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REGIONAL HEALTH-FOR-ALL POLICY AND STRATEGY FOR THE 21st CENTURY

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EXECUTIVE SUMMARY

Health for All will continue to be the goal in the 21st century, as it has been for almost a quarter of a century. Its main aim continues to be the "enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being". Primary health care was the approach adopted for the attainment of Health for All and will also continue to be the principal vehicle in the future. Since the 1978 Alma-Ata Declaration, all countries of the Eastern Mediterranean Region have adopted health systems based on primary health care including at least its eight essential elements. Many countries of the Region have made considerable achievements in relation to the set targets for the century. Others have been hampered for various reasons, including poor political commitment, slow economic growth, poor community participation and ineffective intersectoral coordination. Added to all these, civil war and strife in some countries of the Region, have made it difficult to launch programmes within a sustainable health system. Many demographic, political, technological, economic and social changes have also contributed to the low level of achievements in some countries.

New emerging diseases, such as HIV/AIDS, and the resurgence of others, such as tuberculosis and malaria, have resulted in depressive setbacks in integrated control of diseases. Changing lifestyle practices, particularly increased use of tobacco, alcohol and substance abuse, overeating and eating of unhealthy foods in the absence of exercise, have increased the incidence of noncommunicable diseases, notably cardiovascular diseases, cancer, diabetes and obesity. New lifestyles have also resulted in increased numbers of car accidents and accidents at homes, in schools and at places of work and leisure.

The new trends of globalization of trade, travel, commodities, technology, communication and even health care may result in many benefits, but could also have serious effects on the health and welfare of developing and poor countries who cannot compete on equal terms with industrialized countries.

Health-for-all policies and strategies in the 21st century for the Eastern Mediterranean Region will be governed by values which are deeply rooted in the culture of the Region and which will address priority health problems of the Region in a manner which is morally and ethically acceptable, economically, technically and administratively feasible, with full community partnership. The main features of such a policy and strategy include the following values.

- Health is a fundamental right
- Equity is a just cause
- Ethical considerations and religious heritage protect the dignity and integrity of human beings
- Solidarity is a key to success of global efforts in health
- Community participation guarantees sustainability of health care, and effectiveness of health interventions
- A gender perspective is necessary.

Health systems based on such policies will be sustainable and respond to the needs of people. They will make health care available throughout the life span of individuals and ensure that it is equitable, accessible and comprehensive, providing promotive preventive, curative and rehabilitative care. Laws and regulations to govern the functioning of such systems will ensure justice for all. Prevention of the main communicable and noncommunicable diseases and injuries will reduce suffering, increase well-being and longevity and contribute to socioeconomic development.

The cooperation and solidarity of all countries of the Region will be a key factor in the success of the policy and in strategy implementation. Cooperation and solidarity can be accomplished in various ways including sharing resources, sharing knowledge and information, working together in collaborating centres of excellence, and providing prompt and useful epidemiological information to each other in disasters and epidemics.

The role of WHO and its regional and country offices as technical resource and information centres for all public health circumstances will ensure adequate and timely interventions for the benefit of all. WHO offices will support national health programmes based on national health priorities in all fields of health systems development including health promotion and protection, disease prevention, medical care and rehabilitation.

It is essential that countries during the 21st century, with support from WHO, concentrate their efforts on:

- Development of sustainable national health systems based on primary health care providing promotive, preventive, curative and rehabilitative health care;
- Primary health care as the key concept and main entry point to quality and sustainable health care for all individuals and families;
- The basic development needs (BDN) approach to address comprehensive local community development including health;
- Development of the proper mix of human resources as a result of well formulated policies, plans and community-oriented and community-based training programmes, with management of human resources that includes leadership development as one of its important components;
- Using health as a bridge for peace in war, conflicts and emergencies;
- Working with other United Nations agencies, nongovernmental organizations, and regional funds and banks to secure adequate financing for health for all;
- Eradication, elimination or control of some of the most prevalent communicable and noncommunicable diseases;
- Healthy lifestyles and healthy living, free from the harm of alcohol, drugs, and tobacco, and with less exposure to injury, violence and accidents;
- Stopping further degradation to the physical environment by provision of safe water supply, sanitation, and a pollution-free environment.

CHAPTER 1

THE NEED TO REVIEW HEALTH-FOR-ALL POLICY IN THE 21st CENTURY

Health as a human right

1. The WHO Constitution in 1948 defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The World Health Assembly in resolution WHA37.13 recognized that the spiritual dimension plays a great role in motivating people's achievements in all aspects of life, and invited Member States to include in their strategies for health for all a spiritual dimension as defined in this resolution in accordance with their social and cultural patterns. Thus health can be redefined as, a "a state of complete, physical, mental, social and spiritual well-being, and not merely the absence of disease or infirmity".

2. The various dimensions of this definition are deeply rooted in the culture and traditions of the Eastern Mediterranean Region. Health is our focus and disease is the exception. Health means that the body is in a state of dynamic equilibrium. To maintain the equilibrium of this health balance it is important to strengthen one's health potential. Based on these concepts, health protection and promotion should be greatly emphasized whereby a human being may enjoy the best physical, mental, social and spiritual well-being.

3. The WHO Constitution declares that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" and that "the health of all the people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States". Health as a human right was further affirmed in the World Health Declaration adopted by the World Health Assembly in May 1998, in which Member States of the World Health Organization reaffirmed their commitment to the principle enunciated in its Constitution that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being; and in doing so, affirming the dignity and worth of every person, and the equal rights, equal duties and shared responsibilities of all for health.

4. Commitment to this definition of health as a human right constitutes the basis for setting national, regional and global policy goals and underlines the main orientation of health strategies for the 21st century. Several countries have declared health a constitutional right. The Declaration of Alma-Ata in 1978 marked the key strategy to achieve Health for All (HFA) by the Year 2000.

Health for all and primary health care

5. In 1978 the Declaration of Alma-Ata launched the global movement towards health for all. Primary health care was considered as the key strategy to achieve health for all. Primary health care is defined in the Alma-Ata document as "essential care based on practical, scientifically sound and socially acceptable methods and technology made

universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of 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 individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work".

6. Since Alma-Ata significant health gains have been achieved at national, regional and global levels. In the Eastern Mediterranean Region, female life expectancy increased from 57 years in 1985 to 65.6 years in 1996 and male life expectancy increased from 56 years to 62.3 years; and the total adult literacy increased from 38% to 63% during the same period. The infant mortality rate dropped from 97.5 to 75 per 1000 live births, and under-5 mortality from 132 to 115 per 1000 live births.

7. Despite these significant health gains it was recognized that the goal of health for all cannot be achieved by the year 2000, for various reasons, including global political, economic, social and cultural changes and challenges which impact on health. Aware of the timeliness of the health-for-all goal, WHO and its Member States, initiated a challenging exercise aimed at renewing the health-for-all policy and strategy for the next century.

8. The main problems that faced the process of implementing national health for all policies and strategies were the following:

   - Limited intersectoral cooperation for health development;
   - Poor community involvement—the firm conviction that the state is responsible for providing the totality of health services is the main obstacle to active community involvement;
   - Unhealthy individual behaviour and lifestyles such as smoking, substance abuse and inappropriate food consumption;
   - Weaknesses of national health systems, in respect to policy analysis and formulation, coordination and regulation;
   - Inequitable and insufficient resource allocation, with limited resources for promotive and preventive activities and programmes;
   - Inappropriate use of medical technology, leading to escalating cost of health care services;
   - Poor organization and management of health services at all levels and ineffective referral systems;
   - Premature decentralization of health systems based on primary health care in the absence of adequate resources;
   - Weakness of health information systems at central and peripheral levels;

dramatic political and economic changes that followed the end of the Cold War. These will continue to have repercussions well into the 21st century. While long-term benefits of these changes are expected, it is evident that the intermediate outcome remains uncertain in many countries, and the process of transition may be long, harsh and costly.

Political changes

10. The wave of democratization resulting from global political changes has affected many countries throughout the world leading to pluralism, greater transparency in governance and moves toward decentralization. Civil society has been empowered and communities have become more involved in decision-making processes. These changes have had an impact on the organizational structure and on the management of health systems. The role of the state in providing health care to its people is shifting towards more privatization with consequent adverse effects on health promotion and disease prevention and control.

Macro-economic environment

11. The economic crisis of the 1980s had a negative impact on health and health-related sectors, particularly in developing countries where budget cuts were made as a consequence of social adjustment programmes; other economic and financial policies resulted in corruption and misuse of the limited resources for health care and other social services.

12. The ongoing globalization is characterized by the merging of huge companies to form giant industrial institutions, which is expected to have an impact on the development of the social and health sectors in countries of the Region.

13. The predominance of the free market has placed increased pressure on health systems, leading to unplanned privatization with obvious negative consequences for equity in access to health care.

services;

- Poor organization and management of health services at all levels and ineffective referral systems;
- Premature decentralization of health systems based on primary health care in the absence of adequate resources;
- Weakness of health information systems at central and peripheral levels;

The burden of poverty on health

14. The gap between rich and poor countries has widened in recent years. The debt crisis has affected the ability of many developing countries to maintain a satisfactory level of expenditure on health. Civil unrest has diverted a large portion of available resources to maintain security and law and order. The number of people living below the poverty level has increased in developing countries, causing malnutrition, ill health, disease and mortality. Many countries became unable to support sufficiently their national health services, increasing the burden on individuals and families who, in turn, are often unable to buy sufficient food and seek health care when needed.

Globalization

15. The world is witnessing an unprecedented movement towards globalization, supported by very rapid liberalization and global free trade and capital flow. Globalization is accompanied by huge advances in communication, technology and transport and the establishment of the World Trade Organization (WTO) which represented an important milestone in this respect. The impact of globalization on health systems is not well known, but preliminary studies forecast negative impact in terms of equity and social justice, as well as important implications for practice in the field of bioethics.

