

Country Cooperation Strategy for WHO and Jordan

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ABBREVIATIONS

BDN/QOL	Basic development needs/quality of life
BMI	Body mass index
CBR	Community based rehabilitation
CCA	Common country assessment
CCS	Country cooperation strategy
CIP	Civil health insurance
CME	Continuing medical education
CMH	Commission on Macroeconomics and Health
CSP	Country strategy paper
DPT	Diphtheria, pertussis, tetanus
DTPS	District team problem-solving
EC	European Commission
ECHO	European Commission Humanitarian Aid Office
EDL	Essential drug list
EMRO	WHO Regional Office for the Eastern Mediterranean
EU	European Union
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GNP	Gross national product
GDP	Gross domestic product
GPN	Global private network
HDI	Human development index
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HRD	Human resources development
ICD	International classification of diseases
IMCI	Integrated management of childhood illnesses
IMF	International Monetary Fund
IUDs	Intrauterine devices
JAFS	Jordanian Annual Fertility Survey
JD	Jordanian dinar
JPFHS	Jordan Population and Family Health Survey
JPRM	Joint programme review mission
JUH	Jordan University Hospital
MEDA	Euro-Mediterranean Partnership (Barcelona agreement)
MENA	Middle East and North Africa
MoH	Ministry of Health
NHA	National health accounts
NCD	Noncommunicable diseases
NGO	Nongovernmental organization
PHC	Primary health care
PHCI	Primary Health Care Initiatives (USAID funded)
PHR	Partnerships for Health Reform (USAID funded)
PRS	Poverty reduction strategy
PSET	Plan for social and economic transformation
R&D	Research and development
RMS	Royal Medical Services
SSA	Special service agreement
SDPs	MoH service delivery points
TCDC	Technical cooperation between developing countries

UNDAF	United Nations development assistance framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USAID	United States Agency for International Development
WB	The World Bank
WHO	World Health Organization
WHO-CC	World Health Organization collaborating centre
WHR	World health report

EXECUTIVE SUMMARY

Despite the achievements in health reflected in the main indicators, Jordan is faced with important challenges related to the double burden of diseases, ageing population, high public expectations, increasing cost of health care, perceived inequities in health care financing and the need to strengthen the institutional capacity of the Ministry of Health.

The socioeconomic and political environment puts additional strains on the health systems as the perspectives for sustained economic development are often challenged by the geopolitical situation and the increasing level of poverty. The various partners in health development, including bilateral and multilateral organizations from within and outside the UN system, are striving to supplement the efforts of the government in health development. However their contribution is reported to be less than 8 % of total health spending.

Close collaboration has traditionally existed between the Government of Jordan and WHO. Planning for the WHO collaborative programmes takes place every two years through the joint programme review and planning mission (JPRM) exercise. However, both the Government of Jordan and WHO have recently expressed the need to intensify such collaboration. In order to strengthen WHO's contribution to health development in Jordan, an exercise to develop a mid-term strategy (Country Cooperation Strategy) has been conducted.

The WHO's cooperation with Jordan will focus on providing technical assistance in the following seven strategic directions:

- 1) Supporting appropriate policies and interventions aimed at improving the social, environmental and nutritional determinants of health, including poverty reduction strategies, promotion of healthy lifestyles as well as food safety.
- 2) Promoting health throughout the life cycle.
- 3) Strengthening disease control strategies and programmes and developing new strategies to cope with the rising burden of NCDs and related emerging challenges.
- 4) Reducing death and disabilities related to accidents and injuries including occupational health and safety.
- 5) Strengthening institutional capabilities of the MoH through the improvement of the four main functions of the health system.
- 6) Improving intersectoral collaboration, community empowerment and participation for health development.
- 7) Enhancing the role of health research in policy development and service improvement.

The implementation of the planned Country Cooperation Strategy has implications for WHO at the country, regional and global levels in order to provide the necessary technical and financial support. At the country level, the WHO needs to be strengthened to better respond to

the increasing demands for policy advice, technical cooperation and advocacy. This document also addresses the immediate requirements for expanding WHO's country presence and its contribution to health development in Jordan.

1. INTRODUCTION

The WHO Country Cooperation Strategy in Jordan aims at the following objectives:

- Developing a strategic framework for intensifying WHO's technical collaboration and to support biennial planning by streamlining the work of the joint programme review and planning mission (JPRM)
- Ensuring that technical cooperation is in line with the country priorities and WHO's policies and strategies
- Helping to harmonize the inputs of various partners in health development taking into account WHO's comparative advantages
- Identifying ways and means of supporting implementation through strengthening WHO presence in Jordan.

The exercise was carried out by the WHO team (the WHO Representative in Jordan, two representatives from EMRO, one representative from HQ) working with senior officials in the MoH and other ministries as well as interacting with the main partners in health development within and outside the UN system.

The CCS exercise coincided with the launching of a series of activities led by WHO and aimed at developing a strategy for health development in Jordan. The situation analysis report prepared by WHO and the discussion and exchange of views during the two-day consultation 17–18 November 2002, helped the CCS team to better capture the main priorities and the broad elements of response to address them. Data appearing in this strategy on the health situation in Jordan and health development issues were extracted from the above mentioned report.¹

2. GOVERNMENT AND PEOPLE: HEALTH AND DEVELOPMENT CHALLENGES

2.1 Government and people

Jordan is an Arab country which administratively consists of twelve governorates. The estimated midyear population of Jordan in 2001 was 5.182 million, with an overall population density of 56.4 per square kilometre, and the great majority of the population (78.7%) living in urban areas. The declining mortality rate and the high total fertility rate have contributed to overall population growth that averaged 3.3% per year from 1992–1998. The population growth rate for 2001 was 2.8%. Based on 2001 figures, 39.6% of the population falls under 15 years, 57.7% between 15 and 64 years and 2.7% over 65 years. Life expectancy is 71 years for females and 68.8 years for males. The total fertility rate is relatively high, though it has declined steadily in recent years to 3.5 in 2001.

¹ WHO/MoH. *Health in Jordan*. Unpublished report, November 2002.

Table 1. Demographic and socioeconomic indicators

Demographic indicators	Year	Value
Average household size	2000	5.8
Average life expectancy	2001	69.0
Total fertility rate	2001	3.5
Crude birth rate	2001	28.0
Crude death rate	2001	5.0
Socioeconomic indicators	Year	Value
Adult literacy rate (%): both sexes	2001	89.0
Males	2001	94.4
Females	2001	83.8
Per capita GDP (Jordanian Dinars)	2001	1207.8

Source: Ministry of Health and Department of Statistics, 2002

2.2 Economic and social development

Jordan is a small lower-middle income country with limited natural resources and scarce fresh water supplies (one of the world's 10 most water stressed countries), with only 4% arable land. The per capita GDP of Jordan was JD 1207.8, or US\$ 1690, in 2001. The Government of Jordan has identified poverty and unemployment as two of its most important challenges. According to the poverty line used, between 15% and more than 30% of the population falls below that line. The number of poor grew from about 1 million in 1992 to about 1.4 million in 1997. The collapse of oil prices and subsequent drop in worker remittances from neighbouring oil-producing countries has also contributed to the sharp increase of poverty in the 1990s. Poverty is significantly higher in rural areas (37%) as compared to urban areas (29%). However, the number of urban poor is three times that of rural poor. Unemployment, the second most important challenge, is estimated at up to 15% and reaches 26% if underemployment is included.

