the home and are practised by individuals and families. Realizing the importance of these facts, WHO/EMRO initiated this programme, with the following objectives:

- To develop self-reliance in positive healthy attitudes among individuals, families and communities at large, thus bridging the gap between the most peripheral of health facilities and homes; and

- Economizing on health expenditure by motivating communities to play an active role in their health protection and promotion and, thus, reduce their dependence on health services for treatment of minor health problems.

8.1. Strategies to be followed

- Dissemination on a wide scale of health education messages;

- Development of a *Family Health Directory* that describes to family members, in simple language, causes, signs, symptoms, complications and minor remedies and actions to be taken for common health problems in each country;

- The *Health Directory* is to be modified in each country according to its habits, culture, traditions and prevailing health and health-related problems and actual community needs;

- A mass media programme in support of self-care to be planned and implemented at country level complying with different contexts; and

- Families to be motivated and encouraged to be involved and actively participate in activities related to self-care.

8.2. Progress

The *Family Health Directory* has now been finalized and printed. EMRO will provide assistance towards its translation into various regional languages and provide guidance for its wide dissemination and use. Since it is a broad directory (i.e., not specific for a special situation or context), EMRO will also support countries in developing their own self-care programmes and directories. The usefulness of the directory as a tool for self-care will be evaluated in four countries, after its wide use by different sectors of the community. EMRO will prepare the mechanism for such an evaluation.

9. "Healthy Cities" Project

9.1. Urban health and environmental problems

In recent decades, EMR countries have experienced unprecedented growth in their urban populations. Yet efforts being made fall short of needs, to provide the homes and neighbourhoods where these growing populations live with the services and amenities essential for a healthy, satisfactory life-style.

Major deficiencies exist in diverse sectors, such as housing, infrastructure and basic services such as roads, piped water, sanitation, site drainage, electricity, collection of household wastes, as well as in primary health care, education and emergency lifesaving facilities.

In many countries, local and city authorities do not have adequate authority, resources, or trained personnel to meet their responsibilities in providing such services.

A number of environmental problems pose health hazards to both wealthy and low-income settlements alike in urban areas in almost all countries. These include air pollution from motor vehicles and industrial emissions, water pollution leading to the proliferation of vectors, and noise pollution, with all its implications for health, mental and physical. However, in any country, health impacts are felt most severely in low-income settlements, where the means to deal with such problems are the most deficient. In our Region, the proportion of the urban population living in substandard housing varies greatly from country to country and from city to city, but it is in no case insignificant.

In view of the above conditions, there is an urgent need to address some of the serious environmental health problems in the above areas.

9.2. "Healthy cities" project

The officials of a number of countries in the Region have shown a keen interest in "healthy cities" concept (HCC).

The "healthy cities" project seeks to help city administrators address housing, environmental and health problems in a *holistic* way, and to develop self-reliant urban institutions for health-promoting environmental management. A prerequisite of participating cities is political involvement to obtain commitment and a consensus about health goals and healthy public policies. There must be a balance between a strategic political role, to have health high on the political agenda, and an applied technical and operational role in developing and implementing concrete plans to improve health in cities and to take structural, organizational and financial steps to make this possible.

Key aspects of the approach include: dealing comprehensively with a variety of environmental health concerns; development and coordinated involvement of local institutions; and facilitating the full participation of people in resolving the problems of their communities.

It must be understood that the "healthy cities" project, envisioned for the Eastern Mediterranean Region, will not undertake physical construction of environmental services, or run the environmental health programmes. The project has a catalytic role to bring the different groups involved together. In its first phase, the project aims at creating dialogue, understanding and consensus between different municipal and government authorities involved and establishing a system of a "partnership approach" among them to respond to the problems.

For implementation of the project, "healthy cities" project focal points will be first identified. These focal points may be from the health sector, municipalities, universities, NGOs, concerned citizens, etc. With support from these focal points, one or several activities can be undertaken.

For example, in a municipal ward, as part of the "healthy cities" project, a group of concerned individuals could be assisted to organize a solid waste cleaning campaign. These individuals will motivate and organize the resident of the ward to assist in continuous cleaning of the ward. The "healthy cities" project will help these groups and arrange for better dialogue and contact with municipal authorities, where city administration assists the community initiative.

Similarly, contact and efforts could be made by government and municipal authorities to reduce pollution from industries. The guiding principle is to understand each other's problems and responsibilities and mobilize untapped skills, resources, administrative machineries, etc., to solve the problems.

