Health systems based on primary health care in the Eastern Mediterranean Region: How different will they be in the 21st century?

The World Health Report 2008 is devoted to the reinvigoration of primary health care. The Executive Board at its 124th session in January 2009 will consider the strategic and programmatic role of WHO in supporting the renewed commitment of countries to primary health care. This paper reports on the health trends in the Region since the Declaration of Alma-Ata and discusses the challenges for primary health care in the Region.
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Executive summary

The Alma-Ata Declaration of 1978 is a landmark in the history of public health, and for WHO, which focused on primary health care as a global strategy to provide health care for all and expressed in no uncertain terms values such as health equity, universal access, and health as a human right regardless of country of residence, gender, social status and cultural identity. These values are just as valid today and primary health care continues to be the principal approach for strengthening health systems in a wide range of countries the world over. Therefore, on the occasion of the 30th anniversary of the Alma-Ata Declaration, it is appropriate that WHO renews its commitment to primary health care, globally and regionally.

The idea of comprehensive primary health care operates at two levels: first, as a level of contact and care within the health system reconfigured to emphasize the essential health needs; and second, as a philosophy of health work, part of the overall socioeconomic development of the community. The evolution of primary health care has been somewhat uneven since selective primary health care was thought of as more pragmatic, financially sustainable and politically acceptable than the comprehensive approach. However, now the Millennium Declaration, the United Nations International Covenant on Economic, Social and Cultural Rights, and the Global Commission on Social Determinants of Health are thought to be a vindication of the comprehensive primary health care philosophy.

The overall health situation in the Eastern Mediterranean Region has improved since 1978, as can be seen in the improvement in health outcomes, increased capacity of the health systems to deliver services and through improvements in health determinants. However, these changes are not uniform across the Region and in certain instances there has been deterioration in health conditions, particularly in countries in chronic conflicts and complex emergencies. Life expectancy has increased and infant and child mortality reduced in most countries during 1980–2007. Despite the reduction in maternal mortality in many low-income and middle-income countries, it remains unacceptably high in the Region.

In the area of health systems, there has been an increase in the density of physicians in almost all countries; however, the situation of nurses and midwives in the Region continues to be grim and there has been no change, especially in low-income countries. The trend in the density of primary health care facilities also has not shown any increase. There has been a slight increase in the median total health expenditure, almost no change in the median government health expenditure and slight decrease in the median out of pocket health expenditure over the last decade. Improvement in adult literacy, access to safe water and access to sanitation as key determinants over the past 25 years has been noted.

The Region has remained committed to the primary health care approach since the Alma-Ata Declaration, which is firmly rooted in its effort to support strengthening of national health systems. This includes ensuring effective implementation of health system strengthening windows of global health initiatives such as the Global Alliance for Vaccines and Immunization and Global Fund to fight AIDS, Tuberculosis and Malaria, priority public health and health promotion programmes. Most countries have shown commitment to the values of primary health care, with remarkable results demonstrated by some. The wilayat health system in Oman, the shabakeh behdashti and the behvarz in the Islamic Republic of Iran, the experience with 100 000 lady health workers in Pakistan, the family health practice model in Bahrain, Egypt, Oman, Saudi Arabia and Tunisia, and the contracting out of primary health care services in Afghanistan provide innovations and useful lessons in the area of primary health care.

Community-based initiatives is a priority programme in the Region inspired by the universal principles and approach of comprehensive primary health care. It comprises four different programmes: Healthy Villages, Healthy Cities, Basic Development Needs and Gender in Health and Development, which provide useful tools for implementing global commitments such as the achievement of the MDGs, Poverty Reduction Strategies and Sector-wide Approaches. Community-based initiatives are also a well tested approach for tackling the social determinants of health. A review
of the social determinants of health in the Region identified of being importance: women’s empowerment and enablement; early child development, including its impact on child labour and the health of street children; migrant workers – movements within and between countries resulting in health inequities; inequitable health systems as a barrier to accessing essential health care; social dimensions of priority public health conditions; socially determined lifestyles and behaviour; and conflicts and emergencies and the resulting health inequities.

The rapid global changes in the past 30 years have influenced the larger geo-political, socioeconomic, informational, technological and climatic environment in which the health systems function. Globalization and its multi-dimensional influences, uneven episodes of economic growth and crisis and its unfair distribution; the demographic and epidemiologic transition and the increasing proportion of the elderly; and climate change and environmental problems directly or indirectly influence health. The way of putting primary health care into practice thus needs to change significantly if the universal values of primary health care are to influence the conditions in which the disadvantaged populations grow, work, live and age.

The strategic directions that would ensure revitalization of primary health care include: aligning the global and regional movements and alliances to the primary health care approach; making primary health care dynamic and flexible to adapt to the changing world while avoiding the one size fit all approach; acknowledging the role and contribution of the civil society and learning from best practices from within and beyond the Region. In addition, strengthening health systems based on primary health care requires: i) adequate and fair financing of the health system that ensures financial and social risk protection and universal coverage; ii) empowering communities to take decisions regarding their own health and social wellbeing; iii) strengthening the district health system for tackling the implementation bottlenecks in the organization, management and delivery of health services; iv) expanding the range of primary health care services to include non-communicable diseases, high risk behaviours and the care of the elderly; v) integrating vertical programmes as an important element of the primary health care approach; vi) developing a balanced, skilled and well distributed health workforce and providing incentives that enhance motivation and retention; vii) monitoring health system performance oriented to primary health care, especially health equity; and viii) institutional strengthening of ministries of health to provide the required leadership to enable intersectoral action for health; and be more accountable and transparent in health affairs.

Revitalization of primary health care can be successful when there is shared commitment among Member States, WHO and other development partners. Success will be substantiated by raising primary health care on the global, regional and national policy agenda; increased allocation of resources to primary health care programmes and most important an overriding obsession to improve the health of the poor and marginalized segments of the population. Development of health systems based on primary health care will be the principal strategy for its achievement.
1. Primary health care: the vision of Alma-Ata

The Alma-Ata Declaration of 1978 is a landmark in the history of public health, and for the World Health Organization (WHO). The Declaration focused on primary health care as a global strategy to provide equitable health care for all. It responded to increased awareness of inequalities in health status among high-income and low-income populations and of the needs of disadvantaged populations throughout the world who had limited or no access to the benefits of modern knowledge of disease prevention and treatment.

