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3

Description and Content Analysis of the National Health Policy of Pakistan

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Abstract

Health conditions in Pakistan are poor and health indicators are unfavorable. Various governments have pursued health policies to combat disease and improve health conditions. Pakistan's current policy document, the National Health Policy (2001), is aimed at reforming the health sector in accordance with Health for All (HFA). This paper presents the content analysis of the national health policy of Pakistan highlighting the various key areas. The relevance of this policy document is analyzed from the perspective of HFA. According to HFA equity, participation and collaboration are essential principles for health care reform. The article has used qualitative research methods to analyze the National Health Policy of Pakistan (NHP) 2001 and its key areas. Content analysis compares the NHP 2001 with HFA principles, and key persons are asked about their opinion on this issue. It is argued that in formulating health policy the policymakers have not applied important areas of HFA so far. The NHP 2001 still emphasizes upon curative care and institutional facilities for the delivery of health care services in accordance with the principles of biomedical model of health. It is concluded that the *policy content* limits the health development in Pakistan. The article suggests that the country needs to reformulate its national health by paying attention to the principles of HFA.

Key words: Health Policy: content analysis, HFA, reform for health.

Introduction

Health conditions in Pakistan are poor, and health indicators are unfavorable. According to the World Development Report 2005, Pakistan experiences problems of higher child mortality (an infant mortality rate of 74 per 1000 and a mortality rate of 98 per 1000 among the under-fives) and maternal deaths (16,500 annually) as compared to other neighboring countries of the South Asian region (World bank, 2005). For example, in Bangladesh infant mortality rate is 46 per 1000 and a mortality rate among the under-fives is 69 per 1000. In India, infant mortality rate is 63 per 1000 and a mortality rate among the under-fives is 87 per 1000. In Iran infant mortality rate is 30 per 1000 and a mortality rate among the under-fives is 41 per 1000 (World Bank, 2005). Moreover, Pakistan like many other developing countries suffer from the double burden of disease: while the traditional infectious diseases are still uncontrolled, new health problems such as HIV/AIDS, cancer, diabetes, accidents, crime and violence and drug addiction (including tobacco use) are increasing (Khan et al, 2005; Pakistan, 2001; Pakistan 2005). In order to address this double burden of disease, health authorities in Pakistan formulated a New National Health Policy in 2001 (Pakistan, 2001; Pakistan, 2004). The policymakers intend the renewed policy 2001 to be a comprehensive policy document that addresses current health problems in accordance with the principles of the Health For All (HFA) strategy introduced by the World Health Organization (WHO).

The WHO initiated the concept of HFA as a goal for all its member states in 1977 (McDonald, 1992; Naidoo & Wills, 2000). The HFA concept advanced a vision to attain a level of health that would permit all people to lead socially and economically productive lives (WHO, 1997a). With the emergence of the HFA concept and other public health concepts like health promotion and environmental health the classical biomedical model of health came under increasing criticism. Scientists, governments and international organizations began to realize that the biomedical model of health did not provide solutions to the industrial, social and

environmental causes of new health problems. So it was felt important to pay attention not only to healthcare services and biological determinants of health but also to the socio-cultural, economic and environmental determinants (Brener, 1979; de Leeuw, 1989; Doyal, 1979; WHO, 1997a; 1997 b; 1997c).

This article analyses whether in 2005 Pakistan indeed has a comprehensive health policy based upon the principles of HFA which may address increasing health problems in the country. The article starts by describing Health For All (HFA) strategy and how its principles can be operationalized for policy implications. Next, a brief overview of the National Health Policy of Pakistan (2001) is presented to indicate what HFA principles are applied in the policy document. The focus of the content analysis is on identifying the extent to which the general approach and the key areas of the policy document fit with the principles of HFA. This is a mid-term analysis since the new health policy, formulated in 2001, states that the goals have to be reached in 2010. The findings are discussed and recommendations for a new health policy are made at the end.

Methods

To analyze the National Health Policy 2001 of Pakistan qualitative research methods have been used. These methods include document analysis and interviews of important actors/stakeholders involved in the health policy process in the country. Documents include: national and international reports on public health and health policy, official reports of health ministries and departments, health professional organizations and international agencies working in Pakistan. Additionally the content of the Report of the Medical Reforms Commission, 1959, the Rural Health Centers (RHC) Scheme 1961, People's Health Scheme 1972, the National Health Policy 1990 and the National Health Policy 1997 were studied to describe the health policy development in Pakistan. In analyzing the content of the National Health Policy (NHP) 2001 particular attention has been paid to indicate: how far the policy makers in Pakistan have followed the principles of HFA strategy (equity, participation and collaboration) in formulating the said policy document. Besides the document analysis, open-ended interviews of one hundred and fifty-two actors involved in the health policy process at the district (local), provincial, federal and international level were conducted in Islamabad, Lahore, Karachi, Peshawar, Quetta, Rawalpindi, Abbottabad and Geneva in 2004. The interviewees were asked about their opinions and experiences concerning the HFA strategy and its implication in the country.

These interviewees included representatives of international organizations (WHO, The Word Bank and UNDP), elected representatives related to the Ministry of health and other health related ministries, policy makers, civil servants, heath professionals, health managers and representatives of health-related NGOs as well as associations including Pakistan Medical Association, Pakistan Medical and Dental Council and Public Health Association of Pakistan. The interviewees were visited in their offices, homes and public places. They were asked about their opinions and experiences concerning the HFA strategy and its implication in the country. Interviewees were assured anonymity of their whereabouts particularly to those who work within ministries and other governmental departments. The content of the interviewees were analyzed by categorizing their opinions and experiences about environment and lifestyle, equity, participation and collaboration in accordance with HFA (see Table 1). The key areas in the NHP 2001 are presented and analyzed in order to know how far the policy makers

have considered the HFA and its principles and how they have assured its application in health agenda building and policy making. It is analyzed whether the content of NHP has properly considered HFA and policy interventions considered environment and lifestyles by assuring equity, participation and collaboration or has referred these principles indirectly.