At the early phase, for establishment of a "healthy cities" project, the mayor or a high-level equivalent municipal authority must be involved. The health sector should assume a leading role. Also, universities and research centres should promote the idea.

For this project, major emphasis will be placed on involving women groups and youth organizations.

9.3. "Healthy cities" project activity in EMRO

To start the process, and in an attempt to facilitate dialogue and interest, WHO/EMRO has embarked on a number of activities. Case studies have been initiated in Alexandria, Egypt; Teheran, Islamic Republic of Iran and Lahore, Pakistan, to examine all environmental health issues affecting these populations.

An informal consultation on urbanization and environmental health in relation to "healthy cities" was held from 4-6 July 1989 in EMRO. The consultation was attended by regional experts from Egypt, Islamic Republic of Iran, Pakistan and Sudan, along with WHO staff from EMRO and headquarters.

The consultation, after examining the issues and problems of urbanization, recommended a plan of action to start a "healthy cities" project in the Region. Further, the consultation endorsed the draft WHO/EMRO Collaborative Activities on Urbanization, as well as other development areas.

These activities were followed by a seminar on Health in Housing and Urban Environment, in Damascus, Syrian Arab Republic. This seminar, which was attended by participants from 11 countries of the Region, also endorsed the need for action on the "healthy cities" concept.

In July 1990, a major regional "healthy cities" conference was held in Cairo, where mayors and senior health officials from 14 countries participated. The conference, endorsing the "healthy cities" concept as an approach to assist in improving urban conditions, finalized the premises, features and strategy for a "healthy cities" project in the Region. Also, a plan of action was adopted to establish a "healthy cities" network in the Region.

A "healthy cities" project proposal was submitted to the UNDP for funding.

10. Conclusion and Future Outlook

The central aim of health-for-all/PHC strategy is to promote health and improve the life-styles of everyone in the Region. Therefore, it is felt that a broad promotional approach, within health for all/PHC, should be firmly rooted in a strong commitment to promote health and improve the quality of life. Although health providers, including PHC workers, have, in recent years, begun to accept greater responsibility for such a task, still more effort is needed. Increasingly they are working hard to develop coherent local health promotion and protection as well as disease prevention strategies.

Yet concentrating on prevention and individual health behaviour to the exclusion of the "ecosphere" will not cover all activities for health promotion; thus, they have to broaden their strategies to include all socio-economic aspects. Once the essential importance of the "ecosphere" in determining life-style is accepted, it is natural to progress from traditional preventive services to broader health promotion initiatives. The challenge to health providers, particularly PHC workers, will be to start looking beyond the confines of one-to-one consultation, or even of family care, and accept that their role is to work with others to enable the community as a whole to increase its control over the determinants of health. PHC teams will clearly need to deal with local issues, but they could join with other PHC and other

health care workers to initiate and support regional and national health promotion initiatives.

Strong and politically committed leadership of professional and other national communities and organizations is essential to give credibility and impetus to health promotion programmes in the health-for-all/PHC movement. It is also important to make use of demonstrative models (e.g., in countries where BMN or the action-oriented school health curriculum are being implemented, and where PHC providers and communities present supportive activities to the health-for-all movement). In the first case (**BMN**), they might work locally to develop/implement socioeconomic projects/programmes; in the latter (**AOSHC**), they might implement social programmes for improving health and developing healthy life-styles for children, youth, families and the community at large.

All of these innovative activities should be continuously evaluated to learn from their successes or failures. It is also important to have an effective networking system, so that health providers in Member States can be informed of health promotion projects taking place elsewhere, and thus can share experiences with them.

Implementers of health-for-all/PHC strategies should also be encouraged to become more active in health promotion through national or local public debate, and governmental organizations should be encouraged to provide necessary leadership support. Professional bodies could set up consensus panels, produce guidelines and suggest suitable quality control programmes. National and regional conferences could also aid discussion and encourage new projects and other innovative programmes.

Difficulties will inevitably be encountered in moving towards a health promotional approach. In particular, traditional attitudes towards health education as a didactic activity need to be modified, and professional roles may need to be re-examined. Some professionals may believe that the task of trying to influence the ecosphere is beyond them and their responsibilities. Nevertheless, many of these difficulties can be overcome by developing specific objectives for local programmes and activities, by step-wise progression towards new ways of working, and multidisciplinary actions from different concerned sectors (motivated by health providers) coupled with effective backup of community participation.

