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DRAFT REGIONAL HEALTH-FOR-ALL POLICY AND STRATEGY FOR THE TWENTY-FIRST CENTURY

CONTENTS

CHAPTER 1

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

Health as a human right

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

2. The various dimensions of this definition are deeply rooted in the culture and tradition of this Region. Health is our focus and disease is the exception. Health means that the body is in a state of dynamic equilibrium. To maintain the equilibrium of this health balance it is important to strengthen one's health potential. Based on these concepts health protection and health promotion have been greatly emphasized. This is the kind of health a human being should enjoy—the best condition physically, mentally, socially and spiritually.

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

4. Commitment to this health definition and to health as a human right should constitute the basis of setting national, regional and global policy goals and underline the main orientation of health strategies. Several countries have made health a constitutional right. Among the important milestones for the global movement to achieve this noble goal were the Declaration of Alma-Ata in 1978 and the launching of the Global Strategy for Health for All (HFA) by the Year 2000.

Health for all and primary health care

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

participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work".

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

7. Despite these significant health gains it was recognized that the goal of health for all cannot be achieved by the year 2000, for various reasons, including the global political, economic, social and cultural changes and challenges which impact on health systems. In this respect WHO, aware of the timelessness of the health-for-all goal, initiated, with contributions from Member States, a challenging exercise aimed at renewing the health-for-all strategy for the next century.

The main problems facing the process of formulating and implementing national health for all policies and strategies are the following:

- limited intersectoral cooperation for health development with limited coordinated efforts to mitigate the impacts of environment degradation on health;
- lack of community involvement—the acquired attitude of considering the state as responsible for providing the totality of health services is the main obstacle to active community involvement;
- unhealthy behaviour and lifestyles such as smoking, substance abuse and inappropriate food consumption;
- the overall relative weaknesses of national health systems, particularly with respect to policy analysis and formulation, coordination and regulation;
- poor resource allocation, leaving limited resources for promotive and preventive activities and programmes;
- inappropriate use of medical technology, leading to escalating cost of health care services;
- poor organization and management of health services at all levels—the referral system is usually weak with a general tendency to bypass the locally available health facilities;
- weakness of health information systems at central and peripheral levels;

- weak decentralization of health systems based on primary health care, therefore limiting their performance;
- inappropriate human resource planning, leading to imbalances between various health professionals and to geographic maldistribution;
- poor working conditions of public employees in the health sectors with low salaries, leading to demoralized staff.

Main global changes and challenges

8. The final decade of the 20th century is characterized by the consequences of the dramatic political and economic changes that followed the end of the Cold War. These will continue to have repercussions well into the 21st century. While long-term benefits of these changes are expected, it is evident that the intermediate outcome remains uncertain in many countries, and the process of transition may be long, harsh and costly.

Political changes

9. The wave of democratization resulting from global political changes has affected many countries throughout the world leading to pluralism, greater transparency in governance and moves toward decentralization. Civil society has been empowered and communities have become more involved in decision-making processes. These changes have had an impact on the organizational structure and on the management of health systems.

Macro-economic environment

10. The economic crisis of the 1980s had a negative impact on health and health-related sectors, particularly in developing countries where budget cuts were made as a consequence of social adjustment programmes and other economic and financial policies.

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

Globalization

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

Global free trade

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

14. The implementation of various WTO agreements will have an impact on the health sector. The agreements strongly promote protection of intellectual property rights, global free trade and harmonization of international standards. Although the agreements refer to encouraging development and economic reform and take into consideration protection of health and environment, the interests of developing countries, in particular the social sectors including health, appear not to have been taken into consideration during the negotiation phase. More comprehensive studies are needed to investigate the impact of various aspects related to WTO agreements on health and health-related sectors.

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

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

Global communication

17. The revolution in global communications and easy access to huge databases will have tremendous influence on the process of socioeconomic transformation. The recent advances in medical informatics, and in particular in the field of telemedicine, may well raise people's expectations and place additional strains on health delivery systems.

Rapid advances in biotechnology

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

19. Directions in drug design have always been based on the current knowledge of the biochemical pathology of disease. Our knowledge of disease is being expanded rapidly by our ability to scan genomic sequences and define distinct marker sites associated with the inheritance of and the predisposition to disease. This new knowledge will take us, and all other health care practitioners, rapidly in new directions as we approach the start of the new millennium.