Health for All Strategy

As a strategy to attain the goals of HFA, WHO launched Primary Health Care (PHC) at the Alma Ata Conference in 1978 (McDonald, 1992; Naidoo & Wills, 2000). In 1995, WHO initiated renewal of HFA. HFA in the 21st Century presents the values and principles to guide action and policy for health at global, regional, national and local levels (WHO, 1997a; 1997b; 1997c). The HFA strategy is aimed to unify the comprehensive health field covering important determinants of health such as human biology, environment, lifestyle and health care services in order to formulate clear health policies that can offer policy goals and interventions covering all the important determinants of health (WHO, 1997a; 1997b; 1997c). Underpinning the comprehensive HFA strategy is a new public health concept, of which three core principles focus upon all the determinants of health. These principles of new public health are equity, participation and collaboration (McDonald, 1992; Naidoo & Wills, 2000; WHO, 1997a; 1997 b; 1997c).

Equity, or being fair and just, is not the same as equality, which is the state of being equal. Equity refers to material resources, power, status and environment enabling people to achieve goals and services (Conley, 2001; McDonald, 1992; Murdock, 2001; Starfield, 2001). There are arguments for advocating greater social and economic equity as means of promoting health because social, economic, regional and professional inequalities reflect health inequalities (Conley, 2001; Gwatkin, 2001). There is also evidence that all people living in societies with greater inequality experience poorer health compared to more egalitarian societies (Gwatkin, 2001; Hjortsberg & Mwikisa, 2002; Wilkinson, 1997). This provides a strong argument for advocating greater social and economic equity as a means of promoting health.

Participation is the second important principle of HFA. It intends to involve people in the health policy process, recognizing their health needs and looking for solutions which citizens need. It makes health programs more effective. It has been effectively used in fighting against environmental degradation and combating problems of tobacco as well alcohol in many parts of the world (Campbell & Mzaidume, 2001; Minkler, 1999; Moukhyer, 2005). Furthermore, participation could address the issues of access and inclusion more effectively (Cockburn, 2002; Moukhyer, 2005). In addition to that, it makes the health programs more effective, accessible and sustainable (Ali, 2000; Howat et al., 2001). For example in Indian state of Kerala wider participation by local governments, NGOs, and community groups helped health authorities in implementing PHC programs (Varatharajan, et al., 2004).

Collaboration or partnership as third principle means working together with others on shared projects. Collaboration is essential since many governmental sectors, agencies and people are involved in health-related issues (de Leeuw, 1989a; Naidoo & Wills, 2000; WHO, 1997b; 1997c). For example, governmental sectors such as education, environment, water and sanitation, housing, energy, industry and transport affect health directly or indirectly. A collaboration among all these sectors, actors and stakeholders outside the government, NGOs, communities and their representatives can induce more fundamental changes, with an enduring

character and a greater potential to prevent disease and promote health (de Leeuw, 2000; Naidoo & Wills, 2000; WHO, 1997b; 1997c). In Bangladesh collaboration with stakeholders, communities and NGOs has showed positive results in controlling tuberculosis (Zafar Ullah, et al., 2006). To put it otherwise, health policy and health care are not only the issues for health care professionals.

Policy Implications of HFA Strategy

In order to achieve the mission of HFA, the WHO argues that countries should either formulate new health policies or upgrade the existing policies in accordance with HFA (WHO, 1986; 1997c; 1998). The HFA strategy and its mission is not a merely academic exercise. The principles of HFA must be realized through the formulation and implementation of health policies (WHO, 1997a; 1997b). Many developed countries reformulated their health policies by following the mission of HFA (Amhof, 2002; Baum, 2003; Byrant, 2002; de Leeuw, 1989b). For example, the Swedish government tried to reform its health policy by considering all the important determinants of health particularly environment and lifestyle in addressing health problems such as cardiovascular disease, mental illness, tumors, injuries and respiratory diseases (de Leeuw, 1989a; HS90, 1990). New South Wales reformed health policies by considering the impact of broader political, economic and social forces upon health of the people in controlling the problem of drug abuse and child abuse (de Leeuw, 1989a; Orange, 1988). New Zealand tried to promote health by ensuring wider participation and collaboration in policy making and implementation in order to reorient its health services, attain equity, and ensure accessibility of health services particularly in remote rural areas (Dyall, 1988).

For developing countries implementation of the principles of the HFA in policy formulation may cause problems because many countries experience a ‘double’ burden of ‘traditional’ infectious diseases (like malaria, diarrhea, tuberculosis) and ‘modern’ health problems (like HIV/AIDS, cancer, diabetes, accidents, drug abuse), and because resources are lacking and infrastructural conditions are poor. In developing countries assurance of equity and wider participation in health policies is more difficult because there are social, economic, gender, territorial, and professional inequalities. In such a wider context policy makers need to formulate health policies that can offer not only delivery of health services but can also enhance socio cultural and economic environment in order to empower people in enabling them to achieve desired goals and services in an equitable and sustainable way.

Health policy should create supportive environments that enable all the people to combat health problems and attain/develop a healthy life. In such an environment, people are enabled to make choices in reducing health risks and developing healthy lifestyles irrespective of their gender, creed, color and income (Colney, 2001; de Leeuw, 1989; Gwatkin, 2001; WHO, 1998). Assuring equity through policy interventions can provide equal services for people with equal needs and working to reduce known inequalities in health (Cockburn & Trentham, 2002; Perez, Herranz, & Ford, 2001; Vernon & Sherwood, 2001).

Health policy needs to develop a wider participation in the health policy process in order to create health-enhancing environment (physical, political, economic & socio-cultural), recognizing health needs of people and looking for solutions which citizens need (Campbell et al, 2001; Minkler, 1999; Moukhyer, 2005). Health policy interventions may help in decentralizing health system and in creating a space for wider participation from communities, groups,

professionals and NGOs in creating health enhancing environment. Similarly, it is the health policy that can introduce institutional arrangements and structures through which people can participate in the health policy process. Furthermore participation in the health policy process can make health programs more effective, accessible and sustainable through wider participation (Ali, 2000; Howat et al., 2001).

Besides equity and participation health policy makers need to realize collaboration in developing health policy and realizing policy goals. Health policies need to offer ways, methods and opportunities that can develop collaboration in order to bring many sectors, agencies and people together towards achieving the goal of good health in accordance with HFA (WHO, 1997b; 1997c). The role of health policy is also important in maintaining positive and smooth working relationships among various sectors and actors that collaborate together for the purpose of promoting health (Arnhof, 2002; Baum, 2003; Byrnat, 2002; WHO, 1986; Zafar Ullah, et al., 2006).