10.1. Recommendations

Implementation activities

- WHO/EMRO and Member States should recognize and affirm that health for all through PHC has an important role to play in changing the socioeconomic situation and life-style of individuals, families and populations. This will involve health providers (PHC workers in particular) and other workers in relevant sectors, in considering and influencing people's personal health behaviours. But it is important to recognize that they will also need to develop a complementary and legitimate interest in seeking to reduce inequalities in society and in seeking to improve living conditions and a healthy environment. They will require skills in mediating and advocacy, and will need to educate their communities for more empowerment and involvement, and will need to involve themselves actively in intersectoral collaboration.

- Member States will review all innovative programmes initiated by EMRO, and adapt and adopt them as supportive mechanisms for the health-for-all movement.

- Member States should ensure not only that health for all/PHC (including innovative programmes) is given an appropriate priority in the development of health services, within overall socioeconomic development, but also that funding is provided for health promotion action by PHC providers.

- Member States and professional organizations, within them, should develop strategies for using contacts between health providers and the population to influence personal health behaviour for the better, and to look to health as an integral part of socioeconomic development. These strategies will be a first step towards a comprehensive approach to health promotion and development.

- WHO/EMRO and Member States should determine the appropriate mechanisms for considering the importance and implications of practising health promotion within PHC and/or integrated socioeconomic development.

- Member States should set up and develop a network of demonstration projects (in areas within which PHC facilities are available) to develop, promote, refine and test model practices of integrated community socioeconomic development, including health promotion, and to initiate such projects/programmes of intersectoral collaboration involving health and relevant sectors as well as communities. This may include BMN or AOSHC, or programmes promoting healthy life-styles (e.g., anti-smoking campaigns, etc.). WHO/EMRO should monitor these developments and promote/support a network and information service to disseminate information.

10.2. Training and research

- Member States should ensure that, where they do not already exist, academic institutions or departments for PHC or/and integrated community development are established, properly staffed and funded. These institutions or departments should give priority to identifying and evaluating methods for overall community socioeconomic development, with emphasis on health promotion.

- Member States and professional organizations should ensure that suitable curricula and teaching methods for health promotion in PHC/integrated community socioeconomic development are developed in undergraduate, postgraduate and continuing professional education programmes.

- WHO/EMRO, Member States and professional organizations should organize intercountry, national and district conferences on PHC, integrated community development, including health promotion, leading for plans for future activities.

10.3. Promoting intersectoral collaboration and community involvement

- WHO/EMRO and Member States and health providers (including the implementers of health-for-all/PHC strategies) should recognize the importance of intersectoral collaboration, which involves various activities and attempts to improve the socioeconomic situation, health promotion and life-style. Public participation and community involvement are essential prerequisites for productive collaboration.

- Member States should develop policies and planning mechanisms for active collaboration between the health sector and relevant sectors, as well as different community organizations and private sectors for the attainment of health for all through PHC.

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

EM/RC37/Tech.Disc/1
July 1990

Thirty-seventh Session

Original: English

Agenda Item 13

Programmes in Support of Health for All

Summary of Recommendations

The Member States

- reaffirm their commitment to the attainment of the goal of health for all by the year 2000;
- recognize and affirm that the objective of HFA/2000 through PHC has an important role to play in changing the socio-economic status and lifestyles of individuals, families and communities.
- develop and maintain suitable mechanisms for effective community involvement and participation.
- develop and maintain intersectoral collaboration in planning and actions pertinent to overall community socio-economic development, including health.
- will determine the appropriate mechanisms for considering the importance and implications of practising health promotion within PHC and/or socio-economic development.

The Member States will:

- review all innovative programmes, initiated by the Regional Office and adapt, and adopt them as supportive mechanisms for the progress of health-for-all movement.
- ensure that funds are provided by MOH for health promotion action.
- motivate professional organizations to develop strategies to influence health behaviour for the better and consider health as an integral part of socio-economic development.
- establish and develop a network of demonstration projects (in areas where PHC facilities are available) to develop, promote, refine and test model practices of integrated community socio-economic development, including health.

- ensure that, academic institutions or departments for PHC or/and integrated community socio-economic development are established where they do not already exist, properly staffed and funded.
- ensure that professional organizations responsible for training will develop suitable teaching methods for health development and promotion through PHC/integrated community socio-economic development in educational programmes at various levels.
- will collaborate with WHO and professional organizations in the organization of intercountry, national and district conferences and research activities on PHC integrated development, including health promotion leading for plans for future activities.
- work closely with EMRO to improve and promote effective leadership at different levels of health systems for health development.