The Declaration expresses in no uncertain terms values and principles, such as health equity, universal access and health as a human right, which are relevant for everyone, regardless of country of residence, gender, social status and cultural identity. These values and principles are just as valid today as they were 30 years ago, and primary health care continues to be the principal approach for strengthening health systems in a wide range of countries, rich and poor, the world over. Therefore, on the occasion of the 30th anniversary of the Alma-Ata Declaration, it is appropriate that WHO is renewing its commitment to primary health care, both globally and regionally. This commitment was emphasized by Dr Margaret Chan, Director-General of WHO at the 61st World Health Assembly in May 2008 [1], and has received unequivocal support from all Regional Directors [2].

This paper has been prepared Regional Office for the Eastern Mediterranean to mark the 30th Anniversary of Alma-Ata and to reaffirm its commitment to primary health care. The paper provides an overview of the changes in population health in the Eastern Mediterranean Region over the past three decades, shares examples of good practice at the country level and highlights the challenges as a result of the changes the Region has undergone. In addition to the geo-political challenges that have featured prominently, the Region has undergone a socioeconomic transformation, accompanied by changes in people’s health needs and expectations, and the ability of health systems to respond to these. The paper considers how these challenges and changes have affected primary health care and how primary health care has responded to them. Finally, building on this analysis, the paper suggests what primary health care in the Eastern Mediterranean Region will look like in the future.

2. Evolution of primary health care post Alma-Ata: A bird’s eye view

The vision of primary health care embodied in the Alma-Ata Declaration was comprehensive and integrated, however, its evolution has been somewhat uneven. The Declaration provided an approach that could be applied in all settings and was particularly attractive for low- and middle-income countries (Box 1). The idea of comprehensive primary health care operated at two levels: first, as a level of contact and care within the health system reconfigured to emphasize the essential health needs of the population; and second, as a philosophy of health work, which was part of the overall social and economic development of the community [3]. The pillars of the primary health care philosophy include community empowerment and participation and intersectoral coordination for health as a means of explicit linkage between health and social development. It also calls for the use of appropriate and affordable technology [4].

Box 1. Excerpts from the Declaration of Alma-Ata [3]

Article I.
“health…is a fundamental human right and……. the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

Article II.
“The existing gross inequality in the health status of the people particularly between developed and developing countries, as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.”

Article V.
“Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.”

Article VI.
“Primary health care is essential health 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.”
This vision was challenged by a selective primary health care [5], which was promoted by many donor agencies as more pragmatic, financially sustainable and politically more palatable than the comprehensive approach. Selective primary health care was characterized by a top-down, technocratic approach and ignored the broader concerns of social determinants including poverty, development and equity. In these respects it could be seen as contrary to the values and practice of comprehensive primary health care. Many developing countries, including Costa Rica, Cuba, India (Kerala State) and Sri Lanka, remained committed to the more comprehensive approach and were able to achieve better health status than expected given their economic resources. These polities shared a commitment to primary health care and all that it entailed [6]. In the Eastern Mediterranean Region many countries have remained committed to health for all (HFA) through primary health care; however, with varying levels of implementation.

By the mid-1980s, governments of many low-income and middle-income countries were threatened by prolonged global economic recession and a debt crisis that pushed them to the brink of economic collapse. These events provided the context for lending governments and international financial institutions (the World Bank and the International Monetary Fund) to require these countries to restructure their economies according to neo-liberal reforms, which favoured vertical disease-based programmes and focused on cost-effectiveness rather than health equity, in order to qualify for debt rescheduling and continuing aid. Health systems suffered as these structural adjustment programmes required countries to cut spending on social sectors including health and undertake health sector reforms that included levying charges for primary care and promoting private insurance [7]. In order to mobilize necessary resources for health for all through primary health care, WHO in 1988 advised its Member States to allocate at least 5% of their GDP to achieve this goal [8].

The World development report 1993: investing in health, published by the World Bank, defined and costed a basic benefit package of essential public health and clinical interventions estimated at US$ 12 per capita. This report strengthened the selective approach and supported structural reforms in the health sector. During this period, WHO also sent mixed signals about primary health care. In its 1998 annual report, WHO reinvigorated the strategy of Health for All in the 21st Century. However, WHO’s World Health Report 2000 on health systems did not follow up on this message.

The Millennium Development Goals (MDGs) enshrined in the United Nations Millennium Declaration of 2000 represent a commitment to reduce poverty and hunger, achieve gender equality and improve child and maternal health, inter alia, by 2015 [9]. In the same year, the right to health was strengthened by additions to the United Nations International Covenant on Economic, Social and Cultural Rights, which obliged health policy-makers and practitioners to ensure the right of equitable access to health care and health facilities [10]. In 2005, WHO launched the Global Commission on Social Determinants of Health, drawing attention to social determinants that are known to be among the most important causes of poor health and inequalities between and within countries. To many, these global movements are a vindication of the comprehensive primary health care philosophy originally envisaged in the Alma-Ata Declaration. The current leadership in WHO has taken upon itself the revival of primary health care, making it the guiding principle of its future work and the subject of the upcoming World Health Report 2008.

3. Health situation and trends in the Region since Alma-Ata

The overall health situation in the Region has improved since 1978 as can be seen in the improvement in health outcomes, increased capacity of the health systems to deliver health services and through positive changes in the upstream health determinants. However, these changes have not been uniform across the region and in certain instances there have been deterioration in health conditions, particularly in countries in chronic conflicts and complex emergencies. This section briefly presents the trend in selected indicators of health status, health system and health determinants since Alma-Ata, using official figures from WHO.
3.1 Health outcomes

Life expectancy in the Region increased in most countries during the period 1980–2007. Life expectancy in Egypt, Libyan Arab Jamahiriya, Oman and Yemen has increased by more than 15 years. Countries that recorded the least increase during this period are those that have been or continue to be involved in prolonged conflicts. Life expectancy in Iraq actually decreased by 3.5 years during the same period (Figures 1a, 1b).