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

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

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

Environmental degradation

22. Environmental degradation has a negative impact on social development in many ways. It increases the pressures on rural areas, leading to poverty and migration to the cities,

and contributes to the depletion of natural resources. In this respect, the 1996 World Water Forum foresaw a water crisis in the near future.

Conclusion

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

CHAPTER 2

REGIONAL SITUATION

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

Political trends

25. Despite the end of the cold war and the hopes raised by the Oslo accords and the peace process in general, Palestinian, Syrian and Lebanese territories remain under Israeli occupation and the prospects for a just peace settlement are gloomy. Such a situation has a negative impact on the health of displaced and colonized populations in the Region.

26. Ethnic, religious and civil strife are causing human losses and suffering for millions of people in Afghanistan, Somalia and southern Sudan, disrupting health systems and limiting access to basic health care.

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

28. In many countries the role of the government in both the financing and delivery of health care have been revisited in line with new policies aimed at decentralization and at increasing the role of the private sector in health care. Fears have been expressed regarding the potential impact of the latter on the health status of the poor and vulnerable populations.

Trends in socioeconomic development

Economic trends

29. The main obstacle to economic growth in the majority of Eastern Mediterranean Region countries continues to be the unprecedented level of external debt, amounting to thousands of millions of US dollars. The cost of servicing such debts constitutes a continuing burden weighing upon the economic development of these countries. Some have already adopted structural adjustment programmes (Egypt, Morocco, Tunisia) or are in the process of making modifications (Lebanon, Republic of Yemen) to introduce flexibility into the management of their economies. The cancelling of part of the external debt in favour of some countries (Egypt, Jordan, Morocco) will hopefully have a positive impact on economic development.

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

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

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

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

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

35. As for the provision of health care, the private sector plays an important and growing role in most countries, as a consequence of economic and policy reforms and the adoption of incentives to support private providers. In several countries, 40%–50% of outpatient services are provided privately, but the contribution to hospital care is relatively modest, except in Cyprus and Lebanon. The development of the private

sector, both in financing and in providing health care, has also been possible through the implementation of regulatory mechanisms by ministries of health in terms of licensing, standard setting, fee schedules and quality assurance. The growing role of the private sector in health services delivery has raised concerns over quality and also over equity in access to heath care. It is perceived that efforts need to be made to strengthen the role of the public sector to reduce the impact of these changes on the patterns of health care provision and the overarching role played by the private sector. Efforts are being made in many countries to look for appropriate public private mix in health systems.

Demographic trends

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

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

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

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

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

Social trends

41. Education is a priority social issue that affects on health. The gross school enrolment ratio (first level)—the ratio between the actual number of pupils in the first level of education (often referred to as compulsory education) and the population size in the corresponding age group—has reached 90% or more in 13 countries, but is less than 50% in four countries. Those who do not attend school will become illiterate adults. More favourably, the gap by gender appears to be narrowing.

42. Looking at the adult literacy rate indicator, i.e. the proportion of adults (15 years or above) that are literate, the regional average for the period 1985–96 showed a substantial increase from 38% in 1985 to 52% in 1996.

Health trends

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

44. At first glance, the results indicate that the health situation improved during the decade since the start of implementation of the health–for-all strategy. Despite the burden of rapid regional population growth and continuing social and military conflicts, good progress has been made towards achievement of health-for-all targets. Already achieved or attainable targets relate to gross national product, percentage of the latter devoted to national health expenditure, immunization coverage by BCG, DPT3 and OPV3 and life expectancy.

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

46. The main findings show that:

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

        - Continuing rapid population growth in almost all countries, as well as change in age structure in some countries, which itself generates an epidemiological transition, bringing changes in the pattern of both communicable and non-communicable diseases.

- Increased expectations of quality health care as a consequence of literacy, health education and health promotion.
- New health needs generated by rapid dissemination of medical, pharmaceutical and technical knowledge.

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

c) Political endorsement of health for all at the highest official levels has not always been translated into strong financial support at the primary health care level. Tertiary level hospitals continue to absorb most public sector health expenditure.

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

e) Because of the epidemiological transition, which most countries of the Region are undergoing, the double burden of communicable and noncommunicable diseases will stretch health resources as never before.

