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

منظمة الصحة العالمية
المكتب الإقليمي لشرق المتوسط

Regional Committee for the Eastern Mediterranean

EM/RC52/Tech.Disc.1
July 2005

Fifty-second Session

Original: Arabic

Agenda item 6 (a)

Technical discussions

Regional strategic framework for health promotion

Contents

Executive summary

This document outlines the proposed Eastern Mediterranean Regional Strategy on Health Promotion. The strategy was developed based on current scholarship in health promotion. As such, four contemporary approaches to health promotion frame the strategy: the population health approach, the settings approach, the life course approach to health, and the best practices approach. The regional context of health and health promotion also strongly influenced the development of the strategy.

The vision of the regional strategy is to instil health in the minds, hearts and daily actions of individuals, families, communities and governments. The goal of the strategy is to assist countries to create and maintain enabling environments and conditions leading to improved health status and quality of life of people in the Eastern Mediterranean Region, all the while focusing on the unique strengths and opportunities of the Region, and overcoming the threats. Several aspects of the regional culture are thought to be protective against ill health or risky health behaviours. These include community cohesiveness and strong family networks, traditional and religious values. However, rapid changes related to urbanization, globalization and growing property threaten to undermine such assets.

The strategy proposes four strategic directions for health promotion in the Region: intersectoral collaboration; programme development; providing support for health promotion, and research related to health promotion. It also discusses opportunities for increasing financing for health promotion that are inherent in health sector reform efforts under way in a number of countries of the Region. Finally, this paper recommends specific actions needed to implement the regional strategy.

1. Introduction

The regional strategy on health promotion is grounded in a holistic view of health, which includes "physical, mental, social and spiritual well-being, and not merely the absence of disease or infirmity" [1] and which considers health to be a fundamental human right [2]. The strategy is also grounded in current scholarship on effective approaches to health promotion, and on recent emphasis on the social determinants of health.

In 1986, the Ottawa Charter for Health Promotion defined health promotion as "the process of enabling people to increase control over their health." [3] Health promotion moves beyond maintaining health to improving health status and, consequently, is concerned with health gains. It seeks to develop the health potential of the individual. Health potential may take the form of proper nutrition, or good immunity, or physical fitness which enables a person to cope well with the stress which the body may face. Health potential may also be in the form of mental and personal security and stability which enable people to deal with the mental stress that may beset them. Indeed, the health potential is all these aspects put together [1]. By improving health and extending life, health promotion also has a positive impact on economic development through gaining healthy life years, increased productivity and decreased economic burden of disease.

The regional strategy on health promotion aims to promote health of the people of the Region by enabling them to increase control over, and to improve, their health. It is intended to be shared with and used by all individuals, nongovernmental organizations, ministries, schools, health centres, and others whose mission is health directed (specifically targeted at health improvement) or health related (targeted at determinants of health) [4]. The suggested actions outlined in the strategy are mainly intended for countries. It is anticipated, however, that country plans will specify actions for a variety of sectors and stakeholders. The strategy has been developed as a guide to be adapted to national requirements by all stakeholders in health in order to improve quality of life and health status in the Region.

2. Situation analysis

2.1 Indicators of health and socioeconomic status in the Eastern Mediterranean Region

The WHO Eastern Mediterranean Region consists of 22 countries with varied population and demographic profiles, and a total population of about 500 million people. In 2002, the population of countries in the Region ranged from nearly 150 million in Pakistan to less than 1 million in Bahrain, Djibouti and Qatar. The Region is young, with approximately 40% of its population 15 years of age or younger. In 2002, the percentage of population over 60 years of age ranged from less than 3% in Kuwait and the United Arab Emirates to more than 8% in Lebanon and Tunisia [5]. Per capita Gross National Product in international dollars ranged from over US$ 28 000 in Qatar to US$ 160 in Afghanistan [6]. The annual population growth rate (1992–2002) of countries in the Region ranged from 1.3% in Tunisia to 3.9% in Jordan and Yemen. The total fertility rate in 2002 was less than 2.5 children per woman in the Islamic Republic of Iran, Lebanon and Tunisia and 7 or more in Somalia. Life expectancy at birth in 2002 ranged from 76.2 in Kuwait to 42.6 in Afghanistan. Child mortality rates the same year were 258 and 256 per 1000 live births for boys and girls, respectively, in Afghanistan and 10 per 1000 live births for both sexes in the United Arab Emirates [5]. Maternal mortality is still high in some countries of the Region.