Global free trade

16. The WTO was established on 1 January 1995 following the conclusion of the Uruguay Round of multilateral trade negotiations in April 1994. The new organization replaces the old General Agreement on Tariffs and Trade (GATT) administrative structure, which organized international trade under a set of principles contained in the GATT, originally adopted in 1947.

17. The implementation of various WTO agreements will have an impact on the health sector. The agreements strongly promote protection of intellectual property rights, global free trade and harmonization of international standards. Although the agreements refer to encouraging development and economic reform and take into consideration protection of health and environment, the interests of developing countries, in particular the social sectors including health, appear not to have been taken into consideration during the negotiation phase. There are fears in developing countries that the implementation of intellectual property rights will harm the pharmaceutical industry and lead to increase in the cost of drugs. More comprehensive studies are needed to investigate the impact of various aspects related to WTO agreements on health and health-related sectors. Privatization and commercialization of health care is expected to have negative effects on the demand for health care by the poor and under-privileged sectors of developing and least developed countries. Community health services, particularly those related to health promotion and protection, disease prevention and control and environmental health services may be adversely affected if countries do not provide the necessary resources for them.

18. Particular attention should be given to the implementation of special and differential provisions in various WTO agreements in favour of developing countries, as well as the implementation of the Decision on Measures in Favour of Least Developed Countries and the Decision on Measures Concerning the Possible Negative Effects of the Reform Programme on Least Developed and Net Food Importing Developing Countries. Developing countries should continuously review the implementation of the commitments of developed countries in the Uruguay Round Agreements, particularly in areas of export interest to developing countries, and address any shortcomings that they face.

19. The future work of the WTO should be of utmost priority to all Member States. It is important to ensure that the interests of developing countries are fully taken into account in the built-in agenda of the Uruguay Round Agreements and in any future WTO negotiations. It is imperative that developing countries assume an active role in shaping the future of international economic relations. Active participation in the WTO is key to the preservation and furtherance of interests of developing countries. It is of great importance in this context for developing countries to identify their interests and develop a proactive "positive agenda" to promote these interests.

Global communication

20. The revolution in global communications and easy access to huge databases will have tremendous influence on the process of socioeconomic transformation. The recent advances in medical informatics, and in particular in the field of telemedicine, may well raise people's expectations and place additional strains on health delivery systems. However, the rapid spread of information will also lead to early detection of disease outbreaks and epidemics and to joint efforts to combat such epidemics and outbreaks. In addition, the revolution in global communications may have an impact on social behaviour, changing for example individual habits and perceptions with regard to sexual health.

Rapid advances in biotechnology

21. Advances in medical technology play an important role in health system performance with huge improvements in the field of preventive and curative care. However, the use and abuse of medical technology account for a big share in the escalating costs of health care in both developing and developed countries. Recent developments in genetic engineering, organ transplants and cloning have had a real impact on bioethics and have raised serious concerns. The progress in health and biomedical technology has widened the gap between developed and developing countries as the latter lack appropriate expertise and easy access to scientific databases.

22. Directions in drug design have always been based on the current knowledge of the biochemical pathology of disease. Our knowledge of disease is being expanded rapidly by our ability to scan genomic sequences and define distinct marker sites associated with the inheritance of and the predisposition to disease. This new knowledge will take

us, and all other health care practitioners, rapidly in new directions as we approach the start of the new millennium.

23. The position of some 4000-plus marker sites for disease on the human genome is known. This knowledge will give medicine an entirely new direction in the beginning of the next century and that new direction is already within sight. Standard medical practice will move gradually but persistently with increased emphasis on prevention and prophylaxis in disease.

24. The main challenges of health technology development, assessment and transfer in developing countries can be summarized as follows:

- Lack of access to databases or other sources of information; most libraries have limited resources with which to subscribe to journals;
- Lack of funding to undertake technology assessments;
- Weak national health care systems poorly equipped to adopt new health care technology;
- Lack of national expertise.
- Drain of qualified experts from developing countries

Environmental degradation

25. Environmental degradation has a negative impact on economic and social development in many ways. It increases the pressure on scarce natural resources in the Region, deprives rural populations of their resource base, and causes poverty and migration. Environmental pollution results in contaminated water, air and food as well as degradation of human settlements with numerous adverse health and social consequences. The 1996 World Water Forum foresaw a water crisis in the near future. Other global hazards such as climate change, air pollution, ozone depletion, insecticide and pesticide pollution, and marine pollution increase the risk of disease spread in poor countries. Uncontrolled industrialization and disposal of hazardous substances threaten health and the environment. Hazardous occupational conditions result in disabilities and occupational diseases. Insufficient and contaminated water leads to many infectious diseases, and poor sanitation is dangerous to the health of populations of poor countries.

Conclusion

26. As a response to the above global changes and challenges, the WHO Governing Bodies—the World Health Assembly and Regional Committees—have initiated a process of renewal of health-for-all policy and strategies, using a holistic approach to health development that incorporates the noble principles of equity and social solidarity, emphasizes individual, family and community responsibility for health, and places health within the overall development framework.

CHAPTER 2

REGIONAL SITUATION

27. The regional health situation was recently assessed through the third evaluation of the implementation of health-for-all strategy and its main findings provide the most up-to-date baseline information.

Political trends

28. Despite the end of the cold war and the hopes raised by the Oslo accords and the peace process in general, Palestinian, Syrian and Lebanese territories remain under Israeli occupation and the prospects for a just peace settlement are gloomy. Such a situation has a negative impact on the health of displaced and colonized populations in the Region. Military expenditures in certain countries of the Region continue to be high which negatively affects spending on social services, including health.

29. Ethnic, religious and civil strife are causing human losses and suffering for millions of people in Afghanistan, Somalia and southern Sudan, disrupting health systems and limiting access to basic health care. Political and economic sanctions are slowing the process of health development in certain countries (e.g. Iraq, Libyan Arab Jamahiriya, Pakistan and Sudan) and may lead to health tragedies.

30. Most countries of the Region have initiated decentralization of their health systems as part of the move toward greater social participation. However, the successes of decentralization are rather limited in many countries due to institutional weaknesses.

31. In many countries the role of the state in both the financing and delivery of health care has been changed in line with new policies aimed at decentralization and at increasing the role of the private sector in health care. Fears have been expressed about the potential impact of the latter on the health status of the poor and vulnerable populations. Privatization policies and increasing pressures from trade unions and syndicates of private professionals may influence the shaping of health policies and strategic planning. Decentralization when inadequately resourced, and burdened by unnecessary additional administrative expenses, has often resulted in poor upkeep and functioning of health care facilities rather than the benefits envisaged.

Trends in socioeconomic development

Economic trends

32. The main obstacle to economic growth in the majority of Eastern Mediterranean Region countries continues to be the unprecedented level of external debt, amounting to thousands of millions of US dollars. The cost of servicing such debts constitutes a continuing burden weighing upon the economic development of these countries. Some have already adopted structural adjustment programmes (Egypt, Morocco, Tunisia) or

are in the process of making modifications (Lebanon, Republic of Yemen) to introduce flexibility into the management of their economies. The cancelling of part of the external debt in favour of some countries (Egypt, Jordan, Morocco) will hopefully have a positive impact on economic development.

33. In terms of per capita gross national product (GNP), the Eastern Mediterranean Region experienced tangible growth during the period 1990 to 1996. The regional average gross domestic product (GDP) per capita increased from US$ 1093 in 1990 to US$ 1476 in 1996, an increase of some 35%. This regional increase does not reflect the important gaps existing within and among Eastern Mediterranean countries. For 1996, the per capita GNP ranged from US$ 150 in Somalia to US$ 18 430 in Kuwait. The percentage of the population below the poverty line in some countries is high, contributing to an increase in the gap between the social classes.

34. In the Eastern Mediterranean Region, the per capita total health expenditure ranges (1990 figures) from US$ 8 in Somalia to US$ 630 in Qatar. Public expenditure on health as a percentage of total health expenditure ranges from 7.3% in Somalia, 11% in Sudan and 16.6% in the Syrian Arab Republic to about 64% in Bahrain, Cyprus, Kuwait, Qatar, Saudi Arabia and Tunisia. These data clearly show that the expenditures of the public and private sectors vary across countries in the Region.

35. At the same time, human development indices (HDI) for the Eastern Mediterranean Region also indicate that though most of the Member States in the Region do not enjoy high economic standards, the performance nevertheless should have been much better in most countries, as shown by the negative value between the rank of real GDP per capita (in purchasing power parity-adjusted dollars) minus HDI rank. These data clearly indicate the need for different approaches to address health sector reforms in various countries. The ultimate goals of any reform are to ensure equity and accessibility, to increase efficiency and to improve the effectiveness of health systems.

36. In analysing the trends in health care financing, it appears that there is a clear tendency to shift the burden of health care financing from the government to individuals and families. Even high-income countries, e.g. the oil producing countries, are considering the options of relieving government budgets through the adoption of user charges and risk sharing schemes, e.g. health insurance. The contribution of social health insurance to public spending is relatively limited. The expansion of its coverage is hampered by the large numbers of workers in the informal or self-employed sectors and by the limited capacity for collecting and administering payroll tax-based funds. Direct out-of-pocket spending by households appears to account for a major portion of private spending in most countries, and private insurance premiums account for a limited fraction of private spending, with the possible exceptions of Lebanon, Jordan and some member countries of the Gulf Cooperation Council. This reliance on out-of-pocket spending means that households bear a substantial proportion of health care costs while having little or no financial protection (i.e. insurance) when major illness or injury occurs.

