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THIRD REPORT ON MONITORING PROGRESS IN THE
IMPLEMENTATION OF HEALTH FOR ALL STRATEGIES

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**THIRD REGIONAL REPORT ON MONITORING PROGRESS IN
THE IMPLEMENTATION OF HEALTH-FOR-ALL STRATEGIES**

(Agenda item 10)

INTRODUCTION

In 1981, the World Health Assembly (WHA) adopted the Global Strategy for Health for All by the Year 2000 (HFA/2000), (Resolution WHA34.36), followed by the Plan of Action for its implementation (Resolution WHA35.23).

The monitoring and evaluation of national strategies and plans are essentially national responsibilities. However, the Plan of Action also required that WHO governing bodies periodically monitor and evaluate the regional and global strategies. These activities must be largely based on national monitoring/evaluation reports, and/or on other official documents. According to the Plan of Action and its amendment (as per Resolution WHA39.7), the following reports were presented to the Regional Committee for the Eastern Mediterranean (EMR):

- The First Regional Monitoring Report, 1983
- The First Regional Evaluation Report, 1985
- The Second Regional Monitoring Report, 1988
- The Second Regional Evaluation Report, 1991

They are referred to here as M1, E1, M2 and E2, respectively. Following discussion by the Regional Committee, the reports were forwarded for inclusion in the respective "global reports".

The framework for the present monitoring (CFM3) was distributed to Member States of the EMR before mid-1993; they were requested to submit the national reports (referring to the situation in 1993 if available, otherwise to 1992), at the latest by the end of January 1994. A regional meeting was held in September 1993 to explain this new framework and how to prepare the national reports. After several reminders, and to abide by specified dates to distribute documents for the present Regional Committee, a cut-off date was set at 21 April 1994. For one reason or another there was no response from Afghanistan, Islamic Republic of Iran, Lebanon, Libyan Arab Jamahiriya, Somalia, United Arab Emirates or Republic of Yemen. This report is based on replies from 15 Member States, and on information available in the Regional Office about the other seven. Clarifications about statements or figures that seemed unclear or inconsistent received by the cut-off date have been included. Reports or clarifications arriving after that date will be included in the final report as the contribution to the global report.

In reviewing this report, please note the following:

- i) "1988 data" means latest data available as of the M2 (1988) report, irrespective of the actual reference year. This should underline the problem of timeliness of indicator values reported, and the negative effect of different reference years in giving a meaningful Regional average value.
- ii) The presence of contradictory figures in different official sources, or data with apparent internal inconsistencies, is a common problem.
- iii) There has been some change in the composition of the EMR since the first evaluation (1985) report, which included Israel but not Morocco. The former two Yemens appear in this report as one.
- iv) In interpreting longitudinal trends, the number and identity of countries reporting an indicator value affect, to a varying degree, the value of the regional average. It is also worth noting that the reference year of reported data affects the value of the regional average of all indicators, as its calculation is often based on reported country data for different reference years when there is no available data for the same year.
- v) Names of countries are given merely as examples to substantiate the statements, favourable or otherwise, without being exclusive.

1. POPULATION AND SOCIOECONOMIC TRENDS

1.1 Sociopolitical development

Several favourable changes occurred in the political situation in the Eastern Mediterranean Region such as the settling of the problem in Lebanon, evolution of a unified Yemen and, more recently, the signature of the Declaration of Principles on Palestinian self-rule. However, the negative aspects were more significant. Repercussions of the 1990/91 Gulf War still affect many countries, due to massive population movements, huge expenditures and a drop in revenues. The thorny Arab-Israeli conflict, protracted internal conflicts, massive refugee movements, drops in crude oil prices, UN sanctions against two Member States, and various border hostilities, in a prevailing sluggish world economy, all contribute to the scenario in the EMR which includes 5 out of the 47 least developed countries (LDCs) in the world. Lack of funds, food, drugs and other supplies, of security and the concomitant inability to implement health programmes, all add to the suffering of people. Reduction of international support in health development, due to the emerging new world situation that followed changes in Eastern Europe and the former USSR, tremendously aggravated the health situation in many countries.

1.2 Demographic trends

1.2.1 Population size

The Region's total population in 1993 reached about 415.4 million (other than 2.84 million Palestinians in UNRWA-operation fields), representing 7.5% of the world's population of 5572 million, compared to 320 million reported at the time of the first evaluation report (in 1985); thus, the population of the Region increased by about 30%.

Progress in the control of many communicable diseases resulted in a rapid drop in mortality. The EMR weighted average crude death rate (CDR) is now about 10.2 per 1000 population, 5/1000 or less in five countries, but is still 15/1000 or higher in four countries (all are LDCs). Compared with 1985, when the average was 12.5/1000, the present average decreased by 18%, but is still higher than the present world average of 9.2/1000. Meanwhile, family planning efforts in some large-population countries have started to show results. The EMR weighted average crude birth rate (CBR), which was 42.3/1000 in 1985, and 41.6/1000 in 1990, is now 37.6 per 1000 population, but is 45/1000 or higher in 5 countries (of which 4 are among the LDCs). The rate is 26.0 for the world total, 14.2 in the more developed regions (MDRs) (North America, Europe, the newly independent states of the former USSR, Japan, Australia and New Zealand), 29.4 in the less developed regions (LDRs) (i.e., other), but 43.9 for the LDCs. Thus, the rate of natural increase is 2.7% for 1993, below the rate of net population increase; the population influx into the Region is about 0.8 million a year. Table 1 gives a general profile of the EMR, underlining particularly the percentage change which occurred from 1985 to 1994 for each selected indicator.

1.2.2 Population distribution

The overall population density of the EMR is 30.2 per km², but the inhabitable area constitutes only a fraction of the total in some countries. The urban population constitutes 44% of the total, up from 39% in 1985. The Region has four urban agglomerations each with a population over 5 million, and 27 urban centres each with over one million.

1.2.3 Population composition

Due to high birth rates, the EMR has a young population. By age, 44% of the total are below 15 years of age (almost the same since 1985), ranging between 26% in Cyprus and 53% in the Republic of Yemen. The elderly population (65 years and over) constitutes 3.1% (10% for Cyprus). Thus, the dependency ratio (those below 15 years, or 65 years and above, per 100 persons aged 15-64 years) averaged 89% for the EMR. It was 50% in the United Arab Emirates (due to a selective expatriate labour force) and 126% in the Republic of Yemen. The EMR average was 92% in 1985. This shows the economic burden on "working-age" people, though certainly not all are working and earning.

Table 1

Selected demographic and socioeconomic data for the Region
for the First (1985) Evaluation Report (E1)
and Third (1994) Monitoring Report (M3)

I T E M	REG. AVERAGE		%	M3 DATA	
	E1	M3		R A N G E	TOTAL (million)
Surface area (km ²)	13.00 m	13.74 m	5.7	695-2.506 m	13.740
Total population (million)	320.5	415.4	29.6	0.520-126.4 m	415.4
Population density (/km ²)	22.9	30.2	31.9	2.6-774/km ²	-
Population composition (% out of total pop.):					
. Under 5 years	16	17	6.2	9.0-21.3%	70.2
. 5 - 14 years	28	27	-3.6	16.6-31.2%	112.2
. 15 - 64 years	52	53	1.9	44.2-67.7%	220.2
. 65 yr and over	4	3	-25.0	1.1-10.0%	12.5
. Males, total	51	52	2.0	49-63%	214.3
. Males, 15 yr and over*	52	51	-1.9	41-69%	120.7
. Females, child-bearing age	...	22	...	17.7-27.1%	93.0
. Urban population	39	44	12.8	18-100%	182.9
. Rural and nomadic pop.	61	56	-8.2	0-82%	232.6
Population growth (%):					
. Natural increase	2.6	2.7	3.8	1.0-3.8%	11.2
. Net increase	3.0	2.9	-3.3	0.2-4.4%	12.0
Vital statistics:					
. Crude births (/1000 pop.)	42.3	37.6	-11.1	20.0-52.3	15.62
. Crude deaths (/1000 pop.)	12.5	10.2	-18.4	2.1-28.0	4.24
. Infant mortality (/1000 LB)	97	74	-23.7	9.7-182	1.15
. Under-5 mortality(/1000 LB)	132	105	-20.5	12.3-252	1.63
. Maternal mortality (/10 000 LB)	37**	34	-8.1	0-110	0.053
Life expectancy (yr): M	56	62	10.7	42.0-74.1 yr	-
F	57	64	12.3	41.0-78.6 yr	-
Socioeconomic data:					
. Adult literacy (%): Total	38	46	21.1	11-94%	106.4
M	49	57	16.3	18-98%	67.0
F	26	33	26.9	6-91%	37.9
. Per capita (US\$) : GNP	1 645	1 162	-29.4	170-17730	-
GDP	1 375	1 620	17.8	89-17610	-
. Unemployment (%)	3.9	10.1	159.0	0.0-28.0%	23.5

* As percentage among those aged 15 years and over

** For second (1991) evaluation report

... = Data not available

Table 2. Adult literacy rate (%) by sex

Adult literacy rate		Total		Males		Females	
%		C	P	C	P	C	P
Less than 50%		8	53	5	43	12	87
50% - 69%		5	36	5	39	5	11
70% or more		9	11	12	18	5	2
Total	Range	11% - 94%		18% - 98%		6% - 91%	
E M R	Reg. average	46%		57%		33%	
Trends	E2 (C)	44% (23)		55% (23)		31% (23)	
Regional	M2 (C)	45% (23)		56% (22)		32% (22)	
Average	E1 (C)	38% (21)		45% (20)		26% (20)	
Global	World total	66%		...		...	
(E2)	MDRs	95%		...		...	
Data	Developing C.	65%		...		...	
	(LDCs only)	40%		...		...	

C = No. of countries in the interval.

P = % of the Region's population therein.

The sex ratio in a population reflects the impact of differentials by sex in mortality and migration. Adult males constitute 45% or less in Cyprus and Morocco, against 60% or more in most Gulf countries. Overall, 51.6% of the population are males, and 22.4% are women of child-bearing age (WCBA). Thus, maternal and child health (MCH) services must deal with almost 40% of the population (about 166 million).

1.3 Socioeconomic trends

Adult literacy (usually for ages 15 years or more), particularly among females, plays a major role in the improvement of health care, for the family, the community and the nation. The EMR weighted average adult literacy rate (Global Indicator 19) was 46% (Table 2); it was higher

Table 3. Per capita GNP and GDP (US\$)

Per capita (\$)		GNP		GDP	
		C	P	C	P
Less than \$500		5	43	3	37
\$500 - \$1999		7	45	10	52
\$2000 or more		10	12	9	11
Total	Range	\$170-17730		\$89-17610	
E M R	Reg. average	\$1161		\$1620	
Trends	E2 (C)	\$1093 (23)		\$1445 (23)	
Regional	M2 (C)	\$1131 (23)		\$1560 (23)	
Average	E1 (C)	\$1375 (22)		\$1645 (22)	
Global	World total	\$3727		...	
(E2)	MDRs	\$17777		...	
Data	Developing c.	\$700		...	
	(LDCs only)	\$219		...	

C = No. of countries in the interval.

P = % of the Region's population therein.

among males (57%, range 18-98%) than females (33%, range 6-91%), and among urban (57%) than rural population (29%); urban/rural data were available from 12 countries only. The rate for females was below 50% in twelve countries with 87% of the female population in the Region. The EMR average changed minimally since 1980, and is below the global average for developing countries (65%). The rate reached the target of 70% in nine countries with just 11% of the EMR population, and was 70% for each sex in only five countries with less than 2% of the EMR population. It seems unlikely that the EMR will achieve that target by the year 2000.

Severe negative effects on health occur among the low-income class. Unemployment data are usually incomplete in developing countries and, in view of the prevailing way of life, the concept itself may be inappropriate. The EMR weighted average unemployment rate rose steadily, from 3.9% in 1985 to reach 10.1% in 1993. It exceeds 15% in five countries with 31% of the EMR population. Underemployment, an important element in economic activity, has increased more than unemployment.

In Table 3, the EMR weighted average per capita gross national product (GNP) (Global Indicator 20) is US\$1162, with a 100-fold range, but is less than the target level of US\$500 in 5 countries with about 43% of the EMR population. It is below the 1985 level, and much below the world average (US\$3727). The average per capita gross domestic product (GDP) is higher (US\$1620) than GNP, with 3 countries only below US\$500. The impact of the drop in crude oil prices and increasing unemployment will be more prominent later. Changes in national GNP and GDP data expressed in US\$ may reflect changes in exchange rates rather than a real rise or drop in the GNP/GDP.

2. TRENDS IN HEALTH STATUS

Health status is the level of health of an individual, family or community at a given time. Since it is difficult to define and measure "complete physical, mental and social well-being", negative measures of mortality and morbidity are commonly used as proxy indicators.

2.1 Mortality trends

2.1.1 General mortality

Trends in the crude death rate (CDR) have already been discussed under "population size" (1.2.1).