Countries in the Region are facing major problems due to the increase in noncommunicable diseases and failure to promote healthy lifestyles. Noncommunicable diseases and injuries account for 57.6% of deaths in the Region [7], and smoking and obesity remain prevalent.

With respect to spending on health, total expenditures in health as a percentage of Gross Domestic Product in 2001 ranged from 2.6% in Somalia to 12.2% in Lebanon [8]. The overall trend in health care financing shows a clear shift of the burden from governments to households, even in oil producing and welfare countries of the Region [8]. This will create additional financial burdens for

already poor households and will likely result in late seeking of health care, ultimately increasing health care costs.

The Region has a long way to go to achieve the Millennium Development Goals [9]. According to the World Bank, 30% of the population of the Middle East and North Africa still live on less than US$ 2 per day [10]. In addition, 78.3 million people living in 17 countries in the Region were undernourished in 2001 [10]. With respect to gender equity and empowerment of women, although education has increased for boys and girls in the Region, disparity between the sexes is still wide in some countries. Little progress has been made with regard to the goal of ensuring environmental sustainability, and the rate of unemployment among youth is increasing. Although maternal mortality is decreasing, intensified efforts will be needed in some countries of the Region to achieve the related Goal. Good progress is being made in the Region towards achieving universal primary education, and moderate progress is being made in reducing child mortality. Childhood mortality due to measles has decreased by 13% since 1999 and neonatal tetanus has been eliminated in 16 countries of the Region. Most countries are at low risk for malaria and have low and declining rates of tuberculosis.

Environmental issues are a source of concern for many countries, particularly rapid urbanization and the scarcity of water resources. Although data on the magnitude of environmental hazards are lacking, there is evidence that rural water and sanitation coverage is less than 50% in several low-income and some middle-income countries [8].

Additional contributors to ill health in the Region are disasters and complex emergencies. At present, five countries in the Region, comprising 19% of the regional population, are in complex emergency situations. Such situations result in destruction of infrastructure, increasing poverty and a relatively high prevalence of mental health conditions.

2.2 Challenges to health and health promotion in the Region

There are many challenges facing health status in the Region. Rapid social changes have occurred in the past few decades, accompanied by rapid urbanization. Space is becoming scarce, poverty is increasing and the population is growing. The extended family is being replaced by nuclear families. Globalization is affecting the Region, and disasters, emergencies and conflicts present a continual challenge to health.

These challenges are eroding characteristics of the Eastern Mediterranean culture traditionally thought to be protective against ill health or risky health behaviours. These include community cohesiveness and strong family networks and religious and cultural traditions. With respect to community cohesiveness, the Region in general has solid bonds of clanship and identity that result in strong social capital, particularly in rural areas. In addition, the family remains a strong influence and source of moral, emotional and social support. Religious values emanating from all the religions practised in the Region provide guidance for healthy living. This has been used beneficially in several regional health promotion initiatives, such as in religious injunctions against smoking.

Health promotion in the Region is guided by principles such as the Amman Declaration on Health Promotion and relevant resolutions of the Regional Committee for the Eastern Mediterranean (EM/RC50/R.6 and EM/48/R.5 on Healthy Lifestyle Promotion). Health promotion underlies the regional publication series *The Right Path to Health* (Health Education through Religion) as well as successful regional approaches such as healthy cities, healthy villages, health promoting schools, basic development needs and other community-based initiatives which target social determinants of health through a community participatory approach.

There are also a number of challenges to health promotion specifically. These include scarcity of data on which to identify priority problems for intervention, the scarcity of information on ongoing health promotion initiatives and the lack of evaluation of such initiatives; lack of strategic planning for health promotion; low priority placed on prevention and promotion from decision-makers and other stakeholders; insufficient legislation in favour of health promotion; limited intersectoral cooperation

and coordination; inadequate human resources to implement health promotion activities; and inadequate structures of financing for such activities.