Economic growth in Jordan has been erratic over the past decades. Despite a short-term increase in real growth rate of 8.2% registered in 1990–1995 (due to Jordanians returning from the Gulf), since the mid-1990s economic growth has been declining. The GDP growth rate reported its lowest value (1%) in 1996. The GDP of Jordan in 2001 was JD 6.3 billion (US\$ 8.8 billion). The country's external debt burden as a percentage of the GDP was 84.2%. A Memorandum on Economic and Financial Policies prepared by the IMF, however, states that Jordan's economic performance in 2001 was characterized by stronger than expected growth, low inflation and a significant reduction in net public debt in relation to GDP. The real GDP grew by 4.2% in 2001.

The medium term macroeconomic framework for 2002 emphasizes the need for structural reforms and fostering HRD to promote private investment and employment generation, along with emphasis on education and health development and poverty alleviation. The cost of the Plan for Social and Economic Transformation (PSET) is projected to be up to JD 275 million annually for the next four years, on top of the existing allocation for social sector programmes in the budget. The government is seeking multi-year financing from donors in order to ensure achievement of the medium-term objectives.

The *Human Development Report 2000* classified Jordan as 94 out of 174 countries. Jordan is one of only two Arab countries whose HDI ranking is higher than its per capita income ranking, a fact which indicates that Jordan has invested its scarce resources relatively efficiently in building human capabilities. However, these indices reflect broad gender equality in terms of health and education (human capabilities) but significant gender inequalities in terms of income (human opportunities). Only 14% of women are employed, and their earnings are lower than men employed in the same sectors with the same level of education.

2.3 Health profile

2.3.1 Health goals attainment and system performance assessment

The *World Health Report 2000* ranked 191 countries according to health goals attainment and health system performance. Table 2 shows Jordan's overall achievement for the three main goals (health, responsiveness and fair financing) as well as the ranking.

Table 2. Goal attainment and health system performance in Jordan

Goal	Ranking	
Overall goal attainment ^a	84	
Overall system performance assessment ^b	83	
Objective	Level	Distribution
Health ^c	101	83
Responsiveness ^d	84–86	53–57
Fair financing ^e	-	49–50

Source: *World health report 2000*

^a Determines what is achieved with respect to the three objectives of good health, responsiveness and fair financial contribution.

^b Compares the attainment with what the health system should be able to accomplish – that is, the best that could be achieved with the same resources.

^c Health is the defining objective of the health system. This means making the health status of the entire population as good as possible over the people's whole life cycle, taking account of both premature mortality and disability.

^d Responsiveness is a measure of how the system performs relative to the non-health aspects, meeting or not meeting a population's expectations of how it should be treated by providers of prevention, care or non-personal services.

^e Fair financing in health systems means that the risks each household faces due to the cost of the health system are distributed according to the ability to pay rather than the risk of illness: a fairly financed system ensures financial protection for everyone.

2.3.2 Mortality trends

Major achievements have been made in the health field during the last few decades. The 2001 Jordan Annual Fertility Survey (JAFS) estimated the infant mortality rate (IMR) at 33 per 1000 live births in 1998 and under-5 mortality at 40 per 1000 live births. The urban IMR was found higher than rural (33.7 vs 30 per 1000 live births). The maternal mortality rate decreased to approximately 38 per 100 000 live births in 2000. During the same period, coverage of antenatal care expanded to include more than 90% of pregnant women, and 92% of births were attended by trained health personnel.

Death registration is not universal and death certification by cause is not accurate. Cardiovascular diseases, according to death certificates, accounted for an average of 42% for all deaths in 1997. Cancer ranked second, accounting for 13% of total deaths, while accidents ranked third, responsible for 10.5% of total deaths.

2.3.3 Morbidity trends

Chronic and noncommunicable diseases (NCD)

The major cardiovascular diseases are hypertension, coronary heart disease and stroke, which have become the leading cause of mortality, and along with cancer are responsible for more than half of all deaths. According to the 1996 National Morbidity Study, the prevalence of hypertension was estimated to be 32% among those aged 25 years and above, of whom 89% had uncontrolled hypertension. The prevalence of diabetes mellitus is 14%, and impaired glucose tolerance has been detected in an additional 9.8% of the population.

The determinants of noncommunicable diseases and levels of risk factors have risen. More than 40% of adult men and 5%–10% of women smoke regularly. More alarming is the outcome of a WHO/UNICEF survey that estimated prevalence of smoking among schoolchildren to be 20%. Obesity is emerging as a major problem, and in semi-urban communities, obesity (BMI equal to or more than 30) has been found to affect 60% of females and 33% of males aged 25 years and over. The same study showed prevalence of hypercholesterolaemia and hypertriglyceridaemia at 23% and 23.8%, respectively.

Table 3. Health status indicators for Jordan

Health status indicators	Year	Value
Newborns with birth weight 2500g or more (%)	2000	92.7
Children with acceptable weight for age (%)	1997	95
Infant mortality rate (per 1000 live births)	2000	31.3
Probability of dying before 5th birthday (per 1000 live births)	1999	33.0
Maternal mortality ratio (per100.000 live births)	2000	38
Number of reported new cases of:	Year	Value
Polio	2000	0
Malaria	2000	158
Total tuberculosis	2000	265
Pulmonary tuberculosis	2000	152
HIV/AIDS	2000	14
Measles	2000	32

Source: MoH

According to the National Cancer Registry, 3796 new cases of cancer were registered in 1999, of which 3142 (82.8%) were Jordanians. About 8% of cancers occurred before the age of 20 and 38% after the age of 60. In males the commonest cancers were lung (11.2%), bladder (9.4%), colo-rectum (8.7%) and leukaemia (7.7%). In females, breast cancer is most common (32.4%), followed by colo-rectum (9.7%) and leukaemia (5.9%).

MoH statistics for 1997 reported 39 005 road traffic accidents causing 577 deaths and 16 259 injuries. Recent data reported by the Jordanian Traffic Institute indicate that deaths from road traffic accidents increased from 686 in 2000 to 783 in 2001. Occupational accidents numbered 15 619, causing an estimated 97 522 work days lost.

Communicable diseases

Communicable diseases have largely been controlled in Jordan; however, diarrhoeal diseases, acute respiratory infections and hepatitis are still leading conditions reported from health facilities. There is lack of information on the prevalence of hepatitis B and C virus infections. The trend of vaccine-preventable diseases has shown a remarkable decline in the last 20 years. No cases of polio have been reported for the last 7 years. Reasons for the remarkable decline in the number of vaccine-preventable diseases include the high immunization rates among children, which are 97% for poliovaccine and DPT, as well as improved surveillance.

The incidence of pulmonary tuberculosis declined from 7.3 per 100 000 population in 1993 to 3.4 per 100 000 population in 2001. All malaria cases currently detected in Jordan are imported. Jordan is considered to be a low prevalence country for HIV/AIDS. The estimated prevalence is less than 0.02%. As at the end of December 2001, the total cumulative number of all reported HIV/AIDS cases in Jordan was 294 out of which 123 were among Jordanians. In 72% of cases, the infection was acquired outside Jordan. More than 50% of all detected cases were due to sexual contacts.

Nutrition

Based on a national survey, the prevalence of anaemia among women aged 15–49 years has been estimated at 28.6%. A flour fortification programme (with iron and folic acid) has been initiated in 2002 in collaboration with WHO and UNICEF. The prevalence of iodine deficiency among schoolchildren was estimated to be 37.7% in 1994. This has been successfully addressed through the universal salt iodization programme. An impact evaluation study was conducted in 2000, showing improvements in total goitre rate and median iodine concentration in urine. A programme of vitamin A supplementation to schoolchildren has been launched in high-risk areas.

According to the 1996 Living Conditions Survey, malnutrition is manifested mainly in the form of low height for age (9%), followed by low weight for age (4%), and low weight for height (1.5%). Given the high prevalence of obesity it needs to be addressed as a nutritional disorder.

