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Executive summary

Alma-Ata is a name that has become synonymous with one of the great public health movements of history – the quest for equity in health, expressed as the goal of “Health for All by the Year 2000”. The 40th anniversary of the Alma-Ata Declaration on Primary Health Care is a watershed moment and an occasion to reflect on how primary health care (PHC) has progressed, challenges have been confronted and opportunities seized. The PHC approach has matured to become the foundation for health systems development in the 21st century.

Primary health care, with its values rooted in social justice and equity, has complemented many parallel health reforms in countries in the Eastern Mediterranean Region, notably the health sector reforms, Millennium Development Goals (MDGs), universal health coverage (UHC) and now the Sustainable Development Goals. This review focuses on how PHC has progressed in the Region over the last decade, but also touches on prior events that have shaped and influenced the history of PHC in the Region, which has remained committed to this approach since the Alma-Ata Declaration of 1978. The core principles and values of PHC have been influential in shaping health systems across the Region, and the commitment to PHC is clearly evident in the Regional Committee resolutions, technical reports and other key documents that the Region has endorsed to date.

The Qatar Declaration was a significant event in the recent history of PHC in the Region. In November 2008, on the occasion of the 30th anniversary of the Alma-Ata Declaration, the World Health Organization (WHO) Regional Office for the Eastern Mediterranean, in collaboration with the Ministry of Public Health in Qatar, organized an international conference that resulted in the Qatar Declaration on Primary Health Care, reaffirming the Region’s longstanding commitment to PHC. During the same year, two seminal global reports reinforced each other and gave further impetus to PHC globally and in the Region. The first was the “World Health Report 2008: primary health care more than ever” and the second was the report of the WHO Commission on the Social Determinants of Health, which was uniquely instrumental in raising health equity on the regional health agenda. The report on the social determinants of health and the health equity initiative were in many ways a vindication of the Community-Based Initiatives, which were conceptualized and championed by WHO for many years.
The seminal paper presented to the Member States of the WHO Region for the Eastern Mediterranean in 2012 during the 59th session of the Regional Committee was instrumental in shaping the strategic directions for strengthening health systems in the Region. The paper emphasized that strengthening health systems in the Region is based on and guided by the values and principles of PHC. The paper proposed seven strategic priorities which are aligned with the PHC approach: 1) move towards UHC; 2) strengthen leadership and governance in health; 3) strengthen health information systems; 4) promote a balanced and well managed health workforce; 5) improve access to quality health care services; 6) engage with the private health sector; and 7) ensure access to essential technologies.

The aspiration towards implementing UHC is not new; it was articulated in the WHO constitution of 1948 and is integral to the Alma-Ata Declaration of 1978. More recently, the sustainable development goals (SDGs) resolution “Transforming our world: the 2030 agenda for sustainable development” further emphasized that UHC is the core driver of SDG 3. The UHC approach is fully aligned with the values and principles of PHC. The Region has passed a number of resolutions and organized high level meetings and has developed a framework for action on advancing UHC in the Region, which has four strategic components: 1) developing a vision and strategy for UHC; 2) improving health financing system performance and enhancing financial risk protection; 3) expanding the coverage of needed health services; and 4) ensuring the expansion and monitoring of population coverage.

The Eastern Mediterranean Region, like other WHO regions, has faced several challenges in terms of rapid expansion of the private health sector, the desire of governments to increasingly partner with the private sector, the changing demography and epidemiology related to ageing of the population, the rapid changes in technology, the effort to ensure financial protection to households while receiving health care and the rising expectations of a more informed population. To add to this, several countries have been overwhelmed by ongoing complex emergencies and longstanding conflicts, leading to a large number of internally displaced persons and refugees, both in the countries affected and in neighbouring countries. This has been detrimental to the health and nutritional status of vulnerable populations, especially women and children. Any PHC approach has to be aware and should internalize these challenges in a rapidly changing environment.
The PHC journey in the Eastern Mediterranean Region has endured as long as the Alma-Ata Declaration of 1978 itself. During this period the countries and the Regional Office can take collective pride in having achieved several landmarks. Lessons have been learnt that offer a good opportunity for reflection.

- **Commitment to PHC matters** – the countries and the Regional Office have remained steadfast over the last few decades, vindicating the Region’s commitment to PHC during periods when market oriented reforms were dominating PHC reforms.

- **PHC values and principles are universal** – The foundational significance of social justice, participation and intersectorality is unlikely to be questioned. However, implementation modalities will change over time as experience accumulates with more innovative approaches to PHC; a strong pro-equity agenda with progressive universalism is a prominent feature of PHC in the SDG era.

- **PHC will lose its significance unless reconfigured to the changing demographic and epidemiologic burden** – Countries need to review the PHC service packages to include the prevention, control and management of noncommunicable diseases, mental health, nutrition, early childhood development and environmental and occupational health problems. At the same time, maternal, neonatal and child health and communicable diseases remain regional priorities along with the unfinished agenda of the (MDGs), especially in the high burden countries.

- **PHC and public–private partnership, does it work?** – There has been a transition from directly delivering PHC services to outsourcing these to the private sector, for-profit as well as not-for-profit; WHO is committed to undertaking a systematic review to assess the effectiveness of public–private partnerships in terms of improving quality, access, efficiency, equity and sustainability.

- **Family practice is the basis for PHC in 21st century** – Aligned with the global strategy of person-centred integrated health services, the Region has adopted the family practice-based approach to ensuring quality PHC, and has produced the tools and approaches for establishing and scaling up family practice-based primary care in countries.
• **Financing the critical link between PHC and UHC** – The financing aspect of PHC has not received adequate attention in the past, hence countries are unable to document spending on PHC. Expenditure on PHC should become an integral component of national health accounts analysis.

• **Community engagement is essential** – Despite the rhetoric about community engagement and participation, there are only a few successful PHC models that have effectively involved the beneficiaries. Community engagement has become even more essential as they have become better informed, have higher expectations and expect providers to be accountable to them, and a strengthened and expanded community health platform is a core component of PHC.

• **No PHC without an adequate health workforce** – Currently, half the countries of the Region do not meet the global health workforce target of 4.45 per 1000 population. Countries would need to develop short- and medium-term health workforce strategies in order to reach appropriate numbers with the right skills mix and distribution to ensure delivery of quality PHC.

• **Public health is an essential element of PHC** – The core public health functions of promotion, prevention, protection, preparedness and surveillance are integral to PHC as part of the service package and as non-personal interventions. Priority public health programmes related to immunization, reproductive health, HIV, TB and malaria need to be integrated at least functionally to improve their effectiveness and ensure long term sustainability.

• **Multisectorality and PHC** – Of itself, the concept of multisectorality is not new. It was termed intersectoral coordination at the time of Alma-Ata Declaration of 1978. It has grown to include what are called Health in All policies, and is reinforced by the fact that many health-related SDGs influence health and well-being. Ministries of health in the Region need to adopt this newer governance arrangement, which engages, and even gives a central role to, other governmental and nongovernmental agencies.

• **Delivering PHC in emergencies** – Millions of internally displaced persons and refugees need PHC in countries of the Region that are in complex emergencies as well as in
neighbouring countries that are also affected. Hence, a high level of preparedness is required to ensure delivery of primary care to mothers, children, the elderly and those facing chronic diseases and injuries.


Alma-Ata is a name that has become synonymous with one of the great public health movements of history – the quest for equity in health, expressed as the goal of “Health for All by the Year 2000” (WHO, 1988). The 40th anniversary of the Alma-Ata Declaration on Primary Health Care is a watershed moment and an occasion to reflect on how primary health care (PHC) has progressed, challenges have been confronted and opportunities seized. The PHC journey has by no means been a smooth one over the last four decades. Despite these challenges, PHC as an approach has not only survived but has matured to be the foundation for health systems development in the 21st century.

The Declaration of Alma-Ata states that PHC is essential health care based on scientifically sound and socially acceptable methods, universally accessible to individuals and families with their full participation at a cost that the community and country can afford in a spirit of self-reliance and self-determination (PHC, 1978). The ultimate goal of PHC is better health for all; WHO has identified five key elements to achieving this: universal coverage to reduce exclusion and social disparities in health; service delivery organized around people's needs and expectations; public policy that integrates health into all sectors; leadership that enhances collaborative models of policy dialogue; and increased stakeholder participation (WHO, 2018).

Primary health care has had a global influence on health policies among all countries of the world in all six WHO Regions. The degree of influence and the level of implementation have varied across the countries. The WHO Region for the Eastern Mediterranean comprises 22 countries (including Palestine) and extends from Morocco to Pakistan. This document endeavours to review the commitment and progress towards PHC in countries of the Region and the technical support and guidance countries have received from the Regional Office in achieving the goal of Health for All.
Primary health care, with its values rooted in social justice and equity, has endured in the Eastern Mediterranean Region and complemented many parallel health reforms in the countries, notably the health sector reforms, Millennium Development Goals (MDGs), universal health coverage (UHC) and now the sustainable development goals (SDGs). This speaks to its universality and is a reflection of this Region’s commitment to PHC. This paper has been prepared for the Regional Office for with inputs from the United Nations Children’s Fund (UNICEF) to inform the contemporary global debate on PHC and to propose a roadmap for the future, as the countries of the world come together in Astana, Kazakhstan in October 2018 to reaffirm their commitment on the occasion of the 40th anniversary of the Alma-Ata Declaration.

2. Scope and analytical approach

This review paper focuses on how PHC has progressed in the Eastern Mediterranean Region over the last decade, 2008–2018. It nevertheless touches on events prior to 2008 that have shaped and influenced the history of PHC in the Region. The countries of the Region (including Palestine) can be segregated into three groups – the upper income, which is the Gulf Cooperation Council countries, the middle income countries, and the low and low middle income countries. A fourth overlapping group includes the countries in complex emergencies and prolonged conflicts that need urgent provision of PHC services under the most challenging circumstances.

The paper relies heavily on analysis based on extensive review of published literature from the Region, regional reports and policy papers developed by the Regional Office and UNICEF, reports from the ministries of health of Eastern Mediterranean Region countries, and updates from the WHO country and regional offices. The paper furnishes information on the achievements, challenges and opportunities, provides insight on priorities for the future and proposes a roadmap for action in support of PHC informed by the best available evidence.

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1 The Aga Khan University, Karachi, has been invited to develop this paper working in close collaboration with the Regional Adviser, Primary Health Care and Director Health System Development, WHO Regional Office for the Eastern Mediterranean.

2 High-income – Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates; middle-income – Egypt, Jordan, Islamic Republic of Iran, Iraq, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic, Tunisia; lower-and lower middle-income countries – Afghanistan, Djibouti, Pakistan, Somalia, Sudan, Yemen.

3 Afghanistan, Iraq, Libya, Somalia, Syrian Arab Republic, Yemen.
3. The primary health care journey in the Eastern Mediterranean Region – the past

3.1 The longstanding commitment to primary health care

The Eastern Mediterranean Region has remained committed to PHC since the Alma-Ata Declaration of 1978 (Sabri, 2008). The Region was quick to pick up the important link between health and development since the launch of the Health for All movement that coincided with the relentless economic and political instability of the 1980s (Shawky, 2010). In that period, countries in the Region experienced large scale economic reforms and underwent several cuts to public health investment. Despite the economic challenges, the technical support of WHO to the Region remained steadfast to the core value system of PHC (EMRO, 2003b).