37. In middle-income and low-income countries, resources additional to the health sector are provided by nongovernmental organizations and bilateral and international donors. The role played by nongovernmental organizations in both the provision and financing of health services is growing in many countries as a consequence of diminishing resources in the public sector. As the prospects of financial assistance from many donor countries are not bright, owing to economic recession and cuts in development assistance programmes, as well as political orientations, efforts are being directed towards financial institutions for loans aimed at supporting health development. The portfolio of the World Bank for health projects, including population, is growing substantially at global and regional levels, including in the Eastern Mediterranean Region.

38. As for the provision of health care, the private sector plays an important and growing role in most countries, as a consequence of economic and policy reforms and the adoption of incentives to support private providers. In several countries, 40%–50% of outpatient services are provided privately, but the contribution to hospital care is relatively modest, except in Cyprus and Lebanon. The development of the private sector, both in financing and in providing health care, has also been possible through the implementation of regulatory mechanisms by ministries of health in terms of licensing, standard setting, fee schedules and quality assurance. The growing role of the private sector in health services delivery has raised concerns over quality and also over equity in access to heath care. It is perceived that efforts need to be made to strengthen the role of the public sector to reduce the impact of these changes on the patterns of health care provision and the overarching role played by the private sector. Efforts are being made in many countries to look for an appropriate public private mix in health systems.

Demographic trends

39. The reported data show that the Eastern Mediterranean Region population in 1996 is still young despite some signs of change; children under 15 years of age account for about 41% of the population. Adults aged 15–64 years and the elderly aged 65 years and over constitute, respectively, 54% and 4% of the population. This structure by age is characterized by a wide range among countries, particularly in the adult age groups owing largely to the magnitude of the expatriate labour force (mostly adult males not accompanied by their families) in some countries in the Arabian Peninsula.

40. The percentage of the population living in urban areas increased from 39% in 1985 to about 46% in 1996. It is estimated that it will grow to around 48% in the year 2000. There are important variations between countries with regard to the urbanization level, ranging in 1996 from 19% and 24% in Afghanistan and the Republic of Yemen to 100% in both Kuwait and Qatar. It is worth noting that in the populous countries of Pakistan and Egypt, 32% and 47% of the population, respectively, live in urban areas.

41. The continued rapid growth in urbanization in many countries of the Region, as well as the pervasive spread of poverty, particularly in the least developed countries, are straining their capacity to provide satisfactory environmental health facilities and

health services. Concerns are being raised regarding the increase in homes for the elderly in urban areas and in the numbers of street children, and the health implications of these changes.

42. Analysis of trends in population size and structure has highlighted the significant demographic change in the Region during the past decade and trends for the future. In terms of population growth rate the regional average is still one of the highest in the world. Despite its gradual decrease, from 3.0% in 1985 to 2.6% in 1996, population growth will continue to be around the same level until the end of this century. There is substantial variation between countries of the Region. It ranged from 0.9% in Cyprus to 8.1% in Qatar as reported by countries for 1995–96 (UN estimates give a regional average of 2.7% for the period 1995–2000 and a range from 0.9% in Cyprus to 5.6% in Afghanistan).

43. As a consequence of increase in life expectancy and reduction in fertility, several countries will begin a demographic transition which will generate concerns in the coming decades about the aging population and their specific needs in terms of health services.

Social trends

44. Education is a priority social issue that affects on health. The gross school enrolment ratio (first level)—the ratio between the actual number of pupils in the first level of education (often referred to as compulsory education) and the population size in the corresponding age group—has reached 90% or more in 13 countries, but is less than 50% in four countries. Those who do not attend school will become illiterate adults. More favourably, the gap by gender appears to be narrowing. Looking at the adult literacy rate indicator, i.e. the proportion of adults (15 years or above) that are literate, the regional average for the period 1985–96 showed a substantial increase from 38% in 1985 to 52% in 1996.

Environmental health

45. The Eastern Mediterranean Region is among the driest parts of the world. With rapid population growth and severe water scarcity, the water crisis in the Region is becoming the most formidable challenge, now and for the future. Currently, out of 23 countries, more than 10 countries extract more than 100% of their annual reservable water resources. The Region has 8% of the world's population, but only 1.45% of the world's reservable fresh water resources. By the year 2020 the per capita actual renewable water resources in 15 countries will be below 1000 cubic meters per person per year (a household with an amount below 1000 m^3/person per year is considered a water-poor household). Eleven countries will have less than 500 m^3/person per year. This is despite the immense efforts that have been made by countries to increase water supply coverage. Based on 1996 data, urban water supply coverage in 17 countries is above 95%. With regard to rural coverage, 13 countries are above 80%. There are severe shortcomings in rural sanitation coverage as compared to water supply. Urban sanitation coverage in 17 countries is more than 95%.

The Region is suffering from rapid urbanization and city dwellers are subject to congestion, pollution and, at times, less than satisfactory environmental health conditions. Lack of proper sewerage and solid waste management systems, air pollution in some major cities, inadequate housing, lack of green areas and poor public transportation are among some of the major environmental health challenges in the cities.

Health trends

46. Based on a review and comparing the average trends for the regional indicators which have fixed health-for-all targets for the period 1985–96 with their 1996 reported country data for the present third evaluation, Annex 1 summarizes the main findings in the form of an overall assessment of progress achieved so far towards health for all in the Eastern Mediterranean Region.

47. At first glance, the results indicate that the health situation improved during the decade since the start of implementation of the health–for-all strategy. Despite the burden of rapid regional population growth and the worsening of its impact on the socioeconomic situation as a result of social and military conflicts experienced by some countries, good progress has been made towards achievement of health-for-all targets. Already achieved or attainable targets relate to gross national product, percentage of the latter devoted to national health expenditure, immunization coverage by BCG, DPT3and OPV3 and life expectancy.

48. To balance the overall impression that the Region as whole is progressing towards the attainment of the most important targets of the health-for-all strategy, Annex 2 gives a complete listing of countries that have not yet reached health-for-all targets. This table, which focuses on each of the health-for-all targets, compares the second evaluation (1990) and the current third evaluation (1996) for both the number of countries not yet reaching the target and the corresponding number of reporting countries, and the list of countries which had not yet achieved the target in 1996 as well as their total population in terms of percentage of population of reporting countries not yet reaching the health-for-all targets.

49. The main findings show that:

a) Demand for health services, in terms of quantity and quality, is increasing critically because of:

- Continuing rapid population growth in almost all countries, as well as change in age structure in some countries, which itself generates an epidemiological transition, bringing changes in the pattern of both communicable and noncommunicable diseases with a gradual shift to increased incidence and prevalence of noncommunicable diseases.
- Increased expectations of quality health care as a consequence of increased literacy, health education and health promotion activities.

- New health demands generated by rapid dissemination of medical, pharmaceutical and technical knowledge, as well as urbanization and demographic change.

b) National health systems, comprising both public and private sectors, do not meet health demands in the majority of countries. The increasing gap between demand and supply in national health system delivery will be at the expense of the poorest and most vulnerable groups, who need most health care in the majority of Eastern Mediterranean countries, particularly in the least developed countries. Health system performance is adversely affected by poor policies, limited resources for primary health care, lack of qualified managers at the various levels of the health system.

c) Political endorsement of health for all at the highest official levels has not always been translated into strong financial support at the primary health care level. Tertiary level hospitals continue to absorb most public sector health expenditure. Politically strong and influential urban communities often manage to get resources diverted from primary to tertiary care.

d) Community participation and intersectoral cooperation and coordination as fundamental pillars of primary health care programmes need to be strengthened. The successful basic development needs projects in the Eastern Mediterranean Region should be the cement to hold together these pillars.

e) The role of families in health protection and promotion needs to be highlighted in line with the prevailing sociocultural values of the Region. It is extremely important to preserve their role in states of dependency, such as old age.

f) Because of the epidemiological transition, which most countries of the Region are undergoing, the double burden of communicable and noncommunicable diseases will stretch health resources as never before. According to projections made on the global burden of diseases, the Region will be faced with an increase of noncommunicable diseases, particularly cardiovascular diseases, diabetes, cancer and mental health problems and injuries and road traffic accidents. The rates of mental retardation and epilepsy in the Region are already among the highest in the world.

g) Continuing degradation of the environment and its negative impact on health will become more challenging without strong official control and critical change in the attitudes and practices of an uninformed population.

CHAPTER 3

VALUES UNDERLYING HEALTH-FOR-ALL POLICY FOR THE 21st CENTURY

50. The formulation of national health policies should be based on clear deeply rooted values and aiming at clearly defined targets addressing priority health aspects. The heritage, values and traditions of the Eastern Mediterranean Region provide a solid basis for health-for-all policy formulation. The main values that contribute to the successful achievement of health-for-all goals in the 21st century are:

a) Recognition that the enjoyment of the highest attainable standard of *health is a fundamental human right*; this value is included as an article in the constitutions of many countries of the Region;

b) *Equity*: implementation of equity-oriented policies and strategies that emphasize solidarity; equity, in its broadest sense includes social justice, equal opportunities, mutual support, and care for others;

c) *Ethics*: continued and strengthened application of ethics to health policy, research and service provision and adherence to religious beliefs and moral values that protect human dignity and integrity;

d) Health care should be based on the essential features of *solidarity, cooperation, self-sufficiency and perfection* to augment national and global efforts to protect health and prevent disease;

e) *Gender sensitivity*: incorporation of a gender perspective into health policies and strategies not only in respect to the requirements of the normal physiological development of females from childhood to old age but also their social and behavioural relationships;

f) *Quality health care*: sustainability of health care throughout life, irrespective of the type of government, is guaranteed by efficient health care services.

These values should constitute the basic principles for formulating health targets and orientations.

