NEW HORIZONS IN HEALTH

World Health Organization
Regional Office for the Western Pacific

September 1994
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The above statements might have sounded utopian in 1948; they have, however, become more relevant and our aspirations of ensuring the right of all people to realize their full potential for positive health have become more realistic as we approach the end of the twentieth century. With conflicting claims on the attention and resources of governments, the need for reviewing our past work, assessing the parameters and targets for health set earlier and questioning the appropriateness of our directions has been intensified.

The Region has developed economically and socially to a point where the basic health infrastructure and educational levels are now more or less in place. This now allows for an approach that emphasizes individual responsibility in the context of supportive environments.

We know that there are many closely interrelated factors which influence a person’s health and well-being. Our approach must reflect the recognition that lives are lead in complex and ever-evolving circumstances. There is a growing role for the individual, the family, the community, and the nation to participate in health matters. Public policies must also reflect this, and must be structured to protect people from harmful elements in the environment.

Each person has the potential to make a long-term difference in their lives. It is our role to support them in achieving this. A people-centred or human-development approach is evolving from the former disease-centred approach.

A radical question for the future must be how to ensure that health and the environment are not damaged by the economic progress for which people have worked so hard. What is the best way to encourage and enable people to help themselves to avoid disease and disability and to develop lifestyles and environments that support positive health? Simple actions for health can start from the first days of life and have an impact throughout life.

All the vaccines in the world will not stop childhood disease unless
parents want their children to be immunized, take them to health centres and ask for the vaccine. Impregnated mosquito nets will not stop malaria unless families use them. Whenever there is a choice, we must help people to make a decision that will let them live longer, healthier lives. This also requires, at country level, sound public policies that support these aims.

A change is necessary in our way of operating to respond to these developments. It is not enough to realign, or even develop new programmes. It is unlikely that dealing only with individual elements will make a sustainable difference. We have to go further, recognizing the limitations of the traditional programme approach in responding to problems as they arise. We need multisectoral and multidisciplinary approaches that mutually support our search for solving human development issues in sustainable ways.

This document is presented to Member States as a framework for our future direction. I propose to put together multidisciplinary teams, which cluster relevant skills and draw on different elements of the present programmes. These new groups will deal holistically with issues relating to preparation for life, protection of life, and quality of life.

Working together within the framework of these proposals, I believe that we can look forward to new horizons in health beyond the year 2000, where self-reliant individuals prepare themselves for healthy living, are vigilant in protecting their environment, and continue to live comfortably and securely until the end of their lives.

People need not die prematurely, the living can lead productive lives and, as they age, die with dignity.

S.T. Han, MD, Ph.D.
Regional Director
1. Directions for the future

Although health is a right, it is not automatically possessed. The human organism is vulnerable and the ecosystem appears increasingly hostile. As fast as control over diseases such as smallpox, poliomyelitis, or leprosy is reached, new threats such as AIDS appear or old threats such as tuberculosis and malaria recur. At the same time, as old environmental issues, such as sanitation, are successfully addressed, and nutritional issues, such as iodine deficiency disorders, are brought under control, new issues emerge: pollution in cities, and diets leading to heart disease and early mortality.

The necessary basic health infrastructure is now in place in all countries and areas of the Region. A major concern is how to use this infrastructure efficiently and effectively to deal with the new and emerging issues as well as the old.

There must be a shift in emphasis from the illness itself, to the risk factors which contribute to the problem and further, to what will constitute good health. A single disease may have many risk factors; and a single risk factor may cause or influence many diseases or conditions.

The definition of what causes ill-health has expanded. The scope of what is recognized as supporting good health has also grown. This enlarged view of responsibilities and involvement encompasses people outside the traditional health sector, including employers, planners, politicians, economists, architects and teachers.

Health professionals must work closely with a wide range of other groups and disciplines to plan and execute health-related activities which ensure the best use of limited financial resources. Rather than simply responding to immediate needs, technical and financial resources must be put to ensuring sustainable improvement in health. Health interventions must be people-centred and wellness-centred, not disease-focused and must focus on positive health as part of human development.

Two central concepts will be particularly important in the coming years: health promotion and health protection.

Health promotion refers to the sort of measures that can be taken to encourage and enhance what people
can do themselves, in conjunction with their families, communities and nation, to improve and manage their own health. The focus is on intrinsic strengths enhanced by education and motivation, in the context of living and working conditions that foster such development.

Health protection recognizes the fragility of human life, and the need to provide whatever reinforcement science and other advances in learning and understanding can bring. Its activities are based on the assumption that there is a constantly growing number of external factors that influence health status such as the environment.

Increasingly, there are partners for health promotion and protection in other sectors which have not traditionally been associated with health. The health sector must seek to combine its resources and efforts towards positive health and quality of life with those of other sectors. Gradually, a whole network of interrelated institutions and disciplines is forming, including schools, industry, transportation, energy, agriculture and environmental groups. There is great scope for effective complementary action among these. For example, transportation industries throughout the Region are vigorously implementing no-smoking policies. Many related parties are involved; individuals, families, communities, nongovernmental organizations and the health services.

The development of such multisectoral and multidisciplinary efforts is an essential step in the movement towards integrated health promotion and protection activities in countries.
2. The Region: emerging issues and the need for a response

"Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger." (WHO Constitution)

"The people have the right and duty to participate individually and collectively in the planning and the implementation of their health care." (Declaration of Alma Ata, 1978)

One of every three people in the world today lives in the Western Pacific Region of WHO - approximately 1600 million people. No other region is developing economically and socially as fast, or raising as many expectations and questions for the future.

The health profile of this Region reveals a combination of diseases associated with poverty and those associated with affluence.

Malaria, tuberculosis, diarrhoeal and parasitic diseases, micronutrient deficiency disorders; these and other afflictions traditionally associated with the developing world, are being joined now by lifestyle-related diseases - heart disease, cancers and diabetes.

Even within the broad category of "developing countries", there is a tremendous divergence in the pace of improvement among and within countries. Levels of diseases and conditions related to population growth, rapid urbanization, unhealthy behaviours and lifestyles, and a damaged and damaging environment are emerging as formidable obstacles.