3.2 Commitment to primary health care – resolutions and reports

The core principles and values of PHC have been influential in shaping health systems across the Eastern Mediterranean Region. The commitment to PHC is clearly evident through the different regional committee resolutions, technical reports and other key documents that the Region has endorsed to date. Among the foundational documents are the regional reviews of integrating PHC into national health systems on the occasions of 25th and 30th anniversaries of the Alma-Ata Declaration (EMRO, 2003b, 2008a, 2010a, 2013b; Sabri, 2008); a key resolution on the role of the governments in health development (EMRO, 2006); and the need for quality assurance in health systems based on PHC and health system priorities in the Region.4

3.3 Primary health care-based health systems strengthening

Several regional initiatives have promoted PHC-based strengthening of national health systems. For instance, in the 1980s the quality assurance and improvement model was introduced in the Region based on PHC. Quality assurance and improvement plans in PHC were developed by different countries (Sheikh, 2004): Jordan, Pakistan, Saudi Arabia, Sudan and Syrian Arab Republic pilot tested comprehensive PHC quality assessment tools. Professionals were trained in quality assurance and improvement techniques through workshops, seminars, courses and conferences.

Over the years, and prior to the end of the millennium, the countries of the Region became geared towards reorienting their national health systems based on PHC models. This included a wide repertoire of initiatives and interventions led by the Regional Office, which supported decentralization and strengthening of district health systems; training of community health workers, traditional health workers and traditional birth attendants; the regional launch of the Community-Based Initiatives in accordance with the basic minimum needs approach; and the development of new initiatives and the use of tools such as national health accounts and burden of disease assessment to monitor progress.

The World Health Report 2000 was a landmark report in terms of putting health systems on top of the global health agenda. There were, however, concerns in the Region that the report did not place adequate emphasis on the principles and values of PHC that had been the leading agenda of WHO for over two decades. Nevertheless, during those years the countries of the Region and the Regional Office remained committed to the values and principles of PHC as can be seen in the regional resolutions and reports of that era (EMRO, 2003b, 2010a; E. WHO, 2008). The World Health Report 2000, however, was truly instrumental in the introduction of measures and interventions concerning alternative financial mechanisms, social protection of the marginalized and vulnerable population, and the introduction of “core packages” of essential health care services, many of which were at the heart of the PHC movement.

From a programmatic perspective, several global initiatives were launched such as the Global Alliance for Vaccines and Immunization and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) as well as other priority public health and health promotion programmes that continue to provide financial assistance to a large number of countries in the Region⁵ and which are an integral component of PHC. The Regional Office has been heavily engaged in providing the necessary technical assistance in the design, implementation, and monitoring and evaluation of these global programmes through its country and regional offices.

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⁵ GAVI supported – Afghanistan, Djibouti, Pakistan, Somalia, Sudan, Yemen; GFATM supported – Afghanistan, Djibouti, Egypt, Jordan, Islamic Republic of Iran, Iraq, Morocco, Pakistan, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen.
3.4 Qatar Declaration (2008) on Primary Health Care: reaffirmation of primary health care on the 30th anniversary of the 1978 Alma-Ata Declaration

The Qatar Declaration was a significant event in the recent history of PHC in the Region. In November 2008, on the occasion of the 30th anniversary of Alma-Ata, WHO, in collaboration with the Ministry of Public Health in Qatar, organized an international conference that resulted in the Qatar Declaration on Primary Health Care, reaffirming the Region’s longstanding commitment. The Qatar Declaration was endorsed and signed by ministers of health of all countries of the Eastern Mediterranean Region and was presented during the 56th Session of the Regional Committee in October 2009 (EMRO, 2010b). According to Shawky (2010), the importance of this declaration resided in the renewal of its necessary shift from the biomedical model of health towards a comprehensive and social model of health (Assai, Siddiqi, & Watts, 2006). Furthermore, it interpreted PHC as the strengthening of national health systems in the Region based on its core values and philosophy. The Declaration was able to influence PHC strategies, programmes and practices in several countries of the Region. For instance, the Ministry of Health in Bahrain organized a regional conference in May 2010 and a national PHC strategy 2005–2012 was developed. Egypt adopted the family health model as a primary strategy for primary care services. The Ministry of Health and Medical Education in the Islamic Republic of Iran began to implement its family practice strategy, which became part of their five-year development plan. Iraq and Jordan approved PHC as a principal approach to strengthening their national health systems. Similar levels of impact can be seen happening in Lebanon, Oman and Yemen (EMRO, 2010a).

3.5 Primary health care and social determinants of health (2008)

Two seminal global reports were published in 2008 that reinforced each other and gave further impetus to PHC globally and in the Region. The first was the “World Health Report 2008: primary health care more than ever”. Four fundamental reforms related to service delivery, universal coverage, leadership and public policy influenced the approach and shaped the policies of PHC in several countries of the Region.

At the same time, the WHO Commission on the Social Determinants of Health, via its final report, was fundamental in reinforcing the comprehensive PHC approach and was uniquely
instrumental in raising health equity on the regional health agenda. Social determinants of health and health equity are the reiteration of PHC core principles and values espoused in 1978. The “health paradigms” from which both discourses are generated are the same. Box 1 delineates six features that are common between PHC and social determinants of health (adapted from Rasanathan K, Montesinos EV, Matheson D, et al., 2010:3).

Box 1. Commonalities between primary health care and the social determinates of health paradigms

- Central focus on health equity
- Relevant in all countries and contexts, regardless of income level
- Health as more than the absence of disease
- Key role for health sector
- Promotion of multisectoral action and consideration of health in all policies
- Emphasize role of empowered communities and the social environment

The social determinants of health and the health equity initiative were in many ways the vindication of the Community-Based Initiatives, which were conceptualized and championed by WHO in the Eastern Mediterranean Region for many years. The Community-Based Initiatives approach is based on the realization that ill health and poverty are mutually reinforcing, and to have a real impact on the quality of life of the people and to gain substantial and sustainable health gains it is necessary to address all determinants of health and to support individuals, families and communities to attain self-sufficiency and self-reliance through integrated and comprehensive development (EMRO, 2003a). The Community-Based Initiatives are divided into four categories: Healthy Villages, Healthy Cities, Basic Development Needs and Gender in Health and Development. These approaches incorporate poverty reduction strategies and sector-wide approaches (EMRO, 2008a). The common goal of these approaches is to create political, physical and economic policies and plans of action for all segments of the community which will produce a positive impact on the overall environment and quality of life. The Community-Based
Initiatives were piloted and tested in various forms in most countries of the Region. Despite successful pilots in some countries, the main challenge was their sustainability and ownership by governments in order to scale up the pilots.

The Regional Office conducted reviews of several aspects of the social determinants of health including those on women’s empowerment, early childhood development, child labour and their health and migrant workers (EMRO, 2008b). The analysis of the social determinants of health in countries in complex emergencies was globally recognized and contributed to the global report on social determinants of health. These reports also highlighted inequitable health systems, barriers to accessing essential health care, social dimensions of public health problems and conflicts and emergencies as determinants of prevalent health inequities in the Region.

Several ministries of health incorporated social determinants of health in their health agenda. However, two countries that championed them in the Region were the Islamic Republic of Iran and Morocco. The social determinants of health secretariat in the Iranian Ministry of Health has now been upgraded to become the Department of Social Affairs and has taken up responsibility for all health related SDGs.

3.6 Primary health care as a basis for health systems strengthening in the Eastern Mediterranean Region

Strengthening health systems in countries of the Region has been guided by the values and principles of PHC since its very inception. Many countries have been engaged in different health systems strengthening initiatives based on PHC over several decades, and some have been highly successful and have served as an exemplar for other countries within and outside the Region. These include – the welayat (district) health systems in Oman, the elaborate PHC network (shabakey behdashti) and the highly successful behvarz (community health worker) initiative of the Islamic Republic of Iran. Similarly, Pakistan established its Lady Health Workers Programme in 1994, which currently has over 100 000 workers, and Afghanistan contracted out their PHC services to nongovernmental organizations, demonstrating that one of the least developed countries can achieve rapid results in improving access to essential care. Several countries, including Bahrain, Egypt, Kuwait, Oman, Saudi Arabia, Tunisia and the United Arab
Emirates, have established family practice programmes as a basis for PHC, with varying degrees of success. An update on these and other initiatives follows in subsequent sections of this paper.

The seminal paper presented to the Member States in 2012 during the 59th Regional Committee was instrumental in shaping the strategic directions for strengthening health systems in the Region (EMRO, 2013b). It emphasized that strengthening health systems in the Eastern Mediterranean Region is based on and guided by the values and principles of PHC.

The paper, which was acknowledged by WHO headquarters and regions, especially the European Region, stated that the Eastern Mediterranean Region is facing several overarching challenges that influence health system performance across countries, especially the need for high-level political commitment to the achievement of UHC; strengthening governance and capacities to engage across sectors by ministries of health; reduction in the share of out-of-pocket payment; enhancement of the contribution of the private sector to public health and its regulation; development of a balanced, skilled and motivated health workforce and adoption of workable models of family practice; reinforcement of health information systems; improvement in access to essential technologies; and support for priority public health programmes. Seven priorities were proposed for improving health system performance of which UHC has been, and continues to be, the overarching priority (Box 2). These strategic priorities, which are aligned with the PHC approach and its values, have to a larger extent guided the Region’s efforts towards health system strengthening over the last three biennia.

**Box 2. Priorities for health system strengthening in the Eastern Mediterranean Region**

- Move towards universal health coverage.
- Strengthen leadership and governance in health.
- Strengthen health information systems.
- Promote a balanced and well managed health workforce.
- Improve access to quality health care services.
• Engage with the private health sector.

• Ensure access to essential technologies – essential medicines, vaccines, medical devices and diagnostics.

4. From primary health care to universal health coverage and Sustainable Development Goals – the present

4.1 Background

The aspiration to move towards UHC is not new. It is articulated in the WHO constitution of 1948 and is integral to the Alma-Ata Declaration of 1978. More recently, the SDG resolution “Transforming our world: the 2030 agenda for sustainable development” has further emphasized that UHC is the core driver of SDG 3. Failure to ensure quality and affordable essential health services means failure to meet SDG 3 by 2030. There are only 13 years left to achieve this ambitious goal (WHO IBRD-IDA, 2017).

Universal health coverage refers to providing all people and communities with access to needed health services (including prevention, promotion, treatment and rehabilitation) that is of sufficient quality, while ensuring that the use of these services does not expose the user to financial hardship. Hence, UHC encompasses three dimensions, represented by the proportions of costs, services and population that are covered. This approach is fully aligned with the values and principles of PHC.

Since the 2005 World Health Assembly resolution, UHC has been the key aspiration for countries to ensure universal access to affordable, quality health services (WHO, 2005); strong PHC systems are the key means of achieving this goal. This notion received global support following the 2010 World Health Report, “Health systems financing: the path to universal coverage”, which provided a roadmap to all countries, rich and poor, for universal coverage through health system financing. In the Eastern Mediterranean Region, the 60th Regional Committee in 2013 endorsed a resolution which emphasized the key role of health system strengthening in enabling countries to move towards UHC (EMRO, 2013a).
During the past few years the Region has passed several resolutions (e.g. RCs 60 and 61), organized several high level regional meetings (EMRO, 2013c), conducted capacity development workshops, developed evidence informed reports and collaborated with countries to engage in a policy dialogue to advance progress towards UHC. An important contribution of the Regional Office was to develop a framework for action on advancing UHC in the Eastern Mediterranean Region (EMRO, 2016a) (Annex 1). The framework has four strategic components: developing a vision and strategy for UHC; improving health financing system performance and enhancing financial risk protection; expanding the coverage of needed health services; and ensuring expansion and monitoring of population coverage.