A Brief Overview of the National Health Policy (2001) of Pakistan

Various governments in Pakistan acknowledged the need for renewing health policy to combat health problems and improve life conditions. The present government also saw the necessity of such a renewal and declared the National Health Policy (NHP) 2001. The Federal Cabinet endorsed this policy document in 2001. According to the ***Foreword*** of the National Health Policy 2001 *"the new health policy provides an overall national vision for the Health Sector based on Health For All approach"* (Pakistan, 2001). It considers health sector investments as a part of the government's poverty alleviation plan. The NHP 2001 states that good governance is the basis for health sector reforms in achieving quality of healthcare. Priority has also been accorded to the primary and secondary level of the health sector (Pakistan, 2001)

The NHP 2001 has adopted a focused approach by identifying ten key areas of action for the health sector, which have the potential to improve the delivery of healthcare services and the overall health status of the population of Pakistan as it is stated in the ***vision*** of the Health Policy. These ten key areas are shortly described.

The ***first key area*** aims to reduce widespread prevalence of communicable diseases such as childhood diseases, TB, Malaria, Hepatitis-B and HIV/AIDS by implementing protective and promotive health programs. These planned programs include Extended Program of Immunization (EPI), a new national program against Tuberculosis based on the Directly Observed Treatment Short Course (DOTS) and a national malaria control program.

In the second key area directed at inadequacies in the primary and secondary health care services, the policy document has identified inadequacies such as deficient state of equipment, deficiency of medical personnel at local level and absenteeism of the staff. There are also major shortcomings in emergency care, surgical services, and anesthesia and laboratory facilities in the hospitals. Furthermore, there is no referral system in operation at local level. In addressing these inadequacies the policy document intends to make family planning and primary healthcare services available to the under-served and un-served population through an integrated community-based approach. A minimum of 6 specialties (Medicine, Surgery, Pediatrics, Gynecology, ENT and Ophthalmology) will be made available at local level hospi-

tals (Tehsil/District level). The performance of basic health units and rural health centers will be specially reviewed and only those facilities will be upgraded which can actually serve the population. Adequately functioning facilities will be strengthened by filling staff positions and allocating financial resources based on performance/utilization. It is also intended to develop a model referral system in the country by 2005.

The ***third key area*** that aims to remove professional and managerial deficiencies in District Health System the NHP 2001 has identified various deficiencies. These deficiencies include the ineffectiveness of the district health office in supervising health services, the lack of appropriate knowledge and skill among District Health Officers and the vacant positions of the doctors, specialist and other paramedics in district (and tehsil) hospitals. The NHP 2001 proposes to reduce these deficiencies by improving supervisory practices through decentralization and devolution, providing appropriate training to the District Health Officers and filling vacant positions by appointing doctors, specialists and other paramedics.

Implementation of the fourth key area, directed to promoting greater gender equity in the health sector, includes the provision of safe motherhood facilities, women's accessibility to the primary health services, and the provision of emergency obstetric care facilities in the hospitals. The NHP 2001 also intends to launch Women Health Projects in order to establish a referral system between the village level and district level hospitals and to increase number of Lady Health Visitors (LHWs), nurses and midwives by investing in training facilities for these professions. It is planned to increase the number of nurses from 23,000 in 2001 to 35,000 by 2005 and 55,000 by 2010. Furthermore, 100,000 family health workers will be trained by 2005.

The fifth key area aims to bridge the basic nutrition gaps in the target population (i.e. children, women and vulnerable population groups). To realize these objectives the NHP 2001 proposes the provision of Vitamin-A supplementation to 30 million children every year and the provision of iodized salt by introducing flour and vegetable oil fortified by the addition of micro-nutrients. Nutrition Projects will also be launched to ensure a food fortification program and the provision of nutrition package, and to create mass awareness of health education. Nutrition Projects aim to reduce the number of low birth weight babies from 25% to 15% by 2010.

The sixth key area aims to address the urban bias in the public health sector. Urban areas have a higher number of governmental hospitals, clinics, other health facilities and health professionals than rural areas. This key area has been proposed mandatory visits by medical students and their teachers to rural areas, compulsory rural service of new medical graduates and filling vacancies for doctors and other paramedics in the rural areas.

The seventh key area particularly intends to improve the performance of the private sector because the quality of private care vary on regional basis (urban rural) from facility to facility (clinic, hospital, laboratory) and private practitioners (physicians and traditional healers). The proposed actions in improving the private health sector include the introduction of drafts of laws and regulation in the private hospitals, clinics laboratories, private medical colleges as well Tibb/Homeopathic teaching institutions. The existing law on Tibb and Homeopathy will be amended to recognize degree and postgraduate level courses in Traditional Medicine.

Furthermore, each provincial government will develop an appropriate framework to encourage private-public cooperation in the health sector.

Actions proposed for the eighth key area, designed to create mass awareness in public health matters, include the increase of funding for the ongoing health education campaign, the establishment of a Nutrition Cell in the Ministry of Health, training of family planning workers and Primary Health Care workers. It is also planned to organize orientation meetings and seminars for the elected councilors of the local councils in order to create awareness of public health.

The ninth key area of the NHP 2001 envisages improving the performance of the drug sector and to ensure the availability, affordability and quality of drugs. In realizing these objectives, it has been planned to encourage drug manufacturers through maximum market competition, to manufacture imported drugs within the country, and to increase the investments in the pharmaceutical sector. The document also intends to strengthen the capacity of the Drug Control Organization in market surveillance and quality control.

For the implementation of its ***tenth key area*** aimed at building the capacity of the Ministry of Health. A research unit is planned in order to ensure the capacity building of the ministry in analyzing, implementing, monitoring and evaluating national health policy. The Health Management Information System (HMIS) will be expanded to all the districts in the country. It is also planned to initiate Disease Early Warning System in collaboration with the World Health Organization in order to combat Cong-Crimean Hemorrhagic Fever (CCHF) and Leishmaniasis.