Efforts to promote health in the Region must take into account these challenges and national context in seeking understanding of the health issues and the development of more effective interventions. The national and local context must also be considered in the selection of priority target populations for intervention.

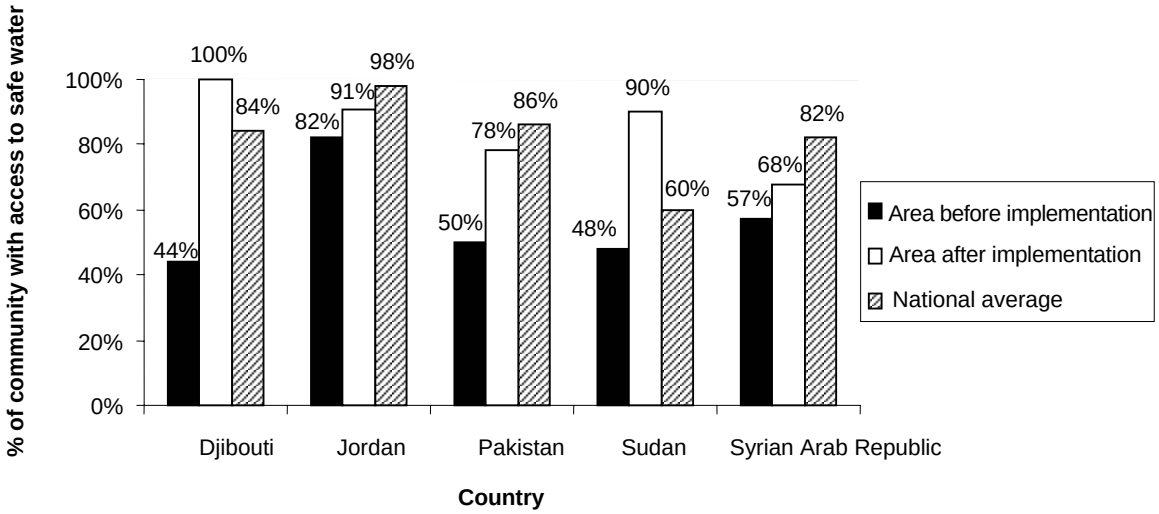
2.3 Examples of health promotion initiatives in the Region

Health promotion through enhancing teacher resources and skills

In 1988, the Regional Office, in collaboration with regional partners UNESCO, UNICEF and ISESCO developed and launched the Prototype Action-Oriented School Health Curriculum as an educational approach to achieving health for all. The programme aims to assist teachers to integrate health education into different subjects and to initiate health education activities with a shift from emphasis on instruction to providing students with action-oriented learning opportunities and experiences that enhance their knowledge and skill. The curriculum was updated in 2004 and broadened in content to cover basic education; an experimental electronic multimedia version has been launched in some countries of the Region.

Community-based initiatives

Community-based initiatives are currently being implemented in most of the countries in the Region. These initiatives, which include the healthy cities and healthy villages programmes, women in health and development and basic development needs approaches, aim at promoting health by establishing intersectoral committees that analyse data, decide on priority health issues and subsequently act to create change. A multi-country evaluation of basic development needs projects in five countries of the Region showed significant improvements in a number of indicators after implementation of the projects. Figure1 shows the improvement in access to safe water in areas implementing relevant community-based initiatives.



Source: WHO/EMRO

Figure 1. Change in community access to water in areas implementing community-based interventions

The Eastern Mediterranean approach to noncommunicable disease

The Eastern Mediterranean approach to noncommunicable diseases (EMAN) network was established in 2001 by the Regional Office to support health promotion through collaborative linking and capacity-building between countries in relation to health promotion, prevention and control of noncommunicable diseases. The EMAN network fosters joint action on noncommunicable disease risk factors as an efficient way to reduce the incidence of noncommunicable disease, stressing the need to integrate and strengthen preventive community-based practices to various health care settings. Twelve countries are enrolled in the network and are working in establishing surveillance system for noncommunicable disease risk factors and implementing and sharing community programmes. Moreover, the Stepwise Surveillance System for noncommunicable disease risk factors is being implemented in 11 countries and diabetes prevention and care has been integrated in primary health care services in four member countries of the Gulf Cooperation Council.