2.1.2 Infant and childhood mortality (Table 4)

The EMR weighted average infant mortality rate (IMR) (Global Indicator 2) is 71 per 1000 live births (LB), down from 97/1000 in 1985, but up from 70 in 1991, partly due to higher revised estimates from Afghanistan and Morocco, and a sharp rise in Iraq (due to the war and economic sanctions). Regionally, it is 98/1000 for rural and 48/1000 for urban areas. The IMR is already below the "target" of 50/1000 live births in 14 countries with 37% of the EMR live births (compared to only 7 countries in 1985), but is 100/1000 or more in 4 countries, all LDCs. This shows a need for greater effort to provide child health services in the LDCs. The global average is 75/1000 for developing countries. Five countries of the Region have already achieved "Regional targets for HFA strategy by the year 2000", as set in Resolution EM/RC36/R.10.

The under-5 mortality rate (U5MR) (Global Indicator 3) dropped further, from 132 per 1000 live births in 1991 to 105 per 1000; it was not used in earlier reports (global average 104/1000). This exceeds the target level of 70/1000, set by WHO in its Ninth General Programme of Work (1996-2001) for nine countries with 65% of the Region's live births. There is a wider range within the EMR regarding the U5MR than regarding the IMR, and a wider gap between the U5MR and the IMR than in the MDRs, pointing to the large number of deaths among children due to causes amenable to socio-economic improvement.

Table 4. Infant mortality rate (IMR) and under-5 mortality rate (U5MR)

Rate (per 1000 live births)		IMR		U5MR	
		C	L	C	L
Less than 50		14	37	10	22
50 - 69		1	5	3	13
70 - 99		3	46	1	5
100 or more		4	12	8	60
Total	Range	9.7 - 182		12.3- 252	
E M R	Reg. average	71		105	
Trends	E2 (C)	70 (23)		132 (23)	
Regional	M2 (C)	79 (22)		...	
Average	E1 (C)	97 (22)		...	
Global (E2) Data	World total	68		104	
	MDRs	14		18	
	Developing C.	75		117	
	(LDCs only)	119		198	

Table 5. Maternal mortality rate (MMR) (per 10 000 live births)

MMR		C	L
No data		1	1
Less than 10		12	33
10 - 29		2	9
30 or more		7	57
Total	Range	0.0 - 110	
E M R	Reg. Average	34	
Trends	E2 (C)	32 (22)	
Regional	M2 (C)	27 (20)	
Average	E1 (C)	37 (20)	

C = No. of countries in the interval.
L = % of the Region's live births therein.

2.1.3 Maternal mortality (Table 5)

The maternal mortality rate (MMR) (Global Indicator 4), shown here as the number of maternal deaths per 10 000 live births, measures the possible risk to a mother when giving birth to a live baby. The weighted average is 34 per 10 000 live births, a minor change since the first evaluation. It is below 10/10 000 in twelve countries in the EMR with 33% of live births, and 30/10 000 or more in 7 countries with 57% of the live births. A downward trend is expected if we achieve the regional target: to have in every village "at least one trained traditional birth attendant, if no other qualified or better trained person is available, to provide the required care." Among the 18 countries providing earlier data, three have achieved the Regional target for MMR.

It is likely that earlier figures have been underestimated, as they are based on limited hospital data or on defective vital registration. However, the average life-time risk of death from maternal causes is roughly 1-2.5 per 10 000 live births if she lives in an industrialized country, and as high as 1 in 15 in the LDCs. The majority of women at risk are poor, live in rural areas, are poorly educated if at all, and have repeated pregnancies at short intervals.

2.1.4 Main causes of mortality

Aside from the problems of under-registration of deaths and the quality of certification of the causes of death, not many countries reported such statistics. If any, they are mostly at the level of main chapters of *International Classification of Diseases* (ICD), or relate only to hospital deaths, thus limiting international comparisons. Acute respiratory infections and diarrhoeal diseases are still prominent causes; e.g., together they led to about 480 000 deaths in Pakistan and 80 000 deaths in Egypt in one year, while deaths from malaria are decreasing (only 112 deaths in Pakistan and none in Egypt). The same applies to EPI-target diseases (except TB), and other infectious diseases in general. Cardiovascular diseases (CVDs), accidents (particularly road-traffic accidents), neoplasms, and other respiratory and urogenital diseases as causes of death are increasing.

2.1.5 Life expectancy (Table 6)

Life expectancy at birth (Global Indicator 1) measures the positive aspect of health status. Life expectancy averaged 63 years (range 42-76 years): 62 years for males and 64 years for females. It was below 50 years in 4 out of the 5 LDCs, and higher among males in two of them, but achieved the target of "over 60 years" in 17 countries (as compared to only 12 in 1985). The EMR average has been progressively rising since the 1985 evaluation, but the rise has recently slowed down. Earlier increases in life expectancy may have been revised estimates following revision of IMR estimates.

Table 6. Life expectancy at birth (in years) by sex

Life expectancy (years)		Total		Males		Females	
		C	P	C	P	C	P
Less than 55 years		4	9	4	9	4	9
55 - 59 years		1	6	2	7	-	-
60 - 69 years		13	84	13	83	13	88
70 years or more		4	1	3	1	5	3
Total	Range	42.5-76 yr		43 - 74 yr		42 - 79 yr	
E M R	Reg. average	63 yr		62 yr		64 yr	
Trends	E2 (C)	62 yr (23)		61 yr (23)		63 yr (23)	
Regional	M2 (C)	60 yr (23)		58 yr (21)		61 yr (21)	
Average	E1 (C)	56 yr (22)		56 yr (22)		57 yr (22)	
Global	World total	65 yr		63 yr		67 yr	
(E2)	MDRs	75 yr		71 yr		78 yr	
Data	Developing C.	62 yr		61 yr		64 yr	
	(LDCs only)	50 yr		49 yr		51 yr	

C = No. of countries in the interval.

P = % of the Region's population (in each sex) therein.

2.2 Morbidity trends

It is difficult to provide meaningful international comparisons in morbidity trends. Data in national reports are quite heterogeneous, and are based on general ambulatory (outpatient) cases, or hospitalized cases, or only on notifications, implying that they will be subject to completeness of notification, if notifiable at all. Some figures referred to incidence, others to prevalence; some referred to cases, others to episodes. The number of diseases reported varies from one country to another, and for the same country from one year to another. Hence, when hereafter the names of some countries appear, this should not mean the absence of the disease nor even a decrease in other countries.

More than 10 000 cases of cholera were reported during 1993 from each of Afghanistan, Djibouti and Pakistan, but 8 other countries also reported the disease. The Islamic Republic of Iran has been regularly reporting cases since 1985, and Iraq, Kuwait and Morocco have reported cases for at least 3 successive years.

The EPI-target diseases are commented upon in conjunction with immunization (5.6). Nine countries reported cases of rabies during the past 3 years, and the number exceeded 2000 cases in 1991 and 1992 in Yemen. No cases of denque were reported; 12 countries reported brucellosis (exceeding 7000 cases from each of Islamic Republic of Iran, Iraq and Saudi Arabia), while meningococcal meningitis was reported by 18 countries (particularly Islamic Republic of Iran, Sudan and the Republic of Yemen). Data on leprosy are difficult to compare; most cases were in Sudan and Pakistan. Gulf countries deport expatriates found to have leprosy. Relatively speaking, numerous cases of syphilis and other sexually-transmitted diseases are reported from Bahrain, Djibouti and Morocco.

During the 3-year period 1991-93, large numbers of cases/episodes of diarrhoeal diseases were reported from Islamic Republic of Iran, Jordan, Oman, Pakistan, Tunisia and Yemen, typhoid and paratyphoid from the Islamic Republic of Iran, Iraq, Pakistan and Sudan, while limited outbreaks of food poisoning occurred in Bahrain, Oman, Qatar and Sudan. Large numbers of cases of acute respiratory infection were reported from Egypt and Oman, and, relatively speaking, also from Qatar. Reported cases of influenza exceeded 25 000 in each of Oman, Pakistan, Tunisia, UNRWA-operation fields; relatively numerous cases occurred in Bahrain.

During the last 3-year period 1991-93, malaria transmission did not occur (or occurred only sporadically) in Bahrain, Cyprus, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Qatar and Tunisia; in most of these countries, however, conditions of transmission still exist and reappearance following imported cases or carriers cannot be excluded. Nationwide control programmes are carried out in Egypt, Islamic Republic of Iran (about 47 000 confirmed cases), Morocco, Oman (about 15 000 cases), Pakistan (about 99 000 cases), Saudi Arabia (about 20 000 cases), Syrian Arab Republic and United Arab Emirates; yet transmission often occurs in limited areas only (e.g., Fayoum in Egypt), while parts are already malaria-free (e.g., eastern region, Saudi Arabia). In the remaining six countries of the Region, control programmes do not cover the whole population, and transmission is heavy at least in parts of their territories; the number of cases reported is about 6600 for Djibouti (1992), 4900 for Iraq (1993), 32 000 for Sudan (1992) and 31 000 for the Republic of Yemen (1993). Eight countries reported the absence of dracunculiasis; Oman, Pakistan and Sudan reported a few cases. Eleven countries reported leishmaniasis during 1991-93, and the number exceeded 5000 cases in each of Islamic Republic of Iran, Iraq, Saudi Arabia and Syrian Arab Republic. The number of schistosomiasis cases is diminishing in most countries; Iraq reported an increase with the appearance of new foci in agricultural areas due to lack of molluscicides.

Data on micronutrient malnutrition in the national monitoring reports were very sporadic, and related to limited studies on different population groups. Thus only two countries commented on vitamin A deficiency, 5 on iron deficiency and 5 on iodine deficiency. As regards the index of DMF teeth, available data from 20 countries give a mean weighted average of 2.0 teeth (range 1.0-4.0 teeth) at the age of 12 years.

2.3 Disability trends

This item was not covered in previous reports, as many EMR countries had not established mechanisms for the collection and compilation of data. The paucity of data limits meaningful comparisons.

2.4 Nutritional status of children (Table 7)

Global Indicator 5, the "percentage of newborns weighing at least 2500g at birth" and its negative indicator, "the percentage of low-birth-weight (LBW) babies", measures the nutritional status of the mother and, in turn, of the fetus until its delivery. Low birth weight significantly affects infant development and survival. The EMR weighted average was 82%, similar to the world total, and compared to 93% for the MDRs. The percentage reached the target of 90% in 15 countries with only 31% of live births (LB) in the EMR, and as low as 70% in two with 38% of the live births. The urban newborn was generally better nourished than the rural one.

The EMR weighted average for Global Indicator 6, the "percentage of children whose weight-for-age and/or weight-for-height are acceptable", i.e., with a weight within 80-120% or ± 2 standard deviations from the national or international reference value for that age (or height), is 67%, well below the target of "at least 90%". Only six countries with 12% of the Region's live births reached that level. Variations between countries were greater here (range 38-97%) than with birth weight (range 70-96%), and the EMR weighted average (67%) was far below that for birth weight (82%), indicating increasing malnutrition as the infants grow due to multiple causes influencing nutritional status. The limited data given show a better nutritional status of the urban than the rural child, and at the age of 12 months than at 24 months. Both indicators show a decreasing trend since the 1985 evaluation. Before concluding a deterioration of nutritional status, it should be noted that country data, particularly earlier ones, were often guess-estimates, or based on small studies, at different ages, and in different population groups.

Table 7. Indicators* on the nutritional status of children

Percentage		a		b	
		C	L	C	L
No data		1	2	3	5
Below 80%		2	38	11	63
80% - 89%		4	29	2	20
90% or more		15	31	6	12
Total	Range	70% - 96%		38% - 97%	
E M R	Reg. average	82%		67%	
Trends	E2 (C)	83% (22)		70% (16)	
Regional	M2 (C)	87% (22)		73% (14)	
Average	E1 (C)	86% (18)		77% (13)	
Global	World total	81%		...	
(E2)	MDRs	93%		...	
Data	Developing C.	78%		...	
	(LDCs only)	62%		...	

* Global Indicator:

a = Percentage of newborns weighing at least
2500 g at birth

b = Percentage of children whose weight-for-age
and/or weight-for height are acceptable

C = No. of countries in the interval

L = % of the Region's live births therein

Table 8. Selected indicators* of health expenditure

Percentage		a		b		c		d	
		C	P	C	P	C	P	C	P
No data		1	3	3	3	0	0	1	14
Less than 2.5%		4	7	9	62	3	9	3	35
2.5% - 4.9%		9	81	9	35	8	62	5	22
5.0% - 7.4%		6	8	1	0	10	29	9	11
7.5% or more		2	1	0	0	1	0	4	18
Total	Range	0.6% - 10.0%		0.9% - 5.1%		1.5% - 9.3%		1.9% - 13.1%	
E M R	Reg. Average	4.6%		2.6%		4.5%		6.2%	
Trends	E2 (C)	4.9% (14)		3.7% (16)		4.5% (23)		6.6% (20)	
Regional	M2 (C)	4.9% (11)		2.7% (12)		4.7% (23)		6.9% (20)	
Average	E1 (C)	3.7% (20)		...		...		...	
Global	World total	3.0%		...		...		...	
(E2)	MDRs	3.3%		...		...		...	
Data	Developing C.	0.9%		...		...		...	
	(LDCs only)	1.4%		...		...		...	