Health as a human right

51. Health has been recognized in most constitutional documents as a human right. This commitment needs to be put into action through considering human beings as the focus of life and objective of socioeconomic development. The commitment to this right depends on the value assigned to health by individuals, states and the international community. It should also be a determining factor in the way states allocate resources to development priorities. However, the compelling force of the commitment has not found concrete expression in national or global policy. The right to health was not adequately translated into special claims on available resources nor did health status become the test of social and economic development. Although article 12 of the International Covenant on Economic, Social and Cultural Rights

recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", the implementation of this right has remained essentially an ideal. It is, therefore, important to give the right to health an operational dimension. Another, more practical, definition of the right to health is the right to the conditions that enable individuals to attain and enjoy their full potential for a healthy life.

Equity

52. Equity of access to health care is a main policy goal. Every national health system should ensure universal access to adequate quality care and avoid unfair and unjustified discrimination between individuals, groups and communities. The striving for equity in access to health care must be a fundamental objective of the process of health sector reform. The efforts aimed at improving health system performances and at increasing efficiency and effectiveness should also protect equity.

Solidarity

53. Self-sufficiency ensures the availability of both human and material resources. All individuals in the community can make their contribution, and the work required will be completed with minimum expense. Cooperation ensures the removal of barriers that separate various sectors of society. It frees experts and specialists from the constraints that prevent them from joining in an all-out effort to benefit the whole community. Perfection brings community participation to completion since everyone tries to do their jobs as perfectly as possible, knowing that God witnesses their work.

54. A society becomes empowered when all its members feel the solidarity that establishes a bond of unity between them. That does not mean that individuals lose their identity within the community. This emphasizes the spirit of solidarity, which is expressed in the feeling of mutual interaction: love, compassion, and sympathy for all, extended to all and reciprocated by all. The other important safeguard that ensures solidarity within the community is *shura* (consultation). Consultation must be practised at all levels, beginning with the smallest social unit, and in all matters, large and small, especially those which affect the whole community. Solidarity in health includes the ways, in which a society shares and becomes responsible for the maintenance of public health and the health care system. In the present context, the goal of health for all is enhanced by a spirit of solidarity that calls for community participation and intersectoral cooperation, involving all the actors from the various sectors concerned with health.

Ethics

55. Ethics are the underlying principles that inform laws, social customs and the codified rules for professional groups. As a constructive discipline, ethics seek to determine which actions, behaviour, relationships, and policies ought to be considered right or wrong. The Eastern Mediterranean Region is the cradle of three of the major religions (Judaism, Christianity and Islam), which share largely common values and are the main source of health ethics in most parts of the world. The following are some of the

principles on which general and global consensus is possible even though some differences of detail may exist in some cultures:

- Respect for human life and recognition of the inherent worth and dignity of the individual and his right to confidentiality;
- Respect for persons, which recognizes all people as autonomous agents and requires that their choices (consent or refusal) be observed;
- "Do good" (beneficence) and "do no harm" (non-maleficence)—two complementary ethical principles which impose affirmative duties on research to maximize any benefits for subjects and minimize risks;
- Justice, which requires that humans are treated equally.

56. A strong ethical framework that includes respect for individual choice, personal autonomy and the avoidance of harm applies to both individual and social aspects of health care and research. Advances in science and technology, genetic engineering, communications and medicine have brought untold opportunities to influence health. If everyone is to share in the progress and promise, ethical principles will have to regulate and guide science and technology development and use. Scientific and technological progress is testing the boundaries of ethical norms and challenging the very notion of what makes us human. Therefore, there must be firm ethical principles on decisions about matters that influence health.

Gender

57. A gender perspective is vital if equitable and effective health policies and strategies are to be developed and implemented. A gender perspective leads to a better understanding of the factors that influence the health of women and of men. It is not only concerned with biological differences between women and men, or with women's reproductive role, but acknowledges the effects of the socially, culturally and behaviourally determined relationships, roles and responsibilities of men and women, especially on individual, family and community health. A gender perspective, linked to the advancement of equity, must be incorporated into health policies and programmes. Specific aspects include:

- Performing gender analysis and encouraging gender awareness;
- Attending to the special needs of girls and boys, women and men, throughout life;
- Supporting the human rights, dignity, self-worth and abilities of girls and women; and
- Creating opportunities for full participation of women with men in decision-making at all levels;
- Preventing harmful practices such as female genital mutilation.

58. Men and women have equal responsibility for building and maintaining human life on earth. Both men and women have the same rights to undertake any profession. Children of both sexes have the same right to education. Men and women enjoy the

same rights to have their reputation and social standing protected against any slander, ridicule or backbiting. Both men and women are equal partners in sharing responsibilities in their home. Women should enjoy the highest standard of health, physically, spiritually, mentally and socially, from early childhood. In Islam, a husband and wife are described as "garments" for each other. It is important to emphasize the great variety of connotations that the use of the term "garment" provides here, such as warmth, screening, closeness, mutual care and benefit.

59. Such a generous, open- minded mentality is not limited to husband and wife. Indeed, it is demonstrated by all members of the nuclear family and the extended family, as well society as a whole. It thus provides the proper remedy for a variety of social problems. It protects society against the numerous social cracks, which are only too evident today in the structure of the societies that are frequently described as advanced. These include loneliness and isolation, lack of care for the elderly, wide gaps between generations, a high rise in the rates of suicide and violent crime, and a continuous increase in crimes committed by children and adolescents. All these are the direct result of the weakening of relationships within society and the denial of the need of mutual care between its members. The role of the extended family in different states of dependency, such as sickness and old age, social cohesion and the transfer of morals and values, which have strong foundations in countries of this Region, must be encouraged and maintained without interfering with normal progress and development.

60. The family means a husband and wife united by a legal bond of marriage, enjoying an atmosphere of mutual love and compassion, providing care for those who are close of kin, males and females, young and old, offspring and elderly. They establish a home where women are men's equal sisters.

Sustainability

61. Sustainability of health care throughout life entails the development of health systems based on scientific grounds and incorporating all the values mentioned above. It also means the training and availability of capable leadership in the health sector who are immune to political fluctuations and partisan whims and desires. Sustainable health systems are the key to effective and efficient health care services and to quality health care provision.

Quality health care

62. Expectations of quality health care are on the rise in the Region and efforts should be made to set appropriate norms and standards for quality assurance and to strengthen monitoring and regulation of health services delivery. The role of government, through Ministries of Health, is of paramount importance in this respect.

CHAPTER 4

STRATEGIC ORIENTATION

Commitment to health-for-all goals

63. It is essential to renew national commitment to the principles of health for all not only at national level, but also at regional and global levels. This commitment should be translated into action aiming at making the spirit of health for all and the quest for equity and other values so deeply rooted in the national socioeconomic development process that they will be sustained.

64. It is essential to emphasize that sustainable health is the focus of socioeconomic development. This means that:

- Each society should identify and define its own profile of vulnerability using health status as a key indicator;
- Development strategies should act on the integral links between health status and economic well-being and productivity, especially in the case of highly vulnerable groups;
- Health-related knowledge should become accessible to people in a form that increases their health self-reliance and their capacity to manage and cope with a rapidly changing health environment; and
- Health-promoting activities should be linked to investments, to income-generating activities and to economic enterprise.

65. Good governance based on transparency, accountability and incentives that promote participation in civil society are crucial to achieve the goals that are set by national authorities. In this context, health professionals need to facilitate the process of priority setting, fostering transparency and involving all partners. Governments can make possible concerted action for health by creating an environment which stimulates and facilitates partnerships for health. Furthermore, particularly in developing countries, a well-defined policy and a solid analytic capacity are required to ensure that national needs take precedence when negotiating with international donors.

National policy framework

66. The development of a sustainable national health care system should be within a well-formulated policy framework. It is important, therefore, to strengthen national capabilities for policy formulation based on critical scientific situation analysis.

67. The process of policy formulation is not aiming at production of a policy document. It is more of a continuous dynamic process of situation analysis, deciding on priorities, setting of goals and targets, and product formulation, developing strategic plans with adequate and relevant indicators for monitoring and evaluation of implementation. Policy formulation, implementation, monitoring and evaluation can be successful only if an efficient national health information system is working and supported by a well

functioning health system research mechanism. The availability of up-to-date, reliable, valid data for decision-making is crucial to national policy formulation.

68. Priority-setting is the responsibility of national authorities alone based on country-specific circumstances. In the meantime, regional priorities can guide cooperation at regional level. National capabilities for research need to be developed within the overall national system for policy monitoring and strategic planning. This will enable Member States and the Regional Office to be pro-active in anticipation of future global, regional and national changes that may have a specific impact on the health sector.

The development of sustainable health systems

69. The challenge of the health system in the 21st century is to provide sustainable health care and maintain health gains, in particular the improvement of health status of the poor and of vulnerable groups. Sustainable health systems have to be built. It is the responsibility of the state to guarantee equity of access to health services and to ensure that essential functions are performed at the highest level of quality for all people. In view of the changing roles of the institutions, there is need to give greater emphasis to ensuring that essential functions are maintained and that individual health care services are made available. Sustainability has three dimensions.

70. Financial sustainability requires detailed cost analysis and development of a national health account; the need to generate additional resources for health, particularly in low and middle-income countries, is of utmost importance. Efforts should be made to protect equity in introducing new cost sharing and other financing reforms. Priority setting in resource allocation should be improved in order to ensure financial sustainability.

71. Technical sustainability requires a clear policy for development of infrastructure and technical expertise as well as the technology required for sustainability of the national health care system. In this respect, countries of the Region have to develop national programmes on health technology. Such programmes should address issues of selection, rational use, developing national capabilities and contribution to modern biotechnology development. National mechanisms for technology transfer should be established with qualified leadership and appropriate links between all sectors concerned. Human capital is a major factor contributing to development. Appropriate human resources infrastructure is essential to ensure successful technology transfer. This necessitates adequate human resources development and training covering all levels of the health sector. For this reason, human resources development is considered among top priorities in this Region.