Involving religion in health promotion: anti-tobacco campaigning

An anti-tobacco *fatwa* (Islamic ruling) was issued in September 2000 by Sheikh Nasr Farid Wassel, then Grand Mufti of Egypt. It considered smoking to be prohibited by Islam, based on research conducted by scholars with regard to the Islamic stance on smoking. A similar ruling was issued by the Egyptian Coptic Church in 1999.

In 2000, a second edition of the *Islamic ruling on smoking* was issued by the Regional Office to reinforce attempts to curb tobacco use through religion. A nationwide anti-smoking poster campaign was also conducted, in which 80 000 posters featuring the *fatwa* were distributed to 53 000 mosques across Egypt. The impact of the intervention was evaluated by the Regional Office in 2002 through external evaluation in four cities in Egypt. The results showed that the percentage of those who followed the *fatwa* was fairly stable and consistent in all age groups (77%–78.9%). 55% of smokers interviewed reported having tried to stop after the *fatwa* was issued, while 49% reduced the number of cigarettes smoked.

Food safety for better health

During recent years, an increasing number of countries have made efforts to improve, update and strengthen their systems and infrastructure for food safety and adopted an approach based on risk management. Jordan and United Arab Emirates have developed modern food control systems based on risk management to monitor and control the safety of domestically produced and imported food. Oman and Tunisia developed national strategies for food control. Egypt, Lebanon, Morocco, Pakistan, Sudan and Syrian Arab Republic drafted new food legislation. Egypt and Sudan harmonized national food standards with those of the Codex Alimentarius. The Islamic Republic of Iran, Jordan and Saudi Arabia established national food and drug authorities. Member countries of the Gulf Cooperation Council developed a common food import policy which allows for shared inspection policy and standards. All these efforts are aimed at promoting healthier nutrition through organizational and policy change.

3. Conceptual approaches to health promotion

Several approaches have been suggested to guide health promotion efforts. These include the population health approach, the settings approach, the life course approach, and the best practices approach to health promotion.

- The population health approach emphasizes the health of population groups, considers a wide range of determinants of health, relies on evidence to make decisions, implements a variety of strategies, underscores the importance of public participation in decisions about health priorities and programs, and stresses multisectoral collaboration [11].
- The settings approach, a development from the Ottawa Charter, highlights the fact that the places where people live, work, and play affect their health, in addition to their own knowledge and

attitudes [12]. Interventions are aimed at changing the aspects of such settings that are detrimental to health, thus creating supportive environments for health enhancing behaviours.

- The life course approach posits that physical and social exposures during gestation, childhood, adolescence, adulthood and older adulthood influence health [13]. This approach stresses primary prevention early in the life course.
- The best practices approach considers evidence as critical in the selection of appropriate interventions, all the while considering the context. Best practices in health promotion have been defined as "those sets of processes and activities that are consistent with health promotion values/goals/ethics, theories/beliefs, evidence, and understanding of the environment, and that are most likely to achieve health promotion goals in a given situation."[14]

For these approaches to be effective and efficient, they must be tailored to the national context and be based on needs defined through participatory processes. It is particularly important that the target population participate in the process of defining health and health-related conditions, prioritizing such issues, and developing, implementing and evaluating interventions to change the status quo. In addition, as a result of research on the influences to health status, emphasis is increasingly being placed on the social determinants of health. Such determinants include gender, culture, socioeconomic factors and structural factors. WHO has established a Commission on the Social Determinants of Health in recognition of the need to address root causes of ill health.

4. The regional strategy on health promotion

4.1 Background

Health is influenced by a wide range of factors which cut across all aspects of life, including society, culture, spirituality and economics. Improvements in health status and quality of life are interlinked. To achieve improved health and quality of life, the concept and principles of health promotion are increasingly being adopted by countries around the world. A number of regional initiatives are being implemented in this regard. Yet, policies and practices which support the concept of health promotion currently tend to be implicit rather than explicit, and in most instances they are not the result of deliberate strategic planning.