Sustainable Development Goal 3.8 aims to “achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (UN, 2015). In order to facilitate UHC monitoring, and in line with the SDGs, various countries and health systems, WHO and the World Bank have produced a UHC monitoring framework that focuses on two main components, coverage of the population with quality, essential health services and population covered by financial protection. (WHO/World Bank, 2017). Governments in almost all countries in the Region have expressed commitment to the achievement of UHC and preparatory work for implementation is under way.

4.2 **Universal health coverage – the population and service coverage dimension**

Sixteen tracer indicators of health service coverage have been chosen embracing these two categories to measure the breadth of essential health services for UHC (SDG target 3.8). (Table 1) Collectively these indicators have been termed the UHC service coverage index. A baseline assessment of the index shows wide variation in the countries of the Region, from the highest coverage index in Kuwait and Qatar (77), which is equal to the highest mean regional UHC index in East Asia and North America and Europe (both 77), to the lowest in Somalia (22) (WHO/WB, 2017) (Figure 1).
<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
</tr>
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<tbody>
<tr>
<td>Reproductive, maternal, neonatal and child health</td>
<td>1. Family planning (FP)</td>
</tr>
<tr>
<td></td>
<td>2. Antenatal care 4+ visits (ANC)</td>
</tr>
<tr>
<td></td>
<td>3. Child immunization (DTP3)</td>
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<td></td>
<td>4. Care seeking suspected pneumonia (Pneumonia)</td>
</tr>
<tr>
<td>Infectious disease control</td>
<td>1. TB effective treatment (TB)</td>
</tr>
<tr>
<td></td>
<td>2. HIV treatment (ART)</td>
</tr>
<tr>
<td></td>
<td>3. Insecticide-treated nets (ITN)</td>
</tr>
<tr>
<td></td>
<td>4. At least basic sanitation (WASH)</td>
</tr>
<tr>
<td>Noncommunicable diseases</td>
<td>1. Normal blood pressure (BP)</td>
</tr>
<tr>
<td></td>
<td>2. Mean fasting plasma glucose (FPG)</td>
</tr>
<tr>
<td></td>
<td>3. Cervical cancer screening</td>
</tr>
<tr>
<td></td>
<td>4. Tobacco non-smoking (Tobacco)</td>
</tr>
<tr>
<td>Service capacity and access</td>
<td>1. Hospital bed density (Hospital)</td>
</tr>
<tr>
<td></td>
<td>2. Health worker density (HWD)</td>
</tr>
<tr>
<td></td>
<td>3. Access to essential medicines</td>
</tr>
<tr>
<td></td>
<td>4. International Heath Regulations core capacity index (IHR)</td>
</tr>
</tbody>
</table>

Source: WHO/WB, 2017
Countries in the Region must review their existing packages of essential health care services and deliver them effectively, particularly through a strengthened PHC system, to achieve UHC service coverage goals. While all countries already have such packages, some diseases and conditions such as noncommunicable diseases and mental health problems need more focus while maternal, neonatal and child health and communicable diseases remain priorities. For instance, Lebanon has introduced preventive maternal, neonatal and child health, noncommunicable diseases and mental health services to its PHC package. The Islamic Republic of Iran has introduced a broad package of health services including preventive services for
noncommunicable diseases and mental, environmental, occupational and school health in its newly established comprehensive health centres. In Jordan, the government’s PHC services package includes a set of comprehensive preventive and curative services related to controlling communicable and noncommunicable diseases; reproductive health; water and food safety; environmental health; early detection of chronic, genetic and congenital diseases; mental health and substance use; school health; occupational health; environmental health; dental health and health promotion. Service packages exist in many middle- and high-income countries in the Region.

The Disease Control Priorities Third Round is collaborating with the Regional Office to bring their methods and messages to regional and country levels. Working with high-level leadership in the Regional Office, the Disease Control Priorities efforts are designed to increase access to economic evaluation of key health issues, identify high-value interventions and provide evidence for establishing health sector priorities, for the Region as well as for specific member states in order to assist countries in providing health services efficiently and cost-effectively. Through its work Disease Control Priorities is also building regional capacity for economic analysis and implementation of health plans at the Regional Office and in Member States (DCP3, 2012).

4.3  Universal health coverage – the financial risk protection dimension

Many countries have included achieving UHC in their national policies and strategic plans and established social insurance schemes that target the poor and vulnerable segments of society. Despite progress in several countries, out-of-pocket payments continue to be a major deterrent to people receiving the quality health care they need, and can expose people to financial hardship.

The Region continues to be a low investor in health, with a high share of out-of-pocket payment in total health spending – exceeding 75% in some low-income countries. It is estimated that around 16.5 million individuals face financial hardship and around 7.5 million are pushed into poverty every year because of high out-of-pocket payments (EMRO, 2017b). Box 3 highlights key facts in relation to health financing in the Region.

Box 3. Health financing in the Eastern Mediterranean Region: some facts and figures
The Region spends only 1.6% of the global health spending for 8.7% of world’s population.

More than 50% of countries in the Region are yet to develop health strategies for universal health coverage. Between 20% and 40% of health resources are wasted because of health system inefficiencies.

For the last 15 years, around 40% of regional health spending has been paid out of pocket.

In 2015, $150 million were allocated by GAVI and the Global Fund alone for health system strengthening in the Region.

The range of government health expenditure to general government expenditure, as a measure of health priority, is 5–10%.

The range of general government expenditure to gross domestic product as a measure of fiscal space is 20–35% in the countries of the Region.

The WHO and the World Bank have proposed two measures to track progress on financial risk protection as part of UHC in the SDGs, the incidence of impoverishment resulting from out-of-pocket health payments and the incidence of financial catastrophe from out-of-pocket expenditure (WHO IBRD-IDA, 2017). While the incidence of catastrophic expenditure is high in a number of countries in the Region, low incidence in some countries such as Afghanistan, Djibouti and Pakistan (Table 2) may reflect a reluctance to use needed but non-affordable services or lack of access to needed services (as reflected by a low UHC service coverage index in Figure 1) rather than better financial risk protection.

Table 2. Sustainable Development Goals tracer measures of financial risk protection in countries of the Eastern Mediterranean Region, 2017
<table>
<thead>
<tr>
<th>Country</th>
<th>Incidence of catastrophic expenditure (%) at 10% of household total consumption or income</th>
<th>Incidence of impoverishment due to out-of-pocket health spending poverty line at 2011 purchasing power parity of US$ 1.90 per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>4.84</td>
<td>0.58</td>
</tr>
<tr>
<td>Djibouti</td>
<td>1.42</td>
<td>0.13</td>
</tr>
<tr>
<td>Egypt</td>
<td>26.2</td>
<td>0.12</td>
</tr>
<tr>
<td>Iran, Islamic Republic of</td>
<td>15.81</td>
<td>0.10</td>
</tr>
<tr>
<td>Jordan</td>
<td>5.31</td>
<td>–</td>
</tr>
<tr>
<td>Lebanon</td>
<td>44.85</td>
<td>0.03</td>
</tr>
<tr>
<td>Morocco</td>
<td>22.00</td>
<td>0.63</td>
</tr>
<tr>
<td>Oman</td>
<td>0.63</td>
<td>–</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1.03</td>
<td>1.00</td>
</tr>
<tr>
<td>Tunisia</td>
<td>16.69</td>
<td>0.44</td>
</tr>
<tr>
<td>Yemen</td>
<td>17.06</td>
<td>–</td>
</tr>
</tbody>
</table>

Countries in the Region have taken a number of approaches to improve financial risk protection for their citizens (Annex 2). In Lebanon, the Ministry of Public Health, with concessional financing and grants from the World Bank, is providing preventative packages (wellness, cardiovascular and diabetes, reproductive, child health and mental health) in addition to the basic package of services, to around 350,000 of the poorest and most vulnerable Lebanese population groups. In Jordan, all uninsured Jordanians (32%) are entitled to utilize the Ministry of Health subsidized services. In addition, vaccines and reproductive health services are provided free for the whole population regardless of nationality, thus covering the large refugee population in the country. The Islamic Republic of Iran has launched a Health Transformation Plan since 2014 that has been able to reduce the share of out-of-pocket spending by almost 15 percentage points to less than 40% of total health spending. Pakistan launched a national health insurance scheme in 2015, which is expected to reduce out-of-pocket payments and provide protection against catastrophic expenditure to the whole population living below the poverty line by 2020.

Countries of the Region face a number of challenges in fulfilling the UHC agenda. Fulfilling the financial commitments is a struggle even for high-income countries. For low- and middle-income countries, mobilizing enough funding from internal resources may be difficult and innovative financing approaches may be needed. For low-income countries and countries in complex emergencies, external resources will be needed if they are to reach their UHC targets by 2030. Monitoring these two measures as well as equity outcomes within and across the countries
requires the collection of data related to these indicators; however this is not currently available for all countries.

Attaining the 2030 UHC goals by sustaining and strengthening PHC systems and ensuring financial risk protection coverage, safe access to services and the availability of monitoring data will be particularly challenging in countries in emergency situations (Tables 3, 4). Any meaningful progress will need a concerted global and regional response geared towards the peaceful resolution of conflicts and reconstruction of health systems. As countries increasingly commit to UHC and equity in health, it is important to instil the concept of “progressive universalism”, i.e. the determination to ensure that people who are poor gain at least as much as those who are better off at every step of the way toward universal coverage, rather than having to wait and catch up as that goal is eventually approached (Gwatkin and Ergo, 2010).

Table 3. Selected health services coverage indicators for three groups of Eastern Mediterranean Region countries

<table>
<thead>
<tr>
<th>Country group</th>
<th>Demand for family planning satisfied with modern methods (%)&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Antenatal care (4+ visits) (%)</th>
<th>Skilled birth attendance (%)</th>
<th>DTP3-containing vaccine/pentavalent coverage (%) among children under 1 year, 2016</th>
<th>Adults &amp; children currently receiving ARV therapy (%) among all living with HIV estimates, 2016</th>
<th>Tuberculosis treatment success rate for new bacteriologically-confirmed cases, 2015 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-income (min–max)</td>
<td>56.7–85.3</td>
<td>56.5–100.0</td>
<td>98–100.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>98–100&lt;sup&gt;b&lt;/sup&gt;</td>
<td>42–86</td>
<td>44–88</td>
</tr>
<tr>
<td>Middle-income (min–max)</td>
<td>70.8–92.1</td>
<td>42.6–96.3&lt;sup&gt;b&lt;/sup&gt;</td>
<td>73.6–100.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>61–100&lt;sup&gt;b&lt;/sup&gt;</td>
<td>14–55</td>
<td>61–91</td>
</tr>
<tr>
<td>Low- and lower middle-income (min–max)</td>
<td>35.7–65.2</td>
<td>3.3–36.6&lt;sup&gt;b&lt;/sup&gt;</td>
<td>38.4–78.0</td>
<td>51–93</td>
<td>7–26</td>
<td>79–93</td>
</tr>
</tbody>
</table>

<sup>a</sup>UN Population Division estimate, 2015.

<sup>b</sup>Some country values are missing.