The Ministry of Health and the Ministry of Agriculture have recently initiated, in collaboration with WHO, a project to develop a comprehensive food and nutrition policy for Jordan. As an initial phase of the project, a situation analysis report is being developed.

Reproductive health

The maternal mortality rate reported by the MoH is 38 per 100 000 live births. Important causes of perinatal morbidity include caesarean section, hypertension of pregnancy and toxemia, and antepartum haemorrhage.

Currently, most of the safe motherhood services are provided at the PHC centres. Antenatal care is offered at all PHC centres. It is estimated that 95% of pregnant women had received at least one antenatal check up during pregnancy and that 86.2% had received four visits or more. Over 90% of deliveries occur at health facilities, out of which 65% are assisted by a physician and 32% by a nurse/trained midwife.

Family planning services are offered by the public sector, UNRWA, Jordanian Association for Family Planning and Protection, and Arab Women's Organization. Pills and condoms are offered in all MoH service delivery points (SDPs). Intrauterine devices (IUDs) are offered in only 32.6% of the SDPs operating within the reproductive health sub-programme, often due to lack of trained professional staff. The 1997, JPFHS results indicated that 58% of married couples were using a method of contraception (39.8% modern or 18% traditional); however, the discontinuation rate was high as 24%.

Environmental health

The fresh water supplies of Jordan are scarce and strategically critical. The average share is 156 litres/citizen/day, one of the lowest in the Middle East. Water scarcity is exacerbated by pollution, which also constitutes a serious threat to health. Public piped water supplies are available to 95% of the population. Water is provided intermittently with supply frequency of once or twice a week, each of 12–24 hours duration. The quality of the supply suffers from interruptions and from the inadequate state of the distribution systems.

Despite considerable efforts made by the government, data are still insufficient regarding the quantities, types, and current practices of handling hazardous wastes. Health care waste in Jordan is not being stored and transported, and a significant proportion is currently being disposed of with the municipal solid waste in open or insanitary landfills, posing potential health hazards to communities living nearby.

2.4 Health policies and strategies

2.4.1 Health care system

The health system in Jordan includes the Ministry of Health, Royal Medical Services, public university hospitals, the private sector and the international and charitable sector, including UNRWA. The MoH has 23 hospitals with 3229 beds (37%). PHC services are mainly delivered through an extensive PHC network, comprising 47 comprehensive health

centres, 333 primary health care centres, 265 village clinics and 345 MCH centres. The Royal Medical Services (RMS) mainly provides secondary and tertiary care services. It has 10 hospitals with 1791 beds (22%). RMS is responsible for providing health services and a comprehensive medical insurance to military and security personnel. RMS also provides care to uninsured patients referred from MoH and the private sector. Jordan University Hospital (JUH) and the recently commissioned King Abdullah Hospital (University of Science and Technology, Irbid) provide secondary and tertiary care services. JUH accounts for 6% of hospital beds. The private sector generally provides clinical services at the primary, secondary and tertiary care levels. It has 52 hospitals with 3212 beds (37%) and about 2600 private clinics of general practice and specialties.

UNRWA provides health care to Palestinian refugees. UNRWA's overall health policy focuses on the direct provision of primary health services to these refugees.

2.4.2 Primary health care

The MoH operates an extensive primary health care network, with about 2.2 centres per 10 000 population and with an average patient travel time to the nearest centre of 30 minutes. The private sector accounts for nearly 40% of all initial patient contacts. Private practice is mainly confined to urban areas and caters to better off Jordanians who can afford private sector fees. PHC centres are also responsible for public health activities not directly related to patient care, which cover health education, water safety, sanitation, food quality control and pest control. These activities tend to be both overstaffed and poorly managed, as physicians are not trained to oversee them.

The Primary Health Care Initiatives (PHCI) studied costs of primary care services in 2001. The cost of primary health care facilities in 1999 amounted to JD 42.3 million. The share of personnel cost was 54% of the recurrent costs, followed by clinical supplies (24%) and drugs (20%). The average cost per visit was JD 4.5. Cost per visit to the general practitioner was JD 3.1. Prenatal/postnatal visits cost JD 14.7. Primary care centres cost JD 4.0 per visit compared to JD 5.7 for comprehensive health centres and JD 6.3 for village health centres. Strengthening referral systems, adopting appointment systems, reconsidering the expansion of village health centres, introducing a cost conscious culture in the health system and among health professionals were some of the recommendations of the study.

Table 4. PHC coverage indicators in Jordan

PHC coverage indicators (%)	Year	Value
Population with safe drinking water	1998	97
Population with adequate excreta disposal facilities	1998	60
Population with local health care	1999	96
Deliveries attended by trained personnel	1997	92
Women of childbearing age using family planning	1998	56.7
Polio (OPV3) immunization	2000	94
DPT immunization	2000	91
Measles immunization	2000	92
Hepatitis (HBV3) immunization	2000	93
Pregnant women immunized with TT2	2000	23

Source: MoH

2.4.3 Hospital care

During 2000, MoH hospitals provided 842 405 inpatient days of service. The average bed occupancy rate was 74%, although there is significant variation between hospitals. The average length of stay was 3.3 days. The private sector hospitals have a lower occupancy rate (46%), but the average length of stay is shorter.

2.4.4 Health care utilization

A health care utilization and expenditure survey of over 8000 households by the PHR project in 2001 showed that Jordanians made 3.55 outpatient visits per capita annually, with females making more visits than males. About half of outpatient visits occur at MoH facilities, 40% occur at private facilities, while the remaining 11% are divided between RMS, JUH, UNRWA and NGOs. Outpatients visits by the illiterate, the poor, and those living in rural areas are much more likely to occur at MoH facilities. On average, Jordanians pay JD 32.7 per annum on outpatient care, of which 75% represents spending on pharmaceuticals. The same survey revealed that the individuals in the sample used 78 inpatient stays per thousand population annually.

The study suggests that while the health care system appears to function well overall, there are subpopulations at risk of inadequate access to health care and severe financial burden. Thus, strategically, there is a need to develop appropriate mechanisms and interventions for protecting risk groups and disadvantaged populations. In this respect, the high out-of-pocket expenditure on pharmaceuticals requires careful consideration.

2.4.5 Decentralization

In Jordan, the governance of MoH hospitals is highly centralized. Senior level executives at headquarters in Amman decide all significant managerial, personnel, budgetary and procurement matters. It is believed that hospitals may be more efficiently operated and quality of patient care enhanced if greater independence was granted to them. Hospital directors have stated that greater independence over personnel, financial and procurement matters is necessary for achieving the MoH cost containment objectives. At a cost of JD 373 per admission, the MoH hospitals work with considerably lower resources per admission than either the RMS (at JD 510 per admission) or the Jordan University Hospital (at JD 1411 per admission). The MoH hospitals face several constraints that hamper their ability to contribute more effectively to providing proper health care to the poor and the uninsured. In addition to the centralized management practices, the lack of incentives to promote efficiency and quality, and inadequate information and communications systems are contributory factors. Hospitals and their staff lack incentives and the basic information on costs and evidence-based medicine to implement standardized treatment protocols or to operate efficiently.

2.4.6 Human resources for health

Table 5 shows some human resources indicators for Jordan.

