FOLLOW-UP OF THE REGIONAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000
Member States of the Eastern Mediterranean Region have shown their determination, over and above variations in ideologies and beliefs, to work together towards national, regional and global health development in a practical way and in unity.

In conformity with the resolution of the Twenty-ninth Regional Committee (EM/RC29A/R.7) they have elaborated their national strategies for the social goal of Health for All by the Year 2000 (HFA/2000) and have thus taken a decisive step towards its achievement.

The national strategies, formulated after an intensive dialogue with representatives of Member Countries at three sub-regional meetings on HFA/2000 in Mogadishu, Damascus and Kuwait in early 1980, constitute the basis for EMRO's regional strategy (Annex I).

The analysis of the national strategy statements has reaffirmed the commitment of all Member States to the Declaration of Alma Ata, their willingness to strengthen regional solidarity through technical cooperation among developing countries, and their adherence to resolution 34/58/1979 of the UN General Assembly, which gives health its rightful place as an integral part of development.

The diversity of political, demographic, social and economic situations among the Member States of this Region has called for a broad and flexible formulation of EMRO's Regional Strategy for HFA/2000 to encompass the widely differing needs and to permit further refinement of the national strategies.

As health development is a dynamic process, the regional strategy will certainly have to be readjusted periodically and should not be considered, to quote Dr H. Mahler, Director-General of WHO, "as a straightjacket to be lived in for twenty years".

The success of the regional strategy formulated to carry out the "social contract for Health for All by the Year 2000" in which Governments, the people and WHO are the three partners, will clearly depend on the extent to which the primary health care concept will be translated into action in the countries.

In spite of the complex situation in the Region during the period under review, considerable progress has been made towards achieving the targets of the primary health care Medium-term Programme for 1978/1983, enumerated in the
Regional Director's Biennial Report to the 29th Session of the Regional Committee. This is evidenced by:

- The overwhelming participation of Member States in the three sub-regional meetings on HFA/2000 (Mogadishu, Damascus and Kuwait in early 1980), and the subsequent formulation of the national strategies for HFA/2000.

- The increasing number of countries that have incorporated or are in the process of introducing primary health care programmes as an inherent component of their health development plans. Many of them have requested WHO cooperation in primary health care programme formulation, implementation and/or evaluation, for example Libya, Oman, Pakistan, Somalia, Sudan and the Yemen Arab Republic.

- The important contribution of countries of the Region to inter-regional or regional studies or meetings concerning crucial issues of health system's support to primary health care, which have led to concrete recommendations or guidelines for use by Member States within or outside the Region: Sudan has participated in the inter-regional workshop on Cost and Financing Patterns of Primary Health Care (Geneva, 1-5 December 1980); Democratic Yemen took part in the joint WHO/UNICEF Study on Country Decision-Making for Primary Health Care (JC23/UNICEF/WHO81.3). Iran and Sudan contributed to the inter-regional study on "The Community Health Worker" (Report on a UNICEF/WHO inter-regional study, PHC/80.2); Delegates of six EMR countries (Bahrain, Democratic Yemen, Lebanon, Saudi Arabia, Syria and Yemen Arab Republic) attended a working group meeting in January 1981, organized by UNICEF with WHO collaboration, to review the current status of the PHC programmes in some countries of the Region and to identify the fundamental elements for converting the Alma Ata commitment into action. The recommendations of the meeting were found to be useful by the Technical Secretariat of the Council of Arab Ministers of Health.

The active participation of delegates from countries of the Region to the technical discussions at the 34th World Health Assembly is another testimony to the efforts deployed and experience acquired by Member States in the pursuit of the social goal of HFA/2000, e.g. developing health systems based on
PHC principles. Only some of the crucial issues in developing such health systems can be highlighted in this review.

Administrative and other reforms

The need for decentralization of political, administrative and planning authority has been recognized in some countries such as Democratic Yemen and Sudan, and social and economic reforms are gradually taking place in order to ensure a more equitable distribution of resources and to support health development activities at community level. To this end considerable political and technical effort is required by Member States. To reinforce this effort a variety of possible approaches are incorporated in EMRO's Regional Strategy. In addition to meetings and workshops on policy, strategy and programme formulation, as mentioned above, they include:

- Dissemination of information on country experiences in the implementation of primary health care programmes.
- The use of mass media to ensure public support.
- The introduction and adoption of managerial processes for health development which associate the population in the planning, implementation and evaluation of primary health care programmes. In this connection it is worth mentioning that in the spirit of regional self-reliance a core of national resource persons from the Region has already been trained with WHO support and can be utilized by Member States for the organization of workshops on country health programming and related managerial processes.

Intersectoral cooperation

The social significance of primary health care, which never emerged from the conventional health services, calls for intersectoral cooperation. Many countries have already established coordinating mechanisms, such as the National Health Development Councils and the Local Health Committees. They will certainly be instrumental in ensuring contributions from other sectors, for instance education, agriculture and public works, which have no doubt a great impact on people's health. Intersectoral collaboration will be promoted by WHO through advisory services on the nature, composition and functions of these mechanisms, and on the formulation of appropriate supportive legislation. Major efforts
will be made to ensure linkage with plans of other sectors which have a bearing on health, for example plans elaborated within the framework of the International Drinking Water Supply and Sanitation Decade. The Regional Health Development Advisory Council, composed of senior national officials of different disciplines could play an important role in promoting the multisectoral approach by establishing close liaison with the National Health Development Councils.

Motivation of the population through health education and information of the public

Finding ways and means to motivate the population to take an active part in its own health development is of extreme importance for effective implementation of primary health care programmes in many countries. The main constraints relate to:

- The political nature of the subject.
- The lack of adequate understanding of the process of community mobilization and the weaknesses of the supportive infrastructure.

The regional strategy, therefore, includes wide dissemination of national experience with community participation; the development of health education methods and materials; contribution to planning and evaluation of integrated health education programmes; support to sociological research as part of action-oriented programmes; promoting integration of health education into the general formal and informal education programmes. To further these ends, a Regional Advisory Panel on Health Education has been set up. The Eastern Mediterranean Region, with its majority of Arabic-speaking countries and the boom in radio and television, constitutes an ideal audience for new health education materials which could be developed in selected institutions for regional distribution.

During the period under review, WHO has collaborated with several countries to strengthen their health education programmes (e.g. Iraq, Lebanon, Libya, Pakistan, Saudi Arabia and Yemen Arab Republic). A regional meeting to exchange experiences and establish research priorities in the still largely unexplored field of community involvement in its own health development is envisaged for 1982.

Organizing the health services infrastructure

The reorganization and strengthening of health infrastructures are required in most countries so that well-defined programmes of the main components of
primary health care can be integrated and cover progressively the entire population. This implies that:

1. The training programmes of health personnel will have to be reoriented towards meeting community needs and suitable training programmes will have to be developed for primary health workers and their teachers. Emphasis is given to increasing the managerial and communication skills of various categories of health personnel and to instilling a sense of social responsibility in all health workers. Thus the health services and manpower development approach, which received impetus following a Ministerial Consultation in Teheran (1978) will have to be further promoted.

2. The production and dissemination of relevant learning materials, including Arabic translations already in process, will continue to be a supportive measure to all training programmes of the health team.

3. Effective referral, supervision and logistic support systems have to be established.

4. Health services research is needed to determine the levels of the health systems at which integration can take place, as well as the methods of integration of priority programmes into the health infrastructure.

National health development networks

The identification of national institutions and human resources that could be linked in a health development network as a supportive mechanism to primary health care is under way in several countries, for instance in Pakistan and the Sudan. WHO will collaborate with Member States upon their request and provide the necessary support in order to strengthen such mechanisms, so as to become effective tools for the promotion of intersectoral cooperation, planning, management, research, training and continuous education. Collaboration has been initiated in this respect with Pakistan and Sudan.

Mobilizing resources

To translate the Alma Ata commitment into action, the mobilization of all possible human, financial and material resources is indispensable. This is the reason for which EMRO attaches great importance to technical cooperation among developing countries. In this connection, the experience acquired within the
framework of the health manpower development programme through the exchange of teachers and students has been very gratifying. Collaboration with other agencies of the UN system, non-governmental organizations, and governmental organizations, such as the League of Arab States, the Secretariat General of Health for Arab Countries of the Gulf Area, etc., will be further strengthened in order to promote economic and technical cooperation among countries and mobilize resources.

Furthermore, to support WHO's efforts in the mobilization and rationalization of resources for health, in accordance with WHA34.37 (Annex II) and the international health policies determined by the World Health Assembly, the Health Resources Group for PHC is undertaking to review the results of the examination of resource flows for health in a number of selected countries which have prepared primary health care plans of action for the attainment of HFA/2000. A number of countries of the Region have been selected for resource utilization studies to be submitted to the Health Resources Group, which may lead to special consideration and funding of their respective primary health care programmes. They include in a first phase Democratic Yemen, Sudan and Yemen Arab Republic.

**Appropriate technology for health**

Programmes, in order to be economic and effective, have to use technology which is scientifically sound, acceptable by the population and at a cost the countries can afford.

WHO is in the process of identifying institutions willing to collaborate in the establishment of a regional information service on appropriate technology. Furthermore, the Regional Office is at present closely collaborating with Pakistan and Sudan in the ATH programme. The experience gained will provide guidance for programme expansion.

In Pakistan, a collaborative project for low-cost spectacles has been implemented and surveys are already in progress to identify errors of refraction and needs for eye-glasses in a sample of schoolchildren.

In Sudan two protocols have been prepared with the Government. The first is for low-cost spectacles covering schoolchildren primarily. The second is related to solar refrigeration in support of primary health care and the Expanded Programme of Immunization, with the Energy Research Institute, Khartoum, as the physical site. The communication transfer project is
currently exploring ways of supporting primary health care workers in their task of promoting health and of bringing about community participation in the solution of health problems.

WHO will intensify its efforts to increase regional research capability in ATH, and to extend further support to selected institutions in the Region to enable them to carry out research into simple, low-cost technology for use in primary health care.
The World Health Assembly, in resolution WHA32.30 (May 1979) after considering document A32/8, on formulating strategies for health for all by the year 2000 (HFA/2000), set out the guidelines for the preparation of national, regional and global strategies to that end. The subject was reviewed at the Twenty-ninth Session of the Regional Committee for the Eastern Mediterranean (Sub-Committee A) in October 1979, which approved resolution EM/RC29A/R.7 urging Member States to formulate national policies, strategies and plans of action for HFA/2000, and to collaborate with the Regional Office in formulating a regional strategy.

The timetable set by the Health Assembly and confirmed by the Regional Committee foresaw the preparation of individual country statements by June 1980, the discussion of a regional strategy based on them at the sessions of the Regional Committees in September/October 1980, and the submission of a global strategy for HFA/2000 to the Thirty-fourth World Health Assembly in 1981.

This document, outlining a possible strategy for the attainment of HFA/2000 in the Eastern Mediterranean Region, has been prepared in response to the above request. It is largely based on the conclusions reached at three WHO subregional meetings on HFA/2000 held in Mogadishu (February 1980), Damascus (March 1980), and Kuwait (April 1980), in which groups of representatives from Member countries participated; and on individual country strategy statements received subsequently. A number of regional strategies have been suggested in the paper, and a proposal for the adoption of a regional health charter is made.
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ANNEX

A CHARTER FOR HEALTH FOR THE EASTERN MEDITERRANEAN REGION
1. **Main Health and Health-Related Problems**

In considering strategies for the Eastern Mediterranean Region, a number of factors have to be taken into consideration.