Although the basic health infrastructure is now in place throughout the Region, there are still urgent health needs in many countries. Many people are living and working in seriously polluted environments, without adequate food and shelter. High fertility in some countries is leading to high mortality among women and children.
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The few affordable luxuries available to people in these conditions, often have serious long-term health sequelae, leading to further ill-health. Tobacco and alcohol use is rising throughout the Region, despite intensive health education campaigns against smoking and drinking.

Adult literacy and infant mortality rates correlate well with not only absence of disease but with good health. They depict a steadily improving health situation in most countries of the Region.

| Key indicators for selected countries in the Region |
|---------------------------------|--------|-----------|-------------|
| Infant mortality (per 1000 live births) | Maternal mortality (per 100,000 live births) | Adult literacy (as % of total adults) | Life expectancy (years) |
| Lao PDR | 118 | 300 | 40 | 50 |
| Papua New Guinea | 72 | 1500 | 32 | 50 |
| New Zealand | 8 | 7 | 97 | 76 |
| Japan | 4 | 9 | 100 | 80 |

Source: Western Pacific Region databank on socioeconomic and health indicators (December 1992)

Adult literacy, especially among women, is one of the most telling indicators from the point of view of assessing development and likely health needs. In the countries with the highest morbidity and mortality rates, adult literacy is commonly less than 50%. In most countries, however, this polarization is not so extreme.

However, although in general the picture has improved, there are still major inequities. Infants, children and pregnant women in some of the poorest countries in the Region are dying at more than twenty-five times the rates of those in the wealthiest countries of the Region. Differences in life expectancy at birth can be as much as thirty years.
Several of the major targets for health for all by the year 2000, such as infant mortality rates, maternal mortality ratios, life expectancy and adult literacy, have been reached by most countries and areas of the Region. The average life expectancy in the Region has increased, from 63 years in 1980, to 68 in 1990. Similarly, the average infant mortality rate has decreased, from 40 per 1000 live births in 1980, to 31 per 1000 in 1990.

Where life expectancy has increased, new areas of need have grown, coupled with other demographic changes. The rapid increase in numbers of the elderly has significant implications in many areas; their health care, the financing of their needs, their accommodation, and their role in a fast-changing and increasingly urban community.

An example of the kind of forecasting needed to accommodate the needs of the elderly can be seen in Japan. In 1977, the aged accounted for 8.4% of the total population, and 27.1% of the nation's health care costs. In 1985, the percentage of health care costs attributable to the aged rose to 37.5%.

Urban populations are growing at many times the rates of populations in rural areas. Rapid population growth, overuse or misuse of the land, and environmental degradation in rural areas have resulted in significant lifestyle-pattern changes and have prompted increasing numbers of the rural population to move to larger towns and cities in search of better opportunities and improved standards of living. For some, this has resulted in positive contributions to health associated with increased personal incomes and
improved services. However, this urban migration is also accompanied by tremendous overcrowding and poor living conditions which are destroying the lives, health and social values of millions of people.

Low incomes, inadequate access to health care services, daily exposure to pollution and toxic substances, and a highly stressful environment have made these disadvantaged populations especially vulnerable to disease and ill-health.

While the most impact is seen on the urban poor, the stresses of urbanization are also seen in more affluent sectors of society. Poor environmental conditions and other urban pressures (such as noise and heavy traffic) also contribute to stress, mental problems, accidents, violence, antisocial behaviour and drug and alcohol abuse.

Urban migration separates people from the stabilizing influence of their cultural background and traditions, encouraging new eating and relaxation patterns. These patterns, compounded by persuasive marketing, promote poor nutrition and detrimental habits such as smoking and excessive use of alcohol. These, in turn, can lead to undernutrition in lower age groups and increasing rates of degenerative diseases in the middle-aged and elderly.

As a general trend in the Region we can see that the vaccine-preventable communicable diseases are decreasing sharply, while the noncommunicable diseases are increasing.

Representative examples of disease trends in the Region

<table>
<thead>
<tr>
<th>Figure 3</th>
<th>Reported diphtheria cases Western Pacific Region 1983-1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Thousands of cases</td>
</tr>
<tr>
<td>1983</td>
<td>12.122</td>
</tr>
<tr>
<td>1984</td>
<td>5.91</td>
</tr>
<tr>
<td>1985</td>
<td>4.804</td>
</tr>
<tr>
<td>1986</td>
<td>4.632</td>
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<tr>
<td>1987</td>
<td>2.518</td>
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<tr>
<td>1988</td>
<td>0.807</td>
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<td>1989</td>
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<td>1991</td>
<td>0.577</td>
</tr>
<tr>
<td>1992</td>
<td>0.354</td>
</tr>
<tr>
<td>1993</td>
<td></td>
</tr>
</tbody>
</table>

1993 data incomplete
(Source: CE/WWPRO August 1994)

<table>
<thead>
<tr>
<th>Figure 4</th>
<th>Trends of leading causes of deaths in Peninsular Malaysia 1975-1989</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Diseases of the alimentary system</td>
</tr>
<tr>
<td>1975</td>
<td>2.2</td>
</tr>
<tr>
<td>1985</td>
<td>4.0</td>
</tr>
<tr>
<td>1989</td>
<td>8.0</td>
</tr>
</tbody>
</table>

(Source: Department of Statistics, Malaysia (1975-1989))
Looking at the health issues emerging in the Region, it is clear that the response must be immediate, creative, and an important part of public policy. Rather than tackling each issue separately, on a programme by programme basis, the issues must be looked at holistically, taking into account the larger context in which people live and work and which helps to shape their health status.

This approach will require a different arrangement of resources and expertise in WHO. Three groupings of programmes are proposed, which deal with specific aspects of health promotion and protection. These would not replace the existing structure but would provide a means of coordinating objectives and approaches and implementing collaborative activities on particular issues.

The factors that influence the achievement of health will be analysed, looking at preventing the detrimental elements and supporting the positive elements. So, for instance, it is important to analyse the factors that influence the early years of life of a child, and relate them to each other. This approach requires a group of programmes to work together.