PER CAPITA (US\$)		e		f	
		C	P	C	P
No data		0	0	2	4
Less than \$10		6	58	3	36
\$10 - \$49		8	35	5	42
\$50 or more		8	7	12	18
Total	Range	\$0.3-738		\$1.3-1030	
E M R	Reg. average	\$23		\$43	
Trends	E2 (C)	\$24		\$43	
Regional	M2 (C)	\$30 (23)		\$52 (23)	
Average	E1 (C)	...		...	

*Indicators

- National health expenditure as % of GNP
- MOH budget as % of GNP
- MOH budget as % of total government budget
- MOH regular budget as % of total government regular budget
- Per capita (\$) MOH expenditure
- Per capita (\$) national health expenditure

C = No. of countries in the interval
P = % of the Region's population therein

3. RESOURCES FOR HEALTH

3.1 Financial resources (Table 8)

Global Indicator 16, the "percentage of gross national product (GNP) spent on health", shows the relative priority given to health. The numerator refers to "national health expenditures", be it government or private. Country data differ as to what is included in the numerator. Some countries, therefore, use smaller aggregates (e.g. government health expenditure, or even the MOH only), as well as a percentage of GDP rather than GNP. With these reservations, the EMR weighted average was 4.6% (range 0.6-10.0%), lower than in 1988 and 1991, though the per capita GNP was nearly the same as in 1988 (Table 3). The proportion was below the target of 5% in 13 countries.

In the absence of details, proxy indicators may be used. Data from 17 countries on the percentage of GNP allocated to the Ministry of Health (MOH) gave a weighted average of 2.6% (range 0.9-5.1%); it was 2.5% or more in 9 countries containing 35% of the EMR population. This average is slightly lower than in 1991 and 1988. The EMR weighted average for the total public expenditure on health as a percentage of GNP was 3.3%.

Since the GNP and health expenditures vary widely in absolute terms, the per capita health expenditure expressed in US\$ is another proxy indicator. The EMR averages are: from the MOH \$23.2 (range \$0.3-738) against \$30 in 1988, all government sources \$38.0, and a total of \$43.3 (range \$1.3-1030) as national (including private) health expenditures. Thus there is some drop in per capita health expenditures, despite inflation and rising prices of drugs, food and other health services. The MOH spends less than \$10 per person yearly in 6 countries containing 5% of the EMR population. Evidently, international comparisons and trends here should be taken cautiously, as they are affected by variations in the exchange rates of national currencies versus the US\$.

Whether these resources are directed according to HFA strategies shows in the "percentage of national health expenditure devoted to local health services" (Global Indicator 17), i.e., health care delivered to individuals, families and communities from the first level of a health system based on PHC (Table 9). The EMR weighted average is 34% (range 4%-88%). Apparently, the countries varied widely in what was meant by "devoted to local health services", specially if the budget structure does not permit calculating this percentage with some accuracy. The global average for the world total is 18% and 37% for the LDCs.

3.2 Human resources

The human resources problems facing EMR countries vary. There has been a massive departure of trained manpower due to known circumstances (Kuwait); and difficulties of replacement (Libyan Arab Jamahiriya, Somalia). Other problems include a shortage of certain categories, particularly dentists, nursing and midwifery personnel, and technicians, either due to cultural and employment factors, or to lack of education and training equipment and facilities; imbalance between categories, e.g. more

Table 9

Selected indicators of health expenditure - percentage of national health expenditure devoted to local health services

Percentage		C	P
No data		3	8
Less than 20%		2	4
20% - 43%		12	42
50% or more		5	46
Total	Range	4% - 88%	
E M R	Reg. average	34%	
Trends	E2 (C)	50% (17)	
Regional	M2 (C)	53% (14)	
Average	E1 (C)	50% (15)	
Global	World total	18%	
(E2)	MDRs	16%	
Data	Developing C.	34%	
	(LDCs only)	37%	

C = No. of countries in the interval

P = % of the Region's population therein

physicians than nursing personnel; an over-supply of physicians; or a shortage in the proportion of nationals, especially physicians (where nationals in some countries constitute only 10-12% of the total) but higher for auxiliary and nursing staff. Expansion of health services needs seems to proceed faster than the increase in availability of trained nationals.

Most countries are trying to improve the situation, both in numbers and in quality. Training institutions are being opened or expanded, mainly for auxiliary disciplines to provide a better balance between the categories, as well as new medical schools (Cyprus, Oman), nursing schools or institutes (Egypt, Qatar) particularly attracting students from the

local area (Oman), and health technical institutes (Saudi Arabia). Few countries have carried out studies to estimate their future manpower needs (Iraq, Somalia). Making better use of existing personnel (Morocco), strengthening the concept of team work with a job description for each member (Kuwait, Saudi Arabia), or paying attention to such specializations as family and community medicine (Jordan, Sudan, Syrian Arab Republic and the Republic of Yemen) are other approaches. Egypt has pooled the training components in all "foreign-financed projects" under its Department of Health Manpower Development, in the Ministry of Health.

The EMR weighted average ratio of physicians has risen from 4.5 per 10 000 population in 1985 to 7.3 (range 0.6-23.5). The ratio was less than 5/10 000 in 8 countries with 41% of total EMR population (including all 5 LDCs), and 15/10 000 or more in 6 (with 20% of the total). There is still a lack of dentists, despite a rise in the ratio from 0.6 to 0.9 (range 0.0-8.3) per 10 000 population; it was 0.1/10 000 or less in 4 countries (all LDCs), but 2.0 or more in 7 countries (20% of EMR population). There was a minor change in the ratio of nursing/midwifery personnel, from 9.0 in 1985 to 10.0/10 000 population (range 1.2-54.2/10 000). Thus there is an overall ratio of 13-14 nursing/midwifery personnel per 10 physicians. For comparison, the ratios around 1982-85 in the Scandinavian countries (Denmark, Finland, Norway and Sweden) were 17.9-23.7 physicians and 60.1-98.2 nurses per 10 000 population, or 26-42 nurses per ten physicians. The limited data on within-country distribution of human resources show wide variations in their availability, e.g. the ratio was 10-times as high or more for physicians in 5 out of 15 countries, for dentists in 7 out of 11, and for nursing/midwifery personnel in 3 out of 13 countries.

In partial response to the countries' needs, EMRO's Leadership Development Programme in International Health (LDP) has continued. The second session took place as a Regional Office activity in 1991/92. It was then decentralized and held in English in Pakistan during 1993/94.

3.3 Physical infrastructure

The EMR weighted average is 1.1 primary health care (PHC) units per 10 000 population, close to the 1985 level. The range is 0.1-2.3 units/10 000, and is less than 1.0/10 000 in 12 countries with 52% of the EMR population. The average for hospital beds is 12.1 beds/10 000 population (range 3.3-57.1/10 000), and is below 10 beds/10 000 in 5 countries (4 of which LDCs). The latter average dropped from its 1985 level of 13.6/10 000 showing that the population is growing faster than the expanding health care facilities.

Global Indicator 18 states that "Resources for PHC are becoming more equitably distributed" although there are within-country variations in the availability of resources (paragraph 3.2). Resources are concentrated mostly in the capital regions, for a variety of reasons, especially in the LDCs. The range was as high as 153-times as high for physicians, 113-times for hospital beds, even 39-times as high for nursing/midwifery personnel,

all in LDCs. To remedy this situation, priority has been given to underserved population groups in constructing new PHC units, or in assigning physicians (Morocco), sometimes by means of legislation (Egypt, Syrian Arab Republic). Iraq offers transfer to provincial capitals after serving a number of years in rural areas, while Oman has spread out its new nursing institutes in an effort to attract students (and future nurses) from nearby areas.

4. DEVELOPMENT OF HEALTH SYSTEMS BASED ON PHC

4.1 National health policies and strategies

Health is a right and a social goal. HFA continues to receive endorsement as policy at the highest level (Global Indicator 13). Thus, countries update their policies/strategies to achieve HFA goals.

For some countries, the objective has been to address specific areas, e.g., to revitalize health facilities damaged during the war (Kuwait), focus on certain programmes in view of imposed sanctions (Iraq, Libyan Arab Jamahiriya), expand to underserved areas, achieve a balance between primary and secondary care (Bahrain), improve management skills, and staff development, especially of nationals (Arab Gulf countries).

4.2 Organization of the health system based on PHC

A health system is usually organized from the local community or primary level, through the intermediate (district/region/province) to the central levels. The latter two levels deal with elements of the health system that are dictated by the country's administrative set-up.

Expansion of PHC services to rural and outreach areas is a priority. Some countries have instituted the system of mobile teams (Syrian Arab Republic) or flying doctors for mountainous areas and islands (Oman). Urban areas, so far receiving PHC services through a variety of outlets, would receive integrated services in "urban health centres" (Egypt). To further orient and reorganize the health systems, existing PHC units are being upgraded by expanding and improving the services already being provided, while identifying priority programmes. Maintaining and proper filing of adequate records (e.g., family folders) is crucial for follow-up of services.

A proper referral system, between the primary and the first level of secondary care, offers the patient more advanced medical care when needed, and reduces costly hospital services, especially where people have direct access to them. The out-patient departments in some hospitals have been changed into specialized clinics to receive referred cases only (Saudi Arabia). Qatar has introduced the fax system to expedite referral appointments. In some countries the referral system is generally weak. It would be incomplete if it were only in one direction; countries try to improve referring back cases to the PHC unit for follow-up (Bahrain).

The district health system based on PHC is a self-contained segment of the health system, for a population in a defined administrative and geographical area, with all institutions (up to and including the first-level referral hospital), staff and the appropriate support services providing health care in that area. Many countries have adopted this system or are taking action to strengthen it through structuring the district health team (health areas in Sudan) and training it in management and analysis of progress (Morocco), creating a "district health directorate" (Egypt) or "board" with members from local bodies in addition to the "district health officer" (Pakistan), or developing the regional (district) health information system (Oman). Modifications exist; in the Syrian Arab Republic the Ministry of Health is revising job descriptions and organization at governorate level to be in line with the PHC concept. According to the "block distribution concept" in Bahrain, each family physician and his staff is assigned to a well-defined catchment area with its own population, schools, clubs, mosques, etc. The health insurance system proposed for Cyprus stipulates 24-hour front-line health care by specialists in family medicine; every person registers with the family doctor of his choice who, working with a practical nurse, will provide diagnostic, treatment and preventive care to all family members. Attention is being given to the role of the private sector which may be encouraged with incentives/loans to build hospitals (Pakistan). Private clinics and hospitals can collect their vaccine supply from central government stores (Bahrain).

4.3 Managerial process

At present, health planning is still mostly centralized, although the rural regions/provinces are gradually beginning to play a role in planning (Oman, Sudan, Tunisia). Centrally, planning may be carried out by the "planning unit" in cooperation with the PHC department (Kuwait) and members from all health sectors (Bahrain), or with a multisectoral committee (Syrian Arab Republic). Implementation is often decentralized to a varying extent (Saudi Arabia). The need for an adequate health information system as a tool in proper planning is well recognized (Jordan), and efforts to strengthen it are being made at the national level (Morocco) and/or regional level (Egypt, Oman). There are plans to provide facilities to make information available to all health sectors at various levels (Bahrain). A "wilayat profile" has been developed in Oman as a management tool in the regions, while the "health map" is used in Tunisia to ensure the rational supply and development of services.

The Regional Advisory Panel on Health Information Systems held its first meeting in May 1993. After identifying the need for an organized process for developing the national health information system (NHIS), the Panel formulated a plan of action for WHO, basically to establish a methodology, adapted to the EMR, towards the development of NHIS. An important component of the methodology is to prepare a "procedure manual" for Member States.

Several countries are also restructuring their health care financing systems and training managers in health economics to cope with declining

resources to the health sector and to increase the health system's efficiency. The Advisory Panel on Health Care Financing held its first meeting in 1993.

4.4 Intersectoral collaboration

Collaboration may be at the central level (Pakistan), at the local level (Sudan), only in specific sectors or programmes (Bahrain, Cyprus, Qatar), or on ad hoc basis but with no permanent system (Djibouti, Morocco). Centrally, it may be carried out through a "board of health" or equivalent (Egypt, Tunisia), provided that it meets and functions. The Fifth Health Plan (1990-95) in Saudi Arabia stipulates creating a council to coordinate health care services as well as health-related activities. A permanent committee may take on the role of coordination, such as the Federal Social Action Programme (SAP) Committee in Pakistan, or programme-specific interministerial committees (Egypt, Oman). At the subnational or local levels, coordination is often through local health committees (Sudan) or regional health boards or committees (Pakistan). Nongovernmental organizations (NGOs) are often also represented on these committees (Tunisia).

Poor understanding of the role of other sectors in coordination is a common obstacle. Insufficient recognition of the spirit of collaboration, or situations in which the MOH is not represented on committees dealing with health-related matters, even on the "Higher Council for Planning", inefficient managerial structures in the ministries concerned, or conflict of interest between the sectors involved, were also quoted.