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

CHAPTER 3

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

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

    a) recognition that the enjoyment of the highest attainable standard of *health is a fundamental human right*;
    b) *equity*: implementation of equity-oriented policies and strategies that emphasize solidarity;
    c) *ethics*: continued and strengthened application of ethics to health policy, research and service provision;
    d) health care should be based on the essential features of *solidarity, cooperation, self-sufficiency and perfection*;
    e) *gender sensitivity*: incorporation of a gender perspective into health policies and strategies.

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

48. Health has been recognized in most constitutional documents as a *human right*. This commitment needs to be put into action. The commitment to this right depends on the value assigned to health by individuals, states and the international community. It should also be a determining factor in the way states allocate resources to development priorities. However, the compelling force of the commitment has not found concrete expression in national or global policy. The right to health was not adequately translated into special claims on available resources nor did health status become the test of social and economic development. Although article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", the implementation of this right has remained essentially an ideal. *It is, therefore, important to give the right to health an operational dimension.* Another, more practical, definition of the right to health is the right to the conditions that enable individuals to attain and enjoy their full potential for a healthy life.

49. *Equity of access to health care* should be one of the main policy goals. Every national health system should ensure universal access to adequate quality care and avoid unfair and unjustified discrimination between individuals, groups and communities. The striving for equity in access to health care must be a fundamental objective of the process of health-service reform.

50. Self-sufficiency ensures the availability of both human and material resources. All individuals in the community can make their contribution, and the work required will be completed with minimum expense. Cooperation ensures the removal of barriers that

separate various sectors of society. It frees experts and specialists from the constraints that prevent them from joining in an all-out effort to benefit the whole community. The factory worker, the farm worker, the engineer, the businessperson, the doctor and everyone else will come together as a single team, working together for the common is good. Perfection brings community participation to completion since everyone tries to do their jobs as perfectly as possible, knowing that God witnesses their work.

51. A society comes into existence when all its members keenly feel the solidarity that establishes a bond of unity between them. That does not mean that individuals lose their identity within the community. A structure does not stand up or become habitable unless all its parts mutually support one another. This emphasizes the elements of solidarity which are all expressed in the mode of mutual interaction: love, compassion, and sympathy are felt by all, extended to all and reciprocated by all. The other important safeguard that ensures solidarity within the community is *shura* (consultation). Consultation must be practised at all levels, beginning with the smallest social unit, and in all matters, large and small, especially those which affect the whole community. Solidarity in health includes the ways in which a society shares and becomes responsible for the maintenance of public health and the health care system. In the present context, the goal of health for all is enhanced by a spirit of solidarity that calls for community participation and intersectoral articulation, involving all the actors from the various sectors concerned with health.

52. Ethics are the underlying principles that inform laws, social customs and the codified rules of professional groups. As a constructive discipline, ethics seek to determine which actions, relationships, and policies ought to be considered right or wrong. The Eastern Mediterranean Region is the cradle of three of the major religions (Judaism, Christianity and Islam), which share largely similar bioethical values and are the main source of health ethics in large areas of the world. The following are some of the principles on which general and global consensus is possible even though some differences of detail may exist in some cultures:

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

    A strong ethical framework that includes respect for individual choice, personal autonomy and the avoidance of harm applies to both individual and social aspects of health care and research. Advances in science and technology, engineering, communications and medicine have brought us untold opportunities to influence health. If everyone is to share in the progress and promise, ethical principles will have to anticipate and guide science and technology development and use. Scientific and technological progress is testing the boundaries of ethical norms and challenging the

very notion of what makes us human. Therefore, there must be firm ethical principles on which to base decisions about matters that influence health.

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

- performing gender analysis and encouraging gender awareness;
- attending to the special needs of girls and boys, women and men, throughout life;
- supporting the human rights, dignity, self-worth and abilities of girls and women; and
- creating opportunities for full participation of women with men in decision-making at all levels.

Men and women have equal responsibility for building and maintaining human life on earth. Both men and women have the same rights to undertake any profession. Children of both sexes have the same right to education. Men and women enjoy the same rights to have their reputation and social standing protected against any slander, ridicule or backbiting. Both men and women are equal partners in sharing responsibilities in their home. Women should enjoy the highest standard of health, physically, mentally and socially, from early childhood. A husband and wife are described as "garments". It is important to emphasize the great variety of connotations that the use of the term "garment" provides here, such as warmth, screening, closeness, mutual care and benefit.