Three such groupings, or teams, are proposed: the first is to direct resources to aspects of preparation for life, focusing on the child. It would seek to encourage what the child and family can do themselves and encourage them to seek support from the health services. The team would analyse and plan interventions that influence later years such as antenatal care, nutrition during pregnancy, safe delivery, immunization and child development.

In the same way, the factors that suppress or inhibit good health throughout life, such as poor eating habits, lack of recreation and exercise, unsafe sexual behaviour, alcohol or drug abuse, etc., coupled with environmental factors such as unsafe working conditions, polluted air and water etc., need to be addressed. A second team is proposed to tackle issues such as these relating to prevention of diseases and the protection of life.

Thirdly, the importance not just of survival, but of quality of existence is recognized. With the increasing proportion of elderly populations in the Region, ways of sustaining and preserving health in this large group are becoming an even more significant consideration. It is not enough just to live longer; the concept of adding life to years, and increasing the number of years lived free from ill-health, needs to be addressed by health sectors throughout the Region. The third team proposed is on quality of life.

Each of the proposed groupings will be supported by infrastructure programmes such as health information and human resources for health. The aim is to build on WHO’s current programmes to provide an enhanced focus on the whole individual, and the measures each individual is able to undertake or control for the protection and improvement of his or her health.
Indicators

There have been many attempts to develop indicators that measure not just disease but "complete physical, mental and social well-being". The few available do not yet give the complete picture. For example, a recently formulated indicator of positive health and well-being, Disability-Adjusted Life Years (DALYS), although reflecting health status rather than disease status, is a complex measure susceptible to subjective biases.

Both a changed framework for monitoring, and new ways of using traditional measurements are needed.

Biomedical statistics such as immunization rates have unquestioned value, but need an additional qualitative perspective.

Indicators of health and well-being will be developed by the teams proposed in this document, as the Region's orientation shifts to emphasize promotion and protection of better health, more than disease treatment and control.

The information needed for the health programmes of the future has to illuminate where resources can most fruitfully be allocated, and activities directed.

Targets

Smallpox was declared to have been eradicated throughout the world in 1980. The Region is well on target to eradicate poliomyelitis by 1995. It is planned that neonatal tetanus will be eliminated by 1995. Leprosy will be eliminated as a public health problem by the year 2000.

It has been shown to be possible to eradicate and control communicable diseases through concerted efforts. These must also be applied to other targets such as reducing infant mortality to 20 per 1000 live births by the year 2000, and reducing the number of deaths from diarrhoea in children under the age of five by 50% between 1990 and 2000.

Our directions and approaches for the future emphasize what individuals can do to protect themselves within a supportive environment. The targets for the future will include a reduction in the incidence of malaria to levels such that it is no longer a public health problem in selected countries and areas in the Region, (if resources are channelled to this effort, this could be achieved within a decade), and, for noncommunicable diseases, a tobacco-advertising-free Region by the year 2000.
3. Operationalization

This section outlines the proposed teams, with details of the main issues each has to confront and resolve in the Region. The teams' composition is explained, with an indication of the lead programmes to be involved (though this will be flexible according to the demands of the activities). Though the teams are described in programme terms, in order to relate to the present budgeting arrangements, the emphasis on this approach is not on the individual programme elements, but on the issues to be addressed, and on the need to arrive at a situation where people are better able to take care of their own health.

Team 1 - preparation for life

Rationale

Historically, the principal goal of health programmes concentrating on children has been child survival. As soon as life is conceived, it needs supportive physical and social environments. Survival alone, however, cannot be an acceptable aim of health policies.

Health policies and practices have to ensure that a child's health potential is strengthened in the course of development.

A healthy mother, able to breastfeed the child and give emotional security within a supportive family, lays the foundation of healthy development.

A low-birth-weight child or a child exposed to environmental pollution and poor living conditions is more susceptible to diseases which have a substantial influence on physical, mental and social growth. Infectious diseases such as poliomyelitis or streptococcal infection can permanently reduce a person's health potential.

The ways of life which shape health-related behaviours during childhood and adolescence are likely to influence behaviour patterns in other stages of life. A child which grows up with an adequate education, a balanced diet, safe space for play and exercise, and emotional support for the development of his or her personality is best equipped to meet the challenges of later life. An informed young person will be more likely to have self-esteem and respect for his or her own body and to avoid tobacco and drugs and alcohol abuse. A young person who understands the close linkage between health and the environment will help the family and community to engage in activities contributing to the reduction of health hazards.

Therefore, it is appropriate, and essential, that health services extend
their scope of activities and ensure, in collaboration with other sectors, that children not only survive but are then given the best support possible for developing healthy behaviour in environments conducive to health.

**Identification of major issues**

In spite of the progress made during the last decade, maternal, infant and child morbidity and mortality are still high in many of the developing countries in the Region. Ignorance and certain damaging traditions still take a high toll of potential future life years.

1. One of the major health problems is a continuing high level of maternal and infant morbidity and mortality. High fertility, a serious problem in several countries, contributes significantly to the loss of lives of mothers and children. The vicious cycle of poverty, infectious diseases and malnutrition, leads to infants and children failing to achieve their physical and mental potential. A high rate of disability among mothers and children, mostly as the result of unplanned, or badly timed and spaced pregnancies, malnutrition, inadequate care, and economic and environmental influences, also suppresses the quality of life in several of the countries and areas of the Region.

2. Continuing high levels of morbidity from infectious diseases among infants and children are also causing concern. Acute respiratory infections, diarrhoeal diseases, measles, neonatal tetanus, and malaria remain the leading problems. The increasing threat of HIV infection and other sexually transmitted diseases is a major new challenge. Rapid uncontrolled urbanization is bringing degradation of living environments in its wake, with environmental pollution, and disruption to traditional societies. All of these elements have an impact on children and future generations. Inadequate sanitation and water supply, often compounded by poor hygiene, still pose threats in many areas.