4.5 Community involvement

Community involvement is the process whereby communities, families and individuals assume responsibility for their own health and welfare, and contribute to their own development and that of the community. Global Indicator 14 specifies: "Mechanisms for involving people in the implementation of strategies are fully functioning or are being further developed". These mechanisms vary, often through elected community representatives or leaders in local or district health committees (Pakistan, Syrian Arab Republic), or through working groups between the PHC centre and community leaders (Bahrain), NGOs (Cyprus), or at the central level in committees (Kuwait). The most common role is monitoring and overseeing the functioning of programmes (Egypt, Pakistan), or identifying needs, motivation, planning, implementation and/or follow-up (Sudan). The private sector has an important role to play in the care of the handicapped and the elderly (Saudi Arabia). New mechanisms include the "Baby-Friendly Hospital Initiative" (Oman), the "Committee for Health Friends" (Saudi Arabia), or the "health caravans" (Tunisia). More and more EMR countries are expressing interest in the "basic minimum needs" (BMN) approach (e.g., a disadvantaged urban area near Alexandria, Egypt). A consultation was held in October 1993 on "accelerating BMN in the EMR", and guidelines on BMN promotional, policy and operational aspects have been prepared.

Cultural and socioeconomic conditions, including a low general level of education, are important obstacles, as well as lack of vertical and horizontal coordination of involvement, lack of the spirit of volunteerism, an acquired attitude considering the State responsible for the totality of health services, the sketchy status of local bodies, both financially and in manpower, or even the lack of a proper system or a clear programme for community involvement depending only on initiatives and needs (Qatar).

4.6 Health system research (HSR)

There is a growing interest in research that focuses on problems of the health system. New divisions dealing with this area have been established in some countries (Iraq, Kuwait) or are planned in others (Cyprus). In some areas, there may be no structure at the MOH level to coordinate research. HSR may be carried out or organized by established institutions, e.g. the National Institute of Health (Morocco), by committees between the MOH and the Medical School to formulate research (Bahrain, Jordan), or through separate projects, e.g. the "Project on HSR and Development" (Pakistan) and the "Centre for Research, Studies and Development in Health" (Djibouti), both financed by the World Bank, or by various professionals (Qatar, Syrian Arab Republic). A "provisional plan for HSR" for the period 1991-95 has identified 18 topics for this research, and there are plans to establish a database as a national information source for research (Oman). Research may be carried out by the MOH in collaboration with other agencies (Egypt).

4.7 Technology for delivery of PHC

Rapid advances in science and technology and their application have profound implications. Special committees have been established for the provision of technology (Bahrain). Standard specifications for drugs, chemicals and equipment have often been set, and are strictly followed (Qatar). Member States of the Gulf Cooperation Council (GCC) collaborate in the selection and purchase of appropriate technology. Morocco is introducing a computerized system on equipment required by establishment, to permit procurement according to the needs and specifications of each locality. A shortage of trained personnel, the absence of a system for exchange of information on technology, and the lack of documented standards for each technology, are the main obstacles in this respect.

4.8 International support for health system development

International support for national efforts in developing health systems should be aimed at strengthening the health infrastructures and promoting appropriate health services and technology, so as to create a multiplier effect in the receiving countries. Global Indicator 15 refers to the "amount of international aid received or given for health, whether as a donation (aid) or as a loan".

intercountry cooperation through the GCC may be in the control of malaria and other diseases, the bulk purchase of drugs, and in the joint production of essential drugs, medical supplies and health education material. Comparison of the amount of support is difficult. Very few countries provided figures that referred to one single year or to a planning period, were often partial, and did not allow for the calculation of a regional average. For example, in 1992, Egypt, Iraq, Morocco and Tunisia received a total amount of international aid of about US\$44 million, US\$1.4 million, US\$13.5 million and US\$5.6 million respectively, while Djibouti received US\$11 million in 1991. However, optimum use of such aid is what counts. Problems include laborious administrative actions, lack of coordination between ministries in aid for health-related activities, inadequate evaluation mechanisms, and a drop in bilateral aid following the Gulf War.

4.9 Emergency preparedness and relief

Unpredictable natural and man-made disasters lead to serious emergency states, affect many services, and require rapid provision of various forms of medical care, safe water and sanitation, environmental health, shelter and involve psychosocial aspects, not to mention creating long-term effects. Examples of these are earthquakes, the Gulf War affecting many countries, and civil strife and the influx of refugees in others.

Intersectoral programmes (including health) are needed for a rapid response during both the emergency and rehabilitation phases. A national plan to deal with health aspects in emergencies may be part of a "national disaster preparedness plan" (Egypt, Oman) or is done separately, often at a later date (Qatar, Saudi Arabia). Plans may need to be tested (Bahrain), tested by situation simulation (Tunisia) or upgraded in the light of actual experience (Egypt). The GCC Ministers of Health have recommended the development of a "disaster centre" for the Gulf States.

5. IMPLEMENTATION OF PHC

5.1 Health education and promotion

Health education and promotion is an essential element of PHC aiming at the adoption of healthy attitudes and practices. It is usually integrated into national health programmes as an activity at the central level, but may also be a subnational (regional) activity (Bahrain, Syrian Arab Republic). Here the MOH often collaborates with other government bodies (Oman, Qatar), NGOs (Syrian Arab Republic), or may depend on other sectors such as the Ministry of Information and Culture (Iraq) or its equivalent. In some countries there is no separate unit for health education.

often, the role of health education is not fully recognized by decision-makers in some countries, or sufficient efforts are not made to develop this specialty. Lack of trained staff, particularly in the national language, weak integration of activities by the various bodies, insufficient supervision and mechanisms for communication, absence of a proper health education programme, or of studies on behaviour performance and needs, the usual "limited budget", insufficient audiovisual aids and lack of transport are many other problems.

5.2 Food supply and proper nutrition

Food and nutrition influence health status. Dependence on imported food items is often the response to insufficient local production, e.g. due to limited cultivable area (Djibouti, Qatar), as an indirect consequence of oil industry development which attracts more people, increases soil salinity and creates a shortage of underground water (Bahrain), or population growth faster than increased food production (Egypt). UN sanctions against Iraq are a special case. Some countries have witnessed an increased consumption of food, changing food habits and a tendency to "quick meals" with low nutritional value and high fat content, less vegetables, fruits and high-fibre food. Those, associated with a sedentary life, smoking and stress, are causing an increase in cases of cancer, CVD, diabetes and obesity.

Some countries have formed "national committees for nutrition" (Iraq), have national nutrition plans (Syrian Arab Republic) or intend to develop them (Cyprus), have carried out surveys to assess nutritional status or intend to do so (Saudi Arabia), or have introduced a system for nutritional surveillance (Tunisia). Setting policies to ration main food items and/or provide supplementary food and nutrients to those in need (Djibouti, Iraq, Pakistan), promoting breast feeding (Qatar), or health education on proper nutrition (Saudi Arabia) are other approaches. Several ministries may be involved in addressing the problem of food shortage, e.g. those of health, agriculture, education, economy.

5.3 Safe water and basic sanitation (Table 10)

In response to Global Subindicator 7.1, "Percentage of the population with safe drinking-water available in the home or with reasonable access", 13 countries containing 43% of the population have reached 80% or higher. The EMR weighted average is 71%, up from 67% in the 1991 evaluation. The urban/rural gap is somewhat narrower than before. Thus 19 countries containing 97% of the urban population have reached a coverage of 80% or more, with an EMR weighted average of 93% (up from 91%), while 8 countries with just 4% of the rural population reached 80% coverage; the rural EMR average is 54%, up from 48%. With respect to the "Percentage of the population with adequate excreta-disposal facilities available" (Subindicator 7.2), coverage is less than with safe drinking water. The EMR weighted averages are 56% overall, 87% urban (up from 80%) and 34% rural (up from 28%). However, 9 countries containing more than two-thirds of the EMR rural population have a coverage rate below 50%.

Table 10

Population coverage: safe drinking-water and adequate sanitation

Coverage %		Safe drinking-water						Adequate sanitation					
		Total		Urban		Rural		Total		Urban		Rural	
		C	P	C	P	C	P	C	P	C	P	C	P
Less than 50%		3	6	2	2	6	55	3	36	1	2	9	68
50% - 79%		6	51	1	1	8	41	8	27	3	24	8	31
80% - 89%		4	35	3	26	2	3	5	34	1	3	1	1
90% or more		9	8	16	71	6	1	6	3	17	71	4	0
Total	Range	20%-100%		27%-100%		14%-100%		0.3% - 100%		2.0% - 100%		0.3% - 100%	
EMR	Reg. average	71%		93%		54%		56%		87%		34%	
Trends	E2 (C)	67% (23)		91% (23)		48% (23)		51% (23)		80% (21)		28% (20)	
Regional	M2 (C)	63% (23)		90% (23)		43% (23)		45% (23)		79% (23)		22% (22)	
Average	E1 (C)	61% (22)		85% (21)		45% (21)		41% (20)		75% (18)		23% (16)	
Global	world total	...		88%		66%		...		75%		31%	
(M2)	MDRs	...		100%		96%		...		99%		96%	
Data	LDRs	...		82%		65%		...		61%		21%	
	LDCs	...		54%		39%		...		46%		17%	

C = No. of countries in the interval.

P = % of the Region's population therein.

Three favourable observations may be noted in Table 10. First, improvement in coverage for both items has been relatively greater for rural than urban areas. Second, the EMR averages are higher than the world total average, except for rural safe water (54% against 66%). Third, the number of countries that have already achieved the Regional targets are: for safe water 16 for urban and 5 for rural areas, and for basic sanitation 16 for urban and 4 for rural areas.

The Regional Centre for Environmental Health Activities (CEHA) in Amman, Jordan, continued its collaboration with Member States in holding

workshops and training courses; waste water reuse and CEHANET procedures for information exchange were the main topics discussed.

Among the problems that face expansion of coverage are: problems of financing and tariffs (Morocco), high internal migration resulting in the development of unhealthy urban fringes (Syrian Arab Republic), lack of fuel for running the machines (Sudan), or lack of spare parts for maintenance and repair of these machines (Iraq).

5.4 Maternal and child care, including family planning for health (Table 11)

5.4.1 Maternal care

Concerning Global Subindicator 8.1, "Percentage of pregnant women attended by trained personnel during pregnancy", less than 50% received antenatal care in 6 countries with 54% of live births in EMR, and reached 80% or more in 10 others with just 14% of the live births. The EMR weighted average is 52% (range 2-100%), lower than in 1991. It is likely that national figures are, in many cases, mere guess-estimates rather than based on adequate statistics. The EMR average is below the global average for developing countries, even for the LDCs. Urban/rural data show an advantage for the former in most countries that reported both figures; the EMR averages are 65% and 28%, respectively. Excluding countries with no data, coverage for urban women was less than 50% in 3 countries with 17% of live births in urban areas, and for rural women in 7 countries with 64% of live births in rural areas.

With respect to Global Subindicator 8.2, "Percentage of deliveries attended by trained personnel", the EMR weighted average is 51%, almost the same for antenatal care, also lower than in the 1988 and 1991 reports, and lower than the global average for developing countries. The coverage rate is below 50% in 7 countries with 62% of live births in the EMR. The EMR averages were 78% for urban and 35% for rural areas. Institutional delivery represents one form of attendance at childbirth by trained personnel. Institutional deliveries as a percentage of all deliveries had an EMR weighted average of 27%, a slight drop from 1991. It was below 50% in 9 countries with 76% of live births in the EMR. For both measures, they were persistently higher in urban than rural areas. The number of countries that have so far achieved the Regional targets is 9 for antenatal care and 5 for care at childbirth, yet the current EMR averages for both are well below the target.

5.4.2 Infant care

Data on the "Percentage of infants cared for by trained personnel" (Global Subindicator 8.3) give an EMR weighted average of 61% (range 30-100%). Like the others it is lower than in the 1988 and 1991 reports, and lower than the world total average. The coverage rate is below 50% in two countries only, but these have 41% of all live births in the EMR. Urban/rural data were available from 11 countries; in no country was coverage for the rural infant higher than for the urban. Only two countries have, so far, achieved the Regional target, but the EMR average is well below it.

Table 11

Population coverage: maternal and child care, including family planning*

Indicators*		8.1		8.2		INST. DEL.		8.3	
		C	L	C	L	C	L	C	L
Coverage %									
No data		0	0	0	0	1	2	3	12
Less than 50%		6	54	7	62	9	76	2	41
50% - 79%		6	32	4	15	4	15	6	22
80% - 89%		3	6	3	10	1	1	3	21
90% or more		7	8	8	13	7	6	8	4
Total	Range	2% - 100%		2% - 100%		2% - 99%		30% - 100%	
E M R	Reg. average	52%		51%		27%		61%	
Trends	E2 (C)	57% (21)		57% (23)		28% (18)		65% (18)	
Regional	M2 (C)	52% (20)		58% (22)		20% (16)		85% (15)	
Average	E1 (C)	39% (22)		27% (20)		15% (19)		41% (12)	
Global	World total	68%		56%		...		64%	
E2	MDRs	89%		89%		...		100%	
Data	Developing C.	65%		53%		...		64%	
	(LDCs only)	52%		31%		...		58%	

Coverage		9	
%		C	L
No data		7	10
Less than 30%		5	49
30% - 39%		3	1
40% - 49%		4	35
50% or more		3	5
Total	Range	7% - 54%	
E M R	Reg. average	33%	

* Indicators:

8.1= % of pregnant women attended by trained personnel during pregnancy

8.2= % of deliveries attended by trained personnel

Inst. Del.= Institutional deliveries, as % of all deliveries

8.3= % of infants cared for by trained personnel

9 = % of (currently married) women of child-bearing age using family planning

C = No. of countries in the interval

L = % of the Region's live births therein

5.4.3 Family planning for health

Global Indicator 9 refers to "Percentage of women of child-bearing age using family planning". However, data in the table refer only to "currently-married women". No data were available from 7 countries with 10% of live births in the EMR. In five others (with 49% of total live births) the rate was below 30%. The EMR weighted average is 33% (range 7-54%), a considerable increase from that of 18% (range 8-47%) in the 1991 report. Coverage may be limited in rural areas and urban fringes, or family planning (FP) may be the responsibility of another Ministry in weak coordination with the MOH. Strengthening of training, revision of the data collection system and expansion of services to rural areas are common remedial measures. Other activities include: use of mobile FP teams for rural areas and domiciliary visits for motivation (Morocco); introducing a community-based motivator and service provider in large villages (Pakistan); expansion of FP services to hospitals (Syrian Arab Republic); or provision of IUDs free in all health centres and coordination with NGOs (Bahrain).