1.1 **Broad regional trends in population**

The estimated population of the Region in 1980 exceeds 268 million. There are great variations in the size of the population between countries - from 152,000 in Djibouti to 82 million in Pakistan. Five out of the twenty-three countries of the Region contain the greatest proportion of the regional population, some 203 million (about 74 per cent of the total). Around 40 per cent of the population of the Region lives in urban areas.

Within the next two decades, it is estimated that the population of the Region will grow to 459 million, i.e., an addition of 190 million people, with a further shift towards urban living.

The crude birth rate in 1980 ranges from 18.0 to 48.1 per thousand population and the crude death rate from 7.3 to 19.2. By the year 2000 it is estimated that both will decrease, the birth rate to 14.3 - 39.1 per thousand and the death rate to 6.7 - 14.1.

At present, some 45 per cent of the total population is below fifteen years of age and this percentage is expected to decrease by about 3 per cent over the next twenty years.

The life expectancy at birth in 1980 ranges from 43.4 to 71.0 years for males and 46.6 to 74.9 for females. The corresponding statistical estimates for the year 2000 are 49.3 to 72.4 and 52.8 to 77.1, respectively.

The population density differs widely, from one to 323 inhabitants per square kilometre, and may increase further by the year 2000, from a low of 3 to a high of 588. These averages, however, do not take into account vast uninhabited desert areas and therefore the existence of much higher densities in overcrowded urban settlements.

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1.2 **Socioeconomic situation**

The level of social development which countries in the Region have attained differs widely and, as is well known, the range of their economic development is extraordinarily varied. Some of the countries are among the richest in the world, measured by per capita income. Others are engaged in a continuing struggle for survival.

The per capita gross national product varies from less than US $ 200 to more than US $ 20 000. As an example of the latter, in 1978 the production of crude oil in Saudi Arabia, Iran, Iraq, Libyan Arab Jamahiriya, Kuwait and Abu Dhabi was 8066, 5234, 2629, 1977, 1880 and 1447 thousand barrels per day respectively. However, the levels of oil production, of exporting, and of prices are changing.

Afghanistan, Democratic Yemen, Djibouti, Somalia, Sudan, and the Yemen Arab Republic have low per capita income and are still listed by the United Nations among the least developed countries. The remaining twelve countries of the Region are in the median range.

In some countries the school enrolment ratio and literacy rates are low. In general, literacy of women is lower than that of men, sometimes substantially.

1.3 **Mortality and morbidity, including special health risks**

The crude death rates have been mentioned under point 1.1, above. Data regarding specific rates by cause of death are mostly incomplete and unreliable.

As for the morbidity data based on officially notified cases\(^1\) factors of underregistration and of over- and under-diagnosis, must be borne in mind.

Among the groups at high risk there are an estimated eleven million child-bearing women, and about fifty million children under five in the Region. The serious vulnerability of the infant and young child is particularly pronounced in impoverished and overcrowded environments. According to data available at 1 July 1979, the range of infant mortality rates was from 13 to 142 per thousand, but estimates for a number of countries suggest that these rates are in actual fact much higher, childhood infections, malnutrition, diarrhoeal diseases, and respiratory infections being the main causes.

Communicable diseases remain among the most significant health problems: 71 per cent of the people of the Region live in areas where malaria transmission occurs

\(^1\)World Health Statistics Annual 1979, Geneva.
and, of these, twenty million live in areas where no specific antimalaria measures are being carried out.

Schistosomiasis is present in most of the countries of the Region, and tuberculosis still represents a serious hazard at all ages.

The provision of basic sanitary measures such as community water supply, water and wastewater treatment, sanitation and food hygiene, remains of critical concern in many rural, peri-urban and urban areas. Moreover, the consequences of rapid industrialization, demographic shifts and expanding population, have serious repercussions on the health conditions of entire groups of population.

Cancer and cardiovascular diseases appear to be increasingly important causes of death in a number of countries of the Region.

Accidents in the home, and especially road traffic accidents, have also become a major cause of death and disability, affecting particularly adolescents and young adults.

Psychiatric diseases and mental illness are requiring greater attention than in the past.

1.4 Health care delivery infrastructure

The amount, nature and quality of services available to rural and peri-urban population groups vary considerably from country to country and often within the same country. Such factors as the availability of financial and human resources, pre-existing services, and health policies or traditions all have a bearing on the matter. In a number of cases, however, there are also still unsolved strategy considerations which contribute to the permanence of unsatisfactory conditions that could be easily changed for the better within existing resources.

Coverage by health services in peripheral areas, and of special groups such as nomads, is still a serious problem in a number of countries where the traditional, hospital-based and curative-oriented care services absorb most of the available financial and personnel resources, catering mainly for privileged groups of the population. Refugee camps, where they exist, present a special challenge.

Though most countries have three-tiered health services - at central, regional and peripheral level - priority is still being given to sophisticated hospital care in urban areas, often to the neglect of village health centres and their personnel where
such already exist. The problems of merging medical care with preventive medicine and health measures are largely unresolved, and in most countries drinking water supply and sanitation are administratively divorced from the health services, which have little or no say in environmental matters.

Though changes in respect to the various problems mentioned above are occurring, much remains to be done to select, decide on, and apply suitable new strategies that can radically overcome some of the existing constraints on the achievement of HFA/2000.

1.5 Health technology

In most situations, applied technology at the central — and to a certain extent at the intermediate — level of the health care delivery system is of a conventional nature, derived mainly by direct transfer or with some adaptation from technologies observed or learned in industrialized countries.

The application of such technologies tends to absorb exaggerated amounts of national material and human resources, while not necessarily meeting the basic needs of the population. The capacity for developing local solutions to primary health care problems, though existing in most countries, has not yet been fully developed.

To this end a preliminary medium-term programme for appropriate technology for health for the Region (1978-1983) has been prepared by WHO. It aims at supporting primary health care and rural development, and at the dissemination of related information.

1.6 Resources for health

No reliable information is available on total expenditure for health in the Region. The trend of expenditure on health by government and other services appears to be on the increase, but the proper distribution of resources within the health services often presents problems. Private practice, which is widespread, is mainly available to the affluent and escapes any form of quantification.

As with other factors, institutional and human resources vary widely from country to country. Thus, according to a survey carried out by the Regional Office in 1978, the number of population per physician ranged from 468 to 16,678, and the number of population per hospital bed, from 205 to 4,573.
The number of nurses, assistant nurses and midwives per physician, in about half the countries ranged between 1 and 2; in others the number was more than 4, with a strong concentration of all categories in urban areas.

1.7 Equitable distribution of resources

It is generally recognized throughout the Region that there are still major inequities in the distribution of national resources used for health, and that considerable change has to occur if a minimum of health protection and care is to be ensured for the entire population. Correction of such imbalance should apply not only to the health sector as a whole but also to the different parts of the sector.

The sub-regional meetings on HFA/2000 held in 1980 did however show that there is growing recognition among senior health officials of the need for equitable distribution, and that measures have been or will be taken by governments to remedy the situation to the extent possible. The problem in fact is not only technical and administrative in nature but is mainly political, and as such requires different forms of intervention if it is to be solved.

1.8 Degree of awareness of existing problems among policy-makers, health workers, and the public

There is little doubt that in the Eastern Mediterranean Region, as in other regions, the decisions of the International Conference on Primary Health Care in Alma Ata have brought to the attention of politicians as well as of health administrators and technicians some of the failings of existing systems, while offering new approaches that can be followed in seeking to remedy those failings. Thus HFA/2000 is no longer a mere slogan but is gradually becoming a real objective for a number of people and administrations that have recognized the value of such a long-term approach and of the message it carries with it.

The Alma Ata Conference also contributed considerably to taking the debate outside the close boundaries of the health sector by involving the representatives of a number of other disciplines or administrations, such as economists, managers, treasury and financial departments, educators, social scientists - and also politicians. Thus the ferment which is apparent in the Region is of a wider nature, and there is a reasonable hope that it will continue until HFA/2000 becomes a reality.

It is however doubtful whether the public, and particularly those who are meant to be the beneficiaries of primary health care, are aware of the changes being planned.
Only after the HFA/2000 strategies and the consequent plans of action have become operative will it be possible to truly assess the degree of community awareness, understanding and participation in the programme.

2. Health and Socio-economic Policies

2.1 Health policies and trends in health

Recent trends in health are encouraging. All countries in the Region have for years had community health services of one type or another, but considerable attention has recently been given to their rationalization and to the development and expansion of primary health care services in keeping with the spirit of the Alma Ata Declaration.

Most programmes encompass the eight major elements of primary health care listed in the Declaration. Plans exist or are being formulated to ensure broader and more integrated population coverage in the various fields (health education, food supply and nutrition, safe water and basic sanitation, maternal and child health, immunization, prevention and control of endemic diseases, simple treatment, and provision of essential drugs), and in some cases to expand further the scope of primary health care to such areas as emergency care, dental health, and mental health.

An example of the progress being achieved is shown by the strategy for primary health care worked out by the Arab States of the Gulf. Under the aegis of the Gulf Health Secretariat, considerable agreement has already been reached on a common definition of primary health care services, their scope, the composition of the basic services team, and the terms of reference of its various team members.

The Regional Committee has also repeatedly stressed the importance of primary health care, for example in resolution EM/RC25A/R.15, where it invites Member States to continue to cooperate in exploring new ways of ensuring maximum coverage of their population by health services, and to cooperate in an expansion of applied research designed to supply the facts and measurements needed in order to develop health services and health manpower on a properly planned basis. Resolution EM/RC29A/R.7 also urges Member States to formulate national policies, strategies and plans of action for HFA/2000, and to collaborate with the Regional Office in formulating a regional strategy.

Altogether, it can be safely stated that the principles of health for all by the year 2000, and of primary health care as the key to it, have not only gained wide
recognition but also general acceptance in the countries of the Region. They have already received wide political support, and it is trusted that the Alma Ata message, in its comprehensiveness, will also give the intersectoral impetus that is essential for future action.

In fact, the planning efforts in this direction being undertaken in practically all countries of the Region have shown the degree of self-reliance which already exists in most cases. One problem which all countries face however, in varying degrees, is of how best to ensure community participation as an essential component of the primary health care effort. It is hoped that full use of technical cooperation among developing countries (TCDC) mechanisms as well as of other possibilities offered through international cooperation may assist countries in finding the right solution to this crucial issue.

At a general level, the efforts of health authorities have found good support in United Nations General Assembly resolution 34/58 of November 1979, which stressed, for the first time in the history of the United Nations, the importance of health as an integral part of development.

At country level this evolution in health ideology and in the development of health services has created the need for a revision of the role and mode of action of ministers of health. In a period of frequent internal political and economic difficulties, health development can become - particularly through primary health care - the spearhead of positive social action with far-reaching effects for a majority of the population. This means that those responsible for health at the highest level should exert greater influence so as to ensure the necessary political, financial and administrative support to their programmes and particularly to primary health care, with the multisectoral and multidisciplinary backing that is required at all levels. Ministers of health have the task, in today's cabinet, of inspiring their colleagues by equitably allocating and distributing resources and spending money on such low-profile projects as mass immunization programmes, health education, maternal and child health programmes, etc. They may on occasion have to point out the health hazards of large development schemes such as dam-building and agricultural extension, to ensure that such endeavours do not lead to the extension of water-related diseases such as schistosomiasis and malaria.