The first National Health Policy that was declared in 1990, aimed to prevent disease and improve health conditions by paying attention to clean water, sanitation, housing and family planning (Pakistan, 1990). It also intended to increase governmental health expenditures up to 5% of the GNP and upgrade the medical education, health care system, environmental conditions and to provide universal health coverage in accordance with the HFA. Furthermore, the NHP 1990 offered several health programs including maternal and child care, immunization and nutrition (Pakistan, 1990). Formulation and declaration of the first national health policy was a positive governmental achievement in 1990. The NHP 1990 acknowledged that the low governmental expenditure upon health sector disturbs health policy process, causes delays in implementation of health projects and ultimately implementation failure of health policies. Indeed it was positive that government not only recognized the low governmental health expenditure a problem but also intended to increase its health expenditure up to 5% of the GNP. Also, it was positive that the government intended to stimulate health promotion and to create healthy environment. However in practice this was not realized since governmental health expenditures did not increase in the following years. In 1997 government replaced NHP 1990 and announced second National Health Policy (NHP)1997.

The NHP1997 aimed to cover all areas of primary health care (PHC) and the HFA strategy (Pakistan, 1997). It also aimed to make health service more responsive to current health needs and to address health problems including HIV/AIDS, cancer, diabetes, (road traffic) accidents, violence and crime, mental health and tuberculosis by following the principles and methods of disease prevention (Pakistan, 1997). The NHP offered several health programs including immunization, family planning, maternal and child health, reproductive health, malaria control, tuberculosis, HIV/AIDS, and cancer control (Pakistan, 1997).

As compared to NHP 1990, the NHP 1997 considered health problems more comprehensively and intended to find their solutions not only in health care services but also in other determinants of health particularly environment and lifestyle. The NHP 1997 also offered various intentions to prevent disease and promote health. However it neither intended to increase governmental health expenditures nor to decentralize the health system. The basic principles of the HFA such as equity, participation and collaboration were not assured in the NHP 1997. As mentioned, government declared its new health policy in 2001.

Content analysis of the National Health Policy 2001 of Pakistan

The analysis will comment on the general approach, followed by an analysis of the ten key areas. The analysis will start with looking for concordance with HFA principles and attention for infrastructural investments (environment and life style). Next the comments of the interviews will be presented. Of the 144 interviewees 105 (73%) gave their opinions and comments about the relevance of the NHP 2001 from the perspective of HFA strategy (see Table 1). Generally, professionals (77%) expressed more frequently comments and concern comparing HFA principles with the actual policy plan than civil servants (70%), while politicians answered the least (67%). At district level 63% commented on HFA issues, at provincial level 86% and at federal level 77%. These differences might be related with familiarity with HFA principles on the one hand and with the ten key areas on the other hand.

Table 1: Interviewees (Actors) that expressed a concern about the relevance of the NHP 2001 from the perspective of HFA strategy

Actors										Total
Federal level				Provincial level			District level			
International	Politicians	Managers	Professionals	Politicians	Managers	Professionals	Politicians	Managers	Professionals	
6	4	8	8	8	24	12	15	32	27	144
6	2	6	6	6	20	12	10	19	18	105
5	1	3	6	4	3	12	4	10	16	64
5	1	6	6	5	4	12	6	16	18	79
5	1	3	4	2	3	6	3	8	12	47
6	2	3	6	5	4	12	10	8	16	72
5	2	3	6	5	3	12	10	8	16	70

As mentioned earlier the NHP 2001 intends to base its reform on HFA strategy. Indeed, it was the argument to develop the said policy document. The view, that the NHP 2001 is seen as an investment in the poverty plan, indicates the intention for an integrated approach. Also it is stated that priority should be given to the primary health care sector.

In its first key area the NHP 2001 aims to reduce the widespread prevalence of communicable diseases such as TB, malaria, hepatitis B and HIV/AIDS by increasing the coverage of immunization. Indeed, immunization is important in combating disease but there is also a need to pay attention to other determinants of health particularly environment and lifestyle as expressed by the interviewees at all levels. Pakistan suffers from environmental degradation that results in various health hazards (Pakistan, 2001; Pakistan, 2004; Pakistan, 2005). Many studies and reports have shown that health hazards, such as the lack of access to safe drinking

water and sanitation, water pollution, urban and industrial pollution and intensive agriculture, are major causes of disease and poor health conditions (de Leeuw, 2000; Kickbusch & de Leeuw, 1999; WHO, 1997a; 1997b; 1998a). Hospital records in Pakistan show that about 80 percent of all diseases are either water-borne or air-borne. Water-borne diseases account for 60 percent of infant deaths and 40 percent of all deaths in Pakistan (Pakistan, 2001). Similarly, exhausts from vehicles are prime factors in the increase of asthma, chronic bronchitis and other diseases of the heart, lung and skin in the country (Illiyas et al, 1997). It is interesting to note that in the first key area 'old' and 'new' diseases are mentioned both. Unhealthy lifestyle is an important source of many health problems such as HIV/AIDS, cancer, diabetes, cardiovascular diseases, and accidents in the country (Hanif, 1992; Illiyas et al, 1997; Khan & Hyder, 2001; Pakistan, 2005).

Many studies and reports show that many persons infected with communicable diseases such as HIV/AIDS transmit them to other persons through various ways including blood transfusion, the use of needles and syringes, and the use of inoculation equipment (Baqi et al., 1999; Haque et al., 2004; UNAIDS, 2004; UNDP, 2004; USAIDS, 2005). Life style is most frequently mentioned as relevant and as a concern for health policy by the interviewees. Most of the interviewees at all levels believe that an increasing trend in smoking particularly among teenagers is a major cause of cancer. There are no restriction upon tobacco advertisements, smoking in public buildings and selling tobacco to the teenagers as pointed out by the health professionals at provincial and district level. Many studies concluded that paying attention to lifestyles may control accidents because major causes of accidents in the country include: traffic rules are not followed, seat belts are not used, and safety measures in vehicles, homes, schools, and workplaces are not practiced (Ghaffar et al,1999; Razzak, 2005; Razzak & Luby, 1998; Qureshi et al, 2004).