72. Managerial sustainability requires the development of a well organized, well functioning and a competent system of civil service. Such a system should continue to function within the national policy framework without interruption resulting from changing political leadership. Managerial sustainability requires the development of an environment that will motivate and encourage civil servants to achieve a well managed

and sustained health care system. It is important in this respect to promote competitive, and motovative working conditions to attract and keep competent personnel. A sound legislative framework and health regulations are necessary to guarantee adherence to healthy lifestyles and good practice. The regional strategy on appropriate use of new health technology should be based on careful analysis of the cost–effectiveness of advanced health technologies.

Primary health care is the key to achieving health for all

73. Since its adoption in 1978 as a priority approach for health for all, primary health care has been the basis of successful reform in national and global policies. Health is now universally considered as central to the overall development process which has resulted in a shifting of priorities and financial resources towards primary health care in a majority of countries. While preparing ourselves for the challenges of the next millennium, it is important to reaffirm the concept of primary health care as the practical, scientifically sound and socially acceptable method to provide sustainable quality health care to all individuals, families and communities. It will continue to be the first entry point to the health system.

74. The eight primary health care elements defined at Alma-Ata are being revisited and expanded in the light of new knowledge and challenges. For example, the spectrum of maternal and child health has been expanded and reconfigured to include reproductive health; the essential drugs concept is being developed as a broader-based technology for health policy; and the previous focus on communicable disease control is expanded whenever necessary to include noncommunicable diseases, including mental health and sexual behaviour. An explicit life span approach will be implemented within the health system; food safety will be addressed when considering food and nutrition; and health education will become a component of health promotion. All unfinished aspects related to communicable diseases control, malnutrition, child and maternal mortality and new emerging diseases will continue to be addressed within the primary health care context, in addition to the new challenges of health sector reform, privatization of services, environmental hazards, urbanization and increasing poverty.

75. To achieve wider acceptability and collaboration from different stakeholders and civil society at large, the ultimate goal of primary health care should be broadened, to attain better quality of life, rather than merely focusing on targets largely restricted to health. Some of the challenges to be tackled during the 21st century include:

- Renewal of the commitment of politicians and decision-makers towards primary health care/health for all and translation of that commitment into reality through increased budget allocation for primary health care;
- Initiation of frank and wide-ranging discussion to unify international vision, strategies and support to primary health care;
- Orientation and reorientation of all health workers to primary health care/health for all through the revision of medical and training curricula;
- Introduction of efficient health sector reforms that will address all current deficiencies through a comprehensive and holistic approach;

- Integrating health and in particular primary health care in socioeconomic development process;
- Improving management skills and capabilities;
- Strengthening intersectoral collaboration and establishing mechanism for its operation;
- Promoting community involvement in health development, through political support and raising the awareness of the people;
- Developing feasible models and strategies for urban primary health care and recognizing the role of alternate therapies of proven value;
- Introducing continuous quality improvement mechanisms;
- Formulation of rules and regulations for the private sector as well as plans for cost sharing without marginalization of the poor.

76. During the 21st century, primary health care should encompass the following concepts.

- There should be universal coverage of the population, with care provided according to need and consideration of such care as a human right of every individual.
- Equity should be ensured for all geographic, economic and ethnic groups regardless of sex as well as for the elderly and special groups.
- Services should be promotive, preventive, curative and rehabilitative with good referral systems to secondary and tertiary levels of care.
- Services should be effective, culturally acceptable, affordable and manageable.
- Alternative financing mechanisms should be explored without undermining the commitment to population needs and social responsibility.
- Communities should be involved in the development of services so as to promote self-reliance and reduce dependence.
- Approaches to health should relate to and involve other sectors of development in a spirit of coordination and cooperation.
- The basic development needs initiative should be consolidated and accelerated as a tool to establish innovative intersectoral and community-based structures to achieve better quality of life.
- Regular and sound evidence should be provided to advance and sustain the cause of primary health care.

Human development and health care (basic development needs approach)

77. The basic development needs (BDN) initiative is a comprehensive approach addressing overall local development in order to achieve better quality of life. BDN has established itself, after several years of promotion of the concept, as one of the main regional approaches to integrated community development and self-reliance. During the past decade, the concept of BDN has been advocated in several countries as an approach that, while mainly addressing poverty alleviation, also directly and indirectly affects the health status of the people. The BDN initiative entails political commitment, community organization, motivation and involvement, intersectoral action, and integrated, decentralized, comprehensive development.

78. Basic development needs initiatives include community-identified projects that integrate social, economic, health and environmental issues. BDN projects are organized and managed by the community, supported by a coordinated intersectoral team, including health-related sectors such as education, water supply, agriculture and housing. Development projects are implemented in partnership with the local population and nongovernmental organizations. BDN projects target income generation and poverty alleviation by implementing realistic, achievable activities, which have to include a "basic" health component.

79. Almost all countries with BDN programmes have included income-generating schemes in their plans. These income-generating schemes could provide an important source, in the long term, to sustain and expand BDN and, thus, health for all. The community centred, project specific and comprehensive BDN initiative has immense potential to appropriately address the differing health needs of rural, peri-urban and urban communities of Eastern Mediterranean Region countries. BDN, therefore, strongly complements and supports other health promotion and prevention activities being undertaken within the primary health care delivery system.

80. The lessons learnt in the 13 countries of EMR where BDN programmes have been implemented include:

- The need to ensure national ownership of the programme;
- The need to demonstrate transparency of the programme to all levels and partners, especially the community;
- The importance of institutionalization of BDN as part of national programmes with explicit and defined roles for each partner;
- The importance of ensuring sustainability of BDN from inception—particular reference should be made to the relation between income-generating projects and support for social projects (e.g. health);
- The need to periodically assess progress, identify weak areas and take necessary action to this effect;
- The need for better advocacy, networking, exchange of experience and sharing of information among the different BDN programmes and collaborating agencies

Human resources for health

81. Development of a sound human resources policies, as an integral part of national health policy, needs to be given considerable attention by all countries. Such policies need to be based on situation analysis, taking into consideration epidemiological changes, major health problems and socioeconomic variables. Technological advances, current and anticipated changes and challenges, and the health-for-all policy for the 21st century should also be reflected in the policies.

82. Human resources policies should be translated into plans that will ensure a balance between the health service demands for a health workforce and the supply of health personnel. These policies need to describe the numbers and categories of health personnel as well as their qualifications, functions, and career ladder. To ensure proper policy formulation and planning for human resources for health, it is essential to

strengthen national capacity in this field, develop human resources management information systems and engage all stakeholders in human resource development in the process of policy and planning formulation.

83. To meet the challenges of health for all in the 21st century, a well educated and trained health workforce that is oriented to meet the needs of the communities has to be developed. Support to the state by WHO and other partners should concentrate on comprehensive capacity building for health. Curricula of training institutions should be dynamic and responsive to new changes in knowledge and technology and the new settings where health workers will perform. The curricula of all health care providers should provide the graduates with the skills and attitudes of critical thinking and the ability to search for information and follow up on recent developments. A greater responsiveness to society's needs could be achieved through expanding community-oriented and community-based medical and health personnel education, as well as research in educational technology, educational methodology and new learning settings.

84. Community-based and community-oriented education of health professionals strengthens partnership between the health care delivery system and training institutions. Efforts should be directed towards involving those who teach as full partners in health care delivery and those who provide services as full partners in training different categories of health personnel. Efforts should also be made to develop standards for health personnel education and to promote a voluntary system of accreditation of medical, nursing and allied health schools. Continuing education programmes for health professionals from both the public and private sectors should gradually become mandatory and should constitute a major requirement for career advancement and licensing for practice. Use of national languages will be further encouraged through the establishment of centres for collective authorship and translation, as well as functional mechanisms for printing and publishing teaching/ learning materials and textbooks in national languages to all categories of health personnel at lower cost.

85. Human resources development should recognize the need to consider different mixes of health care providers working in a multidisciplinary and collaborative fashion to meet new challenges and changing needs. The mix would include professional, technical and auxiliary health workers. To serve the need of the public for better information about all aspects of health, greater attention should be given to training in communications, health promotion skills, care-giving and community assessment. Telecommunications linkages offer new opportunities for distance-learning and diagnostic support in many settings.

86. Human resources management areas which deserve more attention during the 21st century include the problem of internal migration from rural to urban areas and external migration from less fortunate countries of the Region to more fortunate ones. This will require strong collaboration with other national sectors, particularly ministries of finance, planning and civil service. It will also require cooperation

between countries of the Region to regulate the employment conditions of expatriate health personnel in a manner beneficial to both providing and receiving countries.

87. To ensure efficient and effective work by health care providers, sound recruitment and retention policies need to be adopted, programmes for continuing education established and implemented, and appropriate legislation and professional codes of ethics developed and adhered to in the practice. Attention should also be given to staff performance appraisal systems and staff career development as both of them are closely linked and are essential to good management of human resources.

Response to emergencies/health as a bridge for peace

88. Large-scale disasters, both natural as well as man-made, present serious threats in many parts of the world in general and in the Eastern Mediterranean Region in particular. The increase in global population, the deterioration of the environment, widening social and economic gaps, and regional and ethnic conflicts presage the occurrence of more disaster events.