The provision of a safe drinking-water supply is one of the most important steps in delivering health to the majority of the population, and close cooperation is
essential between ministries of health and ministries of public works in planning the allocation of resources and in implementing programmes in this high priority area. In most cases, such cooperation is best ensured through intersectoral, multidisciplinary groups at central, regional and community level.

In many countries, social security systems and health insurance programmes have evolved independently of the ministry of health. This has invariably led to a major emphasis being given to construction of hospitals and clinics, and to the provision of mainly curative services to the detriment of the preventive health services. All these factors, which are being increasingly recognized, demand a new working relationship with the cabinet, and ministers of health should assume a position of social leadership.

In several countries interministerial health development councils have been established to assist health authorities in their new tasks, and to advise on the proper redistribution of usually scarce financial and human resources. As a corollary of any evolution in the direction of community medicine and away from the traditional major hospital institution, a revision of the duties and functions at the various levels of the health administration will have to be undertaken, to ensure that ministries of health are in a proper position to carry out their new, expanded mandate.

2.2 Related socioeconomic policies

Notwithstanding the absence of regional development policies and the variety of situations — political, demographic and economic — to be found among the different Member countries making up the Eastern Mediterranean Region, a number of common elements that are relevant to the setting of strategies for HFA/2000 can be considered.

As a general pattern, there is a national desire and rising community expectations for economic development — expanding agriculture, establishing industries, providing basic services such as water supply and electricity, and upgrading the communications infrastructure. The provision of educational facilities, at all levels, is receiving particular attention.

All countries in the Region are in a constant process of medium- or long-term socioeconomic planning. In most cases, however, social welfare and health cannot expect to be allocated major shares of the resources available for national development. It is therefore of the utmost importance that the distribution of existing
resources should be reassessed and where necessary reprogrammed for the good of the majority.

A major constraint on economic development is the shortage of trained manpower. In some countries, a continual brain-drain to wealthier countries has aggravated the problem.

While overseas aid is of considerable significance, the resources offered in support of long-term development are scarce. Other problems associated with external aid include a policy on the part of some donors to approve capital investment projects only, thus creating an additional burden for national budgets, which have to meet the continuing cost of maintenance and operation.

3. Main Long-term Programmes - Objectives, Targets and Approaches

3.1 Long-term objectives and targets

Though all Member States in the Region are fully committed to the achievement of HFA/2000, their very diversity makes it difficult to define objectives and targets that may have validity for all of them. This being recognized, an attempt has been made to identify certain objectives and relevant targets for primary health care that will facilitate the consideration of regional strategies and later of plans of action to support national activities in this domain. At this stage the targets may appear as modest to some countries that have already overtaken them, or over-ambitious to others. Their value lies not so much in the numerical figure arbitrarily suggested as in the attempt to provoke studies and discussions leading to definitions considered closer to reality by all concerned.

It is fair to assume that all countries have accepted the idea, if not the ideal, that an acceptable level of health for all by the year 2000 is feasible. Though the term "acceptable level" still begs definition, the progress already made or under way in developing primary health services for the underserved testifies to the desire of governments to improve radically the health conditions of their populations on a countrywide basis.

Taking general coverage by primary health care services as the main objective for HFA/2000, an overall target might be to increase life expectancy at birth to a minimum of 65 years for all population groups. Furthermore the following might be taken as sub-objectives and sub-targets for the eight major components of primary health care.
(i) Education as regards prevailing health problems and methods of preventing or controlling them:

Objective. All members of the community should, by the year 2000, be in a position to take informed decisions as to their way of life and the behaviour leading to a healthier life.

Target. Establish a system (or systems) for the selection, elaboration, distribution and use of suitable health information that is readily accessible and understood by the majority of people and which may motivate their attitudes and actions in regard to such matters as personal and family hygiene, community health and sanitation, and also their utilization of and support to the health services.

(ii) Promotion of food supply and proper nutrition:

Objective. Malnutrition (including under- and over-nutrition) attributable to economic, social or attitudinal causes should be reduced to a minimum.

Target. Increase food production and distribution to a level that will ensure a balanced diet to the population as a whole, with special reference to the more vulnerable groups (pregnant women, mothers, infants and children), at a cost accessible also to the poorest strata. Provide for the education of mothers and families in regard to breast-feeding, weaning and infant hygiene. Ensure services for the early diagnosis and treatment of cases of malnutrition.

(iii) Adequate supply of safe water and basic sanitation:

Objective. All people should have reasonable access to water of adequate quality, in sufficient quantity, at all times of the year. All households and organized communities should have at their disposal and should use water supply and waste disposal methods that afford protection against the risks of disease transmission.

Target. Detailed targets have been set for water supply under the International Drinking Water Supply and Sanitation Decade, which is intended to achieve overall coverage in water and sanitation facilities by the year 1990. Further improvements may be planned on the basis of the results obtained through this first effort.

(iv) Maternal and child health care, including family planning:

Objective. Maternal and child mortality should be reduced to acceptable levels by optimizing health conditions for pregnant women, mothers, infants and young children.

Target. Each country will define its own targets in regard to maternal and child mortality, but the rates should not be higher than 10 per 10,000 for maternal mortality
and 40 per 1,000 for infant mortality. Even in the case of special groups they should not exceed 15 per 10,000 and 60 per 1,000. Countries may also wish to set targets for reaching optimum family size.

(v) **Immunization against the major infectious diseases:**

**Objective.** The occurrence of infectious (and possibly other) diseases against which effective immunization exists or will be developed in the coming decades should be reduced to negligible proportions as regards both number and severity of cases.

**Target.** Ensure immunization of children and of new, susceptible generations to reach a minimum of 90 per cent yearly coverage.

(vi) **Prevention and control of locally endemic diseases:**

**Objective.** To reduce the incidence and bring under effective control such communicable diseases as cholera, malaria, schistosomiasis, filariasis, onchocerciasis, tuberculosis, leprosy and trachoma, where they are endemic or constitute a social problem.

**Target.** In this case also targets can be meaningful only if established on a country basis (and for some diseases on an area basis), depending on endemicity. Proper surveillance and notification of cases of transmissible or epidemic diseases would be a regional target.

(vii) **Treatment of common diseases and injuries:**

**Objective.** It is impossible to give objectives in terms of reduction of the human suffering caused by untreated or ill-treated diseases, but the whole purpose of HFA/2000 is to achieve an optimum in this domain compatible with available resources and existing conditions, while ensuring a proper equitability in the distribution and utilization of the relevant health services.

**Target.** Minimum health facilities should be available to, and within easy reach of at least 90 per cent of population living in settled communities, specially designed services being available to special groups such as nomads and refugees, so that the great majority of people are sure of access to primary health care services for the diagnosis and treatment of the most commonly encountered diseases and of accidental injuries.
(viii) Provision of essential drugs:

Objective. All people in need of treatment should be provided with the essential drugs that they require, at no cost to themselves or at a price compatible with their income, together with the advice needed for the proper use of the drugs.

Target. The existence of a selected list of drugs and vaccines for use in primary health care and their availability whenever needed at primary health care level, on a regular basis and at a cost that the community and the State can afford.

3.2 Regional programmes and strategies

3.2.1 Primary health care

All countries are proceeding with one form or another of planning for their future health services, but there still seems to be a considerable gap between the government policy statements that are enunciated (or at times only assumed) and the preparation of plans to cover the next twenty years. The problem lies not only in moving from the present annual to five-year plan formulations to long-term planning with a year 2000 horizon, but also in setting up the strategies that will make such detailed planning possible, i.e., in deciding how best, most economically and most efficiently the political decisions can be translated into detailed plans of action.

A regional programme in this connexion will have to take into account the various aspects of planning, namely, methodology, definition of more refined objectives and targets, selection of indicators for monitoring and evaluation of progress made, etc. The proper administration and management of the expanded services is also of crucial importance and this may require a rethinking and a revision of existing directive, technical and administrative structures - central, regional, provincial and peripheral.

The staffing of primary health care services and of the various echelons above them (including not only referral systems and supervision but also logistic support in all its forms) is and will continue to be the most critical factor in the development of any HFA/2000 programme.

Regional activities in methodological and operational research, in education and training, in establishing commonly acceptable definitions, terms of reference, post descriptions, and in providing teaching and educational material for different categories of staff, can make valuable contributions to individual country programmes.

One of the strategies would be the strengthening of centres of excellence in the Region that would collaborate closely in the development of commonly agreed plans
of work, sharing responsibilities in such fields as research, training, preparation of educational materials, and provision of technical advisory services.

Another strategy would be related to the technologies to be used in primary health care and its several components. Here again, selected institutions, researchers and health workers could contribute, in a coordinated manner, to the selection, testing, evaluation and standardization of appropriate technologies and methods of work, with special regard to new, innovative approaches.

Among the problems identified for further analysis and research by participants in the three subregional meetings on HFA/2000 were: how best to motivate and ensure community participation in both planning and implementing primary health care services; how to structure services at community level, so as to ensure proper supervision and relations with the higher tiers of the system; how to organize, administer and ensure the logistics of primary health care services at their various levels, etc.

In relation to the nature of the services to be offered at village level (which vary considerably from country to country), are there still basic, unsolved strategy considerations such as what role can village health workers best play? how many of the multiple duties foreseen for them will they be able to perform efficiently? and how can vertical and horizontal health services best be integrated? Furthermore, while the essential components of primary health care are generally accepted, as already mentioned, the ways in which they can be applied at village level and to villagers and their families still need definition in most situations. The achievement of linkage between community health services and referral hospitals, while generally accepted in principle, remains still largely untried and needs definition.

These are but a few of the issues that arise in building up primary health care services. Well supported and coordinated regional studies, consultations, exchanges between workers, and the dissemination of technical information should prove of considerable assistance to those responsible for such programmes. Nor should the quest for experience, data and information on these subjects necessarily stop at the boundaries of the Region.

3.2.2 Education on prevailing health problems and methods of preventing or controlling them.

There is a new appreciation of the need for health education in its broadest possible sense. Countries are becoming increasingly aware of the potential of disseminating health awareness through the mass media, particularly radio and television, and
also of developing health curricula in schools. Adult literacy programmes are also proving a suitable vehicle. Some countries are planning mass campaigns devoted mainly to personal health care, nutrition, anti-smoking, and simple hygiene measures. The involvement of educational personnel, especially in rural areas, and the increased use of rural schoolteachers in the health process is being considered in a number of situations, especially in view of the multiplier effect that can be achieved through teacher-training programmes.

The Eastern Mediterranean Region, with its majority of Arabic-speaking countries and the boom in radio and television, constitutes an ideal market for new health educational material—films, videotapes, cassettes, publications, posters, etc.—which could be developed in selected institutions for regional distribution. Prizes for contributions from private institutions could be instituted. Universities might be enlisted to evaluate the impact of existing and new techniques and materials, taking into account the essential contribution that active community participation is meant to play in primary health care development.