The above evidences show that there is a need to protect the environment and promote healthy lifestyles in preventing disease and promoting health in accordance with HFA strategy. And this recognized as a concern by most interviewees, i.e. 75% expressed their concern about the life style approach in the NHP 2001 and 69% about environmental issues. According to health professionals at the national, provincial and local level the NHP has neither planned specific projects in order to protect environment and to develop healthy lifestyle nor mention any need for a wider participation from health organizations, NGOs, professional groups, the media and the community in increasing the coverage of immunization. According to a representative of a professional organization *" Due to lack of community participation people particularly in rural areas are reluctant to trust nutrition and immunization programs and feel alienated from these governmental programs. Many mothers do not bring their children to rural health centers for immunization and some even refuse to get immunized their children during door to door immunization campaigns which are offered free of cost at the door step."*

The **second** key area of NHP 2001 addresses the inadequacies in the primary and secondary level healthcare services by increasing emergency care, surgical services, anesthesia and laboratory facilities in hospitals. It also plans to provide the specialties such as medicine, surgery, pediatrics, gynecology, ENT and ophthalmology in the district hospitals. These are positive steps in improving secondary healthcare services. Also it is stated that primary health care and family planning should become available in so far underserved areas. Such plans support the equity principle and improve the infrastructure for public health and health services. In practice the NHP do not emphasize upon PHC rather it intends to focus upon the health care services in accordance with biomedical model of health as indicated by the representatives of international organizations and professional organizations during their inter-

views. They believe that comprehensive disease prevention and health promotion programs considering all the determinants of health get little attention in the NHP 2001. Interviewees at all level stated that besides improving the quality of health care services it is important to pay attention to other determinants of health particularly environment and lifestyles as shown in the Table 1. According to a representatives of international organization delegated in Pakistan at federal level " *the NHP 1997 and NHP 2001 have stated that the new health policy intends to reform health sector by following the vision of HFA, however, their main focus was mostly upon the delivery of health care services by following the biomedicine and not disease prevention and health promotion in accordance with HFA."*

The equity principle is not mentioned by most interviewees, especially not by managers at provincial level. This indicates that this principles has not really dealt with in the NHP 2001. According to a representative of a professionals organization *"the deprived and disadvantaged people suffer from higher levels of ill health and premature death than affluent and advantaged groups but NHP 2001 does not reflect any concern with equity that is a basic principle of HFA."* Many studies state that Pakistan needs to reorient the health services according to PHC and health care should be based upon health needs of population (Baqi et al., 1998; Baqi et al., 1999; Haque et al., 2004; UNAIDS, 2004). According to a representative of an international organization delegated in Pakistan *"policy makers in Pakistan should not rely to much upon the biomedical model of health because biomedicine operates with a narrow view on health, which often concerns in an increase in emergency care, surgical services, anesthesia and laboratory facilities in hospitals and clinics."*

The **third** key area of the policy document intends to remove existing professional and managerial deficiencies by improving supervision, by providing appropriate training, and by filling vacant positions of doctors, specialists and other paramedics in the public sector hospitals. It is encouraging that policy makers show a concern regarding existing professional deficiencies and intend to remove it. Realization of such key area may improve the quality of health care and strengthen the infrastructure. However, all the planned measures aiming to increase the quantity and quality of physicians, specialists, paramedics and clinical services are the reflections of a better functioning of biomedical model, not the mission of HFA strategy as pointed out by the representatives of international organizations and health professionals at all levels during their interviews. According to a representative of a professional organization *"the existing human resource for health is not balance because health authorities have been trying to increase the number of training opportunities for physicians, nurses and dentists but not for public health professionals."*

Representatives of international organizations and health professionals believe that the HFA strategy demands appropriate training of the health professionals, which must be realized through creating awareness and imparting knowledge of new public health and health promotion. Pakistan experiences an imbalance among health care professionals and public health professionals (Khan et al., 2005; Siddiqi et al., 2004). There were 66,196 physicians in the country and population-physician ratio was 1873 in 1994 till June 2005 there were 113,206 physicians and population-physician ratio was 1359 persons per physician (Pakistan, 2005). The number of public health professionals having master degree in public health was 205 till June 2005 (Pakistan, 2005). According to representatives of international organizations and health professionals at national and provincial level the country lacks a human resource for health having enough knowledge and skill in accordance with the HFA but the NHP 2001 has not paid any attention to this issue. According to a representative of public health association *"traditionally, physicians in Pakistan are trained to work in clinical settings and not the*

broader determinants of health lying outside the biomedical model of health. Consequently such physicians working at federal level (as policy makers) can not offer policy interventions that reflect the mission of HFA."

In addressing the existing health inequities in the country, the **fourth** key area of the policy intends to promote greater gender equity by increasing reproductive health care services in the public sector. The intention for gender equity is indeed important and in line with the equity principle of HFA. Also increasing reproductive health care services is important but not enough to address the problem of gender inequalities and violence against women rooted in the socio-cultural context in the Pakistani society (Khan et al., 2005; Siddiqi et al., 2004); WHO, 2004). Interviewees at all level expressed a similar view about the gender inequalities and violence against women. They also emphasize for a need to do more for health and well-being of women. However, regarding the equity principle representatives of the international organizations and health professions showed more concern than politicians and health managers (see Table 1). According to a representative of a NGO *"the country has signed several international declarations for the protection of human rights and the constitution guarantees equal treatment for women. However, in practice, authorities have never shown any commitment to the constitution and ratified declarations. Male domination is culturally sanctioned and generally women suffer from a suppressive attitude, gender discrimination, domestic violence, inaccessibility to health services and various types of harassments."*

The **fifth** key area of the policy aims to bridge the basic nutrition gaps in the target population (i.e. children, women and vulnerable population groups). Such actions indeed support equity and may improve the health status among vulnerable groups. It is planned to realize this goal by launching nutrition projects for the provision of iodized salt, food and nutritional supplements to schoolchildren, and to ensure the availability of the major food items. Most of the interviewees at all levels indeed believed that nutrition programs will not only help to address the problems of malnutrition but also the problem of inequities in the country. Through the nutrition programs citizens may be motivated to participate in health care programs. According to a health professional working at district level "generally, health programs such as nutrition, immunization and mother child health are neither decentralized nor offer any space for wider participation. Consequently, people can not find any place to participate and to play their role in these programs. Further people do not place their trust in these centralized programs". It seems the execution of this key area is not in line with the participation principle. This was mentioned by health professionals and by health managers at local level. According to a professional working at district level "peoples participation in the immunization program is important to create awareness among people and it can lead to increase in the coverage of immunization." In the proposed actions no connection is made to collaboration with other sectors (education, media.. etc) which might be seen as very important to realize the planned actions. A representative of a NGO added that *"collaboration among health sector, media, education department and elected representatives can effectively combat the false myth attached to immunization and can help the rural people and their children in understanding the importance of immunization in preventing disease."*