ARV = antiretroviral.
Table 4. Health system indicators for the three groups of Eastern Mediterranean Region countries

<table>
<thead>
<tr>
<th>Country group</th>
<th>Density of primary health care facilities (per 10,000 population)</th>
<th>Density of health workers (No. per 10,000 population)</th>
<th>Annual outpatient visits per capita</th>
<th>Per capita total health expenditure (US$)</th>
<th>Out-of-pocket expenditure (% of total health expenditure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-income (min–max)</td>
<td>0.1–0.7</td>
<td>19.6–29.0</td>
<td>44.8–65.0</td>
<td>0.7–6.1</td>
<td>675–2106</td>
</tr>
<tr>
<td>Middle-income (min–max)</td>
<td>0.6–6.9</td>
<td>6.3–31.0</td>
<td>8.9–71.0</td>
<td>0.04–6.2a</td>
<td>67–569</td>
</tr>
<tr>
<td>Low- and lower middle-income (min–max)</td>
<td>0.5–15.6</td>
<td>1.6–10.0a</td>
<td>3.2–8.3a</td>
<td>0.5–4.6a</td>
<td>36–191</td>
</tr>
</tbody>
</table>

*aSome country values are missing.

5 Primary health care in a rapidly changing regional environment

5.1 The changing global and regional scenario

Health systems are evolving. New challenges arise that need to be confronted and opportunities present themselves that should be seized to continuously reform the health system and make it more responsive to the needs of the population. It is essential that during the reformative process countries retain the universal values of PHC despite the rapid transformations.

The Eastern Mediterranean Region, like other regions, has faced similar challenges in terms of rapid expansion of the private health sector, the desire of governments to increasingly engage and partner with the private sector, the changing demography and epidemiology related to ageing of the population in many countries, the rapid changes in technology, the effort to ensure financial protection to households while receiving health care and the rising expectations of a more informed population. Any PHC approach has to be dynamic and should internalize these in a rapidly changing environment.

This section presents how countries of the Region, with the technical assistance of the Regional Office, have responded to the changing global and regional scenario. Several areas that have a
high relevance to PHC have been considered in the regional context. These include the role of the private health sector, public–private partnership, health workforce, public health programmes, access and quality of primary care, the family physician programme and PHC in emergencies.

5.2 Primary health care and the expanding private sector

The importance of the private health sector in most countries of the Region is increasingly being acknowledged by the ministries of health. During the last few years, the Regional Office systematically made efforts to comprehend the private health sector in order to facilitate a dialogue on the subject and eventually lead to the development of a regional strategy (EMRO, 2014a). The private sector has been defined to include all formal service providers, for profit and/or not-for-profit.

The utilization rates for private sector outpatient services in some low and middle income countries are as high as 76%. The percentage of private sector services used by the poorest quintile ranges between 11% and 81% (EMRO, 2014b) (EMRO, 2014a). The range of services provided is variable, standards are questionable, regulation is poor and there is insufficient information about the financial burden to the users. There are almost 50 000 private clinics in Egypt and 75 000 general practitioners in Pakistan that do not fall under any proper regulatory regime. Private care providers are reluctant to invest in preventive care and in remote or deprived areas. Essential information on private sector composition, service coverage, quality and pricing continues to be patchy, although notable efforts have started in many countries (Zaidi, 2012).

The major challenges confronting the countries of the Region regarding the private health sector include: dual of practice between the public and private sectors, resulting in difficulty in accurately reporting workforce statistics; concentration of workforce in urban areas; rapid expansion of private health professional training institutions; and lack of proper accreditation and national standards for the education of health professionals. Most countries have little reliable data about health workforce distribution, salary structure or multiple job holding. Additional challenges include absent and/or weak regulatory systems and weak formal mechanisms to monitor the quality of health care services offered by the various private providers.
In many countries of the Region, the private sector plays a considerable role in providing primary health services. Yet the public and private sectors are poorly coordinated. Utilizing the strengths of the private sector can be a key strategy in achieving adequate service coverage and achieving SDG target 3.8. Private health care providers in most countries can contribute significantly towards improving access, quality and efficiency of primary care by harnessing their full potential. Hence, there is a need for developing an evidence-based strategy on the role and contribution of the private health sector towards the achievement of public health goals in the Region.

5.3 Public–private partnerships

An increasing number of public–private partnerships have been implemented in the Eastern Mediterranean Region, however a major gap is the lack of evidence on performance to select between competing models. There are two types of partnership surfacing, one is collaborative and the other contractual (EMRO, 2014a). Contracting can influence access, equity, quality and efficiency of health services; promote public health goals; and create an environment conducive to public–private collaboration. Contracting out has been implemented in a number of countries in various forms, for example, Afghanistan and Pakistan have contracted out PHC services to nongovernmental organizations. More recently, the Islamic Republic of Iran has established an urban PHC programme which relies heavily on contracting out services to the private sector, including general practitioners.

A study conducted in 10 countries of the Region in mid-2000 concluded that contracting as a purchasing tool, when applied judiciously, could contribute to the improvement of health system performance. It provides an opportunity to obtain greater control over private providers where there is poor regulatory capacity. Five supporting elements were proposed for effective contractual arrangements: a few clearly defined deliverables; supportive stakeholders; trust between contractor and agency contracted; independent monitoring; and a favourable legal system and political environment (Siddiqi S, 2006).

There is a potential in delivering PHC through private providers; nevertheless, caution needs to be exercised as contracting is a means to better health care, not an end in itself. There is a need to review the impact of such interventions in improving health system performance in the countries
of the Region. A recent global review of contracting out to improve the use of clinical health services and health outcomes in low- and middle-income countries identified only two cluster randomized trails that reported “contracting out over 12 months probably makes little or no difference to health service outcomes” (Odendaal, 2018). It concluded that future contracting out programmes should be framed within a rigorous study design to allow valid and reliable measures of their effects.

5.4 Quality of primary health care

Good quality primary care is the cornerstone for ensuring health system performance and UHC. There is a lack of information on quality and safety of the primary care services and hence the need to develop appropriate tools to assess the standards of quality and safety in Eastern Mediterranean Region countries.

The Regional Office followed an elaborate and extensive process to develop core indicators for assessing PHC in countries of the Region. The steps included an elaborate desk and literature review, selection of candidate indicators, a Delphi survey, pre-piloting of shortlisted indicators in 3 countries, expert consultative meetings, validation with national quality and safety focal points during intercountry meetings and preparation of a metadata file and piloting of same in five countries. This process was spread over three years and a final list of 34 PHC quality of care indicators was developed and is available for use by countries (Table 5). The detailed list of indicators is provided in Annex 3.

The measurement of the identified indicator set using the toolkit was implemented through a five-step process in 10 facilities in each of four countries (Islamic Republic of Iran, Jordan, Oman, Tunisia) and through facilities run by the United Nations Relief and Works Agency for Palestine Refugees (UNWRA). The results are available from the Regional Office and the tool is ready for use.

**Table 5. Quality of primary health care indicators**

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Access/equity</th>
<th>Safety</th>
<th>Efficiency</th>
<th>Effectiveness</th>
<th>Centredness</th>
<th>Timeliness</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>(n = 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>(n = 16)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>---------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>----</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>8</td>
<td>3</td>
<td>15</td>
<td>2</td>
<td>2</td>
<td>34</td>
</tr>
</tbody>
</table>

5.5 Primary health care workforce

There is an overall shortage of qualified health workers, along with suboptimal and imbalanced overall production and availability in countries of the Region. The inequitable geographic distribution and inadequate skills mix together with the increasing mobility of health workers are daunting challenges which need to be addressed. There are also concerns regarding the quality, relevance and performance of health workers. A number of countries are facing a protracted crisis resulting from the outflow of health workers; this has led to shortages and concerns regarding the safety and security of health workers. Reliable and updated health workforce information to guide policies and plans is seriously lacking, and the increasing global demand and need for health workers presents additional challenges to countries (EMR, 2018).

More recent estimates for health workforce needs have used the benchmark of 4.45 health workers per 1000 population (including physicians, nurses and midwives, and all other cadres), to progress towards UHC (EMRO, 2010a). Using these as the proxy for the PHC workforce, Figure 2 illustrates the density of various cadres of workforce in 2015 for all countries of the Region. Ten countries fall below the benchmark of 45 workforce per 10 000 population of which seven countries have a workforce density of less than 20 per 10 000. Table 6 provides an overview of the existing situation in the Region, the variations in distribution and the estimated need for developing a health workforce by 2030.
Figure 2. Density of health workforce cadres in countries of the Eastern Mediterranean Region, 2015

Table 6. Current status and projections of health workforce (HWF) needs for progressing towards universal health coverage in the Eastern Mediterranean Region, 2013–30 (4.45 per 1000 population)

<table>
<thead>
<tr>
<th>Item</th>
<th>Physicians</th>
<th>Nurses/Midwives</th>
<th>All other cadres</th>
<th>Total health workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing HWF, 2013 estimate</td>
<td>785 629</td>
<td>1 295 020</td>
<td>979 097</td>
<td>3 059 747</td>
</tr>
<tr>
<td>Proportion of global HWF (%)</td>
<td>8.0</td>
<td>6.3</td>
<td>7.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Density per 1000 population</td>
<td>1.2</td>
<td>2.1</td>
<td>1.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Range (min–max)</td>
<td>0.1–8.0</td>
<td>0.5–12.3</td>
<td>0.3–7.5</td>
<td>0.9–27.8</td>
</tr>
<tr>
<td>Mean (standard deviation)</td>
<td>1.6 (1.7)</td>
<td>3.0 (2.7)</td>
<td>1.9 (1.6)</td>
<td>6.5 (5.8)</td>
</tr>
<tr>
<td>Estimated HWF needed by 2030</td>
<td>1 262 257</td>
<td>1 782 107</td>
<td>2 207 977</td>
<td>5 252 342</td>
</tr>
<tr>
<td>Change in HWF by 2030 (%)</td>
<td>61</td>
<td>38</td>
<td>126</td>
<td>72</td>
</tr>
</tbody>
</table>


In the Eastern Mediterranean Region, several measures have been taken to overcome these challenges. For example, WHO has supported the establishment of several educational institutions, professional associations, licensing and certification bodies, continuing education programmes and fellowships (EMRO, 2013b). Recently two frameworks have been developed: a framework for action for health workforce development (2017–2030), based on the recommendations of WHO in the Global strategy on human resources for health: workforce 2030.
(WHO, 2016) and the High-Level Commission on Health Employment and Economic Growth (ILO, 2016); a regional framework for action on reforming medical education (EMRO, 2015b) and the framework for action to strengthen nursing and midwifery, 2016–2025 (EMRO, 2016d). Studies carried out in the Region have also shown the positive impact of physician and nurse densities on health outcomes (life expectancy, maternal mortality rate and infant mortality rate) (Edmond et al., 2018; El-Jardali et al., 2007).

There is a global resurgence of interest in community health worker programmes as a cost-effective means to achieving UHC. Community health workers are a key element of community-based health, which is the foundation of PHC, and are increasingly being considered as integral components of the community health system. Strengthening the community health system is believed to be an effective means of reaching UHC and achieving the SDGs.

5.6 Family physician programme

The 60th session of the Regional Committee in 2013, in resolution EM/RC60/R.2 on UHC, urged Member States and WHO to expand the provision of integrated health services based on PHC (EMRO, 2016c). Experience shows that integrated PHC services can be best provided through the family practice approach. Family practice can be defined as the health care services provided by a family physician and his/her multidisciplinary team that are characterized by comprehensive, continuous, coordinated, collaborative, personal, family and community-oriented services.