3.2.3 Promotion of food supply and proper nutrition

This is a field which clearly transcends the responsibilities of the health administration alone, while being of basic importance to HFA/2000. Joint strategies will have to be developed with departments of agriculture, trade and transport to ensure the promotion of food production, particularly of food that will improve the nutritional status of the population, and its purchase and distribution as necessary.

There is growing recognition that governments have a high level of responsibility for bringing better nutrition to the neglected and vulnerable segments of the population. Some countries are adopting a multi-intervention strategy involving food supplements, food distribution, nutrition education, and improved food preparation techniques. Improvement of food production through community participation is also envisaged.

The role in the community of such groups as women's organizations and clubs of village health workers, and of schoolteachers and agriculture extension field staff, merits attention.

Breastfeeding will be promoted through health education programmes, and by the preparation and distribution of advisory material to food-processing manufacturers and food stores. Revision of legislation on food hygiene, and the improvement of inspection procedures for premises and for food-handlers, will also require attention.
The great loss of foodstuffs due to insects and rodents should also be the subject of planning and action.

In these various aspects also, regional activities could provide valuable support to country programmes by promoting and supporting research, training staff, sponsoring the exchange of information and of expertise, and maintaining a common fund of knowledge covering such fields as legislation, techniques, research findings, etc.

3.2.4 Supply of safe water and basic sanitation

Although the programmes being undertaken in response to the International Drinking Water Supply and Sanitation Decade are gaining momentum, there are still a number of issues in this domain which require attention and which could benefit from regional strategies.

Research should for example be undertaken by a network of national institutions and laboratories, combined with the training of the scientific and operational staff of the countries in the Region in such subjects as development of low-cost technology using local materials, or development of solar energy and of cheap sources of energy from composting, bio-energy, etc. Cost-effectiveness studies as between the wide-range application of low-cost schemes and the concentrated use of high technology may also be needed to ensure optimal use of resources.

Another area requiring study, but of a more operational character, is how best to involve primary health care workers in the education of the community that will lead to community support and participation in programmes of water supply, and more particularly of sanitation, waste disposal, and safe excreta disposal. Better knowledge of the support to be obtained from national, regional and international nongovernmental or other organizations may prove of great value in solving some of the resource problems that such far-ranging, and at times ambitious, programmes present. Combined efforts by countries in seeking valid solutions, including the development of skilled manpower and the quest for financing, could be of great value in promoting individual programmes. The TCDC approach could be used with benefit in a number of cases. Efficient mechanisms to achieve intersectoral coordination of the different administrations and technical offices, and the participation of the community in safe water supply and basic sanitation schemes, should also be the object of a strategy approach.
3.2.5 Maternal and child health care, including family planning

Regional (and possibly global) strategies may help countries to answer such questions as: what is the role of primary health care in relation to the development of services for the vulnerable sectors of the population, particularly mothers and children? and what is the role of primary health care workers in regard to maternal and child health work, to immunization, to nutrition, and to family planning where this is recognized government policy?

As part of a regional strategy further efforts could be made to identify and strengthen existing national or regional institutions working on various aspects of maternal and child health, in particular national research, development and training centres. Strengthening the work of such institutions could include:

(a) teacher training in appropriate maternal and child health care, including modern educational methods;

(b) health services research on the development and implementation of maternal and child health care and relevant technology, including training for such research;

(c) studies in family self-care and community participation in maternal and child health care, including studies on child-bearing and child-rearing patterns;

(d) systematic exchange of information among workers from various disciplines in health and in other sectors concerned with the health and social well-being of mothers, children and families;

(e) development of methods and approaches for the preparation and local adaptation of curricula and of learning/teaching materials, including self-instructional material for the training in maternal and child health of different categories of health workers, e.g., primary health care workers, traditional birth attendants, and their teachers and supervisors.

3.2.6 Immunization against the major infectious diseases

In the wake of the successful completion of the smallpox eradication campaign, the Expanded Programme of Immunization is rapidly developing as a major tool for the prevention of diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis.

Guides to national strategies for such programme have already been established and could be strengthened by the adoption, in the Eastern Mediterranean Region, of
wider strategies to ensure coordination of activities across national boundaries; to develop vaccine production and testing on a regional basis; to assist in the training of campaign leaders and key directing and supervisory staff; and to develop technical and information materials in Arabic and other languages of the Region based on the evaluation of existing experiments.

The setting up of one or more regional focal points for the analysis and study, with a view to proper evaluation of programmes, of the data from mass vaccination might also be of economic value to countries whose health services do not have ready access to computer equipment.

3.2.7 Prevention and control of locally endemic diseases

Though it is accepted that primary health care services have an essential role to play in the prevention and control of endemic diseases, it is equally recognized that successful epidemiological surveillance and control measures are only possible when there exist technically strong, well-staffed and well-equipped communicable disease control services, with specialized branches for malaria, schistosomiasis, tuberculosis or other diseases, depending on the pathology of the country.

The transition from the single-disease control approach to an integrated approach, with the expansion of primary health care services at community level, creates a number of problems of interrelationship between vertical and horizontal services, of staffing and staff responsibilities, of distribution of resources and of logistics and infrastructure. These need to be solved if progress is indeed to be achieved on a wide front with a view to HFA/2000.

Though in most cases answers must be found at local or national level, there is a growing body of experience which, if duly collected, analyzed and disseminated, could be of great general value in preventing the repetition of known errors and opening the way to short cuts based on cases actually tried out.

Regional (and global) strategies in communicable disease control should therefore not only foster research, strengthening of research institutions and their staff, training of scientists, epidemiologists, communicable disease specialists, statisticians, etc., collaboration with other national and international research institutions; and joint planning and coordination of programmes among adjoining countries suffering from the same infectious diseases; they should also promote operational research with a view to finding suitable, cost-effective approaches to the staffing, financial,
managerial and operative problems of communicable disease control as the integral part of a much wider national health effort.

Technical cooperation among developing countries; the establishment of research and coordination networks of regionally accepted training institutions; the exchange of visits and of workers; the distribution of information - these are all possible mechanisms of such a strategy.

3.2.8 Treatment of common diseases and injuries

This component, which to the beneficiaries of expanded primary health care services may be the latter's most visible and important element, presents a number of special aspects which have a bearing on a country's health structure in its entirety. The definition of the role and duties of primary health care workers must be consistent with the overall organization and potential of the nation's health services as a whole. Referral of cases is an important aspect, and so is the technical supervision of such workers and the evaluation of their diagnostic and treatment capabilities. The terms of reference, staffing, equipment and modus operandi of middle-level clinical centres and hospitals may have to be reassessed and modified; their relationship to specialized centres, institutions and hospitals at regional and central level may also require redefinition and mutual adaptation. Even the physical structure of centres and of hospital buildings may be affected. Thus, the whole of the national curative services are involved, and changes may be required in policy, infrastructure build-up, management, staffing, equipment, and - last but not least - in the attitudes of health workers and professional groupings in the various categories.

Regional (and global) strategies in this domain must therefore seek to provide guidance and give intellectual and technical support to the national health administrators and planners responsible for bringing about these changes. A regional programme of research apportioned among existing institutions interested in this type of problem could become the basis for assessing difficulties, studying and suggesting remedial measures, working out national research protocols, and training and supporting the staff involved in such research and in the application of the solutions it puts forward. Meetings of decision-makers, administrators and planners might prove useful by allowing them to compare experience and seek new answers to problems. Training of management personnel and leaders of operational activities could also be of value. Research in and testing of new technology could well be established on a regional basis, as also the development of programmes for the maintenance and repair of medical equipment.
Special aspects of primary health care, e.g. its extension to factories and work-places in rapidly industrializing countries, may also benefit from a regional approach in studying and advising on such matters as revision of legislation, improved inspection, better design of work environments, and safety education of workers. The same principle would apply to major agriculture and development programmes in rural areas.

3.2.9 Provision of essential drugs

The need for maintaining supplies of essential drugs to primary health care units and to the supporting infrastructure (referral hospitals, etc.) is at the core of the primary health care programme. The adoption by most health administrations of WHO's list of essential drugs already constitutes a valuable step forward.

Storage and distribution logistics are often serious constraints. Strategies will also need to be evolved for meeting the cost of drugs and for preventing misuse or wastage by the health services and their customers.

Participation by countries in regional purchasing operations with, as a corollary, the adoption of standard lists of drugs and national formularies, would seem an acceptable regional strategy. Another would be the strengthening of existing public health laboratories as an essential support to drug testing and production, epidemiological surveillance and communicable disease control, and other aspects of primary health care programmes, e.g., drinking water supply. In countries with more sophisticated services, the quality and techniques of blood transfusion might also benefit from a regional approach.

4. Support Measures

It was fully accepted at the Alma Ata Conference that primary health care, to become a reality, would need broad support in a variety of fields. An attempt has been made below to identify some of the more important measures that need to be taken to implement primary health care programmes, and subsequently to suggest objectives for regional strategies.

4.1 Political

Progress towards HFA/2000 will only be possible if full national political commitment to the programme is obtained and the necessary political decisions are taken. This involves not only the minister of health and his department, but the government as a whole and all other ministries (and they are numerous) that can actively participate and contribute, along with the relevant administrations at different levels.
Mobilization of public opinion is part of this process of political motivation and participation.

Acceptance of and adherence to existing international health agreements can help crystallize political will. It is furthermore suggested that, as part of the regional strategy for HFA/2000 in the Eastern Mediterranean Region, countries should be invited to subscribe to a Covenant for Health, or Health Charter (see Annex) spelling out the goals to which the countries, collectively and individually, are committed.

A good example of the importance that regional bodies attach to health is provided by the work of the Council of Arab Ministers of Health, under the aegis of the League of Arab States, and of the Secretariat General of the Council of Health of the Arab Countries of the Gulf Area.

The acceptance by the United Nations General Assembly of resolution 34/58 (November 1979) on health as an integral part of development is proof of the growing recognition given by political bodies to health. Additional efforts could be undertaken to keep this interest, and the consequent commitment, alive in other international and regional political bodies. A case in point might be the Governing Council of UNDP, to ensure that health development (in particular primary health care) continues to be assigned priority among the programmes eligible for funding by that Programme. Other bodies where continuing reference to health as a major development factor could be useful are the United Nations proper, its regional economic commissions, the World Bank, the regional development banks and, particularly in the Eastern Mediterranean Region, the numerous financial institutions that have so far given only very limited recognition and support to health.

Other bodies that need to understand and support the goal of HFA/2000 are intergovernmental groupings such as the OAU, the Interparliamentary Union, OPEC, the group of non-aligned States, and also the major nongovernmental organizations active in the Region.

The Regional Committee could enhance still further its role of bringing the realities of HFA/2000 beyond the boundaries of health and to the attention of the political level in the various areas which it calls its own. TCDC could also be developed further as a suitable vehicle for the dissemination of information and knowledge and for political influence.
4.2 Economic

Economic support is basic to the primary health care programme. Reference has already been made in the preceding paragraphs to bodies whose approach to development is both political and economic. Besides these, a number of multilateral and bilateral assistance agencies have provided or could provide increased support to health programmes if this is the wish of the recipient country. Account must also be taken of the opportunities for health development afforded as part of broader development package deals, e.g., the financing of health services in the case of resettlement programmes for agricultural development projects, etc.