3. Children and adolescents are not achieving their full physical, mental and social potential. They are exposed to risks, such as inappropriate nutrition, lack of exercise, and harmful habits, which may prevent them from achieving their full potential as adults. Health and behavioural problems among adolescents are increasingly a cause of considerable concern. It is in childhood and early life that many lifestyle patterns are developed that subsequently either support healthy aging or lead to the development of chronic degenerative diseases in adulthood.

**Aim**

To ensure that infants and young children not only survive the first years of life, but are suitably prepared to enable them to realize their health potential throughout their lives.
Objectives

1. To ensure that every mother has the best opportunities for appropriate timing and spacing of pregnancies, safe delivery of a healthy infant in an environment conducive to health, with adequate antenatal care, sufficient nutrition and preparation for breast-feeding her child.

2. To increase child survival and decrease infant morbidity by promoting healthy environments, immunization, and by providing adequate case management for infectious diseases which are the major causes of mortality.

3. To support the development of healthy lifestyles through promoting education and activities to establish life-long health protective behaviours during childhood and adolescence.

Approaches

Responsible parenthood will be promoted through information and education. Community awareness, especially among adolescents, women and their husbands, and community leaders, will be increased with regard to reproductive health and child health issues. This awareness will be maintained at a high level so that women can access and utilize quality clinical services, be aware of the consequences of pregnancy and high fertility, and can go safely through pregnancy and childbirth. The community will be mobilized to provide necessary services and care for mothers and children. All infants born should be wanted children whose parents take them for immunizations and other health protecting activities, and ensure that they are adequately nourished and securely nurtured.

Provision of quality health care for women, children and adolescents will be promoted and supported through better training of health staff and dissemination of up-to-date technical knowledge and information. This will particularly apply to management of pregnancy, delivery practices and the care of the newborn by qualified and well equipped personnel.

The mother will be made sufficiently aware of safe food preparation and good nutritional practices so that she will take the initiative to obtain vitamin A and iodine supplements when necessary, seek out and comply with iron supplementation regimens during pregnancy, and decide to breast-feed her infants.
Indicators

A sample of the existing indicators that could be applied to this objective are listed. These will be refined and supplemented by more qualitative indicators as the team's operations develop.

- infant mortality rate
- maternal mortality ratio
- female literacy rate
- percentage of mothers receiving antenatal, delivery and postnatal care
- nutritional status of women of child-bearing age, including their iodine and iron stores
- percentage of infants in the healthy birth-weight range
- percentage of children exclusively breast-fed
- percentage of children with adequate micronutrient status and weight and height for their age
- percentage of teenage pregnancies
- percentage of families with adequate child timing and spacing
- percentage of couples using family planning

Approaches

Prevention of disease and disability in infants and young children will be enhanced by immunization against the target diseases of the expanded programme on immunization (including hepatitis B); provision of safe water and adequate sanitation; appropriate weaning and nutrition practices, and adequate diet; and protection from insects and other disease vectors by use of treated bednets, destruction of breeding sites and other environmental health measures.

Promotion of better care of the sick child will be achieved by improving health services; early diagnosis and treatment; and the knowledge and ability of individuals, (i.e., caretakers and other family members) to give appropriate home care, recognize severe illness, and take such children promptly to health services for treatment.

Both the preventive and curative approaches are best achieved by increasing the awareness of the caretakers, family and the entire community of how prevention and case management measures have an impact on the health of their children.

Indicators

- infant mortality rate
- under-five mortality rate
- percentage of children six months to six years with adequate vitamin A status
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- percentage of children with protein-energy malnutrition
- percentage of children fully immunized
- eradication or elimination of major diseases (e.g., poliomyelitis, neonatal tetanus, measles)
- safe water and sanitation, and adequate housing
- incidence of communicable diseases
- percentage of cases (acute respiratory infections, diarrhoeal diseases and malaria) for which adequate treatment is provided
- maternal knowledge on appropriate home treatment and mother's care-seeking behaviour
- projected loss of life years (Disability-Adjusted Life Years - DALY) due to infant and child morbidity and mortality

Objective (4) - To support the development of healthy lifestyles through promoting education and activities to establish life-long health protective behaviours during childhood and adolescence

Approaches

Learning about health, which includes establishing positive concepts about one's body during childhood and early life and taking care of the environment, will be emphasized with the aim of stimulating a sense of responsibility for health in all individuals in the Region.

A major thrust will be to ensure that adolescents are secure enough and properly informed so that they can make their own choices about lifestyles relating to drugs, diet, and sexual behaviours, despite peer group pressure to indulge in high-risk behaviours. Another principal emphasis will be to develop suitable educational and health promotional materials, with particular emphasis on adolescent health as an integral part of secondary school curricula.

Achieving a tobacco-advertising-free Region will be a major emphasis. This will help young people not to start smoking and will make smoking less attractive for women. Comprehensive national policies and programmes need to be established which address alcohol, drug and tobacco issues, especially with regard to children and adolescents.

Another emphasis will be the development of awareness in adolescents and adults of safe sexual behaviour, including the understanding of sexually transmitted diseases and condom promotion.

Through health promotion, the majority of children and families will take the initiative to seek annual dental check-ups for their children. They will have easy access to affordable basic curative services, and adequate knowledge of sound preventive dental practice.
Other major health promotion activities will focus on appropriate food and eating habits in early life, including attention to micronutrient deficiencies and obesity; mental health and mental development of the young; and prevention of accidents among young people.