89. Health concerns can transcend political divisions, promote dialogue, foster solidarity and contribute to peace among people and between nations. Health can be deliberately employed in a variety of situations to help prevent disputes from arising, prevent them from escalating, and to foster peace building and rehabilitation. The health sector can play a vital role during all stages of wars and other conflicts. During peace time, health interventions such as the promotion of health for all or socioeconomic development will decrease tensions and the chance of conflict, while during war, health-related activities can promote confidence-building measures, provide humanitarian assistance and intervene as a mediator for cessation of hostilities and attainment of peace. Agreements on periods of tranquillity and cease-fire in case of conflict make it possible for important health activities to be carried out, such as immunization, distribution of food and drugs and provision of emergency care.

90. WHO strongly advocates a multisectoral approach to emergency management within a framework involving all interested sectors, through vulnerability analysis and joint planning mechanisms, and promotes the necessity of integrating vulnerability components into sustainable human development strategies and projects.

91. In order to ensure a smooth transition from relief to rehabilitation and development, emergency assistance should be provided in ways that will be supportive of recovery and long-term development. Therefore, greater WHO efforts are needed in the 21st century in order to prevent and mitigate natural disasters and emergencies, to assist developing countries to strengthen their capacities to respond to disasters and establish databases, and to improve the pooling, analysis and dissemination of early warning information on natural disasters and other emergencies. To do so emergency preparedness programmes need be initiated in areas of conflict and civil strife. Aid programmes require proper planning, coordination and management training.

Securing adequate and sustainable financing

92. Because of the increasing cost of health care and as a result of the inability of most governments to provide free health care for all the population, it has become evident that other means of financing the health services and sharing the cost of health care have to be found. Most countries are initiating health care financing reforms which aim to promote cost–sharing through user fees and health insurance and are adopting new approaches with regard to the role of the private sector. Reforms should be of manageable scale, reproducible and closely monitored, taking into account institutional obstacles, conflicts of interest and the overall socioeconomic conditions of a country. In many countries, some of the services related to health promotion and protection, disease prevention and control and environmental health services must continue to be provided for by the state as the private sector may not have any interest or motivation to finance them. Vulnerable groups and the poor will continue to depend on the state for a major portion of the provision for their health care.

93. Government action and regulations are needed to secure an adequate level of financing (through public or private sources), to promote cost containment and fiscal discipline, and to ensure that national resources are used equitably to meet health needs. In an equitable health care system, there would be universal access to an adequate level of care throughout a person's life span. The costs of ensuring access to essential health care, as well as the effects of rationing, will be distributed fairly across the population, according to need. Solidarity-based financial mechanisms and insurance systems can be used to advance equity by ensuring that the sick and the poor are supported by the healthy and the employed members of society.

94. Social health insurance is one method of financing health services. The main objectives of social health insurance are:

- Access to health care for the entire population;
- High-quality and appropriate care; and
- Cost-containment and affordable care.

Social health insurance can help to meet health policy goals that require additional funding not easily available from other sources and can contribute to improving the performance of health systems.

Promotion and protection of a healthy environment as an integral component of sustainable development

95. Environmental services that help protect and maintain health are the responsibility of national and local governments. Such services should ensure access to safe water and sanitation, clean air and safe food, manage disposal of hazardous chemicals and wastes, and control disease vectors and pollution of land, water and air. Further, incorporating health needs and concerns into town planning, and developing adequate inspection and monitoring of environmental health hazards, are mainly local authority functions. These services are often provided outside health systems, with very little involvement or control from the central health authorities. As a result of this, standards

of environmental health vary from one region or province to another in any country. Standards and norms set are often not followed. Legislation to enforce such standards needs to be developed and enforced. Important environmental issues to be addressed in future include drought and desertification, marine and shore pollution, lifestyle pollution including air and noise pollution, medical waste disposal, food production and food safety. Health care during the 21st century must accord greater attention to these hazards through proper environmental surveillance. The place of environmental health within the health care systems and the government as a whole needs to be clearly defined and responsibilities delimited.

96. Disease prevention and health protection services in the workplace are essential components of an integrated approach to improving the health of workers. The current emphasis on preventing exposure to specific agents and on promoting safety and ergonomics at work should be extended to cover all preventable conditions that affect adults in the workplace. Where people work at home, their occupational health needs should be met by local or district health services.

Promotion of healthy lifestyles

97. All human beings are in possession of a certain health potential, which they must develop in order to enjoy complete well-being and ward off disease. The lifestyles followed by human beings have a major impact on their health and well-being. Lifestyles embrace numerous positive patterns promoting health and rejecting any behaviour which is deleterious to health. Governments and voluntary and nongovernmental organizations should promote health by encouraging positive lifestyles, particularly through:

- Advocating health-promoting actions, such as exercise, balanced diet and abstention from alcohol, drug abuse and tobacco use, and advocating healthy lifestyles through proper channels, as appropriate to the circumstances of each country. All government controlled media should at least be banned from promotion of unhealthy lifestyles and practices.
- Providing conditions that are conducive to the promotion of health and healthy lifestyles, and not contradicting such through advertising unhealthy lifestyles, supporting the production of materials harmful to health or promoting unhealthy behaviour. Governments need instead to encourage health clubs, sports competitions, anti-smoking campaigns and health education campaigns on healthy living.
- Encouraging the comprehensive development of local communities, and supporting them in attaining their basic needs through self-reliance, this being a practical introduction to the implementation of healthy lifestyles.
- Reorienting health, educational, instructional and public information institutions, in a manner that promotes health and encourages healthy lifestyles. Curricula for schoolchildren should include action-oriented health behaviour in all subjects taught to students at these early stages of their education.
- Reorienting educational institutions in the health field, in such a way as to give a human dimension to the health professions, and to make each of these professions

a vocation rather than a mere occupation. The role of health workers in promoting healthy lifestyles can be augmented by continuing education programmes directed at informing all health workers about approaches and methodologies of health education of the public.

Eradication, elimination and control of specific diseases

98. Reducing the burden of communicable diseases requires an integrated approach coupled with promotion of nutrition, healthy lifestyles and development of environmental services, including access to safe water and sanitation, clean air, safe food, sanitary waste disposal and vector control.

99. Efforts against communicable diseases will be directed towards eradication, elimination and control. Dracunculiasis and poliomyelitis will be eradicated. Measles, neonatal tetanus and leprosy will be eliminated. Tuberculosis, diphtheria, pertussis, congenital rubella, and hepatitis B will be controlled. Malaria eradication will be maintained in the countries that have achieved it. Sustaining effective control may lead to eradication in some of the countries and establishing effective health systems may result in malaria control in the others. The Roll Back Malaria initiative will receive full technical, administrative and financial support in all affected countries.

Priority will be given to the strengthening of surveillance of emerging and re-emerging diseases, development of early warning systems, and forecasting, prevention, early detection and containment of the epidemics of major infectious diseases. Priority will also be given to early detection, prevention, diagnosis and treatment of other emerging diseases like tuberculosis, HIV/AIDS and sexually transmitted diseases.

Noncommunicable diseases which are gaining importance in many countries due to demographic and lifestyle changes, such as cardiovascular diseases, cancer, diabetes chronic lung disease and asthma, will receive great attention. Reduction of common risk factors are essential for the control of these diseases. Such factors include smoking, alcohol and substance abuse, uncontrolled food consumption, stress and lack of exercise. Programmes for reducing these risk factors through health education, advocacy and control of advertising will be supported. These will be coupled with provision of means of early detection, treatment and rehabilitation services. Provision of emergency services will be encouraged, to reduce the effects of injury from violence and car accidents in the streets, as well as accidents at home, in the work place and places of leisure.

Intersectoral collaboration

100. It is widely recognized that health is not the concern of the health sector alone but is dependent on the actions of many social and economic sectors, both governmental and nongovernmental. Such action areas include education for literacy, income supplementation, clean water and adequate sanitation, improved housing, food and other agricultural products and building of roads. All may have a substantial and synergistic impact on health. However, few innovative examples exist of sustained

intersectoral collaboration for health between the sectors involved in those activities and the health sector.

101. Many practical possibilities for action exist. Identification of the needs of vulnerable groups can provide the basis for collaboration at community level. Involvement in the process by people themselves adds to its effectiveness. The homeless and street children represent a big challenge in big urban cities. Existing intersectoral mechanisms, such as district development committees, need to be further utilized by the health sector. This will require more effective advocacy on the part of health personnel on relating to other sectors. At national level, ways of strengthening sectoral policies need to be found so as to maximize the impact of health-enhancing action while eliminating or reducing the impact of those actions that are harmful. The particular energies and interests of nongovernmental organizations may serve as important catalysts in all of these. The main coordinating body at national level will continue to be the concerned government authorities and ministries themselves. Intersectoral collaboration and coordination between United Nations agencies and nongovernmental organizations working in health is the responsibility of the government and may be accorded to the Ministry of Health at central, intermediate and peripheral levels. Mechanisms for such coordination need to be worked out and tested for efficiency and effectiveness.

Partnerships for health

102. Partnerships are needed between the many levels and actors concerned with health, and will be a primary component of health-for-all implementation. Productive partnerships will enable different ideologies, cultures and talents to come together which will stimulate working towards improved health. Community partners may take the shape of national voluntary organizations, social organizations, religious organizations, youth clubs, women's associations, tribal gatherings and groups. Analysis of what all these groupings can do to promote and protect health is largely the responsibility of the health authorities. It is also the responsibility of the health authorities to make maximum use of these organizations.

103. Community partnerships and the development of skills constitute the essence of health for all. Partnerships between people and institutions at all levels allow for sharing of the experience, expertise and resources necessary for the attainment of health for all, and increased commitment by all is needed to ensure its full implementation. Governments should therefore aim to create an environment that stimulates and facilities partnerships for health. Both formal partnerships and community-based informal networks at different levels are needed. WHO and governments should consider developing guidelines, with the private sector and nongovernmental organizations, aimed at ensuring that new partnerships are mutually beneficial and always benefit health. Reactivation (establishment (or re-establishment) of cultural, sports, religious and women's groups through a system of local governance can enhance social cohesion and a social environment conducive to health.