In the Region interest in health activities has been shown, in principle, by a number of funds and development-supporting institutions such as the Islamic Development Bank, the Iraqi Fund for External Development, the OPEC Special Fund, the Arab Fund for Social Development, the Kuwait Fund for Arab Economic Development, the Abu Dhabi Fund for Arab Economic Development and the Saudi Fund for Development. Little or no lending has hitherto materialized, mainly because of the lack of definite requests from countries with access to these institutions. Primary health care, with its broad social and economic objectives and with its activities designed to serve entire populations, should qualify for consideration by these funds. It is the responsibility of interested Member States to approach the funds with well-prepared projects that have been given the necessary high priority by the developmental and financial authorities of the country.

Considerable assistance has also been given to health projects on a bilateral basis, in some cases through funds-in-trust arrangements with WHO. In a Region with considerable differences in national resources, still more could be done to ensure a more equitable distribution to underserved population groups, irrespective of national boundaries. In this case also the existence of well-planned, well-documented programmes and project proposals would go a long way towards facilitating the dialogue between governments. The choice of simple, effective and easily understood strategies and plans of action for HFA/2000 is essential for this purpose.

There is already international support for HFA/2000 on a broad basis, UNICEF and WHO are fully committed to its principles and objectives; UNDP and UNFPA are also assisting with selected aspects of the programme, in response to requests from governments.
Other agencies such as UNEP, ILO, UNESCO and UNIDO, may also make valuable technical contributions in a coordinated approach aimed at special sub-objectives of HFA/2000, e.g. environmental health, workers' health, education and motivation of the people, programmes aimed at special groups, nutrition, prevention of zoonoses and production of pharmaceuticals.

Regional strategies to obtain financing for HFA/2000 might include inter alia the holding of meetings between countries in need of support and interested bilateral or multilateral agencies or funds to examine programme proposals, along the lines of the meeting successfully sponsored in Asia by WHO in July 1978. Another approach might be the creation of an intercountry cooperation and coordination committee, with representation from governments and the major funds and bilateral assistance organizations, to discuss coordination of the different inputs and additional funding possibilities. Regional approaches of this kind can best concentrate on selected major programmes of Member countries and on intercountry or regional activities.

Careful timing and preparation of such meetings is crucial. It is essential that carefully prepared and costed programme proposals should be presented well in advance by the countries interested in receiving support. Such preparation may take from one to two years. In other terms, funding operations in health development require the same painstaking preparation as is required for financing the construction of a large dam. WHO can assist countries in covering the costs of the preparatory phase from its own resources (possibly with the support of UNDP or other sources) and in the preparation of the technical documentation required.

Another possible approach would be to set up a regional fund in support of HFA/2000 activities. Such a fund could accept contributions for use in the less endowed countries to assist and promote their programmes in accordance with criteria and rules to be agreed upon jointly by contributors and recipients. Such an approach could lead to an assessment of the order of magnitude of resources required by individual countries from external sources, and it might attract a wide range of multilateral and bilateral funds.

4.3 Social

While primary health care is a logical spearhead for social development, it can also measurably benefit by other social programmes. Thus, educational programmes can be excellent vehicles for health education; and the extension of literacy will contribute to better health.
A good example of how health and other social services interrelate is provided by UNICEF, whose objective is to serve the child as a whole and which does so by a multisectoral approach of which health is a component.

At national level, there must be coordination with social welfare programmes, which can provide valuable support through their networks of information and services. Other social organizations, usually private, such as women's groups, parent/teacher associations, youth clubs, etc., can also contribute to disseminating the HFA/2000 message and to the proper motivation of the population. International groups such as Rotary, Lion's Club, etc., might also be interested in providing support.

4.4 Technical

Different aspects of the technical support which the primary health care programme will require have been mentioned in the preceding pages, as well as the support that may be obtained from technical nongovernmental organizations and specialized agencies in the United Nations system.

There is one facet, however, which is crucial to the programme, whatever its form or objectives, namely health manpower, and this deserves more detailed consideration.

4.4.1 Health manpower

All countries of the Region have formulated medium- or long-term national socio-economic development plans, mainly of five to seven years' duration, in which the health sector is invariably represented. From the point of view of staffing the health services, however, there is inadequate coordination between the authorities responsible for running the services and those responsible for training health personnel. Usually the mechanisms for intersectoral coordination are not explicitly formulated. The resulting deficiencies, both qualitative and quantitative, are a major constraint on improving the health services.

The perpetuation of the above constraint prompted the convening of a Ministerial Consultation on Health Services and Manpower Development (Tehran, 1978)¹, with the main purpose of discussing how best to coordinate health services and manpower development. The conclusions and recommendations of the Consultation are highly relevant to the HFA/2000 context, and can be easily translated into a regional strategy.

¹WHO/EMRO Technical Publications, No.1
Countries that have not done so are urged to prepare national plans of action for the functionally integrated development of health services and health manpower, with the participation of those involved in health services development and the training of all categories of health personnel, those working in other development sectors, and the consumers of health services.

Although the responsibility for education and training may be divided between the ministries of education and of health, this purely administrative barrier should not prevent the teaching staff of all training institutions from becoming familiar with the national health plans. The functions or tasks defined as necessary for health care delivery should serve as a basis for formulating the objectives of teaching and training institutions and for determining the competence to be acquired by students.

As a major support measure, educational and training institutions should actively generate and/or participate in health services research. Mechanisms for implementation or promotion of the required collaboration are suggested in the report of the Ministerial Consultation referred to above.¹

Of particular relevance is the recommendation that educational policies should reflect health services needs, and should consequently meet the health needs of those at present receiving little or no health care.

There is a strong tendency towards starting new schools of medicine, of nursing and of other health disciplines in a number of countries of the Region. However, although the actual needs may be justified, serious attempts should be made to depart from outmoded, imported educational models. Education and training should lay emphasis on the formation of the new teams of health workers required to serve deprived populations.

In several countries of the Region proper primary health care programmes have been formulated or a prominent place has been given to primary health care in country health programmes, or other policy statements. From the regional point of view, however, such formulation is yet to be completed.

The main relevant strategies can be summarized as follows:

- Recruit primary health care workers from the community and in consultation with community leaders, basing recruitment on criteria that suit local conditions.

¹WHO/EMRO Technical Publications, No.1
- Reorient existing health workers from among the ranks of the most suitable auxiliary personnel.
- Train traditional birth attendants and healers in appropriate simple modern techniques.
- Train the teachers in training methods, content, supervision and evaluation.
- Review the training curricula of medical and nursing students so as to adapt them to HFA/2000 concepts and programmes.
- Formulate suitable training curricula for primary health workers.
- Decide on places of training.
- Prepare manuals for primary health care workers, in local languages.
- Ensure continuous on-the-job training.
- Evolve career structures for the different categories of health personnel.

The introduction of front-line primary health care will necessarily affect the responsibilities, functions and duties of health workers at the referral level. They also will require suitable reorientation.

Primary health care and middle-level personnel should be trained locally and more attention may be given in a number of situations to supervised on-the-job training. With regard to the training of health professionals, a more selective use should be made of opportunities such as fellowships, or participation in seminars and other educational meetings, concentrating on areas where there may be a shortage of expertise and competence, e.g. in community medicine, maternal and child health, or teacher-training (including teachers of primary health care workers).

4.5 Managerial support

Management is the making of decisions to improve the way a system works. The manager is responsible for deciding how resources will be used, so that the system's outputs will be as beneficial as possible.

Management includes making decisions about the system's objectives, and what should be included in the system; thus it defines its own responsibilities and its area of concern. It also deals with operational decisions. Given that the objectives and extent of the system have been defined, management is then concerned with modifying its parts so as to attain those objectives.
Having defined the objective of the health system as being "Health for all by the year 2000", the manager must make decisions about the resources by which the objective can be successfully achieved. Good management is essential if resources are to be fully utilized in a cost-effective manner, and HFA/2000 is to become reality.

4.5.1 Managerial support structures

A management structure must be designed so that the parts of the system are controlled without duplication or omission, and decisions are made at the correct level by the managers who are most knowledgeable and skilled.

In respect of the higher-level strategic decisions for HFA/2000, it may be necessary to establish national health councils. These bodies can represent all the major interests in a country, such as the consumers (the community), the producers (the health workers), and other sectors (e.g. education and agriculture) that have a role to play in the creation of a healthy environment and in effective health promotive activities.

At lower levels, and particularly at village level, there are similar requirements concerning collective involvement in decision-making. For example, each village should set up a consultative committee (or strengthen an existing structure such as a village council), so that decisions can be based on collaboration between consumers and producers.

4.5.2 Managerial support processes

The aim should be to create or strengthen an integrated managerial process, which:

- encourages all managers in a system to use the same methods and technical terms;
- ensures that all management functions (planning, implementation, evaluation, etc.) are carried out in the correct sequence;
- promotes collaboration and communication between managers in the system, so that they contribute to the system's overall objectives rather than only to their own narrower subsystem goals.

It is essential that managerial processes for HFA/2000 should be simple, because the critical decisions are those made at primary health care level by front-line workers and the community. Practical training of managers will be required. It should
not be concentrated only on senior and high-level decision-makers, because they cannot by themselves achieve the objectives of HFA/2000. Moreover high- and low-level managers should be trained in similar ways, and preferably simultaneously in heterogeneous groups. This will help to ensure that the training is practical and simple, and that a spirit of mutual interdependence is created.

4.6 Health information systems

Information systems normally cover a range of data which are crucial for decision-making, planning and the management process. Often, in fact, the availability of data exceeds the capacity for utilization, while at the same time not meeting essential needs. Thus intuition and pooled judgements may be required to cover the need for additional information, not obtainable in a formal way.

National health information systems must be designed for the needs of actual and potential users. Since health statistical data constitute the main input, a part of the total strategy must be oriented towards the strengthening of health statistical services. It may well be necessary to conduct ad hoc sample surveys to satisfy specific needs for information. These may be less costly, more accurate, and produce data that will actually be used.

Personnel dealing with information systems, at various operational levels in the field, should be made aware of the importance of the data they collect, and of their potential contribution to the success of the total plan.

Firm lines of communication should be established between planning, information and research activities.

A suitable regional strategy should emphasize all these points and should offer possibilities for education and training of staff, for the testing of new methodologies, and for the study and selection of new techniques and equipment.

4.7 Research

Health services and operational research are essential supportive strategies of HFA/2000 and considerable efforts need to be made to reorient research programmes and their various aspects to ensure that they meet the requirements of the programme.

The Eastern Mediterranean Region is well endowed with research institutions; the Directory of Medical Research Institutions in the Region lists 229 of them.
The Regional Advisory Committee on Biomedical Research, established in early 1976, advises the Regional Director on regional research policy and priorities, and on the means for coordinating research at national, regional and global levels. It also provides advice on the establishment and strengthening of research capabilities in Member States, and on the scientific aspects of research projects.

There are 34 WHO collaborating centres in the Region whose main role is to meet the needs of WHO and Member countries with respect to expert advice, and to carry out technical activities on request. The centres render assistance to research workers in the Region by providing consultation reference services and training. They are selected on the basis of specific criteria, and WHO assists in maintaining their capabilities.

Full consideration is moreover given to developing regional research and research training centres in fields relevant to the health problems of Member States. Regional research panels on specific topics and the meetings of scientific working groups are effective tools in promoting regional research.