General problems and actions

A variety of problems were encountered in providing MCH services. Insufficient numbers of trained staff, especially at the periphery, a lack of supervision, and a lack of transport facilities, especially for emergencies, were common factors. The drain of trained manpower to other countries; qualitative deficiency in training in certain fields, as in the control of diarrhoeal diseases; a lack of diagnostic and management equipment; a lack of motivation in following the infant's growth or the concept of safe motherhood; or changing practices, whereby breast-feeding is currently not a common practice among women in some countries are examples of other problems. The policy in other countries may also be to increase births.

Actions taken include: expansion of training of physicians and nurses (Egypt) and/or TBAs in particular (Sudan); promoting breast-feeding (Saudi Arabia); introducing a child-care quality assurance check-list (Bahrain); safe motherhood campaigns (Pakistan); consultants attending antenatal clinics to supervise and provide on-the-spot training for health centre staff (Qatar); a number of beds in every front-line hospital reserved for emergency obstetrical care (Pakistan); or a committee to investigate the cause of every maternal death (Oman).

5.5 Control of locally endemic diseases

There has been a drop in the incidence of many of the endemic diseases (Kuwait), or of specific diseases of national importance such as schistosomiasis (Egypt). Several factors have led to an increased incidence of some diseases, e.g., slow development of control measures in rural areas or low utilization rates of existing facilities; the prevailing emergency situation with TB becoming a more serious health problem than ever before; lack of chemicals for diagnosis and control, and

Table 12

Immunization coverage for infants and for women

Coverage		BCG		DPT3/OPV3		Measles		TT (Preg.W)	
%		C	L	C	L	C	L	C	L
No data		2	8	2	8	2	8	3	15
Less than 50%		4 ^a	2	0	0	1	7	9 ^b	41
50% - 79%		3	12	4	45	4	38	7	27
80% - 89%		2	35	4	22	10	29	3	17
90% or more		11	43	12	25	5	18	0	0
Total	Range	51 - 100%		51 - 99%		49 - 96%		12% - 87%	
E M R	Reg. average	88%		80%		78%		52%	
Trends	E2 (C)	86% (22)		81% (22)		75% (22)		48% (14)	
Regional	M2 (C)	67% (18)		65% (23)		61% (23)		20% (17)	
Average	E1 (C)	51% (16)		45% (20)		30% (20)		9% (16)	
Global Data	World total	77%		71%		66%		...	
	MDRs	80%		94%		93%		...	
	Developing C.	77%		69%		63%		...	
	(LDCs only)	56%		35%		40%		...	

Coverage		HBV3	
%		C	L
No data		1	1
Less than 50%		13 ^c	82
50% - 78%		2	11
80% - 89%		0	0
90% or more		6	6
Total	Range	15% - 96%	
E M R	Reg. average	...	
Trends	E2 (C)	...	
Regional	M2 (C)	...	
Average	E1 (C)	...	

C = No. of countries in the interval.
L = % of the Region's population therein.

TT Preg. W = Tetanus toxoid (2 doses) during pregnancy.

^a BCG is not included in national EPI

^b Includes 3 countries where TT2 is not included in national EPI

^c Includes 11 countries where HBV is not included in national EPI.

the appearance of new foci of urinary bilharziasis in agricultural areas; cyclic variations as for measles; or merely intensified and better notification of cases.

Actions taken have included strengthening (Pakistan), or overall revision, of the disease surveillance system (Oman); decentralizing implementation of control programmes; mobile teams and home visiting for out-reach areas (Morocco); improving the referral system; or rapid repatriation if the patient is a foreigner (Bahrain). Oman introduced a malaria eradication programme in the Sharqeya Region in 1991 and, following its success, is extending it to Batinah Region.

5.6 Immunization (Table 12)

Global Indicator 10 deals with the "Percentage of infants reaching their first birthday that have been fully immunized". For the proper management of the programme, analysis of data separately for each antigen would be needed. The weighted average for 1993 showed the highest coverage rate for BCG (88%), followed by DPT3/OPV3 (80%), then measles (78%). Twelve countries accounting for 25% of total live births in the EMR have reached 90% coverage with at least three doses of DPT/OPV. In addition, 5 out of the 20 countries reporting coverage and accounting for 18% of the Region's live births have achieved more than 90% coverage for measles immunization. Eleven of the 16 countries immunizing with BCG and accounting for 43% of the live births in the Region have already achieved more than 90% coverage. The vaccination coverage for the Palestinian population cared for by UNRWA has reached 95% for BCG, 94% for DPTS/OPV3 and 91% for measles. The EMR average for 1993 immunization coverage among children before their first birthday was slightly lower than that for 1992. It is worthwhile noting, however, that the average for all four immunizations was higher than the global average for developing countries. Four out of the five LDCs (with about 20% of total live births) had consistently the lowest coverage rates. Five countries (Bahrain, Islamic Republic of Iran, Oman, Saudi Arabia, United Arab Emirates) in addition to UNRWA have already achieved the regional target for infants (that is at least 95% by any antigen). Lately, immunization against hepatitis B has been introduced in some countries; only 10 countries (with about 33% of total live births) provided data, and the coverage rate with HBV3 was above 90% in six (overall range 15-96%). Other immunizations being added to the programme are against mumps and German measles (Bahrain, Cyprus, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates) and Haem. influenza B (Qatar).

As for Global Subindicator 8.4, "Percentage of women immunized with tetanus toxoid (TT) during pregnancy", the weighted average is 52%, range 12-87%. Coverage was below 50% in 9 countries with 41% of total live births (including countries where TT2 vaccination of pregnant women is not included in national EPI, e.g. Lebanon, Qatar and United Arab Emirates). No country achieved the Regional target for women's immunization, (viz., at least 95%). The reported coverage with TT for women of child-bearing

age in the EMR was 16% (range 4-86%), which is also lower than that reported in 1991.

From the countries' point of view some obstacles have been encountered. Donor support started to shrink and withdraw, e.g., USAID, CIDA, Rotary and UNICEF (Pakistan, Syrian Arab Republic). Other problems mentioned were: irregular supply of vaccines (Sudan); complacency due to success in achieving "universal coverage" in 1990 (Pakistan); the problem of public comprehension of the necessity of completing the series of vaccinations (Morocco), lack of syringes (Pakistan) and lack of transport (Sudan).

It may be useful here to look at the incidence (in 1993) of the EPI-target diseases (excluding Afghanistan and Somalia which did not send reports), to reflect the impact of the programme. The EMR is quickly approaching the target of "eradication of poliomyelitis by the year 2000". Thus, 11 countries and UNRWA-operation fields reported no cases (against a total of 9 in 1990), and the number of cases was less than ten in 3 more. The total number of reported cases, however, rose between 1990 and 1993 from 1497 to 2451 cases because of the sharp increase in cases reported from Pakistan (now accounting for 74% of the total). During the same period, the total number of reported cases of diphtheria dropped from 3763 to 405 (of which 59% were from Iraq) and 10 countries reported no cases; pertussis dropped from about 27,828 to 2089, measles from 51,390 to 50,347, tetanus all forms from about 10,154 to 4858 (38% of them from Pakistan and 46% from Egypt), and tuberculosis from about 235,422 to 33,929 (of which 66% from the Islamic Republic of Iran). The target for neonatal tetanus elimination is 1995. No cases were reported from 6 countries (and UNRWA); the number of reported cases dropped from 4907 to 3338, of which 88% were from Pakistan and Egypt (see Table 13).

Table 13

Number of reported cases of EPI diseases during 1990 and 1993*

Diseases	1990	1993
Polio	1 497	2 451
Diphtheria	3 763	405
Pertussis	27 828	2 089
Measles	51 390	50 347
Total tetanus	10 154	4 858
Neonatal tetanus	4 907	3 338
Tuberculosis ¹	235 422	33 929

* Source: The Expanded Programme of Immunization, EMRO.

¹This included all types of tuberculosis (all ages) for 1990 and only pulmonary tuberculosis, miliary tuberculosis and tuberculosis meningitis, tuberculosis among children (0-4 years) for 1993.

5.7 Treatment for common diseases and5.8 Primary health care coverage

Global Indicator 11 refers to coverage by local health services (i.e., treatment of common diseases and injuries), including availability of essential drugs within one hour's walk or travel. At the same time, Global Indicator 12 refers to coverage by PHC (with at least the 5 items: safe water and adequate sanitation, MCH, FP, immunization, and treatment of common diseases and injuries). Thus Indicator 12 is rather new in the sense that it is a separate indicator, while in previous reports "coverage with PHC", the overall title included the individual components. This is why countries have interpreted the two indicators differently: sometimes as synonymous, offering one set of data, and sometimes simply repeating the five figures in answering item 5.8; a minority gave two figures. Table 14 summarizes the data provided.

Table 14. Population coverage: local health services/PHC

Coverage		Total		Urban		Rural	
%		C	P	C	P	C	P
Less than 50%		3	9	0	0	4	25
50% - 79%		3	15	2	3	5	52
80% - 89%		2	45	0	0	2	3
90% or more		14	31	20	97	11	20
Total	Range	27%-100%		65%-100%		35%-100%	
E M R	Reg. average	82%		97%		73%	
Trends	E2 (C)	82% (23)		97% (20)		72% (20)	
Regional	M2 (C)	79% (22)		96% (18)		64% (17)	
Average	E1 (C)	73% (21)		94% (14)		62% (14)	
Global (E2) Data	World total	90%		...		...	
	MDRs	100%		...		...	
	Developing C.	89%		...		...	
	(LDCs only)	70%		...		...	

C = No. of countries in the interval.

P = % of the Region's population therein.

The EMR weighted average is 82% (range 27-100%). It reached 90% or more in 14 countries containing 31% of the total population and is higher for the urban than for the rural population due to wide distribution of the latter over sparsely populated areas. The EMR weighted averages were 97% (range 65-100%) for urban, and 73% (range 35-100%) for the rural areas. While 20 countries containing 97% of the urban population have reached a coverage of 90% or more, the comparable figures were only 11 countries containing 20% of the rural population. The figures were almost the same as in the 1991 report. The global average is 90%.

6. TRENDS IN HEALTHY LIFESTYLES AND ENVIRONMENT

Among the changes needed to achieve HFA/2000, healthy lifestyles and healthy environment are two aspects requiring efforts in many sectors of society as well as by the individual, the family and the community.

6.1 Promotion of healthy lifestyles

A person's particular way of life is shaped by the values, priorities and practical opportunities within specific cultural, social and economic situations. Reference has been made (5.2) to changes in food habits, such as increased consumption of food, the tendency to "quick meals" and reduced consumption of fruits and vegetables. These are harmful lifestyles, particularly if accompanied by a sedentary life, smoking and alcohol consumption. The role of liberal sexual behaviour in the spread of AIDS and the harmful effects of female circumcision are of growing concern.

Two other problem areas are tobacco consumption and the abuse of psychoactive substances. Member States are taking various remedial measures, such as intensifying health education, using mass media and occasions of "special days" and keeping in mind the training of required manpower. Anti-smoking clinics have been successful in encouraging about 10% of heavy smokers to quit smoking (Saudi Arabia). Health establishments have been declared smoking-free zones (Egypt), even the compound of the MOH itself, with some other ministries following this example (Oman). Campaigns, increased taxation, regulations dealing with tobacco and/or drug production, advertising, sales and use (Bahrain, Cyprus, Kuwait, Qatar and Saudi Arabia), and promoting sports for youth (Bahrain, Pakistan) are other measures. Control of psychotropic drugs is often undertaken partly by the Ministries of Health through their psychiatric units; often other ministries (Ministry of Interior) and NGOs are also involved. Certain harmful lifestyles, such as the use of khat, have been found resistant to change (Djibouti, Yemen). Lack of sufficient data and the need for epidemiological and socioeconomic surveys is another problem (Tunisia). Intersectoral collaboration is often encouraged (Jordan).