**Indicators**

- percentage of children by gender completing a primary education
- percentage of children regularly exercising
- percentage of primary schoolchildren in the healthy weight range
- percentage of children with adequate nutritional status
- percentage of girls with adequate iodine and haemoglobin status
- percentage of children not using tobacco or other harmful substances
- knowledge of safe sex practices among secondary-schoolchildren and adolescents
- incidence rates of sexually transmitted diseases in adolescents
- healthy teeth (index of decayed-missing-filled (DMF) teeth)
- number of road-traffic accidents involving adolescents

**Structure**

- **Team coordinator**
- **Lead programmes**
  - Vaccine and immunization, including poliomyelitis eradication
  - Health of women and children, and family planning
- **Nutrition**
  - Acute respiratory infections
  - Diarrhoeal diseases, including cholera
  - Malaria and other tropical disease control
- **Health protection and promotion activities for healthy lifestyles**
  - **Food safety**
  - **Health situation and trend assessment**
  - **Adolescent health**
  - **AIDS**
  - **Sexually transmitted diseases**
  - **Oral health**
  - **Mental health**
  - Prevention and control of substance abuse (alcohol, tobacco)

The team should include at least one representative from each of the four technical programme divisions.
Team 2 - protection of life

Rationale

Rising standards of living and health care have resulted in improved health and increased life expectancies throughout the Region. However, these same changes have led to a demographic shift to older populations and an epidemiological transition to changing lifestyles. These changing lifestyles and unhealthy environments are major factors in the dramatic rise in the Region of the chronic and degenerative diseases. These are now the commonest causes of death in most countries and cultures.

Giving a child the best start in life will prepare the young adult for the most productive and creative phases of his or her life. However, the maturing adult is also under considerable stress, in both physical and mental terms, from the environment and the workplace. Early adult morbidity and mortality takes some of the most economically productive and experienced people from the community. It is also the time when the quality of life in older age is being prepared for, and the results of earlier and present lifestyles become evident.

The team's emphasis will therefore be on health promotion, encouraging healthy lifestyles to prevent disease and disability, and on the protection of life through promoting healthy environments and reducing the impact of disease. Several countries have already experienced declines in deaths from some of the noncommunicable diseases, especially cardiovascular and cerebrovascular disease. It is therefore clear that public health measures can have a significant impact. Other countries, on the other hand, have not yet experienced rising noncommunicable diseases rates, the result of changing diets, lifestyles and smoking patterns. It may be possible to avert this rise if action is started now.

Identification of major issues

1. Diseases caused by changing lifestyles are increasing, including those related to different stresses, resulting from high-risk behaviours, such as alcoholism, smoking and the psychosocial problems of cultures in transition.

2. The prevalence of obesity is increasing and levels of physical activity are decreasing. At the same time, women in the reproductive age group continue to be at risk for nutrition-related diseases such as anaemia and iodine deficiency disorders.

3. In over two-thirds of the countries and areas in the Region, the noncommunicable diseases are the commonest causes of adult mortality. This trend is becoming characteristic throughout the Region.
4. Sexually transmitted diseases, including newly emerging communicable diseases such as AIDS, are a growing problem in this Region among young adults.

5. People in the workforce continue to be at risk from accidents, injuries and occupational diseases. Suicide rates appear to be increasing among middle-management in highly industrialized countries.

6. Death and disability, in poor urban communities, continue to be from infectious and environmental causes e.g. tuberculosis, other chronic lung diseases and malaria.

7. In virtually all countries and areas, there are limitations on the resources that can be devoted to health care. Issues of allocation of resources, quality of care and equity need to be confronted.

8. All societies, but particularly the most disadvantaged segments, face increasing problems of toxic wastes, environmental degradation, and ingestion of chemical residues or contaminants through food and water.

Aim

Having progressed through childhood and adolescence, individuals must then be supported in maintaining and fully developing healthy lifestyles, and be protected from a potentially hazardous and degraded environment. The overall aim is to prolong productive, healthy and disability-free lives in the most cost-effective and equitable ways possible.

Objectives

1. To establish comprehensive national policies and programmes which promote healthy lifestyles throughout the lifespan of all individuals, through strengthening their knowledge and skills.

2. To improve the nutritional status of all sectors of the population, especially mothers and other vulnerable groups, and to promote appropriate, balanced diets and safe food preparation.

3. To prevent or delay the onset of the noncommunicable diseases, including reduction in occupational diseases, in order to maximize disability-free and productive lives in older age.

4. To enhance people's quality of life by preventing disability, including blindness and deafness, and by rehabilitating the handicapped, infirm and disabled.

5. To decrease the transmission, morbidity and mortality rates of diseases such as tuberculosis, malaria and other diseases of public health importance, including vectorborne diseases.

6. To promote environmentally sound practices and technologies for the effective prevention and management of environmental health-related disease and disability.
Operations

Objective (1) - To establish comprehensive national policies and programmes which promote healthy lifestyles throughout the lifespan of all individuals, through strengthening their knowledge and skills.

Approaches

Support for health goals will be enlisted from all government sectors, nongovernmental organizations and the private sector to strengthen health promotion activities and health-supporting living conditions and environments.

Focus will be directed towards individual behaviour change and will aim to support health through a variety of measures. These will include improved health legislation; strengthening supportive environments for health through a strategy focused on settings for health, such as healthy schools, health-promoting workplaces and healthy cities; ensuring community involvement, and intersectoral action. Health education and health promotion components will be incorporated in all other health programmes.

Policies and programmes will be established to deal with priority psychosocial and behavioural problems, including the development and implementation of comprehensive national policies and programmes to increase awareness of problems related to alcohol, drugs and tobacco.

Achieving a “tobacco-advertising-free Western Pacific Region” will be one major thrust of implementing the Regional Action Plan on Tobacco or Health for 1995-1999. This will help young people not to start smoking and will make smoking less attractive for women.

Learning about health, which includes establishing positive concepts about one's body and taking care of the environment, will be emphasized.

Sexually transmitted disease activities will aim to develop the individual’s responsibility for, and awareness of, safe sexual behaviour and the role played by individual behaviour in disease transmission. Interventions will be specifically targeted at youth, who represent a highly vulnerable group with regard to HIV infection. Safe sex behaviours will be promoted, including condom promotion and avoidance of injecting drug use.

The promotion of mental health in youth will be addressed. Special emphasis will be placed on the further development of community-based mental health services and related family training, to help the patient and the family to understand the disease treatment, patient care and rehabilitation and to take an active part in it. The role of leisure activities, including sport and entertainment will be addressed, as will the importance of supportive social networks.
Indicators

Satisfactory indicators for many health promotion activities, particularly those involving quality of life issues, are still being developed.