There is a regional system of research training awards and research grants, intended to enable research workers to spend a suitable period working in a defined institution or laboratory under the direct supervision of a qualified senior research worker. The selected project must be closely related to the priorities laid down in the Regional Medical Research Programme.

Information on the actual research being conducted in the major national research and training institutions requires more efficient collation and dissemination. The same applies to information on the manpower engaged in research.

The wide socioeconomic differences between the countries of the Region demand a clear expression of national research priorities. In June 1980, the regional priorities for research were reviewed, especially in the light of HFA/2000. It was considered that the main emphasis should be on developing national research capabilities in such a way as to reflect the national research priorities, within the frame of the country's overall health policies.

The above process will be developed further through closer collaboration with countries in planning and organizing relevant research by training scientists in research practices and methods. National expertise will be utilized to the maximum extent possible in scientific working groups, consultations, and exchanges of visits between countries.
In view of the complexity of HFA/2000, the development of national capabilities in research management should be given a place of prominence.

The strategy to be adopted includes the strengthening of individual and institutional research capabilities, and the developing of practical methodologies for epidemiological studies, control of vectors, and research on the integration of mass control measures into primary health care.

4.8 Public information

Reference has already been made to the importance of an active, continuous and organized exchange of information on HFA/2000 policies, technical aspects and experiences between countries, institutions and health workers engaged in the process.

The impact of proper information of the public is difficult to measure in scientific terms, but it can obviously contribute to changing behaviour and attitudes in a number of cases that have a close bearing on the achievement of HFA/2000, e.g., breastfeeding, prevention and control of gastrointestinal infections and common diseases of early childhood, drug abuse, and smoking.

The regional strategy in this field will have to take into account the growing demand from countries for the production and circulation of health educational films and other public information material in the Arabic language.

5. Generation and Mobilization of Resources

5.1 Human resources

The training and reorientation of health workers have been discussed in earlier sections (see particularly 4.4). Information and motivation of the people have also been touched upon repeatedly in the text and are not repeated here.

Other pertinent points are:

5.1.1 Orientation of non-health workers

Considerable additional support may be obtained from other categories of workers who are active at community level, e.g. teachers, community workers, or agricultural development workers. Their collaboration must be actively ensured. Programmes will have to be developed to instruct them on health matters and to keep alive their interest in the objectives of HFA/2000. Volunteers, whether members of existing organizations or individuals from the cities or from the community itself, can also play a valuable role in initiating action, but can rarely be relied upon to carry out duties over a prolonged period of time.
5.1.2 Health education of the public

The participation of the community in planning and implementation should be an essential element of health care delivery and can contribute enormously to its effectiveness. In particular, the community should be encouraged to participate in health care responsibilities, including the protection by individuals of their own health. Strategies should be developed to ensure the integration of health education in all aspects of primary health care services. Health education programmes should become an integral part of general education programmes; they should cover the principal elements of nutrition and sanitation, and include such aspects as control of communicable diseases and prevention of road and home accidents. Greater emphasis should be given to the planning of health education programmes; to the follow-up of programmes already in operation; and to the training of health personnel in health education and community development.

To further these ends, a Regional Advisory Panel on Health Education has been set up. An important target for a regional strategy in this field would be the establishment in all countries, by 1983, of fully functional, central and provincial health education programmes, headed by qualified health education specialists.

5.2 Financial and material resources

Certain aspects of obtaining financial and material resources for national HFA/2000 activities have already been mentioned in Section 4.2 above and are not repeated here.

Foreign assistance can, however, constitute only a fraction of the overall cost of developing a countrywide primary health care system, which is clearly a national responsibility. Even in countries with a low GNP, this should be possible over a period of time through a number of measures such as the rationalization of existing services and expenditures; the redistribution of resources, moving away from overemphasis on urban-located prestige medical institutions and giving preferential allocation to underserved areas and groups; greater regionalization of the health services and their financing; and increased individual and community involvement. The operation of token payment for services received is still a moot point; many governments consider it their responsibility to provide health services and drugs free of charge.

Much of the progress that can be made towards HFA/2000 rests ultimately on the degree of individual and collective participation by the beneficiaries themselves.
Personal hygiene and cleanliness, breast-feeding and better weaning and feeding practices, family spacing, improvements in housing and village sanitation, proper waste disposal, active support of control measures against communicable diseases, and a number of other contributions to healthier living are dependent on individual motivation and contribution and can be achieved with a minimum of governmental inputs. Only if this is fully recognized and accepted by policy-makers and by those responsible for implementing their decisions, and the relevant — often completely new — strategies are worked out at country level, will there be a serious hope of achieving the objectives of HFA/2000.

In the Eastern Mediterranean Region however, where some of the richest countries in the world live alongside some of the least developed among the developing countries, a greater sharing of financial resources should be possible to hasten the process. Substantial contributions have already been made on a bilateral basis or by funds-in-trust arrangements through WHO, and several of the better endowed countries have voluntarily reduced their demands on the WHO regular budget, thus freeing additional resources for use in other countries. More can, however, be done to ensure that these, and possibly additional resources, are channelled to primary health care programmes. The Regional Committee (resolution EM/RC29A/R.4) has urged all Member States of the Region which are in a position to do so to increase their contributions to the Voluntary Fund for Health Promotion. The Regional Committee could also play an important role in rationalizing the use of the contributions received.

Other bilateral assistance organizations, funds, development banks and other sources of financing can also, as already mentioned, substantially contribute to national efforts provided they receive well-worked-out and costed, reasonable project proposals. The success of two meetings held in Sudan with WHO cooperation, for the funding respectively of primary health care and epidemic disease control measures, is a good example of what can be achieved if suitable preparations are made. Altogether it may be hoped that within the next two or three years enough progress will have been made in replanning health services and in planning for primary health care to give an initial estimate of the resources needed country by country and on a regional basis (which would be quite premature at this stage), and that on that basis a new flow of resources to the needier countries can be expected.
6. Collaborative Mechanisms

6.1 Intra- and intersectoral coordination and collaboration

6.1.1 Intrasectoral coordination

Great importance attaches to continued intrasectoral coordination to ensure that all health activities are geared to the objectives of HFA/2000. Where vertical and horizontal programmes coexist in the national health system, such coordination is even more necessary.

Most countries are approaching primary health care services by way of the following scheme:

- **Local**
  - Basic health units, primary health care units, village "health houses", etc.

- **Intermediate**
  - Rural health centres

- **Regional or provincial**
  - Provincial or regional hospitals, referral hospitals

- **Central**
  - Teaching hospitals, specialized institutions, research institutions

This conception of the services, however, presupposes the need for strong and efficient sectoral coordination.

Countries generally have been meeting these coordination requirements through various mechanisms, e.g., the establishment of central and regional coordination boards, interdepartmental programme activities, etc.

6.1.2 Relations with social security health systems

Many countries of the Region are either planning or operating social security systems in most of which medical care insurance plays the predominant role.

Experience in Europe and North America has shown that, despite the manifest advantages enjoyed by their beneficiaries, such schemes always tend, in time, to become economically embarrassing. Thus, high priority should be given to securing a closer integration between the preventive approach to health care, implicit in HFA/2000, and the curative, highly physician-oriented and hospital-oriented approach of most of the social security systems currently in operation.

A further complication arises from the existence, in many countries, of multiple health care delivery systems, often acting in competition with one another and
leading to duplication of services, emphasis on expensive technology, and concentration in urban centres.

Governments, by subscribing to the Alma Ata Declaration and to regional or national health charters have assumed the responsibility for providing HFA/2000 as a human right of every citizen. This places a heavy responsibility on them to legislate against unnecessary duplication of facilities, and to assume some degree of control over non-productive and competitive publicly or privately operated health care facilities.

Similarly, governments have a responsibility to avoid segmentation of the health services through the development of separate (and competitive) health care facilities by different ministries, particularly by ministries of family planning, labour, and social affairs, education and others.

Most countries have some form of coordination mechanism to deal with health matters, but the terms of reference of such bodies, and of any new ones which may be established, need to be reviewed to take into account the objectives of HFA/2000 and the relevant plans as they are prepared.

In the Eastern Mediterranean Region a Regional Consultative Committee was set up in 1978 to enhance the participation of high-level health administrators in the work of the Organization. A system of regional advisory panels and scientific working groups has been in existence for a number of years now. The possibility of establishing a Regional Health Advisory Council to deal more specifically with HFA/2000 might be considered.

6.1.3 Intersectoral collaboration and coordination

The development and operation of a countrywide network of primary health care services goes considerably beyond the provision of national health administrations and requires the involvement of other sectors and of other services which may exist in a country.

The HFA/2000 concept and the eight main components of primary health care indicate the major directions in which determined thrusts must be made. Thus countries will have to formulate further specific strategies on how best to approach coordination of activities in such areas as agriculture and food production, (quality and quantity of food available, weaning foods for children, food hygiene during storage, food sanitation, protection of food stores from insect and rodent destruction); prevention and
control of water-associated vectorborne diseases, including adequate environmental protection in large resettlement schemes; protection of the human environment with respect to water supplies and sanitation, housing, soil, air and marine pollution, workers' environment (occupational health, industrial hygiene), and rural development; related integrated training, specifically of primary health workers; and integrated research.

These indications of the major areas of concern suggest the institutions, national agencies, associations and others with which coordination must be established or strengthened. A major effort must be made to ensure the linkage of plans that have a bearing on health. Thus plans such as the International Drinking Water Supply and Sanitation Decade and major socioeconomic development schemes have implications that overlap with HFA/2000 plans and need to be fully taken into account.

Coordination of planning, with special consideration given to health matters, is therefore essential between those ministries whose activities have an impact on health. The mechanisms will vary from country to country. They may include national health councils with intersectoral representation, or inter-sectoral governmental committees for health and development.

6.1.4 International cooperation

By jointly sponsoring the Alma Ata Conference, UNICEF and WHO have become close partners in promoting and supporting primary health care as the tool for achieving HFA/2000. Other organizations within the United Nations system and other international organizations, while not formally committed to the same extent as UNICEF, are also supporting the programme and its objective. In most cases cooperation is secured at country level, on the basis of government requests for assistance and under its aegis. Cooperation with UNICEF is coordinated through periodic inter-secretariat programme reviews and through the UNICEF/WHO Joint Committee on Health Policy, in which representatives of the respective Executive Boards participate. In other cases interagency coordination is ensured through ad hoc mechanisms.

6.2 Intercountry collaboration: Technical cooperation among developing countries

The Regional Committee (resolution EM/RC29A/R.3) confirmed "the extent to which in this Region the spirit of Technical Cooperation among Developing Countries (TCDC) has been both accepted and implemented".

In fact there is considerable TCDC activity in health manpower development programme, where mutual sharing of training opportunities of different kinds has long
been a feature. The TCDC approach is especially noteworthy in the core of activities sponsored by WHO in teacher training for the health professions. TCDC is manifest within the fellowships programme in the present trend of limiting training overseas and emphasizing placement in training institutions within the Region.

A Special Working Committee on Medical Arabic Terminology, composed of prominent medical specialists from the Region, has made good progress in the preparation of English-Arabic and French-Arabic medical dictionaries. The Committee has also advised on the selection of publications considered of practical value to health workers in the Region, to be translated into Arabic under the Regional Arabic Programme.