The Regional Office made a conscious decision to use the term “family practice” rather than “family physician” programme, as it seemed more appropriate and relevant for all countries of the Region. The programme is fully aligned with the global strategy for integrated, people-centred health services (EMRO, 2016b). Regionally, there are 13 recognized core elements of family practice (EMR, 2014), that can be summarized into three components: a defined catchment population for PHC facilities; comprehensive, affordable and quality essential health

services ensuring continuity of care with a functional referral system; and availability of sufficient trained health workforce personnel at PHC facilities as a multidisciplinary team.

An assessment of family practice conducted by WHO in 22 countries of the Region in 2014–2016 revealed that family practice is included in national health policies in 16 countries, with 13 having plans to scale it up. There is a huge variation between three distinct groups of countries in terms of the proportion of PHC facilities implementing family practice programmes and the number of family physicians. Only one high-income country has 100% of PHC facilities delivering health services through the family practice approach, while family practice is almost non-existent in most countries in Group 3 (Afghanistan, Pakistan, Somalia, Djibouti and Yemen).

The progress to scaling up family practice is hindered by the lack of availability of trained human resource, mainly due to a shortage of training programmes and lack of support from policy-makers for the specialty. There are a few family practice models comparable to those in the developed countries, while progress in this specialty has been unsatisfactory in several other countries (SEARO, 2003). If the existing rate of production of family physicians continues, only Bahrain will reach (maintain) the ratio of 3 family physicians/10 000 population by 2030. If this is to be achieved, then the recommended annual increase required ranges from 2.77 to 3.56 times the current annual production.

In collaboration with the American University of Beirut, WHO developed a 6-month online course to orient and train general practitioners to become family physicians. This course, though not a replacement for full training of family physicians, can serve as an interim arrangement. Similar initiatives of varying lengths and mechanisms have been initiated by a few countries in the Region, including Egypt, the Islamic Republic of Iran, Morocco, Saudi Arabia and Sudan.

5.7 Priority public health programmes and primary health care

An integral and essential component of PHC is the provision of promotive, preventive, curative, rehabilitative and palliative health services covering priority public health problems that have a high burden of disease and risk. These have historically been delivered as part of vertical programmes, and in some countries as integrated health care. It is beyond the scope of this paper
to provide a detailed analysis of the performance of these programmes (see Table 7 for selected indicators). However, several key points deserve to be emphasized.

- Many Eastern Mediterranean Region countries, especially the low- and middle-income countries, have an increasing burden of noncommunicable diseases and mental health. PHC services have not been adequately reconfigured to respond to the increasing burden in these countries.

- The ageing population in many countries needs home health care services, which, while sporadically present in some countries, do not exist as an organized component of PHC.

- Barring a few exceptions, e.g. most countries of the Gulf Cooperation Council and the Islamic Republic of Iran, many rely on a paper-based system of PHC, which does not support continuity of care, two-way referral, maintenance of health records and a well-functioning and integrated health information system.

- Many low- and middle-income countries receive generous support from GAVI and GFATM to implement immunization and HIV, TB and malaria programmes. These global initiatives also provide health system strengthening support. Efforts are needed to functionally integrate these programmes at the delivery level. This will save costs, ensure long term sustainability and allow the countries to successfully graduate out of the GAVI and GFATM support.

- Despite the remarkable progress in the reduction of maternal, neonatal and under-five mortality over the past two decades, wide disparities continue to exist between and within countries of the Eastern Mediterranean/MENA region, as indicated in the mortality rates for 1990–2015.7

- Between 1990 and 2015, the maternal mortality ratio declined by 50%; under-5 mortality rates fell by 59%; and the neonatal mortality rate declined by 49%. However, deeper analysis shows that even within countries which have shown remarkable progress, the

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7 https://www.unicef.org/mena/health
national figures conceal wider subnational disparities by sociodemographic variables such as age, education, wealth quintile, place of residence, and region. Similarly, the nutrition situation of young children across the Region reveals inequities in the nutrition status of children under five years. The Region has several low- and middle-income countries that face the double burden of malnutrition (i.e. stunting, wasting and micronutrient deficiencies) and over-nutrition (i.e. overweight and obesity) and the associated chronic, noncommunicable diseases. It is well recognized that equity-enhancing approaches save more lives, and are more cost–effective. Investing in the poorest is both a moral obligation and a sound financial investment.

PHC services need to be geared to tackling the unfinished agenda of maternal and child health problems in the 10 high burden countries of the Region. The Region has good experiences in positioning PHC as a strong platform for developing and implementing joint WHO/UNICEF/UNFPA global and regional initiatives related to reproductive, maternal, neonatal, child and adolescent health. The major ones include:

- “Saving lives of mothers and children initiative”, announced in the Dubai Declaration of 29–30 Jan 2013, on accelerating progress toward achieving MDGs 4 and 5;
- RED (Reach Every District) approaches for expansion of immunization coverage;
- “Global action plan for prevention and control of pneumonia and diarrhoea”;
- “Every newborn action plan”;
- “Nurturing care for early childhood development”, launched during the 71st World Health Assembly in May 2018.

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10 [https://www.unicef.org/mena/nutrition](https://www.unicef.org/mena/nutrition)

These represent concrete examples on how PHC could serve as a solid platform for addressing survival and development needs of the poorest and most vulnerable groups, mothers and children, how it has contributed to the achievement of the MDGs and has had a significant role in helping to move the SDG/UHC agenda forward.

Prioritizing such groups has been highlighted in the recent “Tokyo Declaration on UHC: all together to accelerate progress towards UHC” (UHC Forum 2017). Inspired by, and adhering to, the principle of “Leaving no one behind”, the Tokyo Declaration has identified the “most vulnerable members of the world’s population” – children and women, those affected by emergencies, refugees and migrants, and marginalized, stigmatized and minority populations. These should be placed at the centre of the UHC and PHC agenda as such groups so often live in extremely difficult circumstances. The Tokyo Declaration recommended special efforts to design and deliver health services informed by their voices and needs.

Table 7. Selected primary health care-related risk factors in Eastern Mediterranean Region countries

<table>
<thead>
<tr>
<th>Country group</th>
<th>Low birth weight (%)</th>
<th>Children under 5 years who are stunted (%)</th>
<th>Overweight (18+) (%)</th>
<th>Tobacco use (%)(15+ years) 2015 (age standardized)</th>
<th>Raised blood glucose (18+) (%)</th>
<th>Raised blood pressure (18+) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-income, min, max (range)</td>
<td>6.1, 10.3 (4.2)</td>
<td>2.4, 11.6 (9.2)a</td>
<td>67.4, 78.1 (10.7)</td>
<td>9.1, 22.9 (13.8)</td>
<td>16.4, 23.0 (6.6)</td>
<td>14.7, 21.8 (7.1)</td>
</tr>
<tr>
<td>Middle-income, min, max (range)</td>
<td>5.7, 15.4 (9.7)</td>
<td>6.8, 22.6 (15.8)</td>
<td>56.5, 68.7 (12.2)a</td>
<td>10.0, 38.4 (28.4)a</td>
<td>8.5, 18.9 (10.4)</td>
<td>19.3, 35.8 (16.5)</td>
</tr>
<tr>
<td>Low- and middle-income, min, max (range)</td>
<td>8.3, 39.9 (31.6)</td>
<td>29.7, 47.0 (17.3)</td>
<td>16.2, 46.8 (30.6)</td>
<td>9.9, 16.2 (6.3)a</td>
<td>6.8, 15.5 (8.7)</td>
<td>21.7, 26.4 (4.7)</td>
</tr>
</tbody>
</table>

High income – Bahrain, Saudi Arabia, Kuwait, Oman, Qatar, United Arab Emirates; middle-income – Egypt, Jordan, Islamic Republic of Iran, Iraq, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic, Tunisia; low and lower middle-income countries - Afghanistan, Djibouti, Pakistan, Somalia, Sudan, Yemen.

Some country values are missing.

12 http://www.who.int/universal_health_coverage/tokyo-declaration-uhc.pdf
5.8 Essential public health functions and primary health care

Essential public health functions are an essential component of PHC. Many WHO Regions – Pan American Health Organization, Western Pacific Region and European Region – have proposed essential public health functions and developed tools for their assessment. Much of the work undertaken by WHO has aimed at serving Member States by helping them to assess and develop the essential public health functions. The key questions in the assessments are: how are they carried out in the country, what agency has the main responsibility and what is its capacity to perform them? (Alwan, 2015)

Between 2013 and 2016 the Regional Office undertook the task of establishing essential public health functions adapted to the needs of countries in order to strengthen and improve public health capacity within both Member States and the Regional Office (Box 4) (EMRO, 2017a). Many Member States offer public health services, however gaps exist in all countries – rich or poor – that underscore the need for good quality public health work. The sole purpose of the work to strengthen essential public health functions is to help countries build their capacity to protect and promote the health of their citizens as cost–effectively as possible, the essence of good public health. Countries can consider various mechanisms to do this. Two that would be fundamental include strengthening the public health governance of the ministries of health and establishing functionally independent national public health institutes.

Box 4 Essential public health functions – Eastern Mediterranean Region

Core functions

- Surveillance and monitoring of health determinants, risks, morbidity and mortality
- Preparedness and public health response to disease outbreaks, natural disasters and other emergencies
- Health protection, including management of environmental, food, toxicological and occupational safety
• Health promotion and disease prevention through population and personal interventions, including
• action to address the social determinants of health and health inequities

**Enabling functions**

• Assuring effective health governance, public health legislation, financing and institutional structures (stewardship function)
• Assuring a sufficient and competent workforce for effective public health delivery
• Supporting communication and social mobilization for health
• Advancing public health research to inform and influence policy and practice

5.9 *Primary health care and emergencies and conflicts*

Political conflicts in the Region have led to endless cycles of emergencies. According to recent WHO figures, more than 62 million people are affected in the Region as a result of health emergencies and are therefore in dire need of health care. Thirty million people are recorded as displaced persons and others wounded or injured and are at risk of communicable and noncommunicable diseases (EMRO, 2015a). The Region has been divided into four zones according to the severity of emergencies, from highly vulnerable to moderate and protracted countries (Table 8).

**Table 8: Categorization of Eastern Mediterranean Region countries by severity of emergency**

<table>
<thead>
<tr>
<th>Grade 3</th>
<th>Grade 2</th>
<th>Grade 1</th>
<th>Protracted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iraq</td>
<td>Libya</td>
<td>Afghanistan</td>
<td>Somalia</td>
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<tr>
<td>Syrian Arab Republic</td>
<td>Palestine</td>
<td>Pakistan</td>
<td>Sudan</td>
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<tr>
<td>Yemen</td>
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A major challenge in these situations is the provision of PHC to the refugee as well as internally displaced population. An emergency response framework has been adopted by the countries to respond to health emergencies and equip themselves with emergency preparedness activities.
Ten public health areas have been identified as priority areas during times of emergencies, these include communicable diseases, gender, migrant health, noncommunicable diseases, persons with disabilities, maternal, neonatal, child and adolescent health, mental health, nutrition, trauma and surgical care, and water, sanitation and health (EMRO, n.d.). Significant steps have been taken to integrate emergency preparedness and response as part of the institutional agenda and shaping the future of health in the Region (EMRO, 2012). For instance, preserving supplies of food, development of human resources for emergency response, fostering inter- and intra-regional support mechanisms in times of crisis, and forging peace agreements and truces between countries. The Region has also worked upon strengthening the evidence base by regularly monitoring and tracking health emergencies, crisis situations and natural disasters (EMRO, 2012).