6.2 Protection of a healthy environment

The link between environmental hazards and health is of growing concern; a healthy physical environment promotes health. Various sources and conditions cause environmental hazards, so action plans should be both

multisectoral in nature, and should encourage participation of the community (Cyprus). Countries noted that the Ministry of Health should collaborate with the municipalities in water supply and sanitation, the Ministry of Agriculture in use of pesticides, and the industrial sector in management of industrial waste (Egypt) or in the selection of places for development of industries (Qatar). The primary responsibility for coordination may rest with the MOH (Pakistan), a separate Ministry of Environment (Syrian Arab Republic), or with a special "board/council" (Kuwait); here the role of the MOH should be defined. The environmental health sections/divisions in the MOHs need strengthening in order to be able to provide adequate input for promotion and the creation of a supporting environment for health.

Legislation is essential, to define the roles of various bodies involved, for the control of sources of pollution (Bahrain), or to lay down strict specifications related to procedures or the use of substances (Jordan, Saudi Arabia). Introducing advanced methods for the analysis or detection of pollution is also important (Egypt). Oman gave attention to the development of a computerized information system for water, sanitation and food hygiene programmes, to serve in "environmental epidemiology". The appropriate involvement of existing national service, academic or research institutions would be very fruitful (Tunisia). Common related problems included lack of trained staff, inadequate laboratory facilities, reference documents or legislation; inadequate local framework or weak industrial set-up; and above all, limited resources.

7. THE PALESTINIAN POPULATION

The signature of the Declaration of Principles on 13 September 1993 heralds a new era for the Palestinians. It guides their negotiations for a self-government period in the West Bank and Gaza Strip. This will have great implications for the development of health services.

UNRWA cares for approximately 2.9 million registered refugees (as of end 1993), in five "operation fields": West Bank, Gaza Strip, Jordan, Lebanon and Syrian Arab Republic. About 35-40% of them live in camps and the rest live in towns and villages; the urban population constitutes 30-50% of the total. The birth rate is high (35-55/1000), the crude death rate is low (7.4/1000), hence the population growth rate is high (2.9-4.9%). So the population is young; about 50% are below 15 years of age, and women of child-bearing age form another 22%, with an average family size of 6 persons. The per capita income in the Gaza Strip is \$780, and nearly double that (\$1400) in the West Bank; the unemployment rate is very high (25-40%, and may reach 100% when curfew is imposed). The adult literacy rate is about 60%.

The IMR and U5MR are estimated at 41 and 51/1000 live births, respectively, being lower in the camps due to easy access to PHC services provided by UNRWA, but are as high as 48 and 62/1000, respectively, in the villages. The main causes of mortality among infants and children are perinatal problems (26%), respiratory infections (23%), congenital

conditions (15%) and diarrhoeal diseases (13%). The state of violence, unrest and economic hardship prevailing during 1993 affected the overall health situation. Up to the end of September 1993, those killed during the intifada reached 1255 persons, of which 26% were children; 85% of the total were shot.

Respiratory infections are the leading cause of morbidity. During 1993, there were no reported cases of diphtheria, pertussis, neonatal tetanus (none for the last 5 years), malaria, cholera, schistosomiasis or leprosy. One case of acute flaccid paralysis and two cases of polio were reported from the Jordan field; and as regards HIV/AIDS one case was reported from the Jordan field and two from the Lebanon field. Several limited-scale outbreaks of measles were notified in the Jordanian, Lebanese and Syrian fields. The number of reported TB cases has remained relatively constant for the past six years. Cases of influenza, dysentery, hepatitis, zoonoses and tuberculosis need attention. Brucellosis continued to be endemic in the five fields, mainly in the West Bank. Leishmaniasis continued to be reported in the Syrian field, and limited outbreaks of meningococcal meningitis were reported from the west bank. Diabetes, CVDs and cancer cases are increasing. There is increasing suffering from psychotic disturbances and mental disorders. About 17 000 casualties occurred during 1991-93, and 8-9% of all injuries during the intifada lead to permanent disability. A survey of the camps in the Gaza Strip showed that 67% of pregnant women suffered from anaemia in their last months of pregnancy. Some 2.2% of children were underweight during their second year of age.

In the West Bank and Gaza Strip, there are 487 governmental and nongovernmental centres for health care, 23 hospitals, and 1.3 hospital beds per 1000 population. In addition, there are 39 governmental and UNRWA laboratories and 28 dental clinics; all 60 rehabilitation centres are nongovernmental. There is no national drug policy. There are about 2350 physicians, 600 dentists, 650 pharmacists, 2000 nurses and 380 technicians. There is a shortage of nursing/midwifery and auxiliary personnel as well as a shortage of specialists. Health sector operating expenditures amount to \$141 million (excluding private expenditures on drugs), and another \$10 million capital expenditure. Out of the current expenditures, 48% go for hospitals, 35% for PHC and 6.6% for dental services.

According to UNRWA data, first visits for ambulatory general medical care reached 345/1000 population, with an average of 3.2 repeated visits per patient. About 6500 cases of diabetes were registered during 1993, and the cumulative number of registered cases, as of end 1993, reached about 26 000 cases. There were 12 general hospital admissions per 1000 population, with an average bed stay of 4.0 days, and a bed-occupancy rate of 95%. The corresponding figures for UNRWA maternity units were 2.7 per 1000 population, 1.9 days bed stay and a 65% bed-occupancy rate.

About 70 000 pregnant women received antenatal supervision; about 69% of the reported deliveries were in hospitals or camp maternities, in addition to another 16% at private clinics. There were 26 000 family planning (FP) acceptors attending 90 FP clinics; IUD devices were the most

common form (58%) followed by contraceptive pills (27%). About 76 000 infants received care during their first year of life, and 73% of them were regular attendants. Vaccination coverage for infants was 94% for DPT/polio, 96% for BCG and 91% for measles; 38% of pregnant women under supervision were immunized with TT. The proportion of shelters served by indoor water connections was 93%, and 57% were connected to the sewerage systems while 97% of the camps were served with regular refuse disposal arrangements.

8. SUMMARY AND RECOMMENDATIONS

The present monitoring report demonstrates, in general, good progress in implementation of HFA strategies, as shown by the trends in the different indicators given in Figure 1. Yet, certain implementation aspects still show slow progress or even suffer a setback, as a result of known circumstances coupled with a rapid increase in population. Below is a summary of the current situation and trends at the Regional level.

(A) Demographic and socioeconomic trends

1. The crude death rate and the crude birth rate both went down, but the rate of natural increase went up.
2. The adult literacy rate and the per capita GNP (at current prices) both showed a limited increase, against a remarkable increase in the unemployment rate.

(B) Health status

1. The under-5 mortality rate showed a reasonable drop, but both the infant mortality rate and the maternal mortality rate increased.
2. There was a limited increase in life expectancy.
3. Levels of adequate nutritional status of children dropped.
4. Acute respiratory infections and diarrhoeal diseases continue to be prominent causes of mortality. While the incidence of many infectious and parasitic diseases is decreasing, CVDs, neoplasms and accidents (especially traffic accidents) are increasing as causes of death.
5. Large outbreaks of cholera took place in a few countries.

(C) Resources for health

1. Relatively speaking, financial allocations for health, even allocations devoted to local health care, are diminishing despite inflation and the rising cost of health services.
2. The availability of human resources is improving in quantity and in quality, but the relative imbalance between physicians and nursing personnel and imbalances of within-country distribution persist.
3. The availability of facilities for PHC improved, but not for hospitalization.
4. International support for health system development is diminishing.

(D) Development of health systems based on PHC

1. HFA continues to receive endorsement as policy at the highest level.
2. Countries update their policies/strategies to achieve HFA goals. More attention is being given to expansion to underserved areas, regional (subnational) planning, health financing and cost containment, management and information systems, decentralized administration, the district health system, improving the quality of PHC, and instituting a proper referral system.
3. There is wide scope for improvement in the areas of intersectoral collaboration, community involvement, and the role of NGOs.
4. There is a growing interest in the role of health system research.

(E) Implementation of PHC

1. There is a growing dependence on imported food items. Unfavourable factors such as bad food habits, a tendency to "quick meals" and a sedentary lifestyle, etc., are growing.
2. Population coverage with safe drinking water facilities and adequate sanitation has increased, more so for the latter in rural areas.
3. Except for the use of contraceptives, the various indicators of coverage with MCH services exhibit a setback, probably one factor in the aforementioned increases in infant and maternal mortality rates.
4. Immunization coverage for infants shows progress in all antigens; that for pregnant women with tetanus toxoid showed minor change, but that for women of child-bearing age has increased.

RECOMMENDATIONS

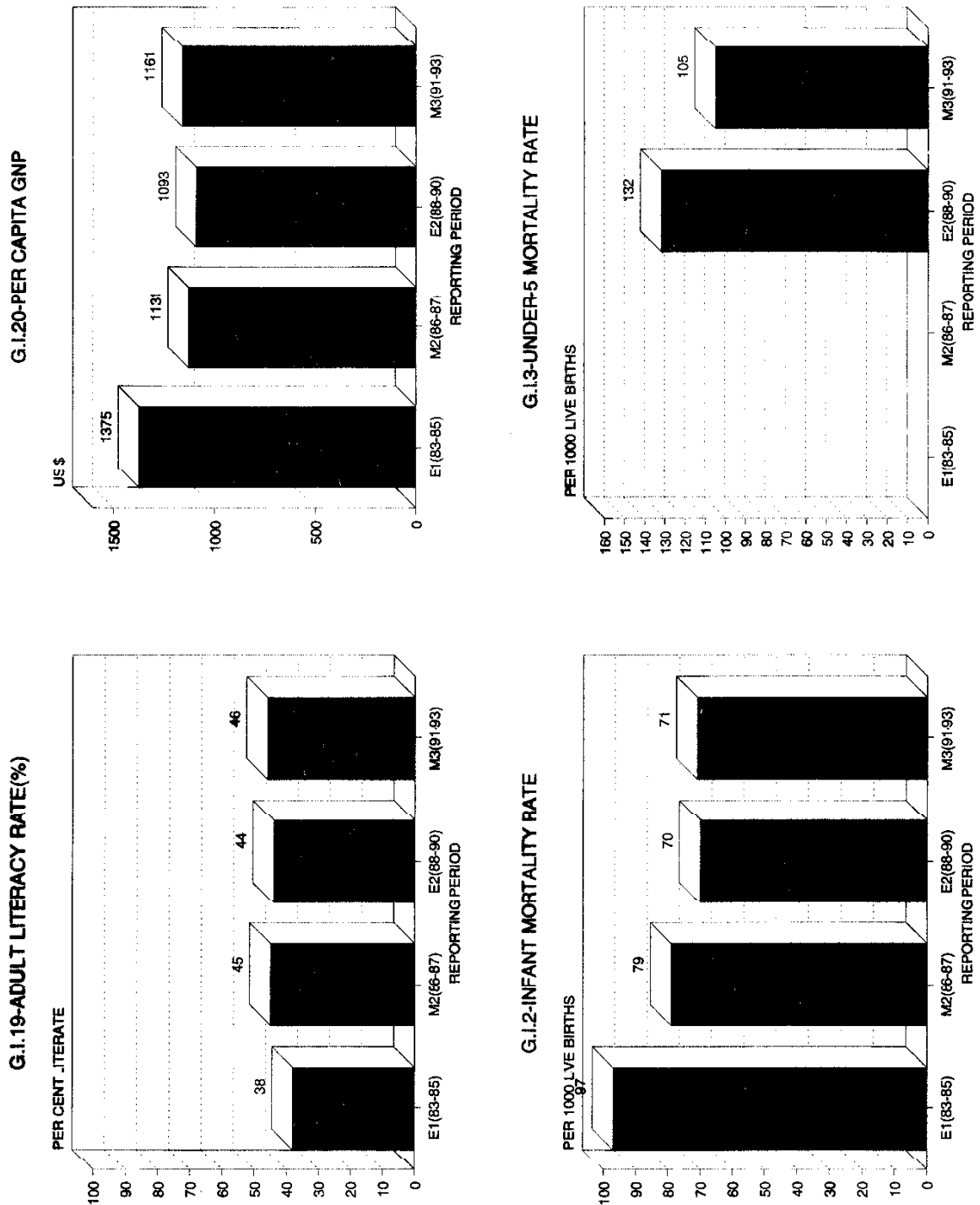
The main recommendations are as follows:

1. Member States should allocate, from public resources, more financial input to health services at least to cover inflation and the rising cost of drugs, equipment and services, if not to expand or improve the quality of service, realizing that the improved health of the population is an investment towards socioeconomic development.
2. Member States should continue seeking international support for health system development, from international, multilateral and bilateral sources, by submitting well-prepared proposals, in areas that will have a multiplier effect, for priority health programmes, but not to replace national responsibilities to meet current expenses. Adequate coordination of international support, and a "master plan" identifying the areas where that support would be needed, are crucial.
3. However, with the prevailing trend of reduction in international support, Member States should not neglect efforts to secure additional national funds:
 - (a) directly, if possible, through the introduction of cost-sharing by the recipient of curative services, or through the promotion of community participation; or,