Table 5. Human resources indicators

Categories	Year	Value (per 10 000 population)
Physicians	2000	19.0
Dentists	2000	5.7
Pharmacists	2000	8.6
Nurses and midwives (all categories)	2000	27.3

Source: MoH

The MoH, with assistance from WHO, assessed the status of human resources development (HRD) in 1998. The assessment highlighted the need for a long-term policy and plan for the production of a balanced human resource. Despite the existence of procedures for HR management issues such as recruitment, hiring, firing, transfer and promotion, they were not used consistently. There were major gaps in relation to performance management. Job descriptions may have existed but were not up-to-date and were very general. There was no formal continuing education system. Accreditation or re-licensing had not been introduced. In addition, the relationship between health service provision and pre-service training institutions (medical and other health professional schools) was loose.

The MoH has recently established the Academy of Health to respond to the above challenges. A one-year diploma course in community medicine, supported by WHO, has been in operation for about 10 years. More than 120 physicians have graduated, most of whom are still working in MoH institutions. A similar, WHO-supported programme in family medicine has been established. A new M.Sc course on health management has been established in collaboration with WHO. Moreover, training courses have been conducted for different categories of health providers. A MoH fellowship plan has recently been developed. However, many of the gaps mentioned in the MoH/WHO assessment still exist.

2.4.7 Pharmaceuticals

The high cost of drugs is a major constraint. Other major constraints encountered by the drug supply system include its fragmented structure, irrational use of drugs and inadequate drug information services. The MoH in collaboration with the World Bank and WHO developed a national drug policy in 1998 to serve as a framework for future development of the pharmaceutical sector and to upgrade the drug control administration, procurement, registration of drugs and traditional medicines, quality control and post-marketing surveillance and utilization system in addition to strengthening initiatives on the rational use of drugs. Lack of expertise in these areas continues to exist.

2.4.8 Health care financing

Jordan's health delivery system is financed by four principal sources: 45% public funding (general taxation, premiums paid by public firms and contributions to charitable NGOs), 43% household spending (payroll deductions for insurance, user fees, and purchase of pharmaceuticals and other health commodities), 8% donor contribution including UNRWA, and 4% by private firms which pay health insurance premiums for their employees.

The average contribution of public expenditure has declined from 51% in 1990 to 39% in 1997 indicating the rising importance of private sources of health care in Jordan. The Jordan National Health Accounts, March 2000, estimates that in 1998 approximately JD 454 million (US\$ 647 million) was spent on the health care sector, which accounted for 9.12 % of the GDP. Almost 47% of the total funds originated from private sources, 45% from public funds and the remaining 8% were contributed by international donors or other sources. The private sources comprise premiums for private commercial insurance, expenditures incurred by self-insured companies and out-of-pocket expenditure for health care. In the public sector 85% of health expenditure was financed through the government budget and 15% from insurance premiums, prescription fees, doctors fees and donations. Almost 58% of public expenditure on health was spent on curative health care, 27% on preventive services and primary care, 5% on administrative activities, 3% on training and 7% on miscellaneous activities. Expenditure on drugs, at JD159 million, accounted for approximately one-third of total expenditure on health care services and 3.2% of GDP in 1998.

2.4.9 Health insurance

One of the main concerns of the MoH is the efficiency and equity of the current health insurance system. The two major public health insurance programmes are civil health insurance (CIP) administered by the MoH and military health insurance, administered by RMS. Under public law, the Ministry is required to provide subsidized health care to all Jordanian citizens. Thus the MoH provides a safety net for Jordanians who require health services and have no insurance coverage.

Military health insurance is reported to cover about 30% of the population and civil health insurance 21%. The other health insurance programmes are UNRWA (covering only primary health care and very limited hospital care), private sector, employer self-insured funds and Jordan University Hospital. CIP is mandatory for government employees and their dependants. A premium of 3% is deducted from employees total salary with a ceiling of 30 JD per month, and some co-payments. The CIP benefits are unlimited and are completely free to all irrespective of their ability to pay. Military personnel and their dependants pay very limited premiums (ranging between 0.75–1.5 JD per month based on military rank) and receive care in MoH and RMS institutions. Jordan University Hospital covers its employees and dependants as well as university students and serves as a fee for services referral centre for other public programmes and private payers. UNRWA provides care to registered Palestinian refugees. Private health insurance is administered either by private insurance companies or by self-insured firms. A survey conducted by PHR-plus indicates that over 50% of workers in the private sector are without any form of employer-sponsored insurance cover.

Currently, approximately 40% of the population in Jordan is uninsured. This does not necessarily mean, however, that the uninsured totally lack access to health care services. The PHR's health utilization and expenditure survey showed that on average, Jordanians pay JD 33 per annum on outpatient care. Of this average, 75% represents spending on pharmaceuticals. Uninsured Jordanians spend nearly twice as much per annum as the insured. For inpatient care, Jordanians pay JD 8.2 out of pocket per capita per annum. The uninsured pay 3.5 times as much as the insured.

Developing, implementing and evaluating universal coverage policies is a complex and highly political undertaking with major economic implications. Implementing universal coverage in Jordan would require additional research and analysis and improved partnerships between public and private sectors, more demographic and health related actuarial data and improved regulation of the health insurance industry.

2.5 Key issues and main challenges

The overall challenge facing health development is to strengthen the national health system, in order to achieve the overall goals of good health, responsiveness to the expectations of the population and fairness of financial contribution. Progress towards these goals depends on how well the health system carries out its major functions of service provision, resource generation, financing and stewardship. Strengthening the health system is also closely linked to priority strategic directions that comprise: a) reducing the excess mortality of poor and marginalized populations, b) dealing effectively with the leading risk factors; and c) placing health at the centre of the broader development agenda.

Specific challenges facing health development in Jordan were identified in a joint MoH/WHO consultation on health strategies in November 2002.

- Demographic and epidemiological changes representing increase in population, higher life expectancy and changing disease pattern characterized by a progressive increase in the magnitude of noncommunicable diseases.
- Considerable changes in lifestyles favouring the development of determinants and risk factors for chronic diseases, accidents, injuries and substance abuse.
- Lack of a rigorous appraisal (and reorientation) of the current state of human resource development in health.
- Inadequate coordination and partnership between health service providers and educational institutions for health professionals.
- Lack of integration of the priority programmes within primary health care.
- Inefficiencies and inequities observed in the provision and financing of health services.
- The negative impact of poverty on accessibility to quality health care, particularly in view of the high proportion of uninsured people.
- Increasing demands and expectations of the public for effective and accessible health care.
- Rapid advances in technology and rising health care costs and lack of instruments for rational technology selection and assessment.

- Inadequate coordination between the public sector and the rapidly expanding private sector; lack of effective systems for regulation and enforcement of standards of care.
- Environmental health issues, and in particular enhancing the quality and security of public water supplies.
- Lack of health system research as an integral part of national health development.

These challenges highlight the need for change to more efficient, goal-oriented health services which improve the responsiveness of the health sector to the needs of the population.

3. DEVELOPMENT ASSISTANCE: AID FLOWS, INSTRUMENTS AND COORDINATION

3.1 Overall trends in aid flows

According to a recent assessment from the EU, Jordan remains heavily dependent on external assistance, with grants still covering over half of the annual budget deficit and amounting to 3%–5% of GDP.

The European Commission (EC) allocated to Jordan in 1996–2000 under MEDA €269 million, which was the second highest grant allocation among EU Mediterranean partners on a per capita basis. The EU as a whole (EC and Member States) has allocated financial assistance of over €1.5 billion over the period 1996–2000, is the largest donor to Jordan. The EC maintains in Amman its Regional Humanitarian Aid Office for the Middle East (ECHO-European Commission Humanitarian Aid Office) whose mandate covers the sub-region, including Yemen and Iraq. Jordan does not benefit from humanitarian aid, except for the Palestinian refugee camps.