Those already developed include:

- prevalence of smoking among youth, by gender
- prevalence of alcohol-related problems, such as morbidity and mortality from violence, or attributable to driving while under the influence of alcohol
- specific per capita measurements of alcohol consumption
- data on alcohol, drugs and tobacco use, by social class, education, occupation, employment status and other relevant social factors, including data on economic impact
- incidences and prevalences of sexually transmitted diseases
- morbidity and mortality due to HIV/AIDS
- the magnitude and nature of stress related to problems such as insomnia, depression, neurosis and suicide
- psychosomatic problems which are manifested as hypertension, peptic ulcer, multiple somatic complaints.

Approaches

The major thrust will be to develop programmes which promote the benefits of healthy diets and exercise and help lead to healthy older age with improved quality of life. These measures will start in childhood, as well as targeting adolescents and adults. Community-based programmes for the prevention and control of cardiovascular and cerebrovascular diseases will be strengthened. There will be a special emphasis on adults and the elderly taking active and continuing responsibility for appropriate exercising, not smoking, and eating a healthy diet. Food safety measures will be promoted through improved information on issues for both consumers and providers. Priority will be given to improving technical capabilities for monitoring, assessing, preventing, controlling and managing food-related risks to health; to the development of national and city-specific health and environment plans; and the formulation or revision of food safety policies, strategies and legislation, adopted into administrative regulations.
Indicators

- percentage of men and women, by ten-year age groups, overweight and obese.
- number of people taking regular exercise (other indicators would overlap with those of the nutrition-related noncommunicable diseases)
- women of child-bearing age with anaemia or evidence of iodine deficiency disorders
- incidence of diseases caused by contaminated foods or beverages, including water

Objective (3) - To prevent or delay the onset of the noncommunicable diseases, including reduction in occupational diseases, in order to maximize disability-free and productive lives in older age.

Approaches

Three principles will be used in addressing noncommunicable diseases: healthy lifestyles at all ages, including during pregnancy, have an impact on both present and future health; the purpose of health promotion activities is to extend both the quality and length of life, by compressing the period of disability; and reduction in noncommunicable diseases prevalence requires healthy and health-promoting environments, including the control of stress, pollution, advertising of harmful products, etc. Links will be strengthened between nutrition and noncommunicable disease activities, such as reductions in intakes of fats, encouragement of individual behaviours such as eating of fresh fruits and vegetables rich in antioxidants, avoidance of smoking and known carcinogens, taking exercise, etc.

Activities will be developed to address lifestyle factors which, if moderated, will help lead to healthy older age with improved quality of life. Health-promoting and health protecting activities will be important, such as improving working conditions, particularly in small-scale enterprises and agriculture. This will help to protect and promote the health of working populations. Industrial accidents will be reduced through comprehensive occupational health and safety measures and workplace health promotion.

Indicators

- disability-free years of life
- increased life expectancies
- age-standardized cardiovascular disease mortality in all countries
- age-standardized cerebrovascular disease mortality
- incidence and prevalence figures of non-insulin dependent diabetes
- cancer incidence
NEW HORIZONS IN HEALTH

- the reduction in the number of people with work-related diseases, disabilities and accidents (indicators to reflect positive health and quality of life will be further developed)

Objective (4) - To enhance people's quality of life by preventing disability, including blindness and deafness, and by rehabilitating the handicapped, infirm and disabled.

Approaches

There are two principal directions for the activities. One is to prevent disabilities, including those due to unnecessary injuries, through health promotion activities, (e.g., road safety campaigns) aimed at reducing disability from injuries, diseases and accidents, and from preventable and curable blindness (e.g., cataract). The other is to promote individual actions that maximize quality of life. This involves using the best methods to live productively with handicap and disability (e.g., hearing impairment and deafness) through community-based rehabilitation services and appropriate rehabilitation technology. Particular emphasis will be given to underserved rural and urban communities.

Indicators

- national data showing reductions in the number of people with handicaps, impairments and disabilities using a regional database on rehabilitation

Objective (5) - To decrease the transmission, morbidity and mortality of diseases such as tuberculosis, malaria and other diseases of public health importance including vectorborne diseases.

Approaches

Mothers will be stimulated to ensure that their infants are immunized with BCG. All adults will be encouraged to ensure that those with a persistent cough are investigated for tuberculosis. If found to have tuberculosis, all adults should complete the full short-course chemotherapy treatment. For malaria control, the focus will be on individual behaviour and on promoting national, regional and community action for controlling malaria (e.g., use of impregnated
bednets, destruction of breeding sites and environmental control). Revitalization of malaria control programmes will include efforts to reduce morbidity and mortality through improving early diagnosis and treatment of the disease; improving appropriate and sustainable community-based vector control measures; and greater community involvement and awareness of the life-threatening nature of *Plasmodium falciparum*. Efforts to prevent the reestablishment of diseases in countries or areas where they have been eliminated will also be important.

**Indicators**

- the number of users of impregnated bednets
- malaria morbidity and mortality
- incidence and prevalence of other diseases of regional, national or local significance
- coverage of BCG
- incidence, prevalence and mortality due to tuberculosis

**Objective (6) -** To promote environmentally sound practices and technologies for the effective prevention and management of environmental health-related disease and disability.

**Approaches**

The awareness of individuals and communities will be increased regarding the interaction between the environment, health and socioeconomic development. This will enable them to act individually and collectively in efforts to improve the environment, and to participate more effectively at all levels in socioeconomic decision-making.

Apart from advocacy and informative activities, another focus will be on improving technical capabilities for monitoring, assessing, controlling and managing the health risks resulting from the environmental consequences of socioeconomic activities, and enhancing methods of protection from such health risks.
Consistent with WHO's ongoing role in Agenda 21, (the global plan of action from the 1992 United Nations Conference on Environment and Development), emphasis will also be placed on further developing and implementing approaches which ensure that health and environment issues are integral to national and urban plans for sustainable development.