Infant and child mortality has declined significantly in the Region since 1980. In the 1960s, child mortality rates in the Region were similar to those in sub-Saharan Africa as a whole; they are now only half of the African rates [11]. With the exception of Iraq, all countries have registered a reduction in infant mortality irrespective of their income status (Figures 2a, 2b). Despite this reduction, the infant mortality rate in all low-income countries remains unacceptably high. Evidence has shown that a major contributor to the high infant mortality is neonatal mortality, or deaths occurring in the first four weeks after birth [12].

Despite the reduction in maternal mortality in many low-income and middle-income countries, maternal mortality in the Region remains unacceptably high. The regional estimate for maternal mortality is still over 350 maternal deaths per 100,000 live births. Maternal mortality in Somalia and Afghanistan continues to be among the highest in the world. The maternal mortality ratio in all low-income and some middle-income countries of the Region, particularly Morocco, is still unacceptably high, while in Iraq it has increased during the past two decades (Figures 3a, 3b).

It is difficult to provide long-term trends in mortality from noncommunicable diseases and injuries and accidents. Estimates show that the fatalities due to road traffic accidents in the Middle East and North Africa Region increased by over 55% between 1990 and 2000 and are predicted to more than double by 2020 (Table 1). Table 2 provides the current estimate of the age-standardized mortality for noncommunicable diseases, cardiovascular diseases and injuries for 15 countries of the Region.

Table 1. Predicted road traffic fatalities by region (in thousands), 1990–2020

<table>
<thead>
<tr>
<th>Region</th>
<th>No. of countries</th>
<th>1990</th>
<th>2000</th>
<th>2010</th>
<th>2020</th>
<th>Change (%) 2000–2020</th>
<th>Fatality rate (deaths per 100,000 persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2000</td>
</tr>
<tr>
<td>East Asia and Pacific</td>
<td>15</td>
<td>112</td>
<td>188</td>
<td>278</td>
<td>337</td>
<td>79</td>
<td>10.9</td>
</tr>
<tr>
<td>East Europe and Central Asia</td>
<td>9</td>
<td>30</td>
<td>32</td>
<td>35</td>
<td>38</td>
<td>19</td>
<td>19.0</td>
</tr>
<tr>
<td>Latin America and Caribbean</td>
<td>31</td>
<td>90</td>
<td>122</td>
<td>154</td>
<td>180</td>
<td>48</td>
<td>26.1</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>13</td>
<td>41</td>
<td>56</td>
<td>73</td>
<td>94</td>
<td>68</td>
<td>19.2</td>
</tr>
<tr>
<td>South Asia</td>
<td>7</td>
<td>87</td>
<td>135</td>
<td>212</td>
<td>330</td>
<td>144</td>
<td>10.2</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>46</td>
<td>59</td>
<td>80</td>
<td>109</td>
<td>144</td>
<td>80</td>
<td>12.3</td>
</tr>
<tr>
<td>Sub-total</td>
<td>121</td>
<td>419</td>
<td>613</td>
<td>862</td>
<td>1124</td>
<td>87</td>
<td>13.3</td>
</tr>
<tr>
<td>High income countries</td>
<td>35</td>
<td>123</td>
<td>110</td>
<td>95</td>
<td>80</td>
<td>-27</td>
<td>11.8</td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td>542</td>
<td>723</td>
<td>957</td>
<td>1204</td>
<td>67</td>
<td>13.0</td>
</tr>
</tbody>
</table>

Table 2. Age-standardized mortality rate for noncommunicable diseases, cardiovascular diseases and injuries (per 100 000 population)

<table>
<thead>
<tr>
<th>Country</th>
<th>Noncommunicable diseases</th>
<th>Cardiovascular diseases</th>
<th>Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>1269</td>
<td>706</td>
<td>134</td>
</tr>
<tr>
<td>Djibouti</td>
<td>926</td>
<td>533</td>
<td>92</td>
</tr>
<tr>
<td>Egypt</td>
<td>959</td>
<td>560</td>
<td>35</td>
</tr>
<tr>
<td>Iran, Islamic Republic of</td>
<td>742</td>
<td>466</td>
<td>133</td>
</tr>
<tr>
<td>Iraq</td>
<td>855</td>
<td>508</td>
<td>141</td>
</tr>
<tr>
<td>Kuwait</td>
<td>512</td>
<td>309</td>
<td>34</td>
</tr>
<tr>
<td>Lebanon</td>
<td>742</td>
<td>453</td>
<td>98</td>
</tr>
<tr>
<td>Libyan Arab Jamahiriya</td>
<td>650</td>
<td>411</td>
<td>55</td>
</tr>
<tr>
<td>Oman</td>
<td>688</td>
<td>409</td>
<td>41</td>
</tr>
<tr>
<td>Pakistan</td>
<td>743</td>
<td>425</td>
<td>99</td>
</tr>
<tr>
<td>Qatar</td>
<td>629</td>
<td>340</td>
<td>40</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>701</td>
<td>405</td>
<td>72</td>
</tr>
<tr>
<td>Somalia</td>
<td>1086</td>
<td>580</td>
<td>235</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>625</td>
<td>369</td>
<td>72</td>
</tr>
<tr>
<td>Yemen</td>
<td>956</td>
<td>553</td>
<td>102</td>
</tr>
</tbody>
</table>


3.2 Health system

There has been an overall increase in the density of physicians in almost all countries of the Region with the exception of Somalia (Figures 4a, 4b). This increase is not uniform and is much greater in the GCC and middle-income countries of the Region. These numbers do not account for the urban–rural maldistribution or the external migration of the health workforce. The Gulf Cooperation Council (GCC) countries rely heavily on an expatriate workforce.

The situation of nurses and midwives in continues to be grim (Figures 5a, 5b). It is not possible to disaggregate the currently available data on nurses and midwives in the Region. The overall trend is not uniform, as some countries have shown increase, others have remained the same and in some there has been a reduction in the numbers irrespective of the income status of the countries. There has been little if any change in the numbers of nurses and midwives in the low-income countries; in some the numbers have actually fallen. In some countries, such as Lebanon and Morocco, the numbers have fallen due to the external migration of nurses to other countries. The numbers in most GCC countries are adequate but there is a high degree of dependence on expatriate nurses, except in the case of Bahrain.