The regional strategy on health promotion was developed in order to provide support to the countries in the Region to develop sound and explicit policies and practices for health promotion, keeping in mind roles and responsibilities of all the stakeholders from different sectors. The strategy was developed through a participatory process involving WHO and leading experts from countries of the Region.

4.2 Guiding principles

The following guiding principles are believed to be fundamental to health promotion in the Region:

- Health is a fundamental human right.
- Health is a key component of development.
- Health is a basic tenet of faith, advocated by all religions
- Empowerment of individuals and communities is necessary for optimum participation in planning and decision-making for health.
- Health is linked to life course exposures and experiences. To enhance health potential, primary prevention programmes early in the life course are encouraged.
- The most cost effective interventions are linked to prevention programmes targeted at populations and carried out in appropriate settings.

4.3 Vision

The vision of health promotion promoted by the strategy is to instil health in the minds, hearts and daily actions of individuals, families, communities and governments by emphasizing primary

prevention, and creating context-appropriate social and physical settings conducive to health. The regional strategy suggests pathways to achieve this vision.

4.4 Goal and aim

The goal of the regional strategy on health promotion is to assist Member States to create and maintain enabling environments and conditions leading to improved health status and quality of life of the people in the Region, while focusing on the unique strengths and opportunities of the Region, as well as specific challenges.

The aim of the strategy is to promote health of the peoples of the Region by enabling people to increase control over, and to improve their health [3].

4.5 Strategic directions

Strategic directions for achieving the goal are listed below. The conceptual approaches relevant to each strategic direction are highlighted in brackets. The first strategic direction is not related to any particular conceptual approach but to ensuring the pressure of a structure capable of carrying out all health promotion action at country level. Generally, strategic directions provide guidance to both WHO and Member States.

Intersectoral collaboration

- Foster intersectoral collaboration and community participation (population health approach/settings approach).

Programme development

- Develop, implement, and evaluate primary prevention programmes intended to effect change in priority determinants and health conditions and in various settings (settings approach, life course approach).
- Document, develop, and update legislation and regulation pertinent to health (population health approach, settings approach, best practices approach).
- Strengthen capacity of different partners (individuals and institutions) in health promotion.

Supporting integrated action

- Develop an integrated structure for health promotion at the country level.

Research

- Establish/strengthen systems for surveillance of risk factors and health determinants and for documenting effectiveness of health promotion initiatives (population health approach, best practices approach).
- Support research in health promotion roles, evaluation and financing (best practices approach).

5. Making health sector reforms responsive to health promotion

Health sector reform initiatives are driven by cost reduction considerations. As primary prevention initiatives are more efficient than secondary or tertiary care programmes, health sector reform initiatives provide an opportunity to introduce or strengthen health promotion programmes. With the changing approaches to the attainment of optimal health and the linking of health with development as enshrined in the Millennium Development Goals, health systems are increasingly under review to assess whether they can respond effectively to the strategic shift from a disease orientation towards health protection and promotion.

During the 20th century, three overlapping generations of health system reforms were initiated. The reforms arose not only as a result of perceived failures in health but also through a quest for greater efficiency, fairness and responsiveness to public expectations [15]. The second wave of reforms paved

the way for radical changes towards systems that were cost-efficient, equitable and accessible. This was best known as the era of primary health care as an approach for achieving affordable universal coverage [15]. Health sector reform is a key strategy to address equity, efficiency and effectiveness in many parts of the world. Despite this, health promotion is rarely mentioned in discussions on health sector reform in general or sustainable health care financing in particular.

WHO health sector reform strategies as laid out in the *World health report 2000* are aimed at reducing the burden of excess mortality and disability, developing health systems that equitably improve health outcomes, reducing risk factors and promoting an effective health dimension to social, economic, environmental and development policy.

6. Financing

Identifying appropriate mechanisms for financing of health promotion is necessary for sustainability of health promotion efforts.