CHAPTER 5

GLOBAL AND REGIONAL HEALTH-FOR-ALL TARGETS

104. The global health-for-all policy document has identified an initial set of targets that will guide the implementation of health-for-all policy and define priorities for action for the first two decades of the next century. It is important to differentiate between systematic targets of a global and regional nature and cumulative targets of a geographical nature. Regional and national targets will be developed within the framework of the global policy and will reflect the diversity of needs and priorities. They should be measurable, time-bound, feasible and stimulating, and will need to be supported by adequate resources. All targets should be reviewed periodically. Indicators will be used to assess the degree of progress being made towards the attainment of the goals and targets, as indispensable aids to effective monitoring and evaluation of programmes.

105. Targets related to health policies and systems need to be met if actions relating to the determinants of health are to lead to improved health outcomes and access to care. The original Health for All by the Year 2000 targets set in 1981 were not supported by baseline data. Considerable experience in strengthening health information systems since then means that the targets for 2020 have been more firmly based on evidence. Achieving these targets will ensure that the goals of health for all are met.

106. The elaboration of regional targets should take into consideration the following priority areas agreed upon during the Forty-third Session of the Regional Committee for the Eastern Mediterranean:

- Development of human resources for health, including health leadership development, and development of managerial capabilities;
- Adoption of the basic development needs approach, including healthy villages, healthy cities, self-reliance at the family level and home health care;
- Collection of health information and its dissemination through various means to countries of the Region;
- Eradication, elimination and control of specific diseases;
- Promotion of healthy lifestyles, particularly in the fields of nutrition, environmental health, maternal, and child health and health of the elderly, and combating unhealthy lifestyles, particularly smoking; and
- Provision of essential drugs and vaccines, as well as essential laboratory and radiological tests.

107. **Health outcomes**

a) By 2005, *health equity indices* will be used within and between countries as a basis for promoting and monitoring equity in health. Initially, equity will be assessed on the basis of a measure of child growth.

b) By 2020, the targets agreed at world conferences for *maternal mortality rates* (MMR), *under-five or child mortality rates* (CMR) and *life expectancy* will be met.

c) By 2020, *the worldwide burden of disease will be substantially decreased.* This will be achieved by implementation of sound disease control programmes aimed at reversing the current trends of increasing incidence and disability caused by tuberculosis, HIV/AIDS, malaria, tobacco-related diseases and violence/trauma.

d) Measles will be eradicated by 2020; leprosy will be eliminated by 2010; and trachoma will be eliminated by 2020. In addition, vitamin A and iodine deficiencies will be eliminated before 2020.

108. **Intersectoral action on the determinants of health**

e) By 2020, all countries, through intersectoral action, will have made major progress in making available safe *drinking-water*, adequate *sanitation*, *food* and *shelter* in sufficient quantity and quality.

f) By 2020, all countries will have introduced, and be actively managing and monitoring strategies that *strengthen health-enhancing lifestyles* and *discourage health-damaging ones*, through a combination of regulatory, economic, educational, organizational and community-based programmes.

109. **Health policies and systems**

g) By 2005, all Member States will have operational mechanisms for developing, implementing and monitoring policies that are consistent with health-for-all policy.

h) By 2010, all people will have *access* throughout their lives to *comprehensive, necessary, quality health care, supported by essential public health functions.*

i) By 2010, appropriate global and national health information, *surveillance and alert systems* will be established.

j) By 2010, *research policies* and institutional mechanisms will be operational at global, regional and country level.

CHAPTER 6

THE ROLE OF THE WORLD HEALTH ORGANIZATION/ EASTERN MEDITERRANEAN REGIONAL OFFICE

110. The role of WHO in developing, implementing, monitoring and evaluating health-for-all policy and strategies in the 21st century should be understood bearing in mind that WHO *is* its Member States and governing bodies; not just its secretariat. Within this concept WHO at country level is not only the WHO country office, but the whole health sector, technically advised by the WHO office. Following the same concept, the WHO regional structure comprises not only the WHO Regional Office; it is rather the Member States of the Region, the governing body—"the Regional Committee", and the technical secretariat—"the WHO Regional Office".

111. The three levels of WHO headquarters, Regional Office and country office work in a continuum, closely coordinating WHO roles and functions. WHO regional and country levels are, therefore, actively participating in global WHO functions identified by the global health-for-all policy document, to:

- Serve as the world's health advocate, by providing leadership for the health-for-all strategy;
- Develop global ethical and scientific norms and standards;
- Develop international instruments that promote and assess global health;
- Engage in technical cooperation with all countries;
- Strengthen countries' abilities to build sustainable health systems and improve the performance of essential public health functions;
- Protect the health of vulnerable and poor communities and countries;
- Foster the use of, and innovation in, science and technology for health;
- Provide leadership for the eradication, elimination or control of selected diseases;
- Provide technical support for prevention of public health emergencies and post-emergency rehabilitation;
- Build partnerships for health.

112. At country level, the WHO country office functions as an integral part of the national health system. WHO has no programmes at country level; there are only national programmes supported by WHO. WHO activities at country level should be more oriented to collaboration with governments in the planning, programming, implementation and evaluation of national health programmes integrated into the national socioeconomic development plan, rather than to the implementation of fragmented projects. Through this role close collaboration between national authorities and WHO at all levels will cover both advisory and operational assistance to develop self-reliance in the health field in the light of socioeconomic conditions and the cultural context.

113. The role of WHO at country level can, therefore, include:

- Supporting the ministry of health and other related sectors in formulating national policy and strengthening its leadership in the health sphere within the government;
- Supporting governments in implementing and evaluating such national health policies and strategies;
- Promoting health issues in other sectors and ministries;
- Planning, monitoring and evaluation of WHO technical cooperation;
- Promoting integrated multi-agency developmental planning and collaboration with the United Nations system, while maintaining WHO constitutional leadership in health;
- Resource mobilization;
- Adequate and prompt response to health emergencies.

Within the context of this collaboration, national authorities are encouraged to use the expertise of WHO at various levels to support the process of health sector reform and the national stance in negotiations and discussions with international organizations and donors.

114. The role and functions of the WHO Regional Office cover the following areas:

- Technical support to national health programmes through WHO country offices. The regional advisers' main function is to support national authorities in various technical areas to develop national policies and strategic plans, to follow up implementation and undertake evaluation, ensuring integration with national health policy.
- Developing and supporting appropriate regional and interregional mechanisms for collaboration among Member States, including suitable mechanisms for technical cooperation among developing countries (TCDC). Solidarity, sovereignty, dignity, equity, and building of national capabilities, talents and sustainability are the root principles of TCDC. Based on the same principles, the Regional Office should formulate technical cooperation with developed countries, based on mutual benefit. The successful experiences of twinning can be promoted. The network of WHO collaborating centres in the Region must be utilized to support national and regional initiatives, not only to promote TCDC but also to ensure original national and regional contributions to the development of science and technology.
- Ensuring the representation of country views and coordinating them in the formulation of international norms, standards, and legislation, as well as supporting the adaptation of agreed-upon international norms, standards and legislation to national situations.
- Collaborating with regional and international regional organizations, including regional development banks, United Nations and non-United Nations organizations, and governmental and nongovernmental organizations, to develop regional instruments that advance the health of the people in the Region.

- Intensifying regional efforts in addressing serious problems that affect the poor and the most vulnerable groups, as well as difficult problems that are resistant to traditional means of solution. Innovative approaches need to be developed at regional level to address these two sets of problems.
- The regional health strategy should develop comprehensive means of regional collaboration and coordination to face the challenges of and adapt to the recent technological development. Regional cooperation is essential for the advancement of self-sufficiency in important health areas.

Annex 1

Overall assessment of achievement towards health-for-all targets in the Eastern Mediterranean Region, 1996

	Global (G) and regional (R) targets	Value of target by the year 2000	Achievement[e] Good	Moderate	Little or none
1.	Gross national product (GNP) per capita (G)	US$ 500	×		
2.	Adult literacy (G)				
	• Male	≥ 70%		×	
	• Female	≥ 70%		×	
3.	Nutritional status (G)				
	• New-born weight	≥ 90%		×	
	• child weight-for-age	≥ 90%			×
4.	Water and sanitation accessibility (R)				
	• safe drinking water	≥ 95%			×
	• adequate excreta disposal	≥ 85%			×
5.	National health expenditure as % of GNP (G)	≥ 5%	×		
6.	Maternal and child care by trained personnel (R)[a]	≥ 95%			×
	• Pregnant women	≥ 95%		×	
	• Infants				
7.	Immunization (R)[b]				
	• BCG	≥ 95%	×		
	• DPT3	≥ 95%	×		
	• OPV3	≥ 95%	×		
	• Measles	≥ 95%		×	
	• TT2	≥ 95%		×	
8.	Coverage by local health services (R)	≥ 95%		×	
9.	Health status				
	• life expectancy (male) (G)	≥ 60 years	×		
	• life expectancy (female) (G)	≥ 60 years	×		
	• infant mortality (G)	< 50 ‰		×	
	• maternal mortality (R)[c]	(–50%)			×
	• poliomyelitis eradication (R)[d]	0		×	

[a] 85% for 1995

[b] 95% for 1995

[c] (–50%) means reduction by 50% of maternal mortality rate of 1990

[d] 0 cases means eradication by the year 2000

[e] Achievement: good: target attainable or already achieved;
moderate: situation improved but much more progress is required;
little or none: target unlikely to be achieved without major effort.