The trends and the change in the density of primary health care facilities per 10 000 population is less clear. This could be due to several reasons: the definition of a primary health care centre may be different between countries or may have changed over the past three decades, many primary health care centres may have become non-functional (especially in countries in conflicts) or upgraded to higher level over time; and the population may have increased at a more rapid pace than the increase in number of primary health care centres. Several countries, from all income groups, have shown a reduction in the number of primary health care facilities per 10 000 population over the past three decades (Figures 6a, 6b).

Data were available from 1995–2005 for monitoring trends in the financing of health care in the Region. There has been a slight increase in the median total health expenditure, almost no change in the median government health expenditure and a slight decrease in the median out-of-pocket expenditure on health (Figures 7–9) during this period. Of particular concern is the exceedingly low government health expenditure in low-income countries and high out-of-pocket expenditure in the low-income and middle-income countries. The latter has increased in seven low-income, middle-income and GCC countries of the Region during the past decade.
3.3 Health determinants

Trends and changes in three health determinants were reviewed for the period 1980–2007 in the Region. These determinants are adult literacy, access to safe water and access to sanitation. In general there has been an improvement in all three over time (Figures 10–12). Due to the current situation in Iraq, all three determinants have deteriorated. Somalia and Palestine have also registered a reduction in the percentage of population with access to safe water.

3.4 Innovations in primary health care in countries of the Region

Most countries of the Region have over the years shown commitment to the values of primary health care with remarkable results demonstrated by some. In the late 1970s, Oman had only a handful of health professionals. People had to travel up to four days just to reach a hospital, where hundreds would be waiting in line to see one of the few expatriate doctors. All this changed in less than a generation [13]. Oman invested consistently in its wilayat health system, a national health service oriented by principles of primary health care and sustained the investment over time. There is now a dense network of 180 local, district and regional health facilities staffed by over 5000 health professionals providing almost universal access to health care for the now over 2.2 million inhabitants [14]. Over 98% of births are attended by trained personnel and over 98% of infants are fully immunized. Life expectancy, which was less than 60 years towards the end of 1970s, is now over 74. Child mortality has dropped by a staggering 94% (Figure 13) [15].

The Islamic Republic of Iran has been a pioneer in primary health care in the Region and the world. Among the many achievements (Figure 14) are: the establishment in the 1980s of the shabakeh behdashti, the equivalent of the district health system, which relied on the recruitment and training of almost 25 000 male and female community health workers called behvarz; the development of a vital horoscope for recording vital statistics, demographic and health information; the intense monitoring and supervision of the programme and the highest level of sustained political commitment successfully transformed the health status of rural populations. In 1983, and as a result of the advocacy of WHO and the World Federation for Medical Education, a decision was made to integrate medical education with health services in the country [16]. Among the great benefits were the development of a curriculum that was rooted in the health needs of the population, provision of a field area for the learning and education of health professionals, promotion of health systems research that was relevant to population needs, and unification of the workforce production and the service delivery arms of the health system.

The national programme for primary health care and family planning in Pakistan, popularly known as the lady health workers programme, was launched in 1993. This federally funded programme has recruited 100 000 government paid, female community health workers meant to provide basic health care to the rural population of the country. Despite many challenges, the programme has been able to sustain itself over 15 years and the last independent evaluation showed improvement in coverage for immunization, antenatal and family planning services in the rural areas of Pakistan [17]. The programme’s success has encouraged other countries to launch similar programmes, especially in Africa.

The family health programme in Egypt started in 1999 to enable the health system to deliver quality primary care promotive, preventive, and curative services, as well as allow for functional integration of vertical programmes into the family health model. The model is based on applying national planning standards and guidelines to provide services through health facilities with reformed infrastructures, staffed according to a pre-defined health team staffing pattern and training programme, providing an essential package of health services, which is supported by an essential medicine list, clinical guidelines for common ailments, functioning referral system, information system, quality and accreditation systems and incorporating elements of community participation. The family health model was initially launched in five of the 28 governorates and since 2006 is being rolled out in phases to cover all the governorates. The model has proved valid, viable, affordable and popular, and is now charted by the Government of Egypt as the accepted norm for primary health care in Egypt.
Similar experience on family practice as a model to promote service delivery is now accumulating from several countries of the Region including Bahrain, Oman, Saudi Arabia and Tunisia.

The experience of the contracting out of primary health care services in Afghanistan emerged from the disruption caused by the war that led many international and national nongovernmental organizations to assume responsibility for the delivery of health services through contracts with donor agencies. In 2002, the new Government of Afghanistan pursued the policy of contracting for a basic package of health services supported by funds from the donors. The policy of contracting out has shown improvement in service coverage and selected health status indicators. With the gradual strengthening of the Ministry of Public Health, options for the future include pursuing the contracting option or increasing public provision of health services [18].

4. Regional commitment to health systems based on primary health care

4.1 Collective commitments

The Eastern Mediterranean Region has remained steadfast to the primary health care approach since the Alma-Ata Declaration. This commitment can be seen in the large number of resolutions that have been endorsed by the Regional Committee for the Eastern Mediterranean on health systems based on primary health care. These resolutions have touched upon the role of the governments in health development EM/RC53/R.8), the need for quality assurance in health systems based on primary health care (EM/RC47/R.6), and health system priorities in the Region (EM/RC48/R.3 and EM/RC51/R.7). They have also reiterated the Region’s commitment to primary health care by endorsing in 1999, the Regional Health For All Policy and Strategy for the 21st Century (EM/RC46/R.4), and in 2003 by honouring the occasion of the 25th anniversary of Alma-Ata (EM/RC50/R.12). The most recent manifestation of the Region’s commitment is the collaborative effort of the Regional Office and the Ministry of Public Health, Qatar, in organizing the international conference on primary health care in November 2008.