The **sixth** key area of the document intends to correct urban bias in the health sector but only by arranging regular visits by medical students and their teachers to rural areas and by sending new medical graduates to work in public sector hospitals in rural areas. Indeed, such measures may close the gap between urban and rural areas in health care accessibility and improve the health care infrastructure as is also intended by key areas 2 and 3. According to a representative of a professional organization *"many positions of health professionals are lying vacant in*

rural health areas. On the other hand there is growing unemployment and geographical disparities among the trained health professionals. Indeed, regulatory measures can solve this problem by providing employing newly graduated health professionals and posting them in rural areas." The sixth key area supposes that medical students, their teachers, and new medical graduates can solve the problem of the urban bias because these students and professionals are familiar with the health needs of the population in rural areas and can serve the rural population as well as improve health conditions. Health professionals at provincial and district level, representatives of NGOs and elected representatives at district level doubt this. According to an elected representative at districts level *"many rural people believe that government sends newly graduated physicians in the rural health centers for the purpose of the training of new physicians and not to treat the people. So people doubt in their healing capabilities rather and doubt that they can add health problem rather than treating"* According to a elected representative at district level *"mostly the new graduates appointed in the rural health centers are male and women are reluctant to be treated by male doctors due to socio-cultural norms."*

During interviews health professionals at provincial and local level and field officers added that these steps are not enough to address the problem of urban bias in the country. These interviewees believe that new medical graduates and medical students do not have enough knowledge and skill in the area of disease prevention and health promotion in order to address health problems in accordance with the principles of new public health and HFA. Furthermore, in addressing urban bias focus upon public sector hospitals is not a proper solution because public sector provides health care services only to 20 percent of the population and rest of population depends upon the private sector. According to an elected representative at district level *"mostly new graduates stay in the rural health centers till they are equipped with practical knowledge and working skills but when they are trained to serve rural communities they leave rural areas."* Studies also believe that public sectors provide health services to 20 percent of the rural population (Abbassi, 1999a; 1999b; Khan et al., 2005). Addressing urban bias also requires collaboration between several sectors (administrative, education, communication). In the NHP 2001 no attention is given to the need of collaboration. Interviewees particularly representatives of the international and professional organizations, health professionals at all levels and all the actors at district level express that collaboration is important not only for addressing the urban bias but also for the effective implementation of health programs such as nutrition, immunization, mother and child health and family planning. It is remarkable that managers/civil servants at federal and provincial level seldom mention the issue of collaboration. It can be due to their positions in the government and tendencies in supporting governmental policies at every cost.

The **seventh** key area aims to introduce required regulation for quality assurance in private medical sector. Regulation can particularly control unqualified traditional healers and quacks providing low quality health care services in the rural areas. However, regulation in order to improve the quality of health care in public sector should also deal with the geographical imbalance of health services following the equity principle. Such a comprehensive approach is not mentioned in this key issue. Health professionals at all levels and field officers working at local level also commented here that participation and public awareness were important to improve quality in the private sector. According to a health professionals at district level *" there are rules and regulations, however, in practice, there is no governmental control on the manufacture, sale, distribution, efficacy and quality of drugs particularly in the private sector. Furthermore, practitioners in the private sector particularly quacks (traditional healers) hardly care for the standardized procedures, rules and regulations".* A representative of a

professional organization added in his interview *"traditional healers and unqualified practitioners prescribe allopathic medicines and advertise their practices by using the terms such as clinic, polyclinic, surgery center, and hospital. They also openly use the prestigious professional titles such as Dr., Professor, and Professor Dr. with their names in advertising their practices".*

The **eighth** key area of the NHP 2001 underlines the importance of mass awareness in public health matters and intends to increase funding for the ongoing health education campaign, training family planning workers and Primary Health Care workers and seminars for the elected members of the local councils. These indeed are basic requirements for participation in health policy processes at all levels. Interviewees particularly representatives of the international organizations, health professionals at provincial and local level and field believed that these steps intended by the government are positive in creating awareness and stimulating participation but no plans are formulated to involve citizen. But they expressed their concerns about the realization of these plans. Among others they stated that government needs to decentralize health system in order to create a space for wider participation. According to a health professional working in an international organization *"government needs to decentralize health system in order to create a space for wider because thinking of wider participation in a highly centralized health system seems a rhetoric not a reality".*

According to interviewees, especially professionals at provincial and district level and international representatives, there is need to involve other health-related departments, organizations, professionals, media, and communities in the health education campaigns and this is lacking in the NHP 2001. An elected representative at district level stated" In creating awareness government need to introduce public health related programs upon TV and should provide free TV sets to community centers and youth centers in the rural areas where people can watch healthy TV programs and films. It can create not only mass awareness but also help in providing a positive recreation to the youth that will certainly keep them away from unhealthy practices such as smoking, drug abuse, crime and violence." As mentioned before, this point is not 'recognized by managers at provincial and district level due to their positions and attitudes that mostly support the governmental view and actions.

The **ninth** key area of the NHP 2001 intends to improve the performance of the drug sector and to ensure the availability, affordability and quality of drugs by initiating several policy interventions. Most of the interviewees at all levels believe the said key area will certainly help in improving the performance of the drug sector in the country. However, to ensure availability, accessibility and quality of drugs there is a need to develop wider participation and collaboration with other sectors, professionals, community and its representatives as expressed by the representatives of the international organizations, professional organizations and all the actors at provincial and district level. According to a representative of a professional organization *"Centralization and lack of wider participation leads to corruption in the health sector. Consequently health services suffer from quality and people do not trust governmental health services". Civil servants at federal level oppose wider participation because they believe that it may weaken the strength of the administrative and legal measures that are taken to improve the quality of drug. Furthermore, they believe that wider participation may increase the chances of corruption in the drug sector.*

The **tenth** key area of the policy states to build the capacity of the Ministry of Health by creating a research unit in the ministry, expanding the Health Management Information System (HMIS) in all the districts and initiating a Disease Early Warning System. These plans

may be seen as important prerequisites for quality control and monitoring developments. They improve the health policy infrastructure. Most of the interviewees were aware of these plans and indeed judge these positively. However, health professionals at provincial and district level commented that the planned research unit has been envisaged for medical research and not the public health. They also believe that the planned expansion of the HMIS has been narrowly focused upon the information related to the incidence of infectious diseases and their clinical treatment based upon biomedicine and not the public health. A health professional working at provincial level disclosed, “ *The research unit and HMIS do not provide reliable data and information regarding health problems such as HIV/AIDS, accidents, road traffic accidents and drug abuse in the country. Furthermore, disease early warning system in districts has still not been introduced”.*