Annex 2
Countries not yet reaching health-for-all targets by type of indicator, 1996

Global (G) and regional (R) targets	Countries not yet reaching health-for-all targets 1990 (E2) No.[b]	1996 (E3) No.[b]	Country	(%)[c]
1. Gross national product (GNP) per capita (G)	5/22	5/23	AFG-DJI-PAK-SOM-SUD	43
2. Adult literacy (G)				
2.1 male	11/22	8/22	AFG-EGY-IRQ-MOR-PAK-SOM-SUD-YEM	71
2.2 female	18/22	14/22	AFG-DJI-EGY-IRA-IRQ-LIY-MOR-PAK-SAA-SOM-SUD-SYR-TUN-YEM	96
3. Nutritional status (G)				
3.1 newborn weight	6/21	6/21	AFG-DJI-IRQ-LEB-PAK-YEM	44
3.2 child weight-for-age	11/15	12/19	AFG-DJI-EGY-IRA-IRQ-LIY-OMA-PAK-SOM-SUD-SYR-YEM	85
4. Water and sanitation accessibility (R)				
4.1 safe drinking water	13/22	16/23	AFG-DJI-EGY-IRA-IRQ-LEB-MOR-OMA-PAK-PAL-SAA-SOM-SUD-SYR-TUN-YEM	97
4.2 adequate excreta disposal	14/22	13/23	AFG-DJI-EGY-IRA-IRQ-MOR-PAK-PAL-SOM-SUD-SYR-TUN-YEM	91
5. National health expenditure as % of GNP (G)	10/14	8/15	AFG-BAA-CYP-IRA-MOR-OMA-SUD-YEM	40
6. Maternal and child care by trained personnel (R)				
6.1 pregnant women	14/20	15/23	AFG-DJI-EGY-IRA-IRQ-JOR-LEB-LIY-MOR-PAK-SAA-SOM-SUD-TUN-YEM	94
6.2 infants	9/17	7/20	AFG-DJI-EGY-IRA-MOR-PAL-SUD	70
7. Immunization (R)				
7.1 BCG[a]	7/17	7/18	AFG-DJI-IRA-SAA-SOM-TUN-YEM	30
7.2 DPT3	20/22	13/23	AFG-DJI-EGY-IRQ-LEB-PAK-QAT-SAA-SOM-SUD-TUN-UAE-YEM	73
7.3 OPV3	20/22	12/23	AFG-DJI-EGY-LEB-PAK-QAT-SAA-SOM-SUD-TUN-UAE-YEM	68
7.4 measles	21/22	15/23	AFG-CYP-DJI-EGY-LEB-LIY-MOR-PAK-QAT-SAA-SOM-SUD-TUN-UAE-YEM	76
7.5 TT2	16/17	19/19	AFG-BAA-DJI-EGY-IRA-IRQ-JOR-KUW-LIY-MOR-OMA-PAK-PAL-SAA-SOM-SUD-SYR-TUN-YEM	100
8. Coverage by local health services (R)	12/22	8/22	AFG-DJI-IRA-MOR-PAK-SOM-TUN-YEM	66
9. Health status				
9.1 life expectancy (male) (G)	6/22	5/22	AFG-IRQ-SOM-SUD-YEM	21
9.2 life expectancy (female) (G)	5/22	5/22	AFG-IRQ-SOM-SUD-YEM	21
9.3 infant mortality (G)	9/22	8/23	AFG-DJI-IRQ-MOR-PAK-SOM-SUD-YEM	58
9.4 poliomyelitis eradication (R)	14/22	7/23	EGY-IRQ-PAK-SOM-SUD-YEM	61

[a] Excluding five countries where BCG is not included in the national programme of immunization (BAA-CYP-JOR-KUW-LEB)

[b] The figure presented in form of a fraction means as follows: numerator = number of countries not yet reaching health-for-all target, denominator = number of countries which reported data on the indicator.

[c] % of population in countries reporting not yet reaching health-for-all target.

Annex 3

Health for All in the 21st century—A case study

Policy, strategy and plan of action for health for all in the 21st century in the United Arab Emirates

Introduction

The Government of the United Arab Emirates decided to carry out a detailed outline of a policy statement, and a strategy for health for all during the 21st century, as well as a detailed plan of action for the first 10 years of the century (2001–2010). Contacts were made with the WHO Regional Office for the Eastern Mediterranean to participate in the study by providing technical support in the form of consultants in policy formulation, health planning and health economics. The study was carried out during the second half of 1998 and the first half of 1999. The study was carried out in four stages.

Stage 1: Data collection, analysis and statement of achievements during the last 25 years of the 21st century.

Stage 2: Formulation and approval of a policy statement including priority setting of programmes.

Stage 3: Preparation of strategies for priority programmes (12 programmes).

Stage 4: Preparation of plans of action for the different administrations responsible for implementing the strategies during the first 10 years of the 21st century (24 administrations).

Formation of working groups and committees

Various committees were formed for the different stages of the study. The committees included staff of the Ministry of Health at state and Emirate levels, as well as staff from other ministries and sectors related to health, and foreign short-term consultants mainly from WHO. The most important committees were:

1. Committee for Health Policies and Strategies

Chaired by the Under-Secretary of the Ministry of Health and the membership of all the heads of administrative units of the Ministry of Health. Its main functions were to:

- Formulate proposals of health policies and strategies for the 21st century
- Review the working group discussions and conclusions at all stages
- Recommend to the Minister of Health lines of action to be followed.

2. A Working Group

Chaired by the Director of Planning, Statistics and Informatics with six other members including a health planner, a statistician, a programmer, an administrator and WHO consultants. The main functions of this committee were:

- Collection and analysis of data
- Review of documentation
- Analysis of achievements during the last 25 years of the 20th century using HFA indicators
- Work with WHO consultants in the formulation of policies, strategies for the 21st century and plans of action for the first 10 years of the 21st century for review by the committee of Health Policies and Strategies.

The task

The whole task was completed in four stages with reasonable intervals for performance of various assignments by the national administrations.

Stage 1: Collection and analysis of data and achievements

In accordance with a ministerial order the working group collected various documents relating to epidemiological and statistical information, the periodic evaluations of health-for-all strategies carried by WHO, World Bank report on the health sector 1995, the five year plan 1986–1990 and all other data relevant to the priority health programmes. This data was tabulated and analysed. The working group prepared a document on health achievements during the last quarter of the twentieth century as a result of the work during this stage. This document contains:

1. A historical background of health services
2. An analysis of the present health situation
3. The development of the health system
4. The status of health resources
5. Preventive health services
6. Directions of the health situation
7. Achievements using health-for-all indicators during the last 25 years of the 20th century

This stage lasted for almost three months (see document 1 for details).

Stage 2: Formulation and approval of a health policy statement

During this stage the working group of nationals with the help of WHO consultants on health planning and health economics prepared a Statement of Policies for the 21st century. The Statement of Policies Document (2) included:

1. Articles of the Constitution of the United Arab Emirates related to health polices
2. Relevant articles from the World Health Declaration

3. A resume of the demographic, social and economic situation in the United Arab Emirates
4. An overview of orientation of the health services during the 21st century
5. A statement on sustainable health in the United Arab Emirates during the 21st century
6. A statement on control of the environment
7. Moral values, religious values and ethics in the delivery of health care during the 21st century
8. A statement on women, family and reproductive health (the gender perspective)
9. Global, scientific and technological changes
10. Globalization and future challenges to health
11. Concluding statements on
    - Main principles of health policies in the United Arab Emirates during the 21st century
    - Objectives of health policies during the 21st century
    - Priority health programmes for the United Arab Emirates during the 21st century (12 programmes)

This policy statement was discussed intensively by the National Committee on Policies and Strategies and approved by the Minister of Health to be used as the basis for formulation of strategies during the 21st century.

Stage 3: Preparation of strategies for priority programmes

After approval of the policy statement by the Minister of Health a meeting of all the concerned administrations was held and it was decided that all administrations concerned in the Ministry of Health would prepare detailed strategies for the twelve priority health programmes identified.

Administrations were advised to foster the assistance and technical support necessary from within the ministry or from any other sector, particularly the support of the WHO consultants and the national working group.

The working group met with all the administrations concerned and discussed with them the outline of the strategies and clarified any relevant problems. A common framework for the strategies was used for all priority programmes and included:

1. Description of the problem/programme
2. The general objective of the programme
3. Specific targets to be achieved
4. Technologies, activities and other actions required to achieve the objectives, targets and solve any problems and constraints
5. The targeted population
6. Indicators for measuring achievements
7. Coordination with other health administrations or government sectors

This task was completed for all the 12 priority programmes in lengthy sessions between the nationals responsible for the programmes, the working group and WHO consultants. (Document 3)

Stage 4: Preparation of plans of action

Upon completion of the detailed strategies for the 12 priority programmes the Minister of Health issued a ministerial order requesting all the administrations in the Ministry of Health involved in implementing the priority programmes to prepare plans of action for the first 10 years of the 21st century (2001–2010). An outline of the plans of action similar to that of the strategies was agreed upon and included in addition to the seven sections of the strategies above the following sections:

1. Suggested organogram of the administration for the coming 10 years.
2. Resources needed to implement the programme to include:
   - Human resources by category, number and time frame
   - Constructions and buildings (institutions)
   - Supplies and equipment
   - Logistic support including transport and communication systems
3. An implementation flow chart.

This task lasted for about four months at the end of which the working group met with all the 24 administrations concerned and discussed with them their detailed plans of action for the decade 2001–2010. These plans of action are included in Document (4).

Annexes

Document 5 is a set of annexes relating to:

1. Ministerial orders or decrees relating to the policies and strategies exercise
2. Responsible persons met by the working group
3. World Bank proposals
4. Report on alternative financing of health services in the United Arab Emirates
5. Tables of demographic trends and human resources during the period 2001–2010
6. Results of questionnaire on policies and strategies for the 21st century.