5.10 Update on progress in primary health care in Eastern Mediterranean Region countries

With the technical assistance of the Regional Office, the countries of the Region have remained committed to PHC over the past decade, and are making a successful transition towards strengthening PHC-based health systems as a basis for UHC. In some areas progress has been remarkable and visible while in others lot more remains to be done. Table 9 provides an updated overview of the current status of PHC. Several characteristics of PHC have been considered relating to service delivery, transition to family practice, public–private partnership, financing, community engagement, multi-sectoral coordination, and PHC in emergencies and the level of preparedness.
Table 9. An updated overview of the status of primary health care (PHC) in countries of the Eastern Mediterranean – 2018

<table>
<thead>
<tr>
<th>Country</th>
<th>PHC service delivery</th>
<th>Family practice-based PHC</th>
<th>Public–private partnership</th>
<th>PHC financing</th>
<th>Community engagement</th>
<th>Multisectoral coordination</th>
<th>Emergencies and PHC</th>
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</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>Quality of services improved but access still limited in conflict and dispersed population areas</td>
<td>New PHC programme “Sehatmandi” for the coming three years (July 2018 – July 2021); significant increase in number of health workforce</td>
<td>Contracting out of public health facilities through public–private partnerships is a primary source of providing health care</td>
<td>Adequate financing is a challenge; however, heavy reliance on donors continues</td>
<td>Work needs to be done on engaging communities</td>
<td>Coordination between the Ministry of Public Health, donors and other nongovernmental bodies to improve health care is strong</td>
<td>In public and health facilities safety is a major issue; health care in emergencies needs to be a priority</td>
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<tr>
<td>Bahrain</td>
<td>Wide range of preventive, curative and promotive services</td>
<td>Highly developed family practice residency programme</td>
<td>Heavy reliance on publically provided health care delivery system</td>
<td>PHC services are free for Bahraini citizens; social health insurance scheme to be introduced</td>
<td>Community mobilization to be added to PHC</td>
<td>Inadequate coordination between public and private sectors partners</td>
<td>On route to institutionalize emergency risk management within the health sector</td>
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<tr>
<td>Egypt</td>
<td>Essential package of health services are available and implemented</td>
<td>Family health model; health sector reforms in 1990s</td>
<td>N/A</td>
<td>Health insurance since 2014, however, there is insufficient depth, financial framework needs to be updated</td>
<td>Community participation in facility management is under way, however, engaging communities is a major challenge</td>
<td>N/A</td>
<td>Core capacities for preparedness, detection, surveillance, and response to public health emergencies in place</td>
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<tr>
<td>Kuwait</td>
<td>Comprehensive and quality package of services available; 90% of PHC facilities provide dental and diabetes care, 25% provide</td>
<td>Family practice is implemented as the major overarching strategy; evidence-informed health financing strategy for UHC is underway</td>
<td>Private sector participation despite government control over health care is increasing</td>
<td>Coverage is free for citizens, while expatriates have a one Kuwaiti dinar user fee for PHC services, medicines included</td>
<td>Focus on community engagement is lacking</td>
<td>Inadequate multisectoral linkages across the health system</td>
<td>Government has information and communication technology disaster response plan implemented through the Central Agency for Information Technology</td>
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<tr>
<td>Country</td>
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<tr>
<td>Islamic Republic of Iran</td>
<td>Well established rural PHC since 1980s; recently established urban PHC, with comprehensive package including noncommunicable diseases, mental health, nutrition</td>
<td>Family physician (FP) programme in rural areas; FP training programmes expanded to over 10 universities</td>
<td>Public–private partnerships for primary care service delivery through outsourcing and contracting out established in some provinces</td>
<td>Free of charge services; over 95% population insured</td>
<td>Linked with communities through community health workers/behvarz in the rural areas</td>
<td>A high level multisectoral advisory council for health is available, however, the coordination needs to be strengthened</td>
<td>Substantial capacity of emergency preparedness, pool of volunteers, logistics support and medical teams</td>
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<tr>
<td>Jordan</td>
<td>Comprehensive preventive and curative services, including social determinants of health</td>
<td>Family practice programme implemented in several governorates with successful results. The programme needs scaling up</td>
<td>Involvement of private sector in providing primary care services is limited</td>
<td>All uninsured Jordanians (32%) are entitled to utilize the Ministry of Health subsidized services; vaccines and reproductive health services are provided free for all</td>
<td>Efforts to involve communities is lacking</td>
<td>Enacted decentralization law allows engaging local government in planning and mobilizing resources for health programmes</td>
<td>Provision of PHC to the millions of refugees from neighbouring countries from national resources and donor support</td>
</tr>
<tr>
<td>Oman</td>
<td>Comprehensive PHC services based on the well-established Welayat health system; home-based and elderly care to be integrated</td>
<td>Introduction and establishment of family health programme; strong communicable surveillance system</td>
<td>Private sector participation is encouraged through investment. long term strategies developed for public–private</td>
<td>Public financing of health care for all citizens as well as expatriates responding to 98.4% of the population</td>
<td>Enhancing community participation is an integral future priority</td>
<td>Decentralization of health-related responsibilities delegated to Welayat health governments</td>
<td>Well laid out emergency and disaster management procedure in place with adequate logistics support to deal with emergencies</td>
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<td>Country</td>
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<td>Libya</td>
<td>Basic package of services available; integration of priority programmes needs to be done</td>
<td>Large number of trained family physicians to serve in PHC facilities</td>
<td>Public–private partnerships have been developed for combating emergency situations and increasing access to health care</td>
<td>Free universal coverage of health services covering 81% of the Libyan population since 1980</td>
<td>PHC is primary service focused; community engagement needs to be integrated</td>
<td>Decentralized PHC system; restricted role of central Ministry of Health</td>
<td>Insecurity led to displacement and humanitarian needs; water, sanitation and hygiene emergency preparedness and response plan in place</td>
</tr>
<tr>
<td>Lebanon</td>
<td>National PHC network covering 5 basic services, general medicine, reproductive health, paediatrics, dental services, cardiology</td>
<td>N/A</td>
<td>Dominance of private sector (for profit by single physicians, and not-for-profit by nongovernmental organizations)</td>
<td>Financing depends on partners, donors, and agencies such as World Bank; 32% reliance on out-of-pocket expenditure</td>
<td>Focus on community participation and involvement is missing</td>
<td>Unified contractual agreements for PHC network have been signed between the Ministry of Public Health, nongovernmental organizations, &amp; municipalities for provision of medicine, services, and capacity building</td>
<td>Early warning and response systems in place through a surveillance and monitoring; humanitarian support provided to Syrian refugees</td>
</tr>
<tr>
<td>Morocco</td>
<td>Health services package includes coverage for chronic diseases, notably cardiovascular diseases, diabetes and screening for</td>
<td>Family practice programme; law on public-private partnership and establishment of national and regional health care commissions; Act on the social</td>
<td>Cooperation partners with the Global Fund, and the project to reinforce PHC supported by the European Union, WHO and</td>
<td>Payroll-based mandatory health insurance plan for public/formal/private sector employees; and publicly financed fund to cover</td>
<td>Community participation is future priority for improving quality of services</td>
<td>Coordination and collaboration between public and private sector is weak; lack of care coordination between the first level and hospital services lead to</td>
<td>National strategy for medical emergencies and health disaster risk; mobile medical emergency and resuscitation services; universal</td>
</tr>
<tr>
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<tr>
<td>Pakistan</td>
<td>Limited services are available at basic health units, rural health centres, and district level hospitals; expanded services in private tertiary care hospitals</td>
<td>determinants of health</td>
<td>Spanish Cooperation etc.,</td>
<td>services for the poor</td>
<td>Facility and village health committees are formed through private sector efforts; measures from public sector lacking, except the Lady Health Workers programme in the rural areas</td>
<td>Coordination among parastatal organizations and nongovernmental organizations is lacking, including federal and interprovincial</td>
<td>Displacement, insecurity, and national disasters, including disease outbreaks are rampant; emergency preparedness and response is weak</td>
</tr>
<tr>
<td>Palestine</td>
<td>Services are primarily provided by the Ministry of Health, nongovernmental organizations, united nations relief and Works Agency (UNRWA), military medical services, and the private sector</td>
<td>Integration of mental health services in the PHC services; noncommunicable diseases programmes in all districts and PHC centres; rolling out of family practice approach in future</td>
<td>High participation of private sector in many municipal businesses owned by local governments, including providing health, environment-related services and protection</td>
<td>Governmental insurance provided for curative services; preventive services provided free of charge for all; financing heavily reliant on external sources</td>
<td>Primarily curative care-oriented, community component needs to be added</td>
<td>Coordination gaps between health care providers; inadequate linkages between PHC and the secondary care hospitals, with limited referral feedback</td>
<td>General situation weak except for mass casualty management in hospitals; detection of epidemic influenza through public surveillance systems is effective</td>
</tr>
<tr>
<td>Qatar</td>
<td>Comprehensive package of services are available, including preventive and early detection</td>
<td>Health care is a constitutional right. PHC corporation is in place under the Ministry of Public Health; national</td>
<td>Number of private sector hospitals, clinics, medical institutions is increasing</td>
<td>Primarily tax-based financing by the public sector however, private health insurance, and</td>
<td>Community-based mental health programme is in place, however, community participation is limited.</td>
<td>National Health Authority is the main coordinating body; secondary level services are decentralized; lack of clarity</td>
<td>National Command Centre is established to manage responses to both local and national emergencies</td>
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<tr>
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<tr>
<td>Saudi Arabia</td>
<td>services, health promotion and education</td>
<td>primary health care strategy (NPHCS) 2013–2018 has been launched;</td>
<td>Significant attention has been paid to public–private partnerships since introduction of the National Transformation Programme</td>
<td>cost sharing also exist</td>
<td>Limited community-based and outreach activities</td>
<td>Multisectoral collaboration and “Health in All” policies to reduce exposure to risk factors of noncommunicable diseases is a work in progress</td>
<td>Despite the number of disasters that have already occurred, an effective disaster health management is lacking</td>
</tr>
<tr>
<td>Somalia</td>
<td>Essential package of services. Expanded package is gradually rolling out</td>
<td>Expansion of family practice; establishment of a national health workforce unit; development of the Health System Transformation Plan</td>
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<tr>
<td>Syria Arab Republic</td>
<td>besides, the core package of services and its access, expansion of services is taking place that includes mental health and others</td>
<td>Family Practice does not exist. Several public health-related laws, policies and strategies are being developed; maternal death registration and surveillance and facility records are available</td>
<td>Increased role of private sector. public–private partnerships are being strengthened restructuring health infrastructures and governance</td>
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<tr>
<td>Tunisia</td>
<td>Apart from essential services, extra provisions for poor patients</td>
<td>the support from WHO</td>
<td>provided by private sector</td>
<td>Weak regulation and control, and limited engagement and partnership with large and growing private sector</td>
<td>More than 80% of population covered by mandatory individual contributions or by a non-contributory programme to cover poor households</td>
<td>High social participation of communities, civil society and other stakeholders exists for health-related issues</td>
<td>Disaster preparedness is part of national health policy; strong disaster management infrastructure, high capacity to deal with emergencies</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>Continuous, integrated, comprehensive, patient-centred, coordinated and accessible care for individuals and families</td>
<td>Well established and elaborated Family Practice Programme across country; this is supported by noncommunicable disease plan, nutrition plan, national MCH plan, and childhood obesity framework; a national adolescent health strategic plan of action and a mental health strategic plan of action are under development</td>
<td>A mix of public and private care is available. however, continuous monitoring of private services is done by the Federal, Ministry of Health and Prevention and local government entities</td>
<td>100% domestic financing; main sources include: Ministry of Health, Ministry of Public Works, Emirates of Dubai and Abu Dhabi, and private funding, in addition to police, armed forces and Diwans of rulers</td>
<td>Community mobile clinics equipped with latest medical equipment to provide medical, preventive and specialized services are introduced but community participation is lacking</td>
<td>Health care is well coordinated and regulated across public and private sector; a robust health information system exist that links people’s record to a centralized system.</td>
<td>Policy exists on disaster and crisis resilience; National Crisis &amp; Emergency Management Authority established; high degree of standards and infrastructure for prevention and protection</td>
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<tr>
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<tr>
<td>Yemen</td>
<td>PHC</td>
<td>Family practice not established; development of vulnerability matrix to identify targeted areas at governorate/district level to improve health service delivery.</td>
<td>Both for-profit and not-for-profit models are prevalent. but focus primarily on service provision on a contractual agreement and not investments</td>
<td>Health care financing from six sources; three major ones: Ministry of Public Health budget, foreign funding, governorate health budget, Social Fund for Development</td>
<td>Increased community health awareness and community involvement in delivering PHC services in remote and hard-to-reach areas</td>
<td>Health sector is highly centralized and poorly coordinated though the structure of coordination is well laid out</td>
<td>Establishment of rapid response teams for disease surveillance and outbreak response; electronic diseases early warning system (eDEWS) has been set up.</td>
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6 Primary health care in the Eastern Mediterranean Region: key messages and lessons for the future