4.2 Strengthening health systems based on primary health care

The longstanding commitment of the Regional Office to primary health care is firmly rooted in its effort to support health system strengthening in countries and is clearly reflected in the work of the Regional Office. Areas of work that merit particular emphasis include:

- Emphasizing the central role of governments in health development; institutional strengthening of ministries of health; developing their capacity in policy formulation and strategic planning; preventing market forces dominating health system priorities and agenda; partnering with the non-public sector organisations; encouraging improved access to information for decision-making; promoting greater accountability and transparency; and ensuring universal coverage to essential health services;
- Ensuring financial risk protection and health equity by encouraging governments to play a major role in health care financing by mobilizing the necessary resources through public budgets and other contributive mechanisms, pooling resources allocated to health development, guiding the process of resource allocation and purchasing health services from various providers;
- Supporting Member States to design appropriate policies for the development of the health workforce aimed at meeting the real needs of the populations, securing appropriate skill mix, improving equity in the distribution of human resources, managing them properly, developing incentive systems to enhance their retention and monitoring their performance;
- Ensuring access to essential health technologies, including essential medicines and vaccines, in order to optimize their usefulness and minimize their irrational use and wastage;
- Promoting access to essential health services, particularly in low income countries and those with disrupted health systems; helping improve quality and patient safety; encouraging partnership and engagement with non-state providers; and assisting countries in implementing models of health care delivery based on primary health care;
• Developing capacity among countries for improved organization and management of health services, with a particular focus on strengthening district health systems to support effective health care delivery;
• Advocating the central role of health in overall socioeconomic development; raising the importance of health on the national policy agenda; emphasizing the role of other sectors in addressing health determinants; and underscoring the importance of intersectoral action for health.

4.3 Health system support through global partnerships to public health programmes

The Regional Office is helping to ensure effective implementation of health system strengthening opportunities in global health initiatives such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The focus of GAVI health system strengthening support is on the six low-income countries of the Region, four of which have already received funding, while GFATM health system support also extends to middle-income countries. The challenge now is to ensure effective implementation and the efficient use funds.

There is increasing recognition of the cross-cutting nature of health promotion programmes and making use of health systems as a platform for launching these. Health promotion programmes are public health goods, which in addition to an effective communication strategy need the support of well functioning health systems to have a tangible impact.

4.4 Community-based initiatives

Community-based initiatives is a priority programme in the Region inspired by the universal principles and approach of comprehensive primary health care. Community-based initiatives have been implemented for the past two decades and have now expanded to 17 countries covering a population of 18 million. Community-based initiatives comprise four different programmes: healthy villages, healthy cities, basic development needs, and gender in health and development.

The concept underlying community-based initiatives, particularly the basic development needs programme, is the intrinsic relationship between poverty and public health, where poverty is considered in its broader meaning rather than solely as income poverty. The underlying approach aims at tackling the major determinants of health at the grass-roots level within the broader development perspective through active community involvement and ownership and intersectoral action, thereby improving health and health equity related outcomes. Community-based initiatives are thus a pro-poor strategy that combines conventional public health programmes, such as the promotion of breastfeeding, safe motherhood and diarrhoea control with social programmes such as literacy, vocational training, food and nutrition, youth development, water and sanitation and income generating projects. Community-based initiatives are particularly effective in overcoming gender discrimination and in providing a social environment that supports women’s development (Figure 15).

The community-based initiatives approach has over the years demonstrated that it is a successful primary health care-based model for improving health and socioeconomic status through health system and non-health system related interventions with the active involvement of the community. The challenge now is for the national governments and policy-makers to own, scale up and institutionalize this approach as part of their regular national programmes. Experience has also shown that the engagement of and ownership by community-based civil society organizations enhances sustainability.

Finally, the community-based initiatives approach provides a useful implementation tool for realizing at the national and subnational level larger or global commitments such as the achievement of the Millennium Development Goals, Poverty Reduction Strategies and Sector-wide Approaches. The catalytic role of WHO in community-based initiatives can be taken up by national public health institutions whereby these function as a technical resource centre for capacity development and support to communities in the design, implementation and monitoring of these initiatives.
4.5 Social determinants of health and health equity

Many of the inequalities in health, both within and between countries, can be understood in terms of social inequalities. A review of the social determinants of health in the Region identified the following as important: a) women’s empowerment/enablement, including education for girls and women and employment; b) early child development, including its impact on child labour and street children and their health; c) migrant workers—movements within and between countries resulting in health inequities; d) inequitable health systems as a barrier to accessing essential health care; e) social dimensions of priority public health conditions; f) socially determined lifestyle and behaviour; and g) conflicts and emergencies and the resulting health inequities [19].

An assessment of the social determinants of health in countries in conflict and crises in 2006 was conducted in six countries, Afghanistan, Iraq, Lebanon, Palestine, Somalia and Sudan, with a total population of around 100 million. The three social determinants found to be peculiar to a conflict setting are: 1) the loss of human rights, which can be seen as the first and most important social determinant in a conflict situation; 2) breaches of medical neutrality, in violation of the Geneva Convention, Article 18, and 3) progression from stress to distress and disease, which results from constant, unremitting exposure to a life threatening situation [20].

5. Challenges to primary health care in a rapidly changing global landscape

5.1 Overview

The past 30 years have seen an unprecedented pace of change in the world. These changes have influenced the larger geo-political, socioeconomic, informational, technological and climatic environment in which the health systems function (Table 3). Despite these wide ranging changes, the values of primary health care have remained unchanged, which is a testimony to their universality. However, the way of putting primary health care into practice can no longer “be business as usual”, and needs to change significantly if the universal values of primary health care are to influence the conditions in which the disadvantaged populations grow, work, live and age.

5.2 Globalization

The challenge for the primary health care approach in the 21st century is to be able to maximize the benefits that globalization offers and minimize the risks it poses to the health of the populations. The dramatic increase in the number of global players and movements over the past three decades has had a direct bearing on the development of health systems based on primary health care. Unravelling the complexities and challenges of the new global health governance is essential as these initiatives will have a major influence in shaping the form and future of primary health care. Global goals, movements and alliances—the Millennium Development Goals, social determinants of health, health as a human right [10], Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), GAVI Alliance—bring together key players linked by modern communication networks and common global concerns. These partners support some of the largest externally funded primary health care programmes to tackle conditions such as malnutrition, problems of reproductive and child health, HIV/AIDS, malaria and tuberculosis, and some such as GAVI and GFATM have recognized the need to strengthen health systems. The challenge is now for the national governments to be able to benefit for achieving valuable gains in health outcomes.