Such a generous, open-handed mentality is not limited to husband and wife. Indeed, it is demonstrated by all members of the nuclear family and the extended family, as well society as a whole. It thus provides the proper remedy for a variety of social problems. It protects society against the numerous social cracks which are only too evident today in the structure of the societies that are frequently described as advanced. These include loneliness and isolation, lack of care for the elderly, wide gaps between generations, a high rise in the rates of suicide and violent crime, and a continuous increase in crimes committed by children and adolescents. All these are the direct result of the weakening of relationships within society and the denial of the need of mutual care between its members.

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

CHAPTER 4

STRATEGIC ORIENTATION

Commitment to health-for-all goals

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

55. It is essential to emphasize the centrality of health in socioeconomic development. This means that:

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

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

National policy framework

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

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

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

59. For policy to be based on scientific evidence, a solid research base in health and epidemiology is needed, together with related information on public preferences as well as on the availability of resources. This requires the strengthening of the scientific and technological infrastructure, the promotion of health policy and systems research, and methodological innovation in measurement, analytical techniques and resource allocation models. Ethical considerations must guide the use of scientific evidence.

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

The development of sustainable health systems

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

62. Sustainability has three dimensions: financial sustainability, which requires detailed cost analysis (development of national health account); financial resources identification; and a mechanism for monitoring the financial allocations and resources.

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

64. Managerial sustainability requires the development of a well organized, well functioning and a competent system of civil service. Such a system should continue to function within the national policy framework without interruption of changes of an political leadership. Managerial sustainability requires the development of environment that will motivate and encourage civil servants to achieve a well managed and sustained health care system. It is important in this respect to promote competitive working conditions to attract and keep competent personnel.

Primary health care is the key to achieving health for all

65. It is important to affirm the concept of primary health care as the practical, scientifically sound and socially acceptable method to make health care universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It forms an integral part both of a country's health system, of which it is the main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work.

66. The eight primary health care elements defined at Alma-Ata are being revisited and expanded in the light of new knowledge and challenges. For example, the spectrum of maternal and child health has been expanded and reconfigured to include reproductive health; the essential drugs concept is being developed as a broader-based technology for health policy; and the previous focus role on communicable disease control is expanded whenever necessary to include noncommunicable diseases. An explicit life span approach will be implemented within the health system; food safety will be explicitly addressed when considering food and nutrition; and health education will become a component of health promotion.

67. Primary health care should encompass the following five concepts:

- There should be universal coverage of the population, with care provided according to need
- Services should be promotive, preventive, curative and rehabilitative
- Services should be effective, culturally acceptable, affordable and manageable
- Communities should be involved in the development of services so as to promote self-reliance and reduce dependence
- Approaches to health should relate to other sectors of development.

Human development and health care/basic development needs

68. The basic development needs (BDN) approach, which is a comprehensive approach addressing overall local development, has continued to gain momentum. BDN has established itself, after several years of promotion of the concept, as one of the main regional approaches. During the past decade, the concept of BDN has been advocated

to several countries as an approach that, while mainly addressing poverty alleviation, also directly and indirectly affects the health status of the people. The BDN initiative entails political commitment, community organization, motivation and involvement, intersectoral action, and integrated, decentralized, comprehensive development.

69. Basic development needs initiatives include community identified projects that integrate social, economic, health and environmental issues. BDN projects are organized and managed by the community, supported by a coordinated intersectoral team. BDN projects target income generation and poverty alleviation by implementing realistic, achievable activities which have to include a "basic" health component.

Almost all countries with BDN programmes have included income-generating schemes in their plans. These income-generating schemes could provide an important source, in the long term, to sustain and expand BDN and, thus, health for all.

BDN has also provided important support to other health promotion and prevention activities within primary health care system development.

70. The lessons learnt in the 12 countries where BDN programmes have been implemented include:

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

Human resources for health

71. To meet the challenges of health for all in the 21st century, a well educated and trained health workforce that is oriented to meet the needs of the communities has to be developed. A well trained and motivated workforce is essential for health systems to function well. Support by the state, WHO and their partners in training institutions should reflect the need for ongoing and comprehensive capacity-building for health. Educational institutions for health personnel should constantly review their curricula in the light of new knowledge, with a view to meeting people's needs. A greater responsiveness to society's needs could be achieved through expanding community-oriented medical and health education and research.

72. Education of health professionals should be community-based and community-oriented and should strengthen partnership between health care delivery and training institutions. Efforts should be made to develop standards for health personnel education and to promote a voluntary system of accreditation of medical schools. Special interest should be paid to developing continuing education for health personnel and to institutionalizing such programmes in national health systems.