The PHC journey in the Eastern Mediterranean Region has endured as long as the Alma-Ata Declaration of 1978 itself. The Region and WHO have remained committed to the PHC philosophy, values and the approach over the last several decades. During this period the countries and the WHO Regional Office can take collective pride in having achieved several landmarks. Overcoming challenges to PHC has led to several achievements, which in turn have created newer challenges. During this iterative process, several lessons have been learnt that offer a good opportunity for reflection:

- **Commitment to PHC matters** – the countries and the Regional Office have remained steadfast over the last few decades, vindicating the Region’s commitment to PHC during periods when market oriented reforms were dominating PHC reforms.

- **PHC values and principles are universal** – The foundational significance of social justice, participation and intersectorality is unlikely to be questioned. However, implementation modalities will change over time as experience accumulates with more innovative approaches to PHC; a strong pro-equity agenda with progressive universalism is a prominent feature of PHC in the SDG era.

- **PHC will lose its significance unless reconfigured to the changing demographic and epidemiologic burden** – Countries need to review the PHC service packages to include the prevention, control and management of noncommunicable diseases, mental health, nutrition, early childhood development and environmental and occupational health problems. At the same time, maternal, neonatal and child health and communicable diseases remain regional priorities along with the unfinished agenda of the MDGs, especially in the high burden countries.

- **PHC and public–private partnership, does it work?** – There has been a transition from directly delivering PHC services to outsourcing these to the private sector, for-profit as well as not-for-profit; WHO is committed to undertaking a systematic review to assess the
effectiveness of public–private partnerships in terms of improving quality, access, efficiency, equity and sustainability.

- **Family practice is the basis for PHC in 21st century** – Aligned with the global strategy of person-centred integrated health services, the Region has adopted the family practice-based approach to ensuring quality PHC, and has produced the tools and approaches for establishing and scaling up family practice-based primary care in countries.

- **Financing the critical link between PHC and UHC** – The financing aspect of PHC has not received adequate attention in the past, hence countries are unable to document spending on PHC. Expenditure on PHC should become an integral component of national health accounts analysis.

- **Community engagement is essential** – Despite the rhetoric about community engagement and participation, there are only a few successful PHC models that have effectively involved the beneficiaries. Community engagement has become even more essential as they have become better informed, have higher expectations and expect providers to be accountable to them, and a strengthened and expanded community health platform is a core component of PHC.

- **No PHC without an adequate health workforce** – Currently, half the countries of the Region do not meet the global health workforce target of 4.45 per 1000 population. Countries would need to develop short- and medium-term health workforce strategies in order to reach appropriate numbers with the right skills mix and distribution to ensure delivery of quality PHC.

- **Public health is an essential element of PHC** – The core public health functions of promotion, prevention, protection, preparedness and surveillance are integral to PHC as part of the service package and as non-personal interventions. Priority public health programmes related to immunization, reproductive health, HIV, TB and malaria need to be integrated at least functionally to improve their effectiveness and ensure long term sustainability.
• Multisectorality and PHC – Of itself, the concept of multisectorality is not new. It was
termed intersectoral coordination at the time of Alma-Ata Declaration of 1978. It has grown
to include what are called Health in All policies, and is reinforced by the fact that many
health-related SDGs influence health and well-being. Ministries of health in the Region need
to adopt this newer governance arrangement, which engages, and even gives a central role to,
other governmental and nongovernmental agencies.

• Delivering PHC in emergencies – Millions of internally displaced persons and refugees
need PHC in countries of the Region that are in complex emergencies as well as in
neighbouring countries that are also affected. Hence, a high level of preparedness is required
to ensure delivery of primary care to mothers, children, the elderly and those facing chronic
diseases and injuries.

5. Conclusion

The 40th anniversary of the Alma-Ata Declaration on Primary Health Care is a watershed
moment and an occasion to reflect on how PHC has progressed, challenges have been confronted
and opportunities seized. The PHC approach has matured to be the foundation for health systems
development in the 21st century. The Region has remained committed to PHC since Alma-Ata
Declaration of 1978. The core principles and values have been influential in shaping health
systems across the Region.

The aspiration towards implementing UHC is not new; it was articulated in the WHO
constitution of 1948 and is integral to the Alma-Ata Declaration of 1978. Most recently, the SDG
resolution “Transforming our world: the 2030 Agenda for Sustainable Development” further
emphasized that UHC is the core driver of SDG 3.

The PHC journey in the Region has been as long as the Alma-Ata Declaration of 1978 itself.
During this period the countries and the Regional Office can take collective pride in achieving
several landmarks. A number of lessons have been learnt over time, which emphasizes that:
commitment to PHC matters at all times; PHC values and principles are universal; PHC will lose
its importance unless reconfigured to the changing demographic and epidemiologic burden; PHC
and public–private partnership can work if well designed, implemented and monitored; family
practice is the basis for PHC in 21st century; financing the critical link between PHC and UHC; community engagement is even more essential for PHC in the 21st Century; there is no PHC without an adequate health workforce; public health is an essential element of PHC; multisectorality has added new dimensions to PHC; and delivering PHC in emergencies as important as at all other times.
Annexes

Annex 1: Framework for action on advancing universal health coverage in the Eastern Mediterranean Region

Framework for action on advancing universal health coverage (UHC) in the Eastern Mediterranean Region

[Diagram of the framework]

- **Strategic component**
  - Developing a vision and strategy for universal health coverage
  - Improving health financing system performance and enhancing financial risk protection
  - Expanding the coverage of needed health services
  - Ensuring expansion and monitoring of population coverage

- **Actions for countries**
  - Formulate a vision to transform the national health system towards UHC
  - Establish a multisectoral mechanism for UHC at the highest level
  - Institutionalize a mechanism for public involvement in the development and promotion of a UHC vision and strategy, e.g., through public representative assemblies and civil society
  - Undertake an evidence-informed health system review for UHC to assess the status of and gaps in financial protection, service and population coverage
  - Develop a roadmap for health system strengthening to achieve UHC with short, medium and long-term goals
  - Strengthen reliable monitoring and evaluation systems to track, evaluate and report UHC progress
  - Enhance public investment and public-private partnership for UHC
  - Promote implementation research for UHC

- **Support from WHO and other development partners**
  - Facilitate convening of stakeholders for dialogues on UHC vision and strategies
  - Share global experience, evidence and good practices in strengthening health systems towards UHC
  - Develop national capacities in health system strengthening and leadership for UHC
  - Provide technical support to strengthen national health information systems to effectively monitor and evaluate achievable progress towards UHC
  - Provide support for improving public investment, public-private partnership, resource mobilization and aid effectiveness

- **Activities**
  - Assist in development of health financing reform options for advancing UHC
  - Support the development of national health care financing strategies towards UHC
  - Support the “health budget dialogue” for UHC, covering issues of fiscal sustainability and public financial management
  - Build capacities on health expenditure surveys, health accounting, economic evaluation and other health financing system diagnostic tools
  - Develop guidance on prepayment arrangements including social health insurance
  - Facilitate exchange of knowledge and experience between policy-makers and financial managers on health financing reform
  - Build regional and national consensus on health financing reforms for UHC

- **Note**
  Developed in consultation with Member States, expert groups and partners.