The communications revolution has the potential to link the most remote primary health care centres as well as unserved communities, using the internet and especially mobile phones to report routine health statistics and act as an early warning system for health emergencies. The communications system, when used by powerful commercial interests, also has the ability to influence remote populations, to persuade them to smoke, eat new kinds of food and engage in new leisure habits. It will be a great challenge for the social marketing of global public health “goods” to be able to measure up to the powerful commercial marketing of the global public health “bads” (health risks) such as tobacco use and the consumption of unhealthy foods.
Table 3. Range of factors that influence primary health care in a changing world

<table>
<thead>
<tr>
<th>Globalization</th>
<th>Economic growth and crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liberalization and marketization</td>
<td>Unequal economic growth</td>
</tr>
<tr>
<td>&quot;Free trade&quot; – uncertain who benefits more?</td>
<td>Increasing pressures on resources</td>
</tr>
<tr>
<td>Everything has a market value; Risk of health and education becoming commodities rather than rights</td>
<td>Doubling of oil and staple food prices; the poor suffer more</td>
</tr>
<tr>
<td>Communications revolution</td>
<td>Demographic changes</td>
</tr>
<tr>
<td>Disparity in access to information – e.g. Internet users in rich and poor countries</td>
<td>Population growth</td>
</tr>
<tr>
<td>Extensive promotion of &quot;global bads&quot; – smoking, fast food, unsafe transportation</td>
<td>In 1980 world population was 4440 million, in 2007 6615 million, and by 2050 is projected to be 9075 million(^6)</td>
</tr>
<tr>
<td>International travel</td>
<td>Demographic transition</td>
</tr>
<tr>
<td>Increased risk of epidemic and global pandemics</td>
<td>Increased youth, increasing aged population</td>
</tr>
<tr>
<td>Updating international health regulations</td>
<td>Urbanization</td>
</tr>
<tr>
<td>Wars and conflicts</td>
<td>Urban residents now half world’s population</td>
</tr>
<tr>
<td>Disruption of health services</td>
<td>Migration</td>
</tr>
<tr>
<td>16 million refugees in 2007, 26 million internally displaced persons (IDPs)(^a)</td>
<td>Forced migration: increased refugees, IDPs, asylum seekers</td>
</tr>
<tr>
<td>Economic growth and crisis</td>
<td>Civil society role and contribution</td>
</tr>
<tr>
<td>Economic growth with unequally distribution between and within countries leading to increasing economic and social inequalities</td>
<td>Increasing &quot;voice&quot; and expectations</td>
</tr>
<tr>
<td>Increasing pressures on resources</td>
<td>Increasing international recognition, influence and voice of civil society</td>
</tr>
<tr>
<td>Environmental changes</td>
<td>Rising expectations among a more literate and better informed population</td>
</tr>
<tr>
<td>Climate change</td>
<td>Environmental changes</td>
</tr>
<tr>
<td>Very young, elderly and malnourished will be most vulnerable</td>
<td>Natural disasters</td>
</tr>
<tr>
<td>70% rise in number of people affected by natural disasters (174 million per year in 1985–1994 to 254 million per year in 1995–2004); In early 1980s, 200 natural disasters per year; currently 500 per year(^a)</td>
<td>Food security</td>
</tr>
<tr>
<td>100 million more face severe hunger in between May 2007 and May 2008 37 countries in food crisis(^a)</td>
<td>Water scarcity</td>
</tr>
<tr>
<td>Absence of safe water and sanitation kills 1.6 m children under 5 every year(^i)</td>
<td>Health challenges</td>
</tr>
<tr>
<td>Health as a human right</td>
<td>Reemergence and recognition of health as a human right</td>
</tr>
<tr>
<td>UN Special Rapporteur on the Right to Health 2003</td>
<td>Growing health inequality</td>
</tr>
<tr>
<td>24 countries experienced a decline in life expectancy during the 1990s, 16 of them in sub-Saharan Africa(^a)</td>
<td>Health security</td>
</tr>
<tr>
<td>Emergence of new diseases: Over 40 million cases of HIV/AIDS; SARS; pandemic influenza</td>
<td>Epidemiological and risk transitions</td>
</tr>
<tr>
<td>Increasing global disease burden of noncommunicable diseases and risks</td>
<td>Rising incidence of injuries and accidents</td>
</tr>
<tr>
<td>Health workforce</td>
<td>Health workforce</td>
</tr>
<tr>
<td>Migration from poor to rich countries</td>
<td>Health decentralization</td>
</tr>
<tr>
<td>Increasing trend towards decentralization with mixed results</td>
<td></td>
</tr>
</tbody>
</table>

Trade agreements are one aspect of globalization that limits the range of policy instruments available to governments. The governments have to put particular emphasis on the rule-setting part of trade negotiations in areas such as intellectual property rights, health and health-related services, domestic regulation, and tariff reduction to ensure that these agreements do not adversely affect access to essential medicines or health services.

The character of armed conflicts has changed in the 21st century; such conflicts affect more civilians, and their origins and perpetuation are related to the global situation. Six countries in the Region are experiencing armed conflict or are in a post-crisis setting, with countries hosting major refugee populations at the end of 2007 including Pakistan (2 million), Syrian Arab Republic (1.5 million), Islamic Republic of Iran (963,000) and Jordan (500,000) [21]. A major challenge is how primary health care can respond to the needs of these refugees, internally displaced persons and the many casualties of these armed conflicts when local health services are severely disrupted.

5.3 Economic growth and crisis

The paradox of economic growth lies in its uneven consequences, the widening gap between rich and poor, and the pressure such growth exerts on the world’s finite resources. The drive for increased economic growth without concomitant redistribution of wealth is unlikely to bring the desired benefits to poor countries and the poor segments of society in almost all countries of the world. By the same token, it is unlikely that economic growth alone will bring similar health benefits to the poor and the vulnerable as to the rich segments of society, unless national policies and programmes emphasize the avoidance of unfair inequalities in health across the entire population, which is the essence of health equity and a core value of primary health care.