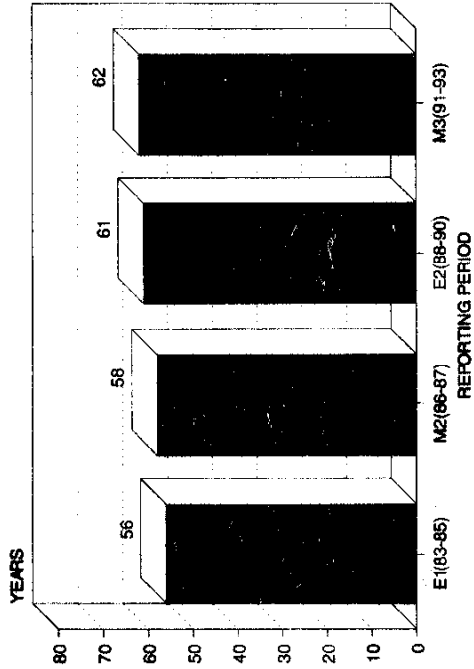
- (b) indirectly, through rationalizing the provision of services, taking cost-containment measures, and providing a greater role for NGOs.
4. It is essential to optimize the utilization of whatever resources (national and international) are available, and all ways to achieve this should be investigated by:
- (a) better planning, identifying and, if necessary, concentrating on priority programmes rather than thinning out resources.
 - (b) better organization of the health system based on PHC, through review, revision and distribution of roles, responsibilities and functions of various health facilities and personnel, at the different levels of the health system, and strengthening the district health system.
 - (c) better management, by establishing adequate national health information systems, making better use of available information, decentralizing administration while raising the managerial capabilities of senior and mid-level managers, and carrying out health system research to solve operational problems of the health services.
 - (d) better implementation, by increasing the knowledge and skills of health workers, by continuous supervision, feedback of information, and strengthening the collaboration and coordination between various levels of the health system, as well as between the health sector and other health-related sectors, rationalizing the provision of health services in terms of equity and quality, and tackling wastage and defective management in these services.
5. To avoid any further setback in implementation of the HFA strategy, the programme areas that should receive top priority, are MCH services and immunization. The nightmare of the resurgence of malaria following premature reduction of national contributions should always be considered.
6. Member States, and WHO, should utilize the findings in this third Regional report on monitoring progress (the last monitoring report until the year 2000), as a guide for joint Government/WHO programme-budgeting and action for health development.
7. The role of WHO collaboration in implementing HFA strategy, in providing technical support even outside the collaborative programmes, in preparing proposals for and in securing international support, in coordinating such support, and in continuous and/or periodic monitoring and evaluation of HFA strategy, should be fully recognized.

Figure 1

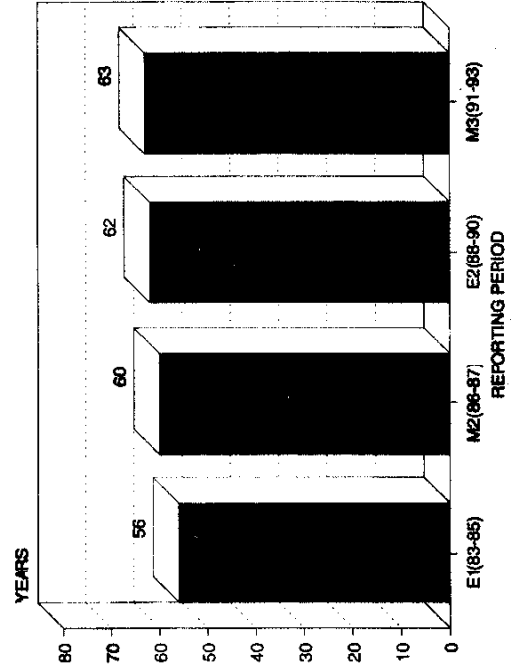
Regional average trends for some selected HPA indicators



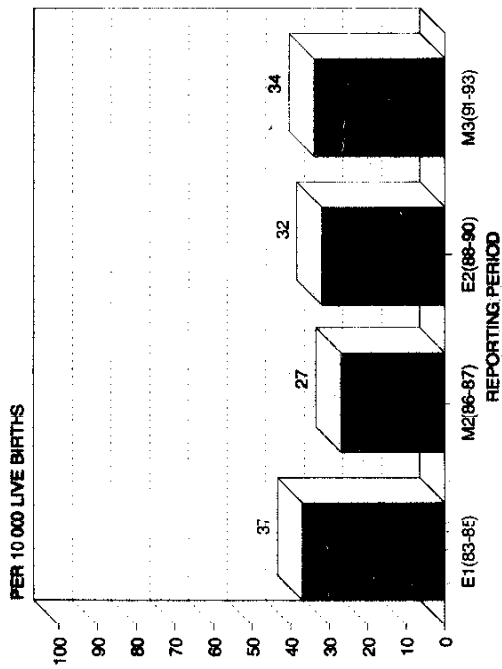
LIFE EXPECTANCY AT BIRTH
(MALES)



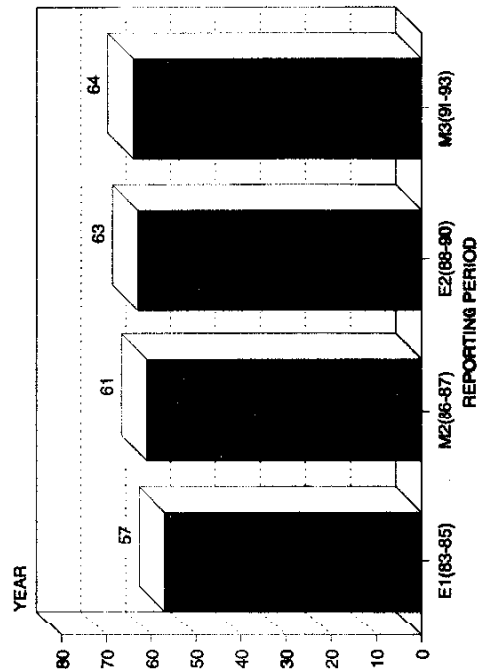
G.I.1-LIFE EXPECTANCY AT BIRTH



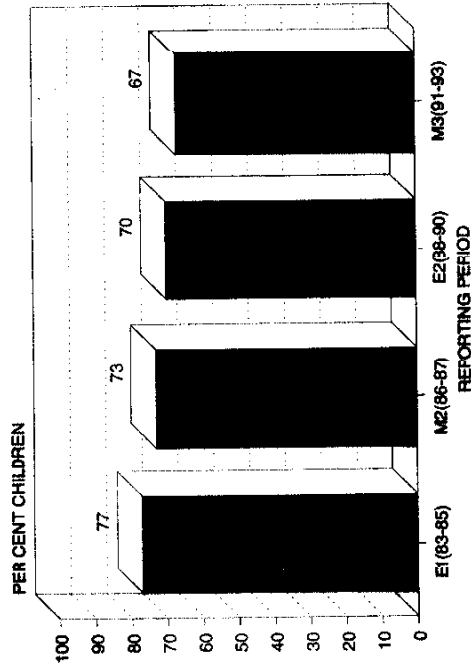
G.I.4-MATERNAL MORTALITY RATE



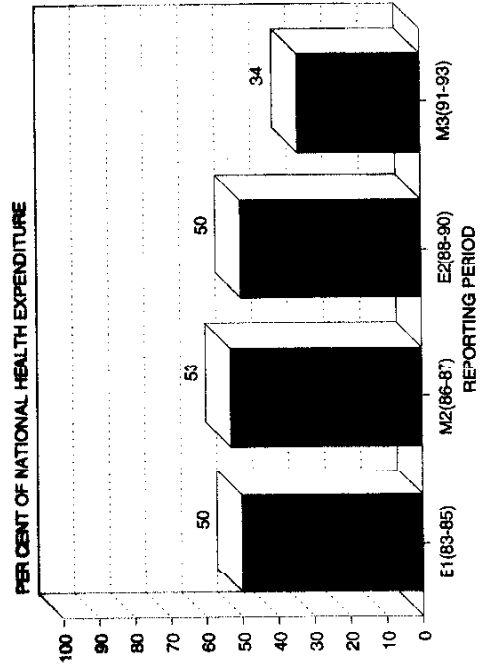
LIFE EXPECTANCY AT BIRTH
(FEMALES)



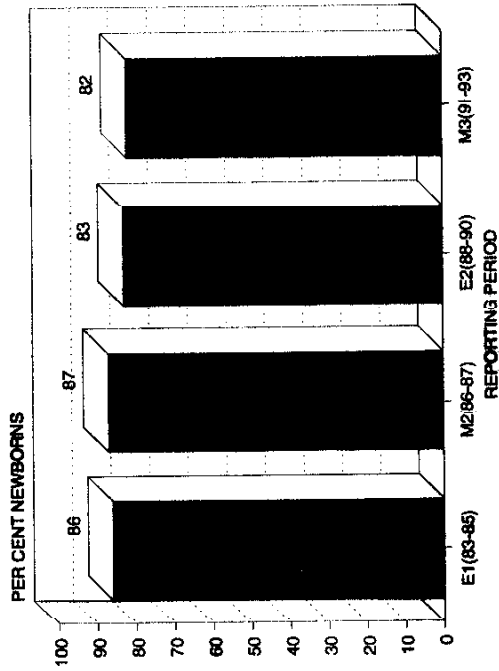
G.I.6-CHILDREN WITH ACCEPTABLE
WEIGHT-FOR-AGE



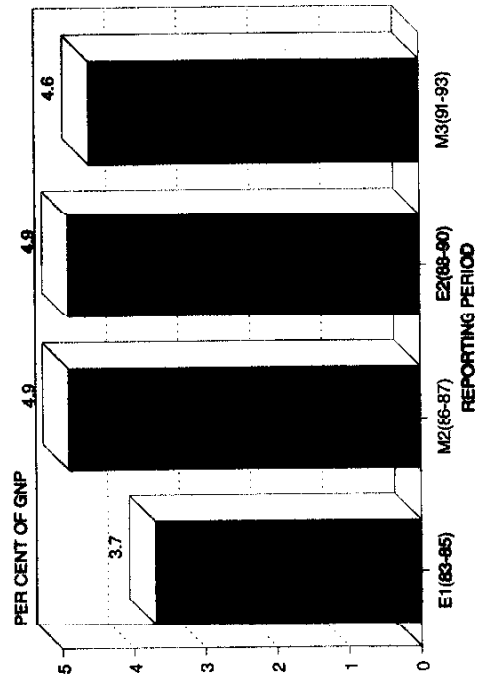
G.I.17-% OF NATIONAL HEALTH EXPENDITURE
DEVOTED TO LOCAL HEALTH SERVICES



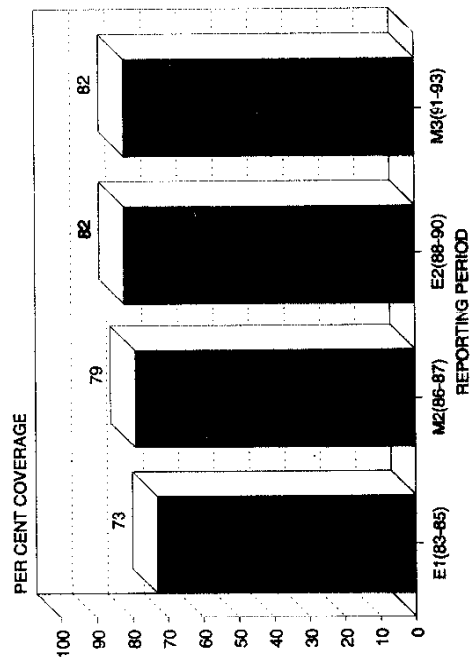
G.I.5-NEWBORNS WEIGHING AT LEAST 2500 G



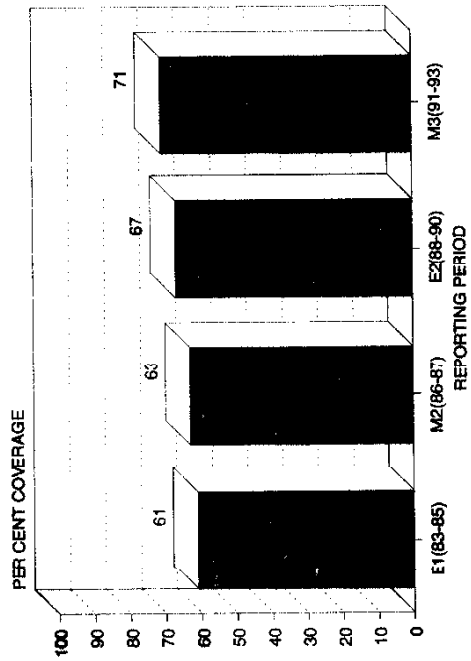
G.I.16-NATIONAL HEALTH EXPENDITURE AS
% OF GNP



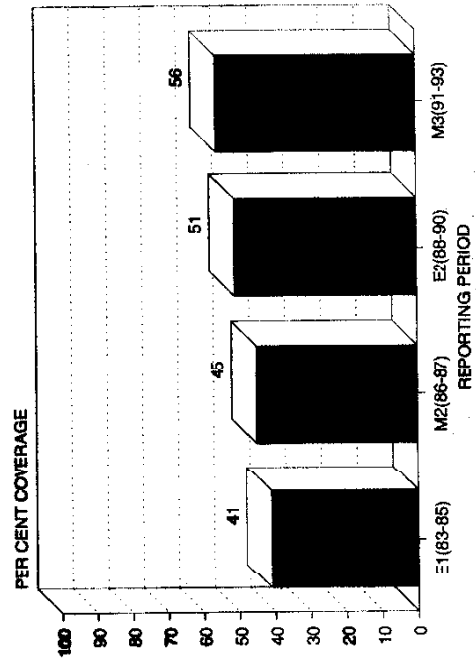
G.I.12-POPULATION COVERED WITH LOCAL
HEALTH SERVICES