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### Annex 2. Major health protection schemes in the countries of the Eastern Mediterranean Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Policy/strategy to pursue universal health coverage</th>
<th>Primary health care (PHC) service coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>A basic health services package and an essential health services package have been developed to cover basic and essential hospital services. Funding is provided by a central grant management unit received from key donors and contracts with nongovernmental organizations and a few Ministry of Public Health facilities through contracting-out and contracting-in modalities.</td>
<td>PHC services are included in the basic health services package.</td>
</tr>
<tr>
<td>Bahrain</td>
<td>A new social health insurance law was promulgated in May 2018, ensuring coverage for the whole population (nationals and expatriates), through public funding in the case of the nationals and employer/employee contributions in the case of the expatriate population.</td>
<td>PHC is covered through a network of PHC facilities through public financing with some co-payments.</td>
</tr>
<tr>
<td>Djibouti</td>
<td>Various health sector reforms introduced “pro-poor” policies since 2008. In 2014, a universal health insurance (UHI) law was enacted to ensure basic medical coverage for all people living in Djibouti, via two arrangements: Compulsory Health Insurance and the Social Assistance Programme for Health.</td>
<td>The UHI law guarantees a universal package for the entire population. Two additional packages are provided under Assurance Maladie Obligatoire and Programme d’Assistance Sociale pour la Santé – the first comprises basic care services, while the second comprises curative care and all prescribed medical examinations by specialist doctors.</td>
</tr>
<tr>
<td>Egypt</td>
<td>A new UHI law was enacted in Dec 2017 to establish three entities: a purchasing organization, a health care organization and a quality and accreditation organization. The law ensures coverage to all population groups using three funding sources (contributions, budget transfer and earmarked taxes).</td>
<td>The new UHI will cover curative and rehabilitative care while the Ministry of Health and Population will continue to cover promotive and preventive care. The proposed package under the UHI law is broad and is loosely defined.</td>
</tr>
<tr>
<td>Islamic Republic of Iran</td>
<td>A health transformation plan was launched in May 2014. The health financing system is a mixed system, structured around the Ministry of Health and Medical Education and two public health insurance organizations.</td>
<td>Basic health care is available to the entire population and guaranteed by the Iranian constitution. An extensive benefits package, with a few exclusions, is defined by the High Council of Health Insurance and guides the</td>
</tr>
<tr>
<td>Country</td>
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<tr>
<td>Iraq</td>
<td>The High Council of Health Insurance is responsible for coordinating the health insurance market. There has been a shift from welfare state to auto-financing facilities and the introduction of user charges, including the introduction of contributory mechanisms in the form of health insurance. The Iraqi constitution mandates the state to protect health and ensure social security. In 2014, a health insurance law was drafted and submitted to parliament. A health insurance law by the Kurdistan Regional Government is being enacted.</td>
<td>entitlements under the Iranian Health Insurance Organization and the Social Security Organization. Services are in principle provided by the Ministry of Health free of charge. The proposed health insurance law does not have clear provisions for the benefit package but identifies a set of services which would remain free at the point of delivery.</td>
</tr>
<tr>
<td>Jordan</td>
<td>The health financing system is a mix of public and private financing agents. A high health council exists and is responsible for general health policy in the country. In addition, the Ministry of Trade is responsible for regulating private insurances.</td>
<td>Public programmes generally cover a comprehensive array of services, including pharmaceuticals, with limited cost-sharing. The Royal Medical Services offers a wide range of health care services, including the ability to treat complex medical cases and those of high cost referred to it by the Ministry of Health, the University Hospital, and the private sector.</td>
</tr>
<tr>
<td>Kuwait</td>
<td>The Ministry of Health is the main provider and purchaser of health services, however, new financing arrangements have been introduced to cover the entire population. A scheme covers Kuwaiti retirees from both the public and private sectors and is run by private insurance companies. A separate scheme covers expatriate workers and their families. Private health insurance companies provide voluntary health insurance.</td>
<td>Most health services are provided by the government. An open-ended package of health services is provided for all Kuwaitis. Expatriates access primary and secondary health care services depending on the type of coverage which they have. The package includes preventive, promotive and curative services.</td>
</tr>
<tr>
<td>Lebanon</td>
<td>The Ministry of Public Health is responsible for the provision of some health services. International organizations cater for the needs of Palestinian and Syrian refugees, primarily using their own systems. The Civil Servant Cooperative (CSC) and the National Social Security Fund (NSSF) are two employment-based social A basic package of service covers both preventive and curative care. NSSF covers curative and ambulatory care. CSC covers additional dental care. Military and security forces fully cover hospitalization and ambulatory services. Private insurance and mutual funds offer different coverage arrangements. The Ministry of</td>
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<tr>
<td>Lybia</td>
<td>The Ministry of Health with development partners govern the health system. The system is based on the principles of solidarity and universal coverage, through: social health insurance schemes, welfare funds and private insurance. The health insurance law mandates health insurance coverage for all citizens through their employers. The law was however not implemented due to the current political situation. The Health Insurance Fund insures the employees and workers of the education sector.</td>
<td>Public Health provides in-kind support to a national PHC network. Health services are financed, owned and directly managed by the Ministry of Health. Resources are mainly concentrated at secondary and tertiary levels, and budget allocation is generally delinked from performance. Around 4% of the health budget is allocated for primary health while 53% is allocated to salaries.</td>
</tr>
<tr>
<td>Morocco</td>
<td>The law guarantees basic medical coverage for all. There are two main public financing schemes Mandatory Health Insurance, and the Medical Assistance Scheme. There are around 30 independent funds covering selected population groups. The National Agency of Health Insurance ensures proper supervision and adequate regulation of the various prepayment schemes.</td>
<td>An essential package of health services exists in urban and rural areas free of charge; and is well defined for PHC level. Private insurers generally offer larger benefit packages than CNSS (Caisse Nationale de Sécurité Sociale), however benefits are often capped by the type of illness and per person. RAMED (Régime d'Assistance Médicale) offers a broad range of free services but limited availability in public hospitals.</td>
</tr>
<tr>
<td>Oman</td>
<td>“Health Vision 2050” was launched by the Ministry of Health in 2014 to depict the features of the future health system, including the health financing system, in 2050.</td>
<td>There is no purchaser–provider split in Oman, as the Ministry of Health is the main purchaser and provider of all services. The Ministry of Health is committed to the “Health for All” goal, hence aims at providing a comprehensive package of health services for the whole population based on PHC.</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Health is primarily a provincial matter. Federal, provincial, and district governments are major financing agents, including the social assistance and protection schemes</td>
<td>The government offers a benefit package at primary, secondary and tertiary levels, free of charge, for all civil workers. The government also provides free preventive and PHC services for all. In the absence of needs-based resource allocation and strategic purchasing, the supply ...</td>
</tr>
<tr>
<td>Country</td>
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<tr>
<td>Palestine</td>
<td>Financing is managed by Ministry of Health, Ministry of Finance, Ministry of the Interior, Ministry of Social Development and Ministry of Prisoners’ Affairs; nongovernmental organizations and civil society organizations; the United Nations Relief and Works Agency for Palestine Refugees (UNWRA); insurance companies and households. Government health insurance (GHI) is also managed by the Ministry of Health.</td>
<td>The Ministry of Health is the main service provider/purchaser and is entitled to all irrespective of their status. UNRWA provides services to refugees. GHI provides the insured population with a comprehensive benefits package through Ministry of Health facilities with minimal co-payment. UNRWA provides comprehensive primary care service freely, and secondary care with co-payment.</td>
</tr>
<tr>
<td>Qatar</td>
<td>The National Health Authority (NHA) replaced the Ministry of Public Health in 2005. The Supreme Council of Health supervises the entire health sector. A department of Financing and Health Insurance was established in 2007. A National Health Insurance Corporation began but was replaced in 2015 by private health insurance. A national health strategy for five years (2018–2022) has recently prepared.</td>
<td>Public health services are accessible for all, however, the Ministry of Public Health does not directly provide health care. The government finances the Primary Health Care Corporation and Hamad Medical Corporation through a fixed budget. The newly launched national health insurance scheme covers all essential health services for the insured population, with a complementary dental package.</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>The Ministry of Health is the major financing agent, in addition to: Ministry of Interior, Ministry of Defence, National Guard Health Affairs, and Ministry of Higher Education. The private financing agents include private insurance companies, households and charitable health societies. The Council of Cooperative Health Insurance regulates the health insurance market. Private sector financing is growing.</td>
<td>There is no separation between purchasing and provision in the public sector, with some services occasionally procured from the private sector. In the private health sector, the compulsory employment-based health insurance purchases services, and nationals receive free care from the public sector. Private health insurance companies offer different packages from a basic plan to a high-level plan.</td>
</tr>
<tr>
<td>Somalia</td>
<td>The health sector has developed a comprehensive medium-term plan (2013–2016). There is a federal health ministry, in addition to the Ministry of Health in each zone. In 2013, the three health authorities decided to scale up the female community health workers programme.</td>
<td>The contracting out approach has been used for purchasing some health care services. There is access to basic health services through development and humanitarian investment guaranteed to about half of the population.</td>
</tr>
<tr>
<td>Country</td>
<td>Policy/strategy to pursue universal health coverage</td>
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<tr>
<td>Sudan</td>
<td>A National Health Insurance Fund (NHIF) has existed since in 1994, endeavouring to cover the population who are poor and vulnerable. A health financing policy and strategy were developed and endorsed in 2016 and a new national health insurance law was enacted.</td>
<td>The Ministry of Health provides free and subsidized services. Prior to the new health insurance law, NHIF used to cover the population. In 2003, a specific package of services was introduced: a basic benefit package for all; an additional benefit package for civil servants and the poor; and a special benefit package to attract the private sector and other informal sectors.</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>The Ministry of Health strategy for health development identifies PHC as its key component.</td>
<td>The Ministry of Health is the main provider of all services. Before the conflict, services were offered free of charge. Preventive care is provided free-of-charge. There is no clearly defined benefit package. All individuals are covered by CNAM (Caisse Nationale d’Assurance Maladie), and are entitled to a wide spectrum of benefits. “Family doctor” or “reimbursement” arrangements are also accessible, including surgical interventions.</td>
</tr>
<tr>
<td>Tunisia</td>
<td>Since 2014, health has been a constitutional right of the citizens. The role of the private sector is increasing. The Ministry of Public Health, the National Health Insurance Fund, the Ministry of Defence and the Ministry of the Interior and private insurers are the main financing agents.</td>
<td>Previously, access to health services was provided to the entire population. Now insurance companies are sharing service provision. In Abu Dhabi, a basic and enhanced insurance package is being provided. In Dubai, nationals and government employees receive a comprehensive benefit package.</td>
</tr>
<tr>
<td>Unite Arab Emirates</td>
<td>The health sector is governed and financially managed at federal and Emirate levels (Abu Dhabi and Dubai). An insurance authority was also established under federal law. A public joint stock company manages the insurance scheme in Abu Dhabi. The Dubai Healthcare City Authority regulates Dubai’s health care free zone.</td>
<td>Health services are principally directly provided by the government. A district health system approach was adopted in 2002 to ensure provision of comprehensive PHC services as part of an essential package of health services. WHO is working to roll out a minimum service package at the primary care and referral hospital levels across the country, with a focus on highly vulnerable districts.</td>
</tr>
<tr>
<td>Yemen</td>
<td>The Ministry of Public Health and Population is the main steward of the health sector. The health system is decentralized at the district level, with district health management teams, including for private and nongovernmental organization health care providers. A social health insurance law was enacted in 2011.</td>
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### 3.7 Annex 3. Selected quality indicators for primary health care according to domain

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and equity</td>
<td>% of catchment population eligible to register with the facility&lt;br&gt;The proportion of patients reporting to PHC per month who are being managed for common mental disorders disaggregated by diagnosis&lt;br&gt;% of pregnant women with first visit at the first trimester</td>
</tr>
<tr>
<td>Safety</td>
<td>% of individual patient files with unique identifier within the health care facility&lt;br&gt;% of health facility staff immunized for Hepatitis B (3 doses)&lt;br&gt;% of safe injections in the health care facility&lt;br&gt;% of staff who have attended continuous training on quality and patient safety during the previous year&lt;br&gt;% compliance with hand hygiene guidelines&lt;br&gt;Number of adverse events reported (immunization/medication)</td>
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<td>Efficiency</td>
<td>% of prescriptions that include antibiotics in out-patient clinics&lt;br&gt;Number of days of stock outs per year for identified 15 essential medicines in the available essential drugs list in the facility&lt;br&gt;% of the 11 essential noncommunicable diseases medicines with no stock out in the last 3 months</td>
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</table>
| Effectiveness               | % of registered noncommunicable diseases patients with 10 years cardiovascular risk recorded in past 1 year<br>% of registered hypertension patients with blood pressure $< 140/90$ at the last follow-up visit<br>% of registered noncommunicable diseases patients with blood pressure recorded twice at last follow up visit<br>% of children assessed for anaemia<br>Proportion of women who received family planning counselling<br>% of women who delivered and received at least three postnatal care visits within the first 6 weeks<br>% of substance users, including tobacco users, in receipt of brief intervention<br>% of children under 23 months fully immunized according to national protocol<br>% of high risk group immunized against influenza<br>% of pregnant women appropriately vaccinated against tetanus<br>% of diabetes patients with HbA1C $< 7\%$ or % of registered diabetic patients with fasting blood sugar controlled at last 2 follow-up visits<br>% of diabetes mellitus patients who had fundus eye examination during previous year<br>% of pregnant women received at least 4 antenatal care visits<br>% of pregnant women who received health education (nutritional care, anaemia, sanitation, and high risk pregnancy signs)<br>% of children under 5 who had weight for age measured in the past 1 year<br>% of infants who are exclusively breastfed for the first six months<br>Proportion of children with pneumonia who are prescribed antibiotics correctly<br>% of patients informed about patients’ rights and responsibilities<br>Staff satisfaction rate (%)<br>User satisfaction rate (%)  
| People Centeredness         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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Acknowledgements

The World Health Organization Eastern Mediterranean Regional Office gratefully acknowledges the work of the Department of Community Health Sciences, Aga Khan University, Pakistan, in preparing this review of regional progress in primary health care in the last decade. Of the Aga Khan University colleagues, special thanks go to Dr Sameen Siddiqi for leading this review and Mr Sohail Bawani and Dr Wafa Aftab for their contributions.

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