The prolonged global economic recession and the associated debt crisis in the developing world in the 1980s pushed many low-income and middle-income countries to the brink of economic collapse and imposed the broader economic structural adjustment programmes which required countries to cut spending on health and to undertake health sector reforms, both of which threatened the primary health care movement. The current rise in oil prices, the food crises and the possibility of a global economic recession should not be allowed to jeopardize the resurgence of primary health care. Instead, primary health care should be seen as a principal strategy for protecting the health of the people in the face of these economic challenges.

5.4 Demographic changes

The world’s population has increased by over two billion over the past 30 years and is likely to increase by another two billion over the next 30 years. In the Eastern Mediterranean Region, the increase in numbers has been accompanied by a change in the demographic structure with a growing cohort of young people raising families and a growing number of elderly. Primary health care services will have to be organized to meet the changing health needs of a growing population.

The urban population is now more than 50% of the world’s total population, which should not overshadow the fact that the majority of the population in many low-income countries is still rural. Nevertheless, the growth of poor urban populations poses further challenges for a primary health care system which originated in a rural setting in most developing countries. The refugees and internally displaced persons resulting from conflicts and crises are a special and vulnerable population group that requires primary health care services.

5.5 Civil society's role and contribution

The primary health care approach in the 21st century has to be responsive to the increasing “voice” of, partnership with, and potential role and contribution of civil society. Civil society can effectively contribute by advocating for primary health care and its values, developing capacity through training and applied research and by engaging in the delivery of health services. Civil society organizations and individual volunteerism should not be seen as an inexpensive way to provide poor people with primary health care services, but as a way to ensure that the services provided meet changing expectations and reach the disadvantaged.
5.6 Environmental changes

Climate change is partially caused by, and has exacerbated, existing environmental problems that originated in the ever-growing demand for resources and the increasing purchasing power of most of the world’s population. The Eastern Mediterranean Region is experiencing unprecedented water scarcity and decline in agricultural biodiversity. Globally, and in the Region, there is a need to fundamentally rethink farming systems so that they can be sustainable, and feed the growing world population [22]. Primary health care has a central role in preventing malnutrition and promoting healthy eating and the use of nutritious local foodstuffs.

5.7 Health challenges

There has been an improvement in the world’s health over the past three decades. Proportionately fewer children die now than in the 1980s and 1990s, and overall life expectancy has increased by seven years. The improvement in health status, however, can be attributed as much to non-health system related determinants as to those related to the health system. Among the former are the increased levels of income and education, improvements in technology, increased access to information and the improved capacity of state and the non-state agencies to translate knowledge into action. Despite these improvements, many countries and regions have been left behind, leading to rising health inequities between countries and regions and within countries. This is arguably the single most important health challenge that the revitalized primary health care approach will have to tackle.

Among the other challenges that the primary health care approach will have to contend with is the rapid expansion of the for-profit private health sector during the past three decades, which in many developing countries is largely unregulated. This requires finding innovative means to harness the private health sector to help achieve the public sector goals. In addition, the shortage of health staff, especially in low income countries is exacerbated by their migration to more affluent countries. In the Eastern Mediterranean Region this has depleted the workforce in countries in conflict, for example in Iraq, where an estimated one half of all physicians have now left the country, and where the material and professional rewards for work are perceived as unsatisfactory [23]. Primary health care will have to find ways and means of retaining the workforce to serve in remote and demanding sites, which appear least attractive to professional and paraprofessional staff.

6. Primary health care-based health systems: directions for the future

There is a growing consensus within WHO, development partners, and countries that a revitalized primary health care is the approach to better performing health systems. Table 4 provides an overview of approaches to health system development, which although different, are not mutually exclusive or necessarily contradictory. At the same time it has to be recognized that revitalization of primary health care will require leadership, vision, commitment and well thought-out strategies to transform the values and principles of primary health care into implementable programmes. Some of the strategic directions that would help move the process forward are considered below.

Table 4. Approaches to health system development

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Primary health care as in Alma-Ata</th>
<th>Health sector reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideology promoted</td>
<td>Social egalitarian</td>
<td>Utilitarian</td>
</tr>
<tr>
<td>Basis</td>
<td>Right-based</td>
<td>Reform-based</td>
</tr>
<tr>
<td>Overall approach</td>
<td>Comprehensive</td>
<td>Selective – essential package of services</td>
</tr>
<tr>
<td>Role of governments</td>
<td>Greater public sector involvement</td>
<td>Restricted role of the government</td>
</tr>
<tr>
<td>Focus on</td>
<td>Equity and social justice</td>
<td>Efficiency and competition</td>
</tr>
<tr>
<td>Champions</td>
<td>Socially driven scientists</td>
<td>Economists</td>
</tr>
<tr>
<td>Type of reforms</td>
<td>Programmatic</td>
<td>Structural</td>
</tr>
</tbody>
</table>

a) Aligning the global and regional movements and alliances to the primary health care approach

The revitalized primary health care approach should align and encourage global initiatives such as the achievement of Millennium Development Goals, poverty reduction strategies, health systems strengthening windows supported by GAVI and GFATM, and WHO’s own Commission on the Social Determinants of Health to uphold and reinforce the universal values of primary health care. Currently, there is clear commitment to primary health care among the leadership of WHO, which binds the Organization’s strategic objectives together with its three levels [1,2]. A greater challenge for WHO’s leadership will be to rally the global and regional stakeholders around the primary health care agenda by providing evidence and advocating for the effectiveness of the primary health care approach in strengthening health systems.

b) Making primary health care dynamic and flexible to adapt to the changing world

Primary health care is not an approach for poor countries, for poor people or for diseases of the poor. Health systems oriented to primary health care should be able to respond to new challenges continuously in all countries, whether developing or developed, rich or poor and in conflict or in peace. The ability and adaptability of the primary health care approach to adapt and respond to challenges—economic shocks, natural or man-made disasters, climate change, food crisis, pandemics—is essential. For instance, primary health care can no longer be oblivious to the public health implications of trade liberalization or food insecurity and should be robust enough to respond to these emerging challenges. Primary health care, must keep pace with the rapid changes taking place across the globe while its universal values are being translated into actionable programmes.