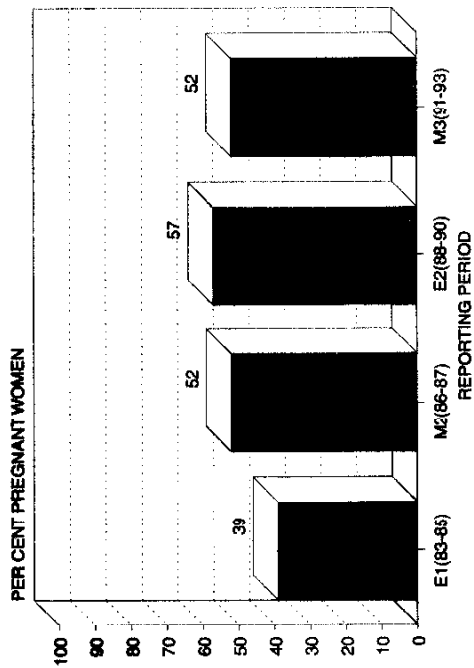
G.I.7.1-COVERAGE WITH SAFE DRINKING
WATER



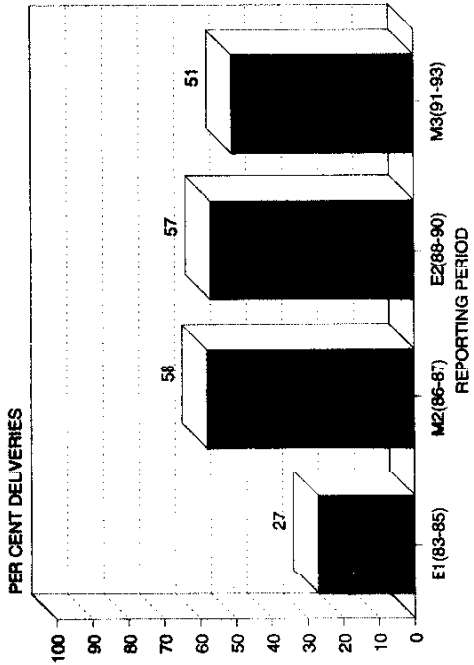
G.I.7.2-COVERAGE WITH ADEQUATE
SANITATION



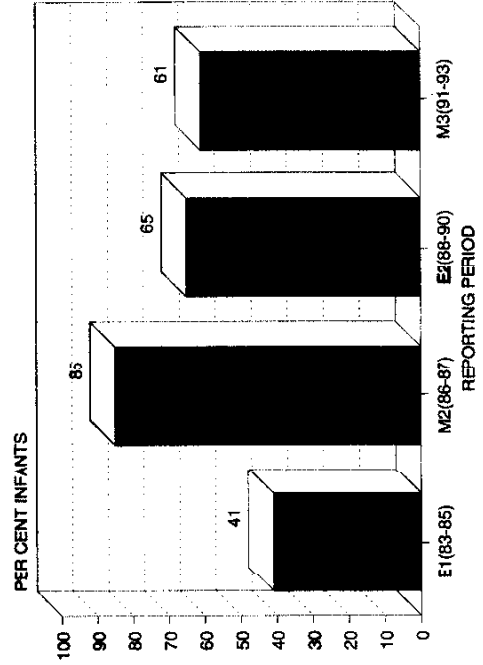
G.I.8.1-PREGNANT WOMEN ATTENDED
BY TRAINED PERSONNEL



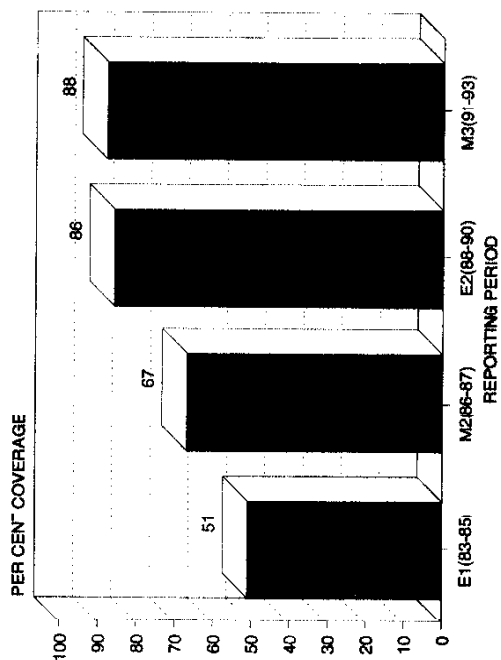
G.I.8.2-DELIVERIES ATTENDED
BY TRAINED PERSONNEL



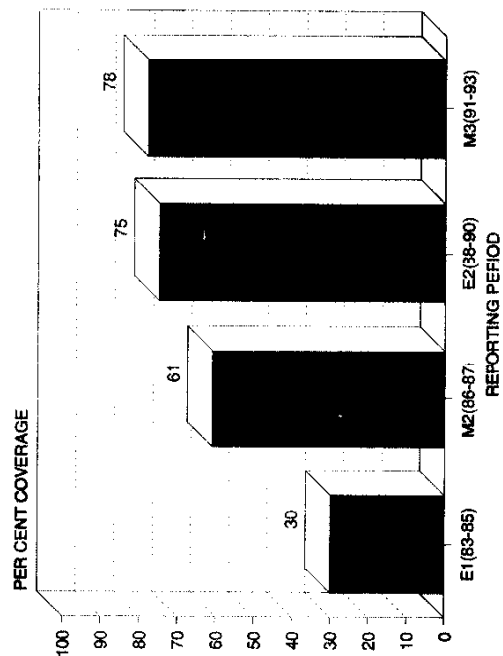
G.I.8.3-INFANTS CARED FOR
BY TRAINED PERSONNEL



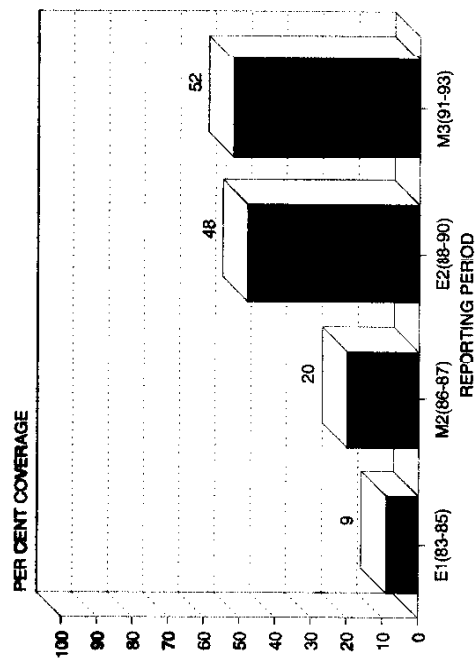
G.I.10.4-BCG IMMUNIZATION COVERAGE



G.I.10.3-MEASLES IMMUNIZATION COVERAGE



G.I.8.4-PREGNANT WOMEN IMMUNIZED
WITH TT2



Forty-first Session

Agenda item 10

**THIRD REPORT ON MONITORING PROGRESS IN THE
IMPLEMENTATION OF HEALTH FOR ALL STRATEGIES**

Summary of Recommendations

1. Member States should allocate, from public resources, more financial input to the health services, at least to cover inflation and the rising costs of drugs, equipment and services, if not to expand or improve the quality of services.
2. Member States should seek, as much as possible, to secure additional national funds, either directly, through the introduction of cost-sharing by the recipients of curative services, or through the promotion of community participation; or, indirectly, through cost-containment measures, and providing a greater role for NGOs.
3. Member States should continue seeking international support for health systems development, by submitting well-prepared proposals, in areas that will have a multiplier effect, for priority health programmes, but not to replace national responsibilities to meet current expenses. Adequate coordination of international support should be realized.
4. Optimal use of available resources should be made through:
 - (a) better planning, identifying and, if necessary, concentrating on priority programmes, rather than thinning out resources;
 - (b) better organization of the health system based on PHC, through the more explicit definition of roles, responsibilities and functions of various health facilities and personnel, at the different levels of the health system, and the strengthening of the district health system;

- (c) better management, by establishing adequate national health information systems, making better use of available information, decentralizing administration, while increasing the managerial capabilities of senior, and mid-level, managers, and carrying out relevant health systems research;
 - (d) better implementation, by increasing the knowledge and skills of health workers, by continuous supervision, feedback of information, and strengthening the collaboration and coordination between various levels of the health system, as well as between the health sector and other health-related sectors, rationalizing the provision of health services in terms of quantity and quality, and tackling wastage and defective management in these services.
5. To avoid any further setback in the implementation of HFA strategies, high priority should be given to MCH programmes. The nightmare of resurgence of malaria following premature reduction of national or international contributions should also always be considered.
6. Member States, and WHO, should utilize the findings in this third regional report on monitoring progress (the last monitoring report until the year 2000) as a guide for joint government/WHO programme budgeting and action for health development, to ensure the achievement of HFA goals.
7. The role of WHO collaboration in implementing HFA strategies--in providing technical support, even outside the collaborative programmes, in preparing proposals for and in securing international support, in coordinating such support, and in continuous and/or periodic monitoring and evaluation of HFA strategies--should be fully recognized and utilized.

Forty-first Session

Agenda item 10

THIRD REPORT ON MONITORING OF PROGRESS IN
THE IMPLEMENTATION OF HEALTH FOR ALL STRATEGIES

Summary for the Report

Despite favourable political developments regarding the restoration of peace in Lebanon and the Israeli-Palestinian agreement, civil strife and wars in Afghanistan and Somalia have caused great loss in human lives, injuries, displacement of populations and the disruption of health delivery systems.

Even if the GNP per capita has increased slightly as compared to the findings of the second evaluation exercise (1990), the difficult economic conditions caused by inflation and deterioration in terms of trade, are putting serious strains on resources devoted to health at a time of increasing demands and expectations. As a result, the limited available data has showed a downward trend in per capita health expenditure in both nominal and real terms. Most governments are giving a low profile to health in their investment budgets. Allocation of resources within Ministry of Health budgets does not always benefit primary health care services.

The problems of availability of human resources for health vary between and within countries and between categories of health personnel. It seems, however, that health services are expanding faster than the increasing numbers of trained nationals. Physical accessibility to health services is improving, although it remains unbalanced within countries in favour of urban areas. In some countries incentives are provided to improve equitable access to health care.

Population growth is still high due to a high level of fertility and a continuing decrease in mortality rates. The regional population is young, with 44% below the age of 15, although some countries are slowly going through a demographic transition. The demographic structure puts more pressure on the health system due to specified health needs (i.e.,

MCH services). The growth of the population which exceeds that of the economy has led to an increase in unemployment and particularly in under-employment, with a negative impact on health status.

Health is considered a human right and a social goal. HFA continues to receive endorsement at the highest level and many countries have updated their policies and strategies in line with HFA goals.

Member States are paying great attention to the development of health systems based on primary health care, with expansion of services to rural and remote areas, decentralization through well-functioning district health systems, proper referral systems and improvement of the managerial process for national health development.

Innovative approaches to intersectoral collaboration and community participation and empowerment are being initiated in many countries, using the Basic Minimum Needs approach and other means. As a consequence, access to safe water and appropriate sanitation is increasing, although coverage of the rural population by adequate sanitation still needs more improvement.

The development of health systems based on primary health care has led to improvement in many areas marked by indicators despite downward trends in coverage by some health services. Figures used in previous reports were either guess-estimates or drawn from limited studies. However, MCH services, including prenatal and postnatal care, assisted deliveries and immunization programmes need more support.

As the impact of health services on "complete physical, mental and social well being" is difficult to measure, negative measures of mortality and morbidity are used as proxy indicators.

Infant mortality is decreasing even though some countries are still far from the regional target. The number of countries which have already

reached their regional target has doubled between 1985 and 1993. The slight increase from the second evaluation report is due to higher revised estimates from some countries and to a sharp increase in infant mortality in Iraq as a consequence of the embargo, as well as the conflict situation in some less developed countries in the Region.

The maternal mortality rate has changed slightly since the first evaluation in 1984. Figures related to maternal mortality are likely underestimated, based on limited hospital data or on defective vital registration. Meanwhile, the majority of the women who die live in poor areas, are poorly educate if at all, and have had repeated pregnancies at short intervals.

Reliable data related to the causes of mortality are scarce and are often limited to hospital deaths, thus limiting international comparisons. Acute respiratory infections and diarrhoeal diseases are still prominent causes of mortality. Deaths resulting from EPI target diseases (except tuberculosis) are decreasing while deaths due to cardiovascular diseases, accidents (particularly road traffic accidents), neoplasms and other respiratory and urogenital diseases are on the increase. This situation has emphasized the epidemiologic transition witnessed in many countries of the Region.

Trends in morbidity are rather difficult to assess for the sake of international comparisons. Data in national reports were quite heterogeneous and based on outpatient and inpatient medical records. However, malaria is still a source of great concern as well as the resurgence of tuberculosis, cholera and AIDS.