A meeting sponsored by the Technical Secretariat of the Council of Arab Ministers of Health (League of Arab States) was held in Kuwait in February 1979. This was also the inaugural meeting of the Supreme Council of the Arab Board for Medical Specialization. The objectives of the Board are to promote the development and upgrading of programmes of postgraduate and continuing education for physicians within the Region. It is hoped that, through the promotion of appropriate post-graduate training in institutions within the Region, such training will be more relevant to the needs of countries and will reduce the migration of physicians to overseas institutions.

Progress has been made by the Secretariat General of Health for Arab Countries of the Gulf Area in promoting uniformity and standardization of drugs and pharmaceutical products. Feasibility studies for drug manufacturing have been carried out.

A number of collaborative programmes and activities are being developed and implemented among countries in the Region, either on a bilateral basis or through regional multilateral agencies, e.g. the Council of Arab Ministers of Health (League of Arab States) and the Secretariat General of Health for Arab Countries of the Gulf Area. In addition, a number of WHO programmes rely to a great extent on TCDC involvement of Member States.

Further progress towards self-reliance in the health field by the countries of the Region can be achieved if TCDC is actively and systematically pursued until it becomes a part of government health policies, plans and programmes.

To achieve these goals, government action will require a firm political commitment to TCDC; the establishment of national focal points (preferably a special point for TCDC in health) preparing a national programme for TCDC; the collection and
inclusion of information on TCDC in the national information system; and the provi-
sion of national information, particularly in the fields of training and of essential
drugs.

7. **Programme Monitoring and Evaluation**

7.1 **Indicators**

Because of the great degree of uncertainty of long-term plans, considerable em-
phasis must be placed on monitoring and evaluation, so that changes can be made during
the plan period in response to new information and opportunities. Provision must be
made in the plan for such monitoring and evaluation, including the national framework
of mechanisms.

It is essential to specify the HFA/2000 objectives in concrete and measurable
terms. Thus, a set of indicators is required, to ensure that HFA/2000 is adequately
implemented, and that progress is monitored continuously and evaluated at appropriate
intervals.

In selecting such indicators, care must be taken to ensure that they are objective,
sensitive and specific. Different types of indicators may be selected by countries,
or at regional level, depending on the programme targets set, the availability of infor-
mation, etc. These indicators may be of four types:

(i) health policy indicators;
(ii) health status indicators;
(iii) social and economic indicators related to health; and
(iv) indicators of the provision of health care.

For the purposes of HFA/2000 the health indicators selected should be related
to the main elements of each national programme, namely, primary health care and its
eight or more components. Preference should be given to choosing a small number of
national indicators that have social and political punch, and will motivate people
and policy-makers to action.

Another important use of indicators is in the management of health activities
and programmes at different levels - local, regional, and central.

For the Eastern Mediterranean Region, taking into account its varied composition
and the constraints on obtaining and processing statistical and other information,
the following national indicators may be considered.
(i) Population statistics

- Population by age and sex, as the basis for all other statistics. Regional distribution of the population would also be important because of inequalities in different parts of a country in health services and health care.
- The birth rate is a health indicator in itself: it is necessary for the calculation of the infant mortality rate, and it reveals the extent of family planning.
- People under 15 and over 65 years, i.e. dependent groups

(ii) Economy, general social conditions, and education

- GNP gives the most essential data on economic activity,
- Income per capita, mean for the population and mean for the lower 10 percent of the population.
- Education - percentage of children going to school (including information on compulsory education in the country).
- Literacy, separately for women and men.
- "Landless/jobless", i.e., that part of the population which does not have a regular source of subsistence through work.

(iii) Government involvement in health

- Total amount of money spent on health and the government's part of that expenditure.
- Expenses for primary care as percentage of total health expenses, also calculated on a per capita basis. Ideally, one should have the mean for the population and the mean for the lower 10 percent of the population.
- Proportion of children born with low birth weight.
- Coverage by immunization.
  (For all these data, interest centres on the mean rate and on the rates for the underprivileged).

7.2 Monitoring and evaluation

The processes of monitoring and evaluation should be built into any primary health care and HFA/2000 programme. These processes should take place at two levels; the policy level, and the managerial and technical level. Responsibility for evaluation
needs to be specifically assigned and the necessary means provided to carry it out. In most cases monitoring and evaluation units are attached to the central office or committee responsible for planning and implementation. They need to be closely linked with the national health information system.

Within the context of HFA/2000, the evaluation network should include the national, intermediate and peripheral levels, with particular emphasis on the monitoring and evaluation of the primary health care programme.

In the Eastern Mediterranean Region, evaluation mechanisms have been outlined broadly in various documents, such as country health programmes, medium-term programmes, project and programme profiles, primary health care programmes, and others. While these may be useful as preliminary guidelines, it is felt that the serious gap in the evaluation process as a whole might be partly overcome by formulating, in close collaboration with the countries, a simple evaluation "protocol" as a basis for evolving more detailed and specific national evaluation guidelines.

It is further proposed that a report on monitoring of progress towards HFA/2000 should be published biennially. Countries would be expected, for example, to send in progress reports in 1982, which should permit the first monitoring report to appear late in that year or in 1983.

Support to the collection and analysis of information for monitoring and evaluation would mainly consist of:

(a) health information system development programmes (training and assignment of staff; data collection, processing and analysis);

(b) preparation of simple guidelines for monitoring and evaluation at national and regional level.

Training of the national manpower to be responsible for monitoring and evaluation should be planned concurrently. Recruitment would be made by the national authorities concerned, based on the background, experience, interest and career prospects of potential candidates. The actual courses could be organized for candidates from groups of countries with similar socioeconomic backgrounds.

8. **WHO's Role in Respect of National and Regional Strategies**

The role which the World Health Assembly has laid down for the Organization includes a promotive and a supporting aspect and both need to be developed in the national and regional strategies.
8.1 Promotion of HFA/2000

Both WHO and UNICEF have received a mandate from their governing bodies to ensure the achievement of HFA/2000 as one of their main tasks. Its promotion is already being carried out among policy-makers at top government level, among professional groups in the health and related fields, and among the public in general. The two agencies are also stimulating the interest and support of other international, bilateral and private organizations.

WHO has already established mechanisms, such as the HFA/2000 Health Resources Group, to ensure increased financial support to the programme from bilateral and multilateral sources. Another task which it has undertaken, and which needs to be further developed, is the collection and dissemination of general and technical information to facilitate the formulation and implementation of policies, strategies and plans of action. As part of this effort, WHO is relying on regional and national centres and on other institutions concerned with health development.

8.2 Support to national strategies and programmes

Although only occasional reference has been made in this document to WHO support to the different strategies discussed and in relation to the various constraints which countries are or will be facing, it is clear that the Organization can provide support and technical cooperation in a number of fields, with a variety of approaches.

In addition to its more traditional programmes, WHO collaboration can be provided, at the request of governments or the Organization's governing bodies, in diverse fields directly related to primary health care such as:

(i) Advising on broad guidelines for national policies for HFA/2000, and their revision at set intervals in the case of countries that have not yet completed their national documents.

(ii) Supporting the action required to gain the backing of political and social leaders, the health professions, and other influential groups.

(iii) Providing devices for monitoring and evaluating progress towards HFA/2000 as tools for the periodic review of national policies, strategies and plans of action.

(iv) Providing advice and continuing assistance in such fields as planning; development of managerial and administrative competence at different levels of government action; and introduction of new, appropriate health legislation where required.
(v) Increasing its contribution to health education methodology, including the preparation of suitable approaches, techniques and demonstration materials in support of better community information and motivation, with a view to ensuring the people's interest and active participation in HFA/2000.

(vi) Prompting and supporting education and training efforts to develop suitable manpower, at the appropriate level for implementing primary health care programmes. This may include teacher training, the production of teaching materials, the elaboration of curricula and of job descriptions and the teaching of supervisors. It may also include assistance to governments and schools of medicine in assessing the role of the future physician and other members of the health team in relation to the new demands made on them by HFA/2000 goals; in revising curricula; and in community health teaching. This assistance can be of even greater importance when the establishment of new schools of medicine or health science institutions is contemplated.

(vii) Analysing with countries the problems encountered in the structuring of primary health care services, in arranging proper supervision, in organizing a referral and an adequate receiving system at higher level, and in the organization, administration and logistics of their primary health care programmes, with a view to establishing a body of knowledge and experience from which all participants can benefit in the local setting.

(viii) Defining with countries the nature of services to be rendered at village level, the role of duties of village health workers, the integration of vertical and horizontal services (particularly in situations where disease control campaigns still rely on strong intrasectoral structures), and the application and integration of the eight essential elements of primary health care in order to ensure their appropriate delivery.

(ix) The problems of achieving proper intersectoral support and coordination may also warrant analysis and the establishment of procedural guidelines of common interest, based on the pooling of national and individual experience.

(x) Cooperating with national administrations in seeking support from external sources, in preparing project proposals and documents, in creating links between funding sources and requesting administrations, and in carrying out cost/benefit analyses of the different approaches to external funding.
(xi) Providing advice and support in the establishment and operation of national information systems, health statistics departments, and programme evaluation and monitoring units.

(xii) Developing a research methodology for the study of operational activities, and supporting research workers and institutions in this field. This list is not exhaustive, but it gives some indication of the many areas in which WHO can be of assistance to national efforts, whether at country, regional or central level.

b.3 Support to regional strategies and programmes

A number of the areas identified for WHO support at country level are also open to a regional approach. Thus the WHO programme will give priority to activities aimed at developing guidelines, methodology and administration, health education and information, and research. Continued emphasis will also be given to education and training activities, to the upgrading of training and research institutions, and to educational methodology.

WHO regional action may also be considered for promoting extrabudgetary funding, e.g. the creation of a Regional Fund for HFA/2000, the convening of meetings to examine programme proposals for funding, or the creation of a standing committee for the coordination of bilateral, multilateral and international assistance provided within the context of HFA/2000.

Increased use of funds-in-trust arrangements, through WHO, between a supporting country and the recipient country might also be taken into consideration.

The Organization may also be the logical central point for the elaboration of a Health Charter linking all the countries in the Region in a single effort to achieve HFA/2000 (See Annex).

In addition to the above, the Regional Office could be asked to:

- create linkages with other regional socioeconomic development bodies in the Region which might contribute actively to the achievement of HFA/2000;

- identify ways of promoting mutual support among countries of the Region and outline modalities for fostering and facilitating technical cooperation among countries in solving specific priority national problems, sharing expertise and training facilities, developing appropriate technology, exchanging experts
and information from national institutions, and developing new knowledge of interest to all countries through collaborative research on priority problems;

- develop an outline for a possible common policy in the selection, purchasing or manufacture of drugs and vaccines; for the development of low-cost technology in priority fields such as water supply, basic equipment and supplies, transport, etc., and for guidance in relations with regional social or commercial organizations and enterprises whose support to HFA/2000 may be of importance;

- establish possible mechanisms for the elaboration of compatible strategies in such fields as biomedical and health services research; education and training of staff; and the control of communicable diseases, particularly in contiguous endemic areas of neighbouring countries.

Nor should it be forgotten that the World Health Assembly in resolution WHA33.17 (May 1980) gave a mandate to the regional committees "...to increase their monitoring, control and evaluation functions".