- Effective and sustainable financing mechanisms are at least partially dependent on participation of the community to enhance ownership, and feelings of shared responsibility.
- For mechanisms of financing of health promotion to be clear, a specific package of services which health promotion encompasses needs to be defined. This is relatively difficult in the context of countries of the Region, as it is unclear who is working in health promotion and what the tasks they carry out include. A role delineation project could be undertaken in the Region in order to develop specifications for a ‘health promotion’ package for which financing mechanisms could be discussed.
- The amount of funds currently allocated to prevention and promotion in developmental budgets needs to be determined. A study of how health promotion is currently being financed is also needed, and a case study of financing under different economic situations would be valuable.

Several alternatives mechanisms for financing have been proposed based on experiences in the Region or internationally. Generally, potential sources of health promotion funds are taxes, including dedicated taxes (sometimes called “sin” taxes, such as on alcohol and tobacco); social insurance systems; private health insurance, employer funds; out-of-pocket expenditure; corporate sponsorship; and community or civic groups. As health promotion is a public good, responsibility for it should rest with the government.

In other WHO Regions such as the European, South-East Asian and Western Pacific regions, health foundations play an important role in setting policy directions and priorities for funding, developing standards and norms for interventions, coordinating and evaluating the outcome of health promotion initiatives implemented by the different government agencies and nongovernmental, and mobilizing and channelling resources from governments and other donors for distribution among different implementing partners. Health foundations are independent organizations that are legally constituted and funded by a variety of mechanisms such as appropriation from state budgets, a combination of dedicated taxes on different products, a levy on health insurance or related insurance mechanisms. A number of mechanisms for health financing have been used by countries of the Region.

- Tobacco taxation for health promotion. In 2000, the Gulf Cooperation Council adopted resolution 3/48 which called upon all member countries of the Council to earmark part of their tobacco taxation for tobacco control activities. Oman, Qatar and Saudi Arabia implemented the resolution at national level. No fixed percentage was earmarked; instead a lump sum that varies from year to year is given to ministries of health for tobacco control. In the case of Qatar the percentage received from tobacco taxes is approximately 2%, amounting to US$ 80 000–100 000 per year. These funds are used for tobacco control advocacy-related campaigns and activities. In Yemen, part of tobacco taxation is allocated to fund different activities undertaken by Ministry of Youth and Sports.

- *Zakat* (alms) and *awqaf* (Islamic endowment) funds. *Zakat* is deducted from all account holders in Pakistan and several other countries in the Region at the beginning of Ramadan every year. In addition to distributing *zakat* directly to the destitute, widows and orphans, *zakat* funds also go to tertiary and district level hospitals for treatment of such people. Opportunity exists for the government to divert some of the *zakat* funds used for curative practices towards health promotion programmes such as health education activities and income generation projects for the poor within the context of basic development needs.

  Awqaf funds are being used in most of the countries of the Gulf Cooperation Council with the aim of helping needy individuals to cope with rising cost of health care. In Kuwait and Qatar, part of *awqaf* funds are being used to support health promotion and education.

Other innovative ideas can be used to find additional resources for health promotion programmes. One such idea is levying a symbolic fee on national airline tickets which can be used for health promotion interventions.

7. Conclusions

Health is determined by a complex interplay between individuals and biological, social and environmental factors. By thinking about health and risks to health in terms of health determinants, lifestyles and resultant patterns of exposure to (multiple) risks and adverse outcomes, we gain a better understanding of how health is maintained or illness produced. This knowledge can be used to develop more effective, comprehensive programmes of multisectoral action at different levels, combining information, policy, social marketing, regulation and community action, to positively influence population health status over time.

Effective health promotion initiatives can address the social and environmental determinants of health by empowering the community to take charge of its health. The public sector and others are already engaged, to varying degrees, in encouraging people to care for themselves, to come together for mutual support, and to change the circumstances and surroundings which act as barriers to the achievement of health. Yet the policies and practices which support health promotion are often not explicit or deliberately planned.

Current health sector reform efforts and the various means of alternative financing for health care delivery services need to be sensitive to the changing approaches to attainment of optimum health. Health sector reforms must shift from addressing disease specific programmes to become more responsive to health promotion programmes and initiatives. At the same time, sectors outside health have to play a larger role in order to enable the community to reap the benefits of good health.