The single most important bilateral donor is the United States of America. Other major development partners to Jordan in different sectors are: Germany with an annual allocation of €32 million, mostly on the water sector; UK with an annual allocation of €7 million, mostly on regulatory reform and law; Italy with €5.2 million in grants during 2000–2002 and €83 million in soft loans. Some grants went to the health sector; France with annual commitments around €23.5 million; other EU Member States such as Sweden, Denmark and the Netherlands. Japan is supporting infrastructure, mainly through soft loans.

Within the UN system, the UNDP's total core contribution is US\$ 2 million over the 5-year period 2003–2007, articulated in three areas of intervention: community development, regional development and decentralization and administrative reform. The World Bank does not have a representative office in Jordan. In its current country assistance strategy, WB is supporting the public sector reform programme for an annual loan of US\$ 120 million in the period 2001–2003.

3.2 Assistance to the health sector

The above-mentioned figures generally refer to development assistance in non-health areas. In general, health receives only a small share of the external official development aid from bilateral donors. The exception is USAID, which currently allocates about US\$ 10 million annually for health out of a total between US\$ 150 and 200 million. The focus is on two major areas: health reform (including insurance) addressed by the Partners for Health Reform project (PHR) and PHC/reproductive health, addressed by the PHCI initiative. The Governments of Norway, Switzerland and Spain are also reported to have provided support to the health sector.

UNDP's programmes in health-related areas are limited to collaboration with the Department of Statistics in planning the household, income and expenditure survey and collaboration in inter-agency projects led by WHO such as HIV/AIDS prevention, media and health, and Healthy Villages.

UNICEF is focusing its 5-year plan on the following areas in the health sector: PHC, nutrition and healthy lifestyles with commitments in 2001 for US\$ 270 000. Areas of future collaboration between WHO and UNICEF have been identified as follows:

- Community mobilization for health including the Healthy Villages programme
- Community-based rehabilitation (CBR)
- Working with universities for integrating PHC into curricula for medical and nursing programmes
- HIV/AIDS prevention
- IMCI
- Healthy lifestyles
- Control of micronutrient deficiencies.

UNFPA is committing resources for US\$ 3.5 million over the 5-year period 2003–2007, addressing, as far as health is concerned, integration of reproductive health into PHC, strengthening of national capacities, community awareness on reproductive health and gender issues, including male involvement and barriers to women's access to reproductive health services. The agency aims to develop a fertility map to assess reproductive health status and indicators in different geographical areas. There is a proposal for a national consultation on reproductive health co-hosted by WHO.

Recently the UN finalized the CCA and UNDAF for Jordan, focusing on eight priority areas for coordinated action of the UN agencies operating in the country. The priorities that include WHO collaboration are: lifestyles/health issues/HIV/AIDS (WHO, UNICEF, UNFPA, UNESCO); environment (UNDP, WHO, WFP, UNESCO, FAO); food security and nutrition (FAO, UNICEF, UNFPA, WHO, WFP); population (UNFPA, WHO, UNICEF, UNESCO); education (UNESCO, UNICEF, WHO, UNFPA); human rights/gender issues (UNIFEM, UNICEF, UNFPA, WHO, FAO, UNHCR, UNESCO); and poverty (UNDP, WHO, UNICEF, UNIFPA, WFP, UNESCO).

There is currently no investment in health from the European Commission. Their emphasis is on public sector reform initiatives. However, there is interest in collaboration in relevant areas such as health insurance and human resources development, both representing major challenges for health development in Jordan. Potentials for future collaboration require further discussion and interaction.

As far as aid agencies of other EU Member States, such as the United Kingdom, it appears that Jordan is less eligible than other developing countries for bilateral support in the social sector including health. However, their interest in the economic and social reform could provide opportunities for collaboration. As an example, the United Kingdom Department for International Development is among the so-called “like-minded” donors actively supporting the WHO Country Focus Initiative for strengthening WHO presence and performance at country level; hence, collaboration could be established on the multilateral channel.

3.3 Mechanisms for donor coordination

In general, donor coordination takes place in the form of the informal Donor and Lenders Consultation Group (DLCG), created in 2002, for which UNDP is providing the secretariat and EU provided the first 6-month rotating presidency. The lead is now with USAID. DLCG is systematically associating high level representatives of the Jordanian government.

Moreover, UNDP, USAID and EC are working together to support the Aid Coordination Unit in the Ministry of Planning to enable it to better play its role vis-à-vis donors. The EU has established an internal Development Cooperation Group (EUDCG), which meets regularly at the Delegation in Amman to improve common strategies, coherence, information exchange and visibility of EU and Member States’ programmes.

In the area of health, there seems to be no effective mechanism for coordination among bilateral and multilateral donors and international technical agencies.

4. CURRENT COUNTRY PROGRAMME

4.1 WHO office

The WHO office in Jordan was established in 1985, and managed by the WHO Representative (WR) also in charge of the Syrian Arab Republic. However, WHO’s presence has recently been strengthened with the assignment of a full-time WR in 2001; the WHO profile and the perceived WHO presence in the country has since increased remarkably.

The biennial programme budget is about US\$ 1.5 million and activities are defined according to the JPRM. Apart from the regular budget, funds are also raised every year (amounting to about US\$ 0.5 million from September 2001 to October 2002). Additional funds are obtained from headquarters and the regional budget to sponsor a large number of training fellowships and participation of Jordanian officials and staff from the Ministry of Health and other ministries in WHO and international/regional meetings or conferences.

Moreover, capacity building activities through participation of nationals in intercountry, regional or global meetings or training courses are often funded by the Regional Office or headquarters. Over 60 nationals, mainly from MoH institutions, attended WHO sponsored meetings outside Jordan in 2002.

WHO advisers and international staff, on short-term assignments, provide additional technical support. In the year 2002, there were 16 consultancy assignments covered by the regular budget and 75 assignments supported by the Regional Office or headquarters. The WHO Representative Office hosted several intercountry or regional meetings held in Jordan. A total of 113 participants from other countries were trained in 2002. The WHO Representative's office also provides support to the Iraq Programme (UN SC Resolution 986).

Premises are currently located in the business area of Amman, close to the UNDP offices, in a building which hosts one of the MoH comprehensive health centres. The premises are inadequate and do not meet the minimum security standards. Action is being taken to move to a more appropriate location. Current staffing consists of one international professional, the WR, and an administrative assistant. Two secretaries work on a temporary basis to provide administrative and logistic support to the Iraq programme. Students, volunteers and technical assistants are hosted/hired ad hoc by the WR for short-term assignments. Table 6 provides an outline of areas of work considered in the current WHO Country programme.

Table 6. WHO current programme in Jordan (2002–2003)

EMRO Classifications	Workplan title	Programme objectives
Health policy and strategic planning	Health policy and strategic planning; health financing	To strengthen health policy, health management, health economics including design of appropriate health care financing policy and ensure quality services. To review and update the national health strategy. To formulate the new health development plan. To review and update the national health account.
HR policy planning and management	HR policy planning and management; (Human resources development)	To support the MoH in strengthening the HRD programme with special emphasis on human resources management and continuing education. To strengthen the partnership between the authorities responsible for human resources development and health delivery services.
Medical and allied sciences	Medical sciences	To strengthen collaboration in medical and health professional education. To assist in developing a continuing medical education system.
Nursing and paramedical resources	Nursing development	To promote continuing nursing education.
Evidence and information for policy	Evidence and information for policy	To enhance capacity building in health information process and in ICD 10 coding for mortality and morbidity. To strengthen mortality statistics and death certification by cause.
Health and biomedical information support	Health information support (PHC library)	To strengthen the national health information services in health care institutions and medical colleges through proper health information support.