c) Learning from best practices from within and beyond the Region

Health systems are context-specific and no single set of solutions can improve performance in all settings. In 1994, a WHO report on progress towards Health for All concluded that dissemination of practical experiences in overcoming problems was the most important tool for progress. This conclusion remains valid today. There are several experiences from within the Region that provide lessons for other countries. In this regard the experiences of the Islamic Republic of Iran and Oman in developing health systems oriented to primary health care provide illustrative models for other countries within and beyond the Region.

d) Promoting health systems based on primary health care: not a “one size fits all” approach

The primary health care approach is unlikely to succeed if it is promoted as a “one size fits all” approach for solving the health problems of all countries. The practical implications of this are well illustrated in the Region, where Somalia, Syrian Arab Republic and Saudi Arabia are keen to adopt the values and develop health systems oriented to primary health care. However, the set of services to be provided, the skill mix required, the monitoring indicators needed and the cost of providing services will be substantially different in the three settings. It is the recognition of universality of the concept and at the same time flexibility in implementation that will make primary health care a successful and sustained approach across all countries of the Region. The following strategies are essential for developing primary health care based health systems.

- Adequate and fair financing of the health system that ensures financial and social risk protection, universal coverage for essential health services, reduction in out-of-pocket expenditure and preventing households from slipping into poverty as a result of catastrophic expenditure on health. Within existing financial constraints, governments need to devise systems for social protection, whether financed through pooling arrangements, employment schemes, more efficient tax collection, or an increased share of the national budget allocated to health.
- Empowering communities to take decisions regarding their own health and social well-being. The experience with community-based initiatives in the Region offers a useful model of community organization, income generation, poverty reduction and improving health outcomes, which has the potential to be scaled up. Evidence of the value of community-based and
community-directed approaches to service delivery continues to mount. Apart from their proven ability to reduce morbidity and mortality, these strategies show great promise in terms of cost-effectiveness and enduring community commitment.

- Strengthening the district health system is critical for tackling the implementation bottlenecks in the organization, management and delivery of health services. In addition, to improved resource management, a degree of innovation and adaptability is desirable in different situations. For instance, the models of family practice, public–private partnership, contracting out, community health workers or interventions such as conditional cash transfers need to be tested in different settings and recommended for scaling up in the local context based on sound evidence.

- Expanding the range of primary health care services to address the implications of epidemiological and demographic and risk transition that focus on noncommunicable diseases, high-risk behaviour and the care of the elderly.

- There is scope for functional and in certain instances complete integration of vertical programmes as an important element of the primary health care approach. The success of the WHO/UNICEF Integrated Management of Childhood Illness (IMCI) initiative, which has been adopted as the child survival strategy in 100 countries, paves the way for the future of integrated approaches. IMCI delivers quality clinical care, in a public health approach, according to the principles of primary health care, and within the constraints of the existing health system.

- Developing a balanced, skilled and well distributed health workforce and providing incentives that enhance motivation and retention. Primary health care can only succeed if its values are inculcated and instilled by the training and development of the health workforce. Thus values such as equity and social justice, community ownership and participation, dignity of patients and respect for their families have to be an integral component of the curriculum.

- Advances in information technology make it possible to link remote health centres with higher levels of expertise. These advances can also revolutionize the collection and use of data within district health systems, thus addressing the perennial problems of inadequate monitoring and evaluation while supporting better priority setting.

- Monitoring health system performance oriented to primary health care, is essential. This entails monitoring health outcomes, service inputs and outputs, and health determinants. Monitoring health equity, responsiveness, user satisfaction and community engagement is also critical.

- Institutional strengthening of ministries of health to provide the required leadership and governance in health is critical. This requires the ministries to: develop the capability to formulate evidence-based health policies and strategic plans; promote the values of primary health care; commit to spending more resources on primary health programmes; develop partnership with the non-state players and communities; coordinate among development partners; lead the process of intersectoral action for health by engaging other ministries and national bodies; and be more accountable and transparent in health affairs. Strengthening these elements is essential for raising the prestige of the health ministries within government hierarchies.

e) Enhancing the role of the civil society

The role of a vibrant civil society is essential for the purposes of health advocacy, capacity building, applied research, service delivery, and to ensure that the values of primary health care are not overlooked in health development. The contribution of civil society, especially at grass-roots level, has grown considerably, and offers new models of service delivery, often based on the ethic of voluntary service. As a resource, civil society initiatives are especially well suited to community-based approaches.

f) Tackling social determinants through intersectoral action for health

The final report of the Commission on Social Determinants of Health, released at the end of August 2008, will provide insight into the wider determinants of health and how they can be addressed through the policies and programmes of various sectors. Many of the fundamental determinants of health lie beyond the direct control of the health sector. Two alternative approaches to tackling health
determinants need to be considered: 1) improved intersectoral action for health; and 2) integrating health policies while allowing for sectoral action during implementation.

Finally, the success of primary health care in the Eastern Mediterranean Region rests heavily on strengthening the public sector, civil society and academic and research institutions and building a critical mass of individuals to lead these. WHO at its end will have to prepare itself to fulfil the ambitious agenda to revitalize primary health care. This means visionary leadership, strengthening its position among global and national partners, providing technical advice based on sound evidence, developing appropriate tools and instruments, and building strong capacity in country offices. Most important, there can be no wavering from the commitment to primary health care for at least another 30 years.

7. Conclusion

The 30th anniversary of the Alma-Ata Declaration provides the appropriate occasion for WHO’s Member States and its secretariat to renew its commitment to primary health care, both globally and regionally. The Declaration expresses in no uncertain terms values and principles, such as health equity, universal access and health as a human right, that are relevant for everyone. The challenge is to improve population health and not just focus on health care; reduce inequities in health and ensure universal health coverage by removing physical, financial and cultural barriers to accessing health care; promote intersectoral action for health; and empower communities to take decisions about their own health.

Revitalization of primary health care can be successful when there is shared commitment of the Member States, WHO and other development partners. This will be substantiated by raising primary health care on the global, regional and national policy agenda; increased allocation of resources to primary health care programmes and most important an overriding focus on improving the health of poor and marginalized segments of the population. Development of health systems based on primary health care will be the principal strategy for its achievement.
References

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