Indicators

Indicators will require development but would include:

• data from countries and areas on the human resources required to effectively implement their health and environment plans

• environmental health indicators (such as pollution and blood lead levels) to track progress in resolving priority health, environment and development issues

Structure

• Team coordinator

• Lead programmes

  - Noncommunicable diseases
  - Environmental health risk assessment and control
  - Malaria and other tropical disease control
  - Occupational health
  - Prevention and control of substance abuse (alcohol, drugs, tobacco)

  - Health protection and promotion activities for healthy lifestyles

  - Tuberculosis
  - Mental health
  - Essential drugs, vaccines, and other supplies
  - Human resources for health
  - AIDS
  - Sexually transmitted diseases

  - Quality of care
  - Organization and management of health systems based on primary health care

The team should include at least one representative from each of the four technical programme divisions.
Team 3 - quality of life

Rationale

While organized interventions by governments and communities at all levels can partially alleviate many of the problems associated with illness, disability and old age, much more can be achieved if such efforts emphasize ways of enabling individuals to contribute to the improvement of their own health status. Individual contributions to quality of life of the elderly can begin even before older age is reached.

A healthy childhood and adulthood is probably the most important determinant of healthy aging. Likewise, healthy living prevents many illnesses, and the disabilities resulting from them. This team, although focusing on quality of life in older age, also addresses the issues of quality of life throughout life. Individuals must provide for their own future health care while they are still in their economically productive years.

Thus, the maintenance of a high quality of life is directly linked to many of the issues being addressed in the current debates on health systems reforms.

The projected increase in the Region of life expectancy at birth from 67.7 years in 1990 to 74.7 years in 2020 has heightened concern for maintaining a high quality of life for the elderly. In addition, many of the emerging disease problems are chronic in nature and associated with increased levels of disability. The detrimental effects of these on the physical, mental and social capacities of individuals are associated with losses of productivity, creative opportunities, and increased vulnerability to further illnesses.

Even as the technologies and knowledge to deal with the many biomedical problems of the chronically ill, the disabled and the elderly are developed, high costs have kept them from being equitably accessible to all but the most affluent. Also, urbanization of rapidly growing populations has further reduced the social and material support mechanisms available through the extended families of formerly rural societies.

Thus, while modernization has brought gains to individuals in terms of the prolongation of life, for many it has taken a toll in terms of perceptible reductions in the quality of living.

Identification of major issues

1. The elderly population is expected to increase as promotive, protective and curative health interventions continue to have a positive impact on the life expectancies of populations.

2. Urbanization, population growth and other socioeconomic changes have altered the level and character of family, community and institutional support which enable individuals to attain a high quality of life.
3. The numbers of people with chronic illness and disabilities in all age groups are increasing due to the rise of degenerative diseases, accidents and other health problems associated with modernization.

4. Technology-based interventions required to allow individuals to live lives of good quality are expensive, complicated and, in many instances, of doubtful effectiveness.

**Aim**

To enable all individuals to acquire and maintain the physical, social and mental capabilities required to lead fully creative, productive and meaningful lives.

**Objectives**

1. To improve the well-being and quality of life of the elderly.

2. To ensure that health systems in the Region are organized, managed and sustained so that appropriate, accessible and affordable services, including those that promote the achievement of personal health potentials and a high quality of life, are available to all people.

3. To develop the potential for healing and health in people who live with chronic illness and disabilities, including their supporters.

4. To ensure people's rights, including the rights of mental patients, and to promote equity in access to resources necessary for optimal health.

5. To provide an environment that enhances quality of life.

**Objective (1) - To improve the well-being and quality of life of the elderly.**

**Approaches**

Countries and areas will be supported in the formulation of policies and implementation of programmes focusing on the concerns of the elderly. In particular, the strengthening of social and community support systems will be encouraged.

Care of the elderly will be stressed in the curricula for all levels of health workers. Special attention will be paid to development of skills that will support continued productivity and participation of the elderly in community and family life.

**Indicators**

- Tools will be developed to assess the quality and effectiveness of national policies for the elderly. These will include measurements of health as well as other socioeconomic indicators such as the number of self-reliant senior age groups.

- Disability-Free Life Expectancy (DFLE)
**Objective (2)** - To ensure that health systems in the Region are organized, managed and sustained so that appropriate, accessible and affordable services, including those that promote the achievement of personal health potentials and a high quality of life, are available to all people.

**Approaches**

Health system reforms will be encouraged to emphasize orientation of health services and facilities to people-centred health improvement through the promotion of healthy lifestyles.

Capabilities of countries and areas to ensure continuous improvements in the quality of care, particularly in the use of health technology, will be developed. This will include collaboration in the development of guidelines for national quality of care programmes.

Programmes for the development of human resources for health will strengthen the health promotion and protection capabilities of present and future health personnel. Training programmes will emphasize the links between the behavioural and environmental determinants of health. They will also focus on the need to enhance health workers’ abilities to transfer health knowledge and skills to individuals and communities, recognizing the limited impact of traditional biomedical technology on emerging health problems.

**Indicators**

- coverage indicators used in the monitoring, evaluation and implementation of health-for-all strategies such as the percentage of population covered by health care
- quality of care instruments used at appropriate levels of health services
- tools for the assessment of technologies and interventions, including measures of cost-benefit and cost-effectiveness

**Objective (3)** - To develop the potential for healing and health in people who live with chronic illness and disabilities, including their supporters.

**Approaches**

Professional support to the public by initiating self-help and self-care activities will be increased through the transfer of knowledge and skills, according to needs, to families and self-help groups.

Greater involvement of the community and employers in health care will be promoted in order to facilitate the rehabilitation and
reintegration into society of the disabled and people living with chronic illness. This includes the promotion of community-based rehabilitation programmes.

**Indicators**

- coverage of community-based rehabilitation programmes in countries and areas throughout the Region (in addition, other indicators of quality of health in the disabled, chronically ill and the elderly will be refined and monitored)

**Objective (4) - To ensure people's rights, including the rights of mental patients, and to promote equity in access to resources necessary for optimal health.**

**Approaches**

Individuals' awareness of how better health is achieved will be increased, as well as increasing the resources available, encouraging lifestyles that promote health, and practices that result in health. These include clean air, nutritious food, protection from infection due to unsanitary conditions and access to adequate economic resources.