73. Human resources planning should recognize the need to consider changing mixes of health care providers working in a multidisciplinary and collaborative fashion. The mix would include public health providers, technicians, therapists, doctors and nurses, among others. To serve the need of the public for better information about all aspects of health, greater attention should be given to training in communications, health promotion skills, care-giving and community assessment. Telecommunications linkages offer new opportunities for distance-learning and diagnostic support in many settings. The health sector should develop national policies that contribute to self-sufficiency in human resources development, appropriate career development and deployment of the health workforce and the working conditions of all health workers.

74. In addition, regional policies must address broader human resources issues, such as the transnational movement of health professionals, the provision of training, the need for international harmonization of education and service standards, and the use of appropriate regulatory and financial mechanisms to maintain and strengthen national capacity.

Response to emergencies/health as a bridge for peace

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

76. Health concerns can transcend political divisions, promote dialogue, foster solidarity and contribute to peace among people and between nations. Health can be deliberately employed in a variety of situations to help prevent disputes from arising, prevent them from escalating, and to foster peace-building and rehabilitation. Health can play a vital role during all stages (peace, tension/conflict, war, post-crisis) of wars and other conflicts. During peace time, health interventions such as the promotion of health for all or socioeconomic development will decrease tensions and the chance of conflict, while during war, health-related activities can promote confidence-building measures, provide humanitarian assistance and can intervene as a mediator for cessation of hostilities and attainment of peace.

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

78. In order to ensure a smooth transition from relief to rehabilitation and development, emergency assistance should be provided in ways that will be supportive of recovery and long-term development. Therefore, greater WHO efforts are needed in the 21st century in order to prevent and mitigate natural disasters and emergencies, to assist developing countries to strengthen their capacities to respond to disasters, and to improve the pooling, analysis and dissemination of early warning information on natural disasters and other emergencies.

Securing adequate and sustainable financing

79. Most countries are initiating health care financing reforms which aim to promote cost-sharing through user fees and health insurance and to adopt new approaches to the role of the private sector. Reforms should be of manageable scale, reproducible and closely monitored, taking into account institutional obstacles, conflicts of interest and the overall socioeconomic conditions of a country.

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

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

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

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

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

82. Environmental services that help protect and maintain health are the responsibility of national and local governments. Such services should ensure access to safe water and sanitation, clean air and safe food, manage hazardous chemicals and wastes, and control vectors and pollution. Further, incorporating health needs and concerns into town planning, and developing adequate inspection and monitoring of environmental health hazards, are mainly local authority functions. While these services are often

provided outside health systems, health professionals should be responsible for ensuring a coordinated approach and should advocate the implementation of such an approach.

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

Promotion of healthy lifestyles

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

- Introducing health-promoting lifestyles, and advocating them through proper channels, as appropriate to the circumstances of each country.
- Providing conditions that are conductive to the promotion of health and healthy lifestyles; and not contradicting such through advertising unhealthy lifestyles, supporting the production of materials harmful to health or promoting unhealthy behaviour.
- Encouraging the comprehensive development of local communities, and supporting them in attaining their basic needs through self-reliance, this being a practical introduction to the implementation of healthy lifestyles.
- Reorienting health, educational, instructional and public information institutions, in such a manner that promotes health and encourages healthy lifestyles.
- Reorienting educational institutions in the health field, in such a way as to give a human dimension to the health professions, and to make each of these professions a vocation rather than a mere occupation.

Eradication, elimination and control of specific diseases

85. Disease prevention for population, across the life span, is crucial to human development. Community-based population-oriented disease prevention and control and health protection services benefit everyone, and their implementation requires little individual participation. Priority should be given to endemic and commonly occurring infections, noncommunicable diseases, injuries and violence. Maintenance and extension of the ability to promote such services should be decentralized as much as possible, recognizing that successful decentralization requires competent local authorities.

Intersectoral collaboration

86. It is widely recognized that health is not the concern of the health sector alone but is dependent on the actions of many social and economic sectors, both governmental and nongovernmental. Education for literacy; income supplementation; clean water and adequate sanitation; improved housing; food and other agricultural products; building of roads—all may have a substantial and synergistic impact on health. However, few innovative examples exist of sustained intersectoral collaboration for health.