EMRO Classifications	Workplan title	Programme objectives
Health care delivery	6.1. Primary health care	To upgrade primary health care services, promote quality and coverage.
	6.2. Genetics and emerging priorities	To organize and initiate a premarital screening programme and to develop community genetics services in Jordan.
Sustainable development approaches	Healthy Villages	To improve health through meeting the basic development needs and community empowerment.
National drug policies based on essential drugs	National drug policies based on essential drugs including quality control	To improve the quality of drugs available on the market by implementing GMP, GLP, TCP standards. To rationalise drug use through: a) implementation of EDL, b) implementation of standard treatment protocols, and c) use of the national drug formulary. To strengthen the national quality assurance system and to include quality control for biological products, vaccines, and hormones.
Promotion of healthy lifestyles	Promotion of healthy lifestyles, nutrition and rehabilitation	To increase the knowledge of dental health worker about cross-infection. To improve the performance of dental workers in implementation of disinfections and sterilization methods. To train rehabilitation workers to be trainers. To evaluate CBR experience in Jordan. To strengthen prosthetic and orthotic services. To develop a national food and nutrition policy. To promote data collection and implement appropriate measures on the control of micronutrient deficiencies.
Safety promotion	Health of special groups: school health, occupational health, health of the elderly	To develop adequate school health services. To insure healthy school environment through protection and promotion of healthy lifestyles. To reduce avoidable occupational disabilities through appropriate preventive and rehabilitative measures. To enable universal access to safe and healthy environment and work conditions. To develop a strategy for ageing and health of the elderly.
Mental health	Mental health including substance abuse	To promote mental health on all health care levels by training workers to have the knowledge and skills in treatment and help of mentally ill persons.
Noncommunicable diseases	Noncommunicable diseases including blindness and deafness	To assist the MOH in establishing a comprehensive programme on the prevention and control of NCDs. To launch Vision2020 and develop a national action plan on blindness prevention. To strengthen baseline data on blindness and deafness, their causes and existing services, needs assessment.
Child and adolescent health	Child health including IMCI	To introduce IMCI to the health system and ensure national adaptation.
Women's health	Women's health	To conduct a situation analysis and develop a data bank on women's health. To identify priorities for future action.

EMRO Classifications	Workplan title	Programme objectives
Environmental health policy	Environmental health including food safety	To assist in strengthening the capabilities of MOH in water quality monitoring. To strengthen national capacity for safe management of chemicals and development of national chemical safety programme. To improve the national capabilities in the context of environmental health risk assessment and management. To assist the national authorities in the formulation of a national food safety policy based on a food safety profile.
Polio eradication	Vaccine-preventable diseases (EPI)	To assist in achieving and maintaining over 95% routine immunization coverage against diphtheria, pertussis, tetanus, poliomyelitis, tuberculosis and measles among children under-one year of age and with tetanus toxic among pregnant women.
Tuberculosis	Tuberculosis control	To assist in detecting at least 70% of the all existing cases of tuberculosis and successfully treat at least 85% of them by 2003.
AIDS and STD	HIV/AIDS and STD	To establish national guidelines for the prevention and treatment of STDs; introduce SCM of STD in medical education curriculum. To support the MoH and the national committee in developing, implementing, and evaluating a comprehensive plan for HIV/AIDS prevention
Tropical diseases	Tropical diseases including vector-borne and zoonotic disorders	To prevent transmission of leishmaniasis. To keep free status from schistosomiasis transmission. To reduce morbidity due to intestinal parasitic infections. To maintain the malaria-free status of the country. To reduce morbidity and mortality causes by zoonotic disease.
Disease surveillance and control	Disease surveillance and control of emerging disease	To reduce morbidity and mortality of communicable disease

4.2 Regional Centre for Environmental Health Activities

4.2.1 Overview

Apart from the WHO Representative's office, Amman hosts the Regional Centre for Environmental Health Activities (CEHA) for the Eastern Mediterranean Region. CEHA staff provides technical support to the WHO Representative in areas such as water, sanitation, chemical safety and other environmental health activities. The following is a thematic description of CEHA activities and services, which were offered to Jordan during the biennium 2002–2003.

4.2.2 Community water supply and sanitation

In collaboration with the Jordan University of Science and Technology and the University of Jordan, a training facility was established to strengthen the capacity of Jordanian experts and agencies in the field of sanitation in small communities. So far, a study of the national policies in wastewater management for small communities was conducted. A manual, *Design, construction and operation of wastewater management systems in small communities*, was developed and field-tested, and several training workshops were held,

including an intercountry workshop which was organized in Amman to disseminate the Jordanian experience to other countries of the Region.

Despite expansion of piped water supplies to urban and rural areas, household water security in terms of safe quality and sufficient quantity remains a big challenge due to water supply shortages and inefficient management of water supply systems and resources. Several activities were implemented to place water demand management and efficient utilization of water at the heart of water resources management processes and to assess the status of household water security for evidence on the links between household water security and health in order to develop effective approaches to enhancing household water security.

CEHA participated in the Jordanian national committee on water quality and health, and facilitated the development of a new project proposal, which was accepted by the EU for a consortium of institutions from Jordan and other countries of the Region to further investigate the quality concerns of intermittent supply and to build capacity of the participating countries. Four Jordanian experts participated in the CEHA first dedicated regional conference on water demand management and conservation, and two more experts will be participating in the second regional conference on water demand management planned by the end of 2003. Jordanian experts will be also participating in an expert consultation on household water security planned by the end of 2003 to identify critical needs for evidence and intervention to enhance household water security.

Wastewater treatment and health aspects of wastewater reuse are priority areas in Jordan. CEHA efforts in this regard continued through the implementation of its joint regional project with AFESD covering Jordan and ten other countries of the Region. More than 50 specialists were trained through courses on health aspects of wastewater treatment and reuse and infestation of helmenthic diseases. A country profile of wastewater management and reuse in Jordan was compiled. In collaboration with the Royal Scientific Society of Jordan, a manual on parasitology was developed in Arabic and English.

4.2.3 Healthy environments for children

The healthy environment for children initiative started in 2003 following the International Conference on Environmental Threats to the Health of Children in Bangkok in March 2002. The initiative components were developed and a proposal for action was approved. Relevant activities were regrouped and consolidated as a project initiative within the programme with the following achievements.

- Building partnerships and creating popular movements for children through convening national seminars and conferences in Jordan. The Jordan national conference was convened under the Patronage of Her Majesty the Queen Rania Al-Abdullah with the participation of over 200 scientists, senior officials and members of civic society. Remarkable celebrations marked the occasion of the World Health Day, dedicated to healthy environments for children. A national network on healthy environments for children has been established at the Jordan University of Science and Technology.

- Gathering and dissemination of information on healthy environments for children within countries of the Region. The HEC database and information clearinghouse has been established. Research information and literature is being collected and categorized for increased accessibility.
- Monitoring of indicators on healthy environments for children and assessment of environmental health risk factors is under way. Published research data are being collected, analysed and incorporated into a database. An assessment of environmental health risk factors and monitoring of indicators on healthy environment for children is planned in Jordan.

4.2.4 Information exchange and management

Since its establishment in 1988, CEHANET is providing information services to the Jordanian community. More than 600 users (environmental health institutions and experts) are making use of the services of CEHA's regional environmental health information centre. On average, about 900 documents are distributed annually to institutions and experts to support their capacity in managing different aspects of environmental health in Jordan. A library of about 12 000 documents is open to users twice a week; during 2002–2003 about 712 users visited the centre and made use of the available services. More than 90 technical inquiries were answered using the available resources and technical expertise.