Discussion

Policy makers in Pakistan have stated that the new health policy, formulated in NHP 2001, provides an overall national vision for the Health Sector based on HFA approach. Indeed , within various key areas the principles of equity (like 2, 4, 5, 6), participation (like 1, 8) and collaboration (like 3, 7, 9) are directly formulated or indirectly present (or might be expected to be an underlying consideration). But most interviewees did not share such a view. Many of them believed that the NHP 2001 does not meet the principles of new public health and HFA. The need to develop a comprehensive health policy has been argued at various international conferences upon new public health and health promotion. For example, the Ottawa Charter (1986), passed at the first international conference upon health promotion, identifies five essential actions areas of health promotion: to build healthy public policy, to create supportive environments, to develop personal skills, to strengthen community action, and to reorient health services (WHO, 1986). These five action areas are mutually interdependent in preventing disease and promoting health in accordance with HFA mission. However, it is fundamentally a health policy that establishes the basic context that makes the other four possible (de Leeuw, 1989; WHO, 1986). As we have shown in the content analysis and through the interviews, this interdependency is absent in the NHP 2001. The NHP 2001 is a fragmented ten point action plan.

In the NHP 2001 important determinants of health particularly environment and lifestyle have not been explored enough in developing policy interventions. For example, the first key area of NHP 2001 intends to reduce widespread of communicable diseases but does not consider the importance of paying attention to environment and lifestyles in combating disease. Environmental degradation results in various health hazards but the policy neither offers any intervention to address the environmental degradation nor to protect the environment as observed by the interviewees. Similarly, unhealthy lifestyle that is a source of many health problems has been ignored by the policy document. The policymakers have neglected (or only paid scant attention to) the important principles of HFA such as equity, participation and collaboration.

The second, fourth, fifth and sixth key areas of the policy intend to address the problems of inadequacies and inequalities seem to address equity, but its meaning is restricted. According to HFA, equity refers not only to the provision of material resources on equitable basis but also assuring enough power and status to the people (Conley, 2001; WHO, 1997a; 1997b; 1997c). Furthermore, HFA advocates for social and economic equity as means of promoting

health because social, economic, regional and professional inequalities reflect health inequalities (Conley, 2001; WHO, 1997a; 1997b). The NHP 2001 has considered a limited view of equity and has interpreted thorough the availability of health care services on the basis of biomedical model of health rather than HFA.

The HFA strategy demands participation in order to make the health programs, strategies and services to meet the needs of the population, to be more effective and health as well as development policies more sustained. The NHP 2001 has not considered wider participation in its plans, as was stated by many interviewees. It is understandable that respondents at district level frequently give such comments, because they experience a large gap between the policy document intentions and daily practice. The policy has also not paid attention to the importance of decentralizing the existing health system in order to create a space for participation from health organizations, NGOs, professional groups, the media and the community. The NHP 2001 offered only limited participation in specific health programs as discussed earlier.

NHP 2001 has not offered any intervention to develop collaboration in order to ensure effective linkages between ministries, other sectors, groups, organizations, actors, and communities to achieve the comprehensive goals of the HFA. This problem is strangely not recognized frequently at provincial level. An explanation may be that especially managers/civil servants at provincial level feel themselves at a higher hierarchical position and status that is only answerable to higher level and not necessarily so concerned with local level. In the absence of a collaborative system, the Ministry of Health can neither develop a partnership nor cooperate with other sectors and agencies in combating health problems and promoting health. In combating new health problems such as HIV/AIDS, cancer, diabetes, accidents, crime and violence, drug addiction (including tobacco use), suicide and mental health, the Ministry of Health needs to develop collaboration with other sectors. For example, the problem of HIV/AIDS can be addressed more affectively by involving the media, health-related ministries and departments, non-governmental organizations (NGOs), and communities.

Collaboration can also address the problem of gender discrimination and violence against women. A majority of women in the country have no access to sanitation and other basic facilities (HRCP, 2004; Khan, et al, 2005b). There are repeated incidences of various forms of violence against women in the country such as domestic violence, stove burning, sexual harassment, rape, and child sexual abuse as stated by the interviewees. Denial of sexual and reproductive rights causes thousands of deaths, illness and disability every year in Pakistan (HRCP, 2004; Khan, et al, 2005b). It is important to collaborate with the other sectors such as education, law and justice and ministry of interior in addressing not only the problem of gender discrimination and violence against women but also to combat drug abuse, control use of tobacco and accidents.

Disease prevention and health promotion according to HFA demands production of an effective human resource for health with an appropriate training of public health and health promotion. Although the NHP 2001 intends to improve the infrastructure concerning information (key area 10) and quality control (key areas 7 and 9) no investments are proposed to build partnerships by working across multidisciplinary boundaries and by involving stakeholders from health related sectors in order to improve health and life conditions. Pakistan lacks opportunities for public health training to upgrade the knowledge and skill of the human resource for health in accordance with HFA mission.

We conclude that the content of NHP 2001 does not mirror in many respects the comprehensive mission of HFA in order to assure quality, to prevent disease and to promote health. The NHP 2001 still tends to emphasize curative care and institutional facilities for the delivery of health care services. It is recommended that the health authorities in Pakistan reformulate the national health policy by paying attention not only to delivery of health care services but also other determinants of health particularly environment and lifestyle by following the principles of HFA with clear targets, concrete plans and feasible implementation instruments. Such a comprehensive health policy considering all-important determinants of health in accordance with HFA needs to follow a multi-sectoral approach by ensuring wider participation and collaboration with all health related actors, sectors, NGOs and communities in preventing disease and promoting health. Collaboration between the Ministry of Health and the Ministries of Housing and Works in executing their tenders and assuring the availability of safe water and sanitation is particularly recommended for disease prevention and health promotion. It is also recommended to develop the collaboration between the Ministry of Health and the Ministry of Local Government to build basic health units, rural health centers and handing them over to the Ministry of Health for their functioning within the specific time frame without any delay. The Ministry of Health and the Ministry of Interior Affairs together may address the causes of risky behaviors such as smoking, drug abuse, negligent driving, low quality of roads and faulty vehicles by collecting important data, analyzing factors and finding ways to control smoking, drug abuse and number of accidents. Such collaboration and a wider participation is important for the programs of disease prevention and health promotion. Participation from communities, their leaders and religious groups is particularly recommended to build awareness, develop healthy lifestyles and to protect environment in accordance with the principles of HFA.