Allocating resources during times of scarcity or diverting resources from traditional health care programmes is always a difficult decision for policy-makers. Financing and controlling costs remain ongoing challenges. The pressures created by an ageing population and the growing incidence of disabilities will take a heavy toll on available financial resources. However, the health promotion strategic directions defined in the regional strategy have the potential over the long term to slow the growth in health care costs.

8. Recommendations

Member States

1. Establish a health promotion steering committee at the national level with representation from various sectors involved in health promotion.
2. Consider allocating funds only to health promotion programmes that include an evaluation of process and impact.
3. Develop a 5-year strategic plan for health promotion in their country with guidance from WHO. The strategic plan should consider national indicators of health status, as well as social and environmental determinants of health and behaviour in prioritizing activities.

4. Make use of the existing guidelines and informational materials to encourage the process of community involvement in health promotion programmes and initiatives, using the community-based initiatives and basic development needs approaches as guides.
5. Support the professional education of individuals in health promotion. Supported individuals should be selected based on their potential to become leaders in health promotion and assurance of returning to serve in the public sector.

WHO

6. Guide countries in developing key performance indicators for health promotion effectiveness.
7. Consider holding a conference every other year for countries to share experiences in health promotion.
8. Support Member States in developing systems (or strengthening existing systems) for modifiable risk factors and health determinants surveillance. The systems should contribute to needs assessment, policy-making, advocacy and the evaluation of health promotion programmes. New systems should be linked to existing surveillance efforts.
9. Initiate, and support countries in, assessment of the various mechanisms that have been used to finance health promotion in the Region and internationally.
10. Support countries to embark upon a role delineation project which defines activities currently being undertaken in health promotion in the Region (or in selected countries) in order to define a "package" of health promoting services.

References

1. Khayat MH. *Health: An Islamic perspective.* Alexandria, World Health Organization Regional Office for the Eastern Mediterranean, 1997.
2. Declaration of Alma-Ata, 1978. Available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (Accessed March 2005).
3. Ottawa Charter for Health Promotion, 1986. Available at http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf (Accessed March 2005)
4. Freeman R, Linden G. Health directed and health related dimensions of oral health behavior of periodontal reference. *Community dental health*. 1995, 12(1): 48–51.
5. WHO statistical information system. Available at http://www3.who.int/whosis/country/indicators (Accessed 2 December 2004).
6. *Health system priorities in the Eastern Mediterranean Region*. Technical paper presented to the 51st session of the Regional Committee for the Eastern Mediterranean, Cairo, October 2004 (unpublished document EM/RC51/5 available from the WHO Regional Office for the Eastern Mediterranean, Cairo).
7. Modified from Burden of disease database. Geneva, World Health Organization, 2001.
8. *Proposed programme budget for the financial period 2004–2005, Eastern Mediterranean Region*. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2002.
9. *Can we achieve MDGs by 2015?* Brief presented to the WHO interregional meeting on the Millennium Development Goals, San Jose, Costa Rica, 11–13 November 2004 (unpublished document available from the WHO Regional Office for the Eastern Mediterranean, Cairo).

10. Sarbib JL. *The role of the Bank in meeting the public health challenges of the 21st century*. Welcome message to the World Bank Middle East and North Africa Regional Public Health Conference, Beirut, Lebanon, 16 June 2002. Available at http://lnweb18.worldbank.org/mna/mena.nsf/Attachments/Beirut-June+2002/$File/Public+Health+Conference+Beirut-6-6-02.pdf

11. *The population health template*: *key elements and actions that define a population health approach*. Ottawa, Health Canada, 2001.

12. Polan BD, Green LW, Rootman I, eds. *Settings for health promotion: linking theory and practice*. Thousand Oaks, California, Sage Publications, 2000.

13. *The World health report 2002: Reducing risks promoting healthy life.* Geneva, World Health Organization, 2002.

14. Kahan B, Goodstadt M. *Manual for using the interactive domain model of best practices in health promotion.* Toronto, Centre for Health Promotion, University of Toronto, 2002.

15. *The World health report 2000: Health systems: improving performance*. Geneva, World Health Organization, 2000.