During 2002–2003, more services were provided using internet and e-mail. Efforts are continuing to support electronic information exchange capacity of several environmental health agencies in Jordan. In collaboration with EMRO, support was provided to establish a national health biomedical information network. The first workshop was organized in collaboration with the National Information Centre in early 2003 and networking activities started. The first output is six-month access to about 2500 electronic health journals, free of charge.

4.2.5 Environmental health activities during emergencies

Technical advisory services and missions were provided to the Ministry of Health and other related agencies to help in improving the environmental health conditions in refugee camps on the Iraqi border. Support was also provided in compiling an emergency preparedness plan.

4.2.6 Solid and hazardous waste management

In the framework of the joint CEHA–World Bank project on mainstreaming health care waste management into health investment projects, a draft manual of good practices was developed and tested in Jordan and other countries. CEHA provided technical assistance in health care waste management in a number of hospitals in Jordan during 2002. CEHA also took part in many meetings on health care waste management in Jordan.

4.2.7 Environmental health impact assessment of development projects

A regional project for strengthening national capabilities in the area of environmental health impact assessment (EHIA) was sponsored by AGFUND and CEHA. In the framework of this project, Jordan developed its national EHIA guidelines of development projects during 2002–2003. This was the output of the continued support offered by CEHA through national training workshop and two regional workshops, which were held in Amman.

4.2.8 Promotion of food safety

Regional projects on HACCP, food irradiation and lead poisoning in food were sponsored by AGFUND, covering Jordan and other countries of the Region. Several training workshops and technical assessment missions were sponsored by CEHA. In collaboration with the University of Jordan, guidelines on the generic HACCP system for traditional popular food in the Region are being compiled. This will be supplemented by training materials in video formats.

4.2.9 Environmental health awareness raising

Environmental health training/education activities of CEHA have continued in sustainable manner as follow-up of previous activities through high schools in Jordan in cooperation with Ministry of Health, Ministry of Education and NGOs. CEHA's environmentally healthy school initiative (EHSI) was introduced and assistance was provided to launch similar projects based on the Jordanian project experience. A source material based on experience from Jordan was drafted in English. Following field-testing of this material, it was translated into Arabic for further sharing and disseminating this experience to other Member States.

Noting the great need for awareness-raising among women in rural and small communities on environmental health issues, CEHA has continued to work with NGOs and UN agencies in Jordan. In collaboration with EMRO and Princess Basma Women's Resource Centre in Jordan, CEHA worked in the preparation of 10 modules on various basic environmental health topics. In the process of development of the modules, several workshops were conducted with rural women which made the modules more valuable.

Information exhibitions and participation national meetings in Jordan was a successful approach to raise environmental health awareness among the Jordanian community. Several exhibitions were organized on several occasions such as the UN and WHO days and national meetings on water and other environmental issues.

In collaboration with the Jordanian Ministry of Water and the Jordan Environment Society, awareness materials were developed and disseminated. The media as well as mosques in Jordan were used for conveying messages related to water conservation and other environmental health issues.

4.3 United Nations Relief and Works Agency for Palestine Refugees in the Near East

The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) has some of its largest premises in Amman. The Director of Health for the five areas of operation of the Agency is a senior staff seconded from WHO. UNRWA is one of the major providers of health care in Jordan for approximately 1.7 million out of the total population of 6 million (28%).

According to a recent USAID-supported survey in Jordan on health care utilization and expenditure, in 2000 the MoH coverage rate was 19.5% among the entire population and 32% among the insured, respectively. The corresponding rates for UNRWA were 11% and 19%, respectively.

UNRWA plays a lead role in integrating effective intervention strategies within its primary health care activities, including family planning, noncommunicable disease care, iron supplementation for children and women and fortification of wheat flour with iron and folates. It maintains well-defined standards for health care delivery including technical guidelines, management protocols and manuals based on WHO concepts and principles.

The UNRWA Department of Health, under the technical supervision of WHO, remains committed to working hand-in-hand with all concerned to contribute to the development of the Country Cooperation Strategy for Jordan.

5. WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

5.1 Strategic directions

Four broad strategic directions have been defined for WHO at global level:

Strategic direction 1: Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations.

Strategic direction 2: Promoting healthy lifestyles and reducing risk factors to human health that arise from environment, economic, social and behavioural causes.

Strategic direction 3: Developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair.

Strategic direction 4: Framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimension to social economic, environmental and developmental policy.

5.2 Country level functions

For WHO operations at country level, five distinct functions have been identified:

- Supporting long-term implementation of routine activities, including capacity building.
- Catalysing adoption and adaptation of technical strategies; seeding large-scale implementation.
- Supporting research and development; monitoring health system performance.
- Information and knowledge sharing; providing generic policy options; standards; advocacy.
- Providing specific policy advice; serving as broker; influencing policy, action and spending.

5.3 WHO corporate priorities

Based on analysis of the major challenges in international health, WHO as an organization has established a set of global priorities. Criteria for selection included: potential for significant change in burden of disease with existing cost-effective interventions; health problems with major impact on socioeconomic development and a disproportionate impact on the lives of the poor; urgent need for new technologies; opportunities to reduce health inequalities within and between countries; WHO's advantages, particularly in relation to provision of public goods; building consensus around policies, strategies and standards; initiation and management of partnerships; and major demand for WHO support from Member States.

The selected global priorities, as stated in the WHO Programme Budget 2002–2003, are as follows.

- Malaria, tuberculosis and HIV/AIDS: these three diseases all pose serious threats to health and economic development and have a disproportionate impact on the lives of the poor.
- Cancer, cardiovascular diseases and diabetes: a growing epidemic in poor and transitional economies, a major threat, not least because of escalating costs of treatment in the industrialized world.
- Tobacco: a major killer in all societies and a rapidly growing problem in developing countries. It is not just a health issue, the economic case for tobacco control is strong.
- Maternal health: the most marked difference in health outcomes between developed and developing countries shows up in maternal mortality data. Maternal health is closely linked to development of health systems; it is difficult to cut down maternal mortality without a well-functioning health system.
- Food safety: a growing public concern, with potentially serious economic consequences.

- **Mental health:** five out of the ten leading causes of disability are mental health problems, major depression is the fifth contributor to the global burden of disease, and may be second by 2020.
- **Safe blood:** both a potential source of infection and a major component of treatment. It is crucial in the fight against HIV/AIDS and for dealing with the growing disease burden among women.
- **Health systems:** development of effective and sustainable health systems underpins all the other priorities. Different approaches to health financing have major implications for equity and efficiency. Workforce management is a neglected area in many health systems and needs a more comprehensive approach. More effective mechanisms for resource allocation, budgeting and financial management are a key to ensuring successful implementation of priority programmes.
- **Investing in change in WHO:** a prerequisite for WHO to become a more efficient and productive organization, and one capable of response within an increasingly complex international environment.

5.4 Regional priorities

In addition to the above global priorities, the Eastern Mediterranean Region has adopted a list of regional priorities. These include programmes aimed at improving the social and economic determinants of health with particular focus on healthy environment, sustainable development through healthy villages and BDN/QOL initiatives. Human Resources development is high on the regional priority agenda, building on existing regional and national training institutions. Control of diseases with special focus on noncommunicable diseases and emerging priorities, strengthening surveillance and promotion of healthy lifestyles are among priorities in most countries of the region.

Regional priorities also focus on the need to enhance access to affordable quality medicines, to promote rational use of pharmaceuticals and to improve blood safety and laboratory services.

6. STRATEGIC AGENDA FOR JORDAN: THE NEXT FIVE YEARS

6.1 Strategic directions for cooperation with Jordan

WHO cooperation with Jordan will focus on providing technical assistance in the following seven strategic directions:

- 1) Supporting appropriate policies and interventions aimed at improving the social, environmental and nutritional determinants of health, including poverty reduction strategies, promotion of healthy lifestyles and food safety.
- 2) Promoting health throughout the life cycle.