References

Abbasi, K. (1999). The World Bank and World Health: Focus on South Asia II- India and Pakistan. British Medical Journal. 318:1132-1135.
Abbasi, K. (1999). The World Bank and World Health: Focus on South Asia II- India and Pakistan. British Medical Journal. 318:1132-1135.
Amhof, R.L. (2002).Health Promotion in the economically developed world. A systematic review of health promotion definitions, theories, and interventions in the United States, Canada, Europe and Australia (review).US Department of Health and Human Services, Center for Disease Control and Prevention (CDG).

Baum, F. (2003).The New Public Health. Oxford. Oxford University Press.

Brener, P. (1979). Mortality and the National Economy. *Lancet.* II: 568-573.

Byrant, T. (2002). Role of knowledge in public health and health promotion policy change. *Health Promotion International.*17(1):89-98.

Campbell, C., & Mzaidume, Z. (2001). Grassroots Participation, Peer Education and HIV Prevention by Sex Workers in South Africa. American Journal of Public Health. 91(12): 1978-1986.

Cockburn, L., & Trentham, B. (2002). Participatory Action Research: Integrating Community Occupational Therapy Practice and Research. Canadian Journal of Occupational Therapy. 69(1):20-30.

Conley, J.F. (2001). Of Professional Policy and Equity. Journal of The California Dental Association. 29(12):801-2.

de Leeuw, E. (1989).The Sane Revolution. Health Promotion: Backgrounds, Scope, Prospects. Assen Van Gorcum.

de Leeuw E. (1989b). Health Policy: An Exploratory Inquiry into the Development of Policy for the New Public Health in the Netherlands. Maastricht. Savannah-Datawyse.

de Leeuw E. (2000). Beyond Community Action: Communication Arrangements and Policy Networks. In Poland BD, Green LW, Rootman I. (Eds.). Settings for Health Promotion: Linking Theory and Practice. Thousand Oaks. Sage. 287-300.

Doyal, L., & Pennel, I. (1979). The Political Economy of Health. London. Pluto Press.

Gwatkin, D.R. (2001). The Need for Equity-Oriented Health Sector Reforms. International Journal of Epidemiology. 30(4):720-3.

Hanif, M. (1992). Sex and Pakistani Society. Newsline. (Sept): 22-31.

HRCP (2004). The State of Human Rights in 2003. Lahore. Human Rights Commission of Pakistan (HRCP).

HS90. (1990). The Swedish health services in the 1990s. Government Printing Office Stockholm.

Illich, I. (1975). Medical Nemesis: The Expropriation of Health. London. Calders & Boyars.

Illiyas, M., Burney, M.I., & Taqi, L. (1997). Environmental Hazards. In Illiyas, M. (Ed.). Community Medicine and Public Health. Karachi. Time Traders. 234-257.

Khan, M.M, Van den Heuvel, W., & Van Dijk JP. (2006). Describing Behavioral and Environmental Health Problems in relation to Policy Interventions in Pakistan. Submitted *Health Policy*.

Khan, M.M, Van Dijk J.P, & Van den Heuvel, W. (2005). The Impact of Economic and Socio-cultural Context upon Health Policy Outcome in Pakistan. *Eastern Mediterranean Health Journal,* accepted pending revisions.

Khan, O.A., & Hyder, A.A. (2001). Responses to an Emerging Threat: HIV/AIDS Policy in Pakistan. Health Policy and Planning. 16(2): 214-218.

McDonald JJ, Primary Health Care. London. Earthscan, 1992.

Minkler, M. (1999). Community Organizing and Community Building for Health. New Brunswick. Rutgers University Press.

Moukhyer, M.E.E. (2005). Health profile of Sudanese adolescents. Maastricht. Universitaire Pers, 2005.

Murdock, J.M., & Gluckman J.L. (2001). African-American and White Head and Neck Carcinoma Patients in a University Medical Center Setting. Are Treatments provided and are Outcomes Similar or Disparate? Cancer. 91(1) Supp.:279-83.

Naidoo J, & Wills J. (2000). Health Promotion: Foundations for Practice. London. Bailliere Tindall.

Pakistan (2005). Economic Survey 2004-2005. Islamabad. Government of Pakistan, Finance Division, Economic Adviser's Wing.

Pakistan (1990). National Health Policy 1990. The Way Forward: Agenda for Health Sector Reform. Islamabad. Government of Pakistan, Ministry of Health.

Pakistan (1997). National Health Policy 1997. The Way Forward: Agenda for Health Sector Reform. Islamabad. Government of Pakistan, Ministry of Health.

Pakistan (2001). National Health Policy 2001, The Way Forward: Agenda for Health Sector Reform. Islamabad. Government of Pakistan, Ministry of Health.
Pakistan (1998). Report on Social Action Program for Pakistan Development Forum 1998-1999. Islamabad. Government of Pakistan, Planning Commission.
Starfield, B. (2001). Improving Equity in Health: a Research Agenda. Health Services Planning, Administration Evaluation. 31(3):545-566.
WHO (1986a). Ottawa Charter For Health Promotion, 1986. Geneva. World Health Organization.
WHO (1986b). Health Promotion. Concepts and Principles in Action. A Policy Framework. Copenhagen. World Health Organization.
WHO (2000). Fifth Global Conference for Health Promotion Health Promotion: Bridging The Equity Gap Mexico 5 - 9 June 2000. World Health Organization.
WHO (1997). Fourth International Conference on Health Promotion (4ICHP) "New Partners for a New Era - Leading Health Promotion into the 21st Century", Jakarta, Indonesia, 21-25 July. World Health Organization.
WHO (1997). Health For All. HFA Policy. Geneva. World Health Organization.
WHO (1997). Inter-sectoral Action for Health: A Cornerstone for Health-for-All in the Twenty-first Century. Report of the International Conference, 20-23 April, 1997 Halifax, Nova Scotia, Canada. Geneva. World Health Organization.
WHO (1998). Health for All Renewal: Building Sustainable Health Systems-From Policy to Action. Geneva. World Health Organization.
World Bank (2005). World Bank Development Report 2005. Oxford. Oxford University Press.