8.4 Modes of WHO action

The implementation of the above proposals, either singly or collectively, would result in a marked redirection and focalizing of WHO's priorities in the Region towards HFA/2000. This may in time lead to the modes of action of the Regional Office being adapted to give greater emphasis to problem-solving approaches that would enhance WHO's value to Member States both collectively and individually.

Thus, for example, in order to further technical cooperation at country request, the Regional Office should be in a position to broaden and strengthen its relations with national centres of expertise and individual experts, so as to draw on their competence and their participation whenever the need arises.

It should also develop further its capacities in terms of staffing and equipment if it is to serve as a focal point for the collection, elaboration and redistribution of basic information that can be used by Member States in the continuing analysis and upgrading of primary health care services and HFA/2000 policies and strategies.

Similar considerations also apply to the Regional Office's role in:

(a) Establishing, with interested Member countries, techniques for evaluation of progress towards HFA/2000 goals based on the choice of appropriate indicators
and benchmarks as a means of providing reliable and objective guidance to
decision-makers, planners and programme executors.

(b) Facilitating TCDC between countries in the Region or other countries facing
similar problems, by providing such guidance and additional support as circum-
stances may require; and acting as a clearing-house for TCDC if experience
should prove this necessary.

(c) Advising on and coordinating national and regional research activities, with
particular regard to the need for knowledge and data of an operational charac-
ter on all aspects of HFA/2000 activities (planning of primary health care
infrastructure, staffing, financing, community mobilization, approaches to
health education, etc.). Given a mandate and the appropriate resources, the
Regional Office could also play a substantial promotional role in this domain.

(d) Continuing and expanding activities aimed at intersectoral coordination with
the relevant regional United Nations and other international institutions as
well as with the various political, scientific, technical and professional
bodies and institutions whose cooperation could be supportive of HFA/2000
goals.

(e) Strengthening, and where necessary establishing, new mechanisms (at national
level with the countries concerned, and also at regional level) for the promo-
tion of continued financial support to those programmes that could not become
fully operational without additional external support.

The above tasks point to a change in emphasis in the work of the Regional Office
which is consistent with the changed requirements of Member States in relation to HFA/
2000. It is only through such adaptation that WHO can really maintain and develop
further its usefulness to the countries and peoples of the Region, fulfilling its
function as the coordinating authority on international health work and the mandate
it has been given in the formulation and implementation of strategies for attaining
health for all by the year 2000.

8.5 Global implications

The various country and regional strategies discussed throughout this paper have

Both the Board and the Health Assembly will need to continue their role of
highlighting the political and social relevance of HFA/2000, monitoring progress,
evaluating results, and obtaining support and resources for the Programme. An important aspect will be the identification, and continued redefinition, of what should constitute the priority areas for WHO action at different levels if maximum benefit is to be obtained from technical cooperation activities.

A major effort will moreover be required of the Secretariat with the assistance of technical advisory groups, individual experts, the networks of national and regional reference centres and research institutions, and TCDC arrangements and other mechanisms, in preparing guidelines on managerial processes for health programme development (including planning and selection and use of indicators for programme monitoring and evaluation); providing guidance on the integration of intrasectoral activities and projects as part of the primary health care approach; on the development of national health information systems; on the establishment and functioning of national and regional centres for health development; on ensuring community participation in primary health care programmes, etc.

By the collection, analysis, distillation and distribution of information (political, socioeconomic, technical and scientific) obtained from countries and through regional experiences, WHO should further play a leadership role in orienting the programme through its periodic reviews and redefinition of objectives, and advising on matters such as education and training, management processes, simple technology, public health research, and other basic matters.

The Central Office will continue to assume information and coordination responsibilities in regard to the United Nations system, the supporting organizations, the development banks, multilateral and bilateral assistance programmes, nongovernmental organizations, and major private organizations with a view to assuring their acceptance and support to the programme and strengthening its financial backing.

9. Tentative Plan for Implementation of Regional Strategies, including Timetable

<table>
<thead>
<tr>
<th>Country level</th>
<th>Suggested deadline</th>
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<td>(i) Though considerable progress has been made in a number of countries in adapting policies to HFA/2000 objectives and in defining national strategies, much more work needs to be done to refine the strategies and especially to prepare revised plans of action covering at least the existing national plan period, but in any case not less than the period up to 1985. A progress report should be submitted to the Regional Committee in ......................... October 1981</td>
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Country level (Cont'd)

(ii) Countries should also establish a process and mechanisms for monitoring, evaluating and updating their strategies and plans of action, reporting thereon to the Regional Committee in ...................... October 1981

(iii) Countries will undertake a revision of the duties, structure, staffing and terms of reference of their central and intermediate-level health administrations, to bring them in line with the new HFA/2000 policies and strategies, reporting to the Regional Committee on actual implementation by ...................... October 1982

(iv) Countries will establish plans for management training (including planning); for training and education programmes of primary health care workers and of health staff at different levels for the organization of health services research; and for the development and application of appropriate technology. They should report thereon to the Regional Committee by ...................... October 1982

(v) Countries will also report to the Regional Committee on the establishment of national development centres and other institutions relevant to the implementation of HFA/2000, as well as on any major action taken to strengthen existing institutions, by ...................... October 1982

(vi) Country evaluation reports on the first five years of the programme are expected by ...................... mid-1985 (Country progress reports to be submitted to the October session of the Regional Committee will need to be received in the Regional Office not later than the preceding 15 June).

Regional level

(i) The Regional Committee will review and approve the regional strategies, committing governments and itself to implement, monitor and evaluate them ...................... October 1980
Regional level (Cont'd)

(ii) The Regional Committee will examine country progress reports (see above under "country level" paragraphs (i) and (ii) and make recommendations thereon. ....... October 1981

(iii) The Regional Committee will review regional strategies on the basis of the country reports (as per points (iii), (iv) and (v) above under "Country level" and will decide the date for a future revision. The country reports for 1981 and 1982 will also be used to fulfil the Regional Committee's responsibilities for the ongoing monitoring and evaluation of the programme, and will assist the establishment of a long-term timetable for this purpose. ....... October 1982

(iv) A major review of progress achieved during the first five years of HFA/2000 will be made, based on reports from countries on the results of their national health plans and programmes and leading to a revision of strategies and plans of action for the next five years. ....... October 1985
ANNEX

A CHARTER FOR HEALTH
FOR THE EASTERN MEDITERRANEAN REGION

We, the representatives of the Member countries of the WHO Eastern Mediterranean Region, individually and collectively, do herewith agree to subscribe and commit ourselves to the following undertakings:

1. To recognize the rights of all citizens of our country to equitable access to health care facilities, without regard to race, creed or social standing.

2. To subscribe to the premise that a healthy population is an essential component in the successful economic development of our country.

3. To accept as a target for our country the attainment of health for all our population by the year 2000.

4. To affirm that the expansion of the primary health care component of our health care system is the key to the provision of equitable access to reasonable care.

5. To declare that prevention offers the soundest economic and the most humanitarian approach to problems of disease and disability, and to commit ourselves particularly to programmes of immunization against communicable disease and to the prevention of accidents in the home and the workplace and on the roads.

6. To confirm the necessity, in developing an economically sound and humanely equitable health care system, of ensuring the fairest possible allocation of our resources, both human and material, avoiding unnecessary emphasis on sophistication of technology, expertise and construction, in order to make health care accessible to the greatest possible number of our citizens.

7. To recognize that each individual bears a responsibility for the protection of his or her own health, we undertake through the educational and public information systems to disseminate to all our citizens the best concepts of positive health, and to increase their awareness of the dangers of misusing toxic substances, particularly alcohol, tobacco and behaviour-modifying substances.

8. To cooperate with all appropriate elements and levels of government with private corporations, with community organizations, and with individual citizens, in developing in our countries an environment conducive to health and particularly in providing to all our citizens accessible and safe drinking water and hygienic disposal of waste material.
9. To take such measures as are necessary to protect our land, air and water against hazardous pollutions from human, agricultural and industrial sources.

10. To provide our vulnerable groups, particularly mothers and children, with the best available care both preventive and curative, and ensure that reasonable access to information and material for intelligent planning of families will be universally available.

11. In a spirit of neighbourliness, to participate in international programmes for the prevention of disease and the promotion of health through subscription to international legislation and the exchange of information and technology.

In the spirit of the Declaration of Alma Ata and in our devotion to the pursuit of the objective of Health for All by the Year 2000, we do herewith subscribe our names to this Covenant.
RESOLUTION OF THE WORLD HEALTH ASSEMBLY

ANNEX II

EM/RC30(81)/7

THIRTY-FOURTH WORLD HEALTH ASSEMBLY

RESOURCES FOR STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000

(Draft resolution proposed by a working group)

The Thirty-fourth World Health Assembly,

Recalling resolution WHA30.43, which defined the goal of health for all by the year 2000, resolutions WHA32.30 and WHA33.24, which endorsed the Declaration of Alma-Ata and urged Member States to formulate national strategies for attaining health for all through primary health care as part of a comprehensive national health system, and resolution 34/58 of the United Nations General Assembly concerning health as an integral part of development;

Also recalling resolutions WHA27.29 and WHA29.32, which requested the Director-General to strengthen WHO's mechanisms for attracting and coordinating an increasing volume of bilateral and multilateral aid for health;

Noting with satisfaction the decision taken by the Executive Board at its sixty-seventh session concerning the establishment of a Health Resources Group;

Aware that some countries have encountered difficulties in developing and implementing their national strategy for health for all, and convinced that these countries urgently require special support to enable them to overcome their difficulties;

1. WELCOMES the efforts being made by Member States to prepare and implement national strategies for health for all through the development of health systems based on primary health care;

2. URGES all Member States to allocate adequate resources for health and in particular for primary health care and the supporting levels of the health system;

3. URGES Member States that are in a position to do so to increase substantially their voluntary contributions, whether to WHO or through all other appropriate channels, for activities in developing countries that form part of a well-defined strategy for health for all, and to cooperate with these countries and support them in overcoming the obstacles impeding the development of their strategies for health for all;

4. INVITES the relevant agencies, programmes and funds of the United Nations system, as well as other bodies concerned, to provide financial and other support to developing countries for the implementation of national strategies to achieve health for all by the year 2000;

5. URGES those Member States that, for the implementation of their strategies for health for all, require external sources of funds in addition to their own resources, to identify those needs and report thereon to their regional committees;
6. INVITES the regional committees to review regularly the needs of Member States in the Region for external resources in support of well-defined strategies for health for all and report thereon to the Executive Board;

7. REQUESTS the Executive Board to review regularly the international flow of resources in support of the strategy for health for all, to ensure that such resources are effectively and efficiently used for that purpose, and to report thereon to the Health Assembly;

8. DECIDES that the World Health Assembly will review from time to time the international flow of resources for health and will encourage those Member States that are in a position to do so to ensure an adequate level of transfer;

9. REQUESTS the Director-General:
   (1) to support developing countries as required in preparing proposals for external funding for health;
   (2) to take appropriate measures for identifying external resource requirements in support of well-defined strategies for health for all, for matching available resources to such needs, for rationalizing the use of such resources, and for mobilizing additional resources if necessary;
   (3) to report regularly to the Executive Board on the measures he has taken and the results he has obtained.