87. Many practical possibilities for action exist. Identification of the needs of vulnerable groups can provide the basis for collaboration at community level. Involvement in the process by people themselves adds to its effectiveness. Existing intersectoral mechanisms such as district development committees need to be further utilized by the health sector. This will require more effective advocacy on the part of health personnel on relating to other sectors. At national level, ways of strengthening sectoral policies need to be found so as to maximize the impact of health-enhancing action while eliminating or reducing the impact of those that are harmful. The particular energies and interests of non-governmental organizations may serve as important catalysts in all of these.

Partnerships for health

88. Partnerships are needed between the many levels and sectors concerned with health, and will be a primary component of health-for-all implementation. Productive partnerships will enable different ideologies, cultures and talents to come together, which will stimulate working towards improved health. Community partnerships and the development of skills constitute the essence of health for all. Partnerships between people and institutions at all levels allow for sharing of the experience, expertise and resources necessary for the attainment of health for all, and increased commitment by all is needed to ensure its full implementation. Governments should therefore aim to create an environment that stimulates and facilitates partnerships for health. Both formal partnerships and community-based informal networks at different levels are needed. WHO and governments should consider developing guidelines with the private sector, aimed at ensuring that new partnerships are mutually beneficial and always benefit health. Establishment (or re-establishment) of cultural, sports, religious and women's groups through a system of local governance can enhance social cohesion and a social environment conductive to health.

CHAPTER 5

GLOBAL AND REGIONAL HEALTH-FOR-ALL TARGETS

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

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

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

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

92. **Health outcomes**

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

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

c) By 2020, *the worldwide burden of disease will be substantially decreased.* This will be achieved by implementation of sound disease-control programmes aimed at

reversing the current trends of increasing incidence and disability caused by tuberculosis, HIV/AIDS, malaria, tobacco-related diseases and violence/trauma.

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

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

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

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

94. **Health policies and systems**

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

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

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

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

CHAPTER 6

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

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

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

- serve as the world's health advocate, by providing leadership for the health-for-all strategy
- develop global ethical and scientific norms and standards
- develop international instruments that promote global health
- engage in technical cooperation with all countries
- strengthen countries' abilities to build sustainable health systems and improve the performance of essential public health functions
- protect the health of vulnerable and poor communities and countries
- foster the use of, and innovation in, science and technology for health
- provide leadership for the eradication, elimination or control of selected diseases
- provide technical support to prevention of public health emergencies and post-emergency rehabilitation
- build partnership for health.

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

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

- supporting the ministry of health in formulating national policy and strengthening its leadership in the health sphere within the government;
- promotion of health issues in other sectors and ministries;
- planning, monitoring and evaluation of WHO technical cooperation;
- promoting integrated multi-agency developmental planning and collaboration with the UN system, while maintaining WHO constitutional leadership in health;
- resource mobilization;
- adequate and prompt response to health emergencies.

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

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

- Technical support to national health programmes through WHO country offices. The regional advisers' main function is to support national authorities in various technical areas to develop national policies and strategic plans, follow-up implementation and evaluation, all to be fully integrated in national health policy.
- Developing and supporting appropriate regional and inter-regional mechanisms for collaboration among Member States including suitable mechanism for technical cooperation among developing countries (TCDC). Solidarity, sovereignty, dignity, equity, building of national capabilities, talents and sustainability are the root principles of TCDC. Based on the same principles, the Regional Office should formulate technical cooperation with developed countries, based on mutual benefit. The successful experiences of twinning can be promoted. The network of WHO collaborating centres in the Region must be utilized to support national and regional initiatives, not only to promote TCDC but also to ensure original national and regional contributions to the development of science and technology.
- Ensuring the representation of country views and coordinating them in the formulation of international norms, standards, and legislation, as well as supporting the adaptation of agreed-upon international norms, standards and legislation to national situations.
- Collaborating with regional and international regional organizations, including regional development banks, UN and non-UN organizations, and governmental and nongovernmental organizations to develop regional instruments that advance the health of the people in the Region.
- Intensifying regional efforts in addressing serious problems that affect the poor and most vulnerable groups, as well as difficult problems that are resistant to traditional means of solution. Innovative approaches need to be developed at regional level to address these two sets of problems.

Annex 1

Table 1. Overall assessment of achievement towards health-for-all targets in the Eastern Mediterranean Region, 1996

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

[a] 85% for 1995

[b] 95% for 1995

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

[d] 0 cases means eradication by the year 2000

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

Annex 2

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

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

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

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

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