Evidence for Policy in Iran

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Introduction

It is a well-known fact that in an ideal world; the most effective health intervention for every condition would be known, every health manager would know the most effective intervention for each condition, and every health manager would practice the most effective interventions that he/she knows. On the other hand, in the real world; much of what should be known is not known, much that is known, is not known by most health managers, and health managers often fail to practice what they know to be the most effective form of health intervention.

Whereas health ministries and the health sector have a responsibility to use the best available evidence to inform planning and decision-making, yet valid and/or reliable information is often not available and with regard to available data, gaps exist in both quality and quantity. Some assessment is done on a periodic basis using indicators, surveys and sentinel reporting. This means that decision-making is often not founded on evidence-based policies and information, and there is a need to learn lessons and build policy-making capacities to ensure that the resulting data are analyzed appropriately and used to inform decision-making.

To this end, countries need to strengthen national capabilities in the area of data collection and analysis by improving routine information systems and by promoting population-based surveys. All ministries of health must establish units for policy analysis and formulation, and build their capacities in the use of analytical tools, burden of disease (BOD) estimates, national health accounts, and cost effectiveness analysis (CEA) studies, for assessing the performance of health system and intelligent use of information for informed decision-making.

Evidence for policy

In 1972, Iran in collaboration with the WHO, undertook a research project in West Azerbaijan province. Among the objectives of this project was the concept of establishing health houses and training auxiliary health workers (Behvarz) which was taken into consideration in developing the country’s Primary Health Care (PHC) network. Following the revolution, the Ministry of Health attempted to design the health system for a more equitable allocation of health resources based on PHC.

A survey on 10% of the urban and rural population in 1984 showed that over 42% of deaths occurred in under 5 yr of age and out of these about 80% occurred in under 1 yr of age, out of which approximately one-sixth were due to vaccine-preventable diseases; almost one-sixth were due to infectious diseases, which in most cases are preventable; and nearly one-fifth occurred as a result of diarrheal diseases.

The survey revealed that altogether more than 52% of deaths were due to causes that could easily be prevented. In other words the study revealed that the death of over half of our children was due to diseases which could basically be overcome by an understanding of the practical approach for their control, by educating families and creating awareness, and by training of peripheral health workers capable of establishing close links with the majority of people. This marked the beginning of efforts towards the establishment of the PHC network in 1985 which was ratified by the parliament with a budget equivalent to US$36 million in the first year of implementation. On the basis of the outcome of the study the basic policies were declared as follows:

Priority of prevention as a long-term investment.

Priority of rural and underprivileged areas in resource allocation.

Priority of ambulatory services to hospitalized services.

Priority of general health care to specialized health care.

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The country’s average annual population growth rate in two consecutive censuses of 1976 and 1986 was reported to be 2.7% and 3.2% respectively, showing an increase of 0.5%. This increase was brought about by a dramatic decrease in mortality, especially between 1981 and 1986, a high birth rate and the influx of Afghans, Iraqis and other refugees. In the first ten years after the revolution, the population growth rate was unprecedentedly high. In 1987, the government decided to take effective steps to reduce the rapid population growth rate. By the decision of the cabinet, the fertility regulation council, with the membership of all ministries and organizations involved in implementation of the fertility regulation policies was formed. In an attempt to promote fertility regulation policy, the parliament also enacted a family planning law. Since 1989, the Islamic Republic of Iran has adopted and implemented appropriate and effective population policies. The important components of these programmes were general education and refresher courses for physicians, experts and health personnel; integration of family planning interventions into overall health services; and full support by the parliament and the government. The implementation of the above policies, along with free and expanded provision of various contraceptives has led to significant achievements. In the Fourth National Five-Year Development Plan (2004-2008), the continuation of population control policy is emphasized. As a result of intensive efforts for development of primary health care services and strengthening of EPI, CDD and ARI programmes, both morbidity and mortality from vaccine preventable infectious diseases, diarrheal diseases and acute respiratory infections are drastically reduced, neonatal tetanus has been eliminated and poliomyelitis is eradicated.

**Health Transition**

During the past two decades, for a variety of reasons such as socioeconomic development, industrialization, rapid urbanization, change in nutritional habits and lifestyle, and an increased access to health services, the “Health Pattern” in Iran has changed significantly. On one hand, most of the endemic infectious diseases have been controlled, eliminated or even eradicated. On the other hand, due to decreased mortality, increased life expectancy and an increasing elderly population, non-communicable diseases have merged as an important health problem; consequently, the country is being faced with a double- burden of diseases.

Based on the available information, the three leading causes of death are cardiovascular diseases, injuries and cancer. Leukemia, stomach cancer and lung cancer are the main three killers among cancer deaths. Road traffic accidents per ten thousand vehicles are fifteen times more than industrialized countries, and take their toll on 20,000 lives every year.

Based on the available evidence regarding the problem of noncommunicable diseases, the government has given high priority to the prevention and control of cardiovascular diseases, cancer, road traffic accidents, mental disorders and metabolic diseases including diabetes.

The Fourth Five-Year Development Plan provides strategic directions on evidence-based interventions that are likely to have the highest impact on the above mentioned health problems. The MOH has established an epidemiological and behavioral surveillance system in order to inform planning and priority-setting, and combat noncommunicable diseases, mental health disorders, injuries and associated risk factors such as tobacco, alcohol, unhealthy diet, and lack of physical activity. The model for prevention and control of non-communicable diseases includes the identification of risk factors, early detection of cases, delivery of comprehensive and long-term care, and more active participation of all members of health team and the community.

**References**