For individuals with debilitating chronic diseases such as cancer, the emphasis will be on achieving maximum quality of life through monitoring and controlling their own pain relief.

Nurses and other health professionals will be encouraged to promote healthy behaviours in all settings of the community and act as role models for personal health improvement.

Quality of care begins with the individual and in the community although support will be encouraged at all levels. The principal emphases will be on training and the establishment of quality assurance activities in different health care settings such as hospitals, clinics, health centres and communities. In addition, models will be developed for analysis and evaluation of quality of care procedures and development of research capability.

Research will be promoted in critical areas related to improving the quality of life of individuals and communities and strengthening institutions to carry out these activities.

**Indicators**

- prevalence rates, by appropriate age group and sex, of:
  - level of education
  - access to health care
- measures of social inequality
- degree of knowledge and motivation needed to ensure taking responsibility for one's own lifestyles
• access to health care facilities and to health care workers (this will also mean the development of positive indicators to measure quality of life and good health adequately)

**Objective (5) - To provide an environment that enhances quality of life.**

**Approaches**

Activities will aim to support implementation of plans to achieve national health development goals throughout the Region. This will emphasizes three concerns: equal access to and use of facilities and services; improved quality of care; and containing the cost of care.

At country level, health reform approaches will concentrate on three areas: finance, organization, and management. The financial measures include resource allocation schemes and health insurance or other financial incentives to direct resources towards desired facilities and services. The organizational measures involve defining responsibilities by central or district level; optimally balancing the provision of services by the public and private sectors; and using internal markets. The management measures will typically relate to quality of care and accountability or transparency issues.

**Indicators**

• formulation of explicit policy statements linking social benefits to economic policies and sustainable development goals (indicators of progress in provision of health services to vulnerable and disadvantaged population groups will also be monitored)

**Structure**

• Team coordinator
• Lead programmes
  - Health of the elderly
  - Disability prevention and rehabilitation
  - Noncommunicable diseases including genetic disorders
• Organization and management of health systems based on primary health care
• Mental health
• Communicable diseases including zoonoses
• Environmental health risk assessment and control
• Nutrition
  - Health protection and promotion activities for healthy lifestyles

The team should include at least one representative from each of the four technical programme divisions.
4. Other managerial issues

A common and critical element of the programme groupings presented is the support of the infrastructure development programmes. This is intended to maximize coordination and collaboration between programmes in order to focus better on the whole individual.

Many elements of development and reform of the health system need to be addressed in support of health promotion and protection. These include development of supportive public policies addressing health issues, health care financing, and quality assurance of all aspects of health care. These issues are common to all three teams but also must be looked at in the context of the whole health system.

Time frame

If approved by the Regional Committee at its forty-fifth session, the teams will be convened before the end of 1994 to allocate resources and activities from existing programmes that could be handled by the team approach and to develop targets based on existing indicators.

The teams should be fully operational by the beginning of 1995. During 1995, work will begin to develop the new qualitative indicators required. During the next year or so, teams will work with national governments to identify areas of concern where such a multiprogramme approach would be effective. Different countries and areas will have different requirements and will need to focus on different issues.

Resources

To be effective, each programme in the team must be an active partner. Initially, each programme will assess planned activities for the 1994-1995 biennium as well as projects funded from extrabudgetary sources, to identify which activities could best be handled by the proposed approach. For example, training activities of different programmes which target the same group of people can be combined. Implementation will commence in 1995. The 1996-1997 budget will be implemented in a way that supports the aims of this approach, emphasizing health promotion, health protection and individual responsibility as far as possible. The 1998-1999 regular budget will be formulated specifically to accommodate the approach. In addition, submissions for extrabudgetary resources will be focused as much as possible on the teams’ aims and objectives.
Accountability

The team process and operation should be carefully evaluated. It is important that the analysis of the outcome of the team’s work is not approached on an individual programme basis. The team would present its work as a panel, during a review of progress and effectiveness involving all of the programme managers in the Regional Office. These could be forums for expertise and resources to be added to the team’s efforts.
The issues discussed in this document are by no means all new. What may be of interest is the *modus operandi* proposed. This is a time to take stock of what needs to be achieved, in the light of what is known, and what can be predicted.

Looking towards the 21st century, we cannot be certain what the challenges in the health field will be. Strategic changes can, however, be made now which will provide direction for WHO to respond quickly and effectively to those future challenges. These changes are evolutionary, not revolutionary, but they have wide-ranging implications for the Organization's role as the directing and coordinating authority on international health work.

A new pattern of threats and opportunities for health in the Western Pacific is emerging. It is influenced by many factors, including the continuing improvement of health status in most countries, achieved through collaborative health-for-all efforts. Human behaviour is being recognized as one of the primary determinants of health, while the often-hostile changes taking place in the environment have recently regained prominence as external influences. In view of this, it is clear that the framework for meeting the health challenges of the future must emphasize health promotion and protection, which will result in improving the quality of life. Individuals must be convinced to take charge of their own future by behaving in healthy ways. Their social and physical environments must be made less hostile to and more supportive of human development through better health.

If we succeed in fostering these developments, we have a chance of securing a future where we live longer, healthier, and better quality lives.
At the global level, the necessity for assessment and reevaluation has been reflected in a number of major exercises. Important among these have been the deliberations of the governing bodies of the World Health Organization on the WHO Response to Global Change which recognized the need for organizational reform. There have been several specialized forums in which aspects of this document’s concerns have been raised, such as the 1990-1992 work of the WHO Commission on Health and Environment; the 1992 United Nations Conference on Environment and Development; the 1992 Ministerial Conference on Malaria; and the 1992 International Conference on Nutrition. Each of these forums, as well as others, have emphasized the critical need to move in a new direction.

A great deal has been written on health promotion and protection. This document does not quote directly except from WHO’s own basic documents, but the existence of many learned debates on the subjects is acknowledged. The source material for the observations and plans made is the work of WHO in the Region, present and past.