- 3) Strengthening disease control strategies and programmes and developing new strategies to cope with the rising burden of NCDs and related emerging challenges.
- 4) Reducing death and disabilities related to accidents and injuries including promoting occupational health and safety.
- 5) Strengthening institutional capabilities of the MoH through the improvement of the four main functions of the health system.
- 6) Improving intersectoral collaboration, community empowerment and participation for health development.
- 7) Enhancing the role of health research in policy development and service improvement.

6.2 Priorities

The following represent priorities in each of the strategic directions mentioned above.

- 1) Supporting appropriate policies and interventions aimed at improving the social, environmental and nutritional determinants of health, including poverty reduction strategies, promotion of healthy lifestyles and food safety.
 - Contributing to the design, implementation and monitoring of the health component of the PRS in the country
 - Supporting the development of national strategies to improve healthy nutrition and to promote physical activities and to control smoking
 - Supporting the existing national programmes on BDN/QOL and healthy villages
 - Improving partnership with NGOs and foundations supporting community-based development initiatives and promoting healthy lifestyles
 - Continuing assistance to the national programmes of food safety
 - Improving the quality of scarce water resources, including at the household level
- 2) Promoting health throughout the life cycle.
 - Adopting public health strategies for the prevention of genetic and congenital disorders
 - Conducting a situation analysis on adolescent health, identifying priorities for action, initiating appropriate interventions including school health education
 - Improving data collection on maternal health, with special focus on maternal morbidity
 - Expanding utilization of reproductive health services by improving the social, cultural, technical and physical elements of service provision
 - Designing a strategy on healthy ageing and care of the elderly
 - Monitoring, in collaboration with other UN agencies, the achievement of the Millennium Development Goals
- 3) Strengthening disease control strategies and programmes and developing new strategies to cope with the rising burden of NCDs and related emerging challenges.
 - Establishing a surveillance system based on monitoring of risk factors, morbidity and mortality for NCDs
 - Supporting the development of multisectoral strategies to prevent and control common NCDs at the primary, secondary and tertiary prevention level

- Launching of a national health promotion and education programme, with support from media and other partners
 - Supporting integration of disease control programmes into PHC
 - Strengthening the laboratory network to support the surveillance system for the monitoring of communicable and noncommunicable diseases
 - Assessing the burden as well as the epidemiological and clinical characteristics of mental health problems with a view to developing appropriate control strategies
 - Developing appropriate strategies for disability prevention and rehabilitation, with emphasis on CBR
- 4) Reducing death and disabilities related to accidents and injuries including occupational health and safety.
- Improving availability of data on accidents and injuries in various settings (households, communities, schools, road traffic, work)
 - Advocating with main partners, including other sectors, media and NGOs, the need for appropriate interventions to create a health promoting environment
 - Developing strategies for addressing issues related to prevention and management of accidents and injuries
- 5) Strengthening institutional capabilities of the MoH through the improvement of the four main functions of the health system.
- Strengthening MoH leadership in evidence-based policy development, strategic thinking in planning and management, regulation, coordination and partnership, and quality assurance and improvement:
 - Mapping of the four main health system functions as part of in-depth sectoral approach
 - Developing analytical tools to support policy making and priority setting, such as national burden of disease assessment; institutionalization and ownership of NHA analysis; costing and cost-effectiveness analysis studies, including the identification and costing of essential interventions; and scenario development for strategic planning (HRD, certificates of need etc.)
 - Developing regulation, coordination and partnership functions in the MoH, including standard setting, licensing and quality assurance and improvement
 - Supporting the national Health Information System and promoting population based surveys to improve informed decision making
 - Improving the organization of service delivery with particular focus on strengthening decentralization, implementing and strengthening referral system and implementing quality assurance protocols:
 - Conducting an in-depth review of the organization of service delivery based on PHC, with emphasis on equity, quality and responsiveness
 - Assessing and supporting health system decentralization, including hospital autonomy and the referral system

- Strengthening the district health system through capacity building and provision of necessary planning and management tools, including district team problem-solving (DTPS) techniques
- Improving human resource development at various levels i.e. policy, planning, production and management:
 - Strengthening of human resources developments functions in the MoH (Planning department) with particular emphasis on nursing, primary care and public health professionals
 - Promotion of tools for strategic planning for HRD using projections, scenarios and other predictive techniques
 - Establishing a national system for health professionals continuing education, including CME
 - Strengthening the partnership between health care providers, professional associations, universities and other training institutions
 - Promoting the Health Academy as a nucleus of a public health institute with research and capacity building functions
- Rationalizing the use of technology, including assessment and selection of biomedical equipment, pharmaceuticals and procedures:
 - Supporting the national programmes on the rational use of drugs, capacity building in registration, licensing, pricing and quality control of pharmaceuticals
- Improving equity in financing of health care through expansion of social health insurance, particularly in the private sector, with the aim of achieving universal health insurance coverage:
 - Conducting an in-depth assessment of the health sector financing, with emphasis on social and private health insurance
 - Developing options for expanding health insurance coverage, including capacity building and necessary technical expertise (actuarial studies, management information systems, payment methods etc.)
 - Promoting mandatory health insurance for workers in the private sectors (laws and bylaws)
- Promoting cost control and cost containment policies in order to improve the efficiency of the system:
 - Promotion of cost containment through implementation of health system research activities at various levels of the health system
- 6) Improving intersectoral collaboration, community empowerment and participation for health development.
 - Strengthen the functioning of the Higher Health Council to foster intersectoral collaboration
 - Strengthen partnerships with bilateral and multilateral development institution and donors' agencies, as well as with NGOs and civil society organizations

7) Enhancing the role of health research in policy development and service improvement.

- Promotion of culture of research and development in the health system
- Capacity building in R&D
- Improve the linkage between research and policies based on evidence

7. IMPLICATIONS FOR WHO

7.1 Country level

Technical needs

- Enhanced human resources to strengthen the capacity of the office in health policy and strategy development
- More emphasis on standardized data collection and analysis to strengthen the knowledge base (databases)
- Stronger capacity in information sharing, dissemination and advocacy
- An effective tool for monitoring and evaluation

The next reprogramming exercise for WHO collaboration with Jordan (JPRM) should offer the opportunity to redirect some of the funding to support the priorities identified in the CCS.

Logistical and administrative needs

- Moving the WHO offices to more spacious and more secure premises
- Improving communication system by connecting to the pilot GPN (ITT)

7.2 Regional level

- Prompt and effective provision of technical support
- Sharing of regional experiences (TCDC), resources (WHO-CC, regional centres of excellence) and development of guidelines and protocols
- Capacity building at regional level
- Monitoring and evaluation
- Coordination of support with headquarters and the country office

7.3 Headquarters level

- Prompt and effective provision of technical support
- Capacity building at regional level
- An effective mechanism for monitoring and evaluation
- Standard setting and clearing house for information and publication
- Necessary financial support through additional budget allocations (to be reflected in the JPRM) and extrabudgetary resources
- Coordination of support with the Regional Office and country office

7.4 Requirements for CCS implementation

In order to provide timely response to implement the CCS, additional technical expertise is needed in the following areas:

- Health system development with emphasis on capacity building to develop the policy analysis tools (1 full-time international staff)
- Human resources development including policies, planning, production and management (1 long-term professional staff/SSA)
- Community-based initiatives and healthy villages (SSA)
- Support staff (secretarial and clerical work)

Additional financial resources are needed to support the areas of intervention identified in the CCS.