

# Country Cooperation Strategy for WHO and the United Arab Emirates 2005–2009

# United Arab Emirates



World Health Organization  
Regional Office for the Eastern Mediterranean

Country Cooperation Strategy  
for WHO and the United Arab Emirates  
2005–2009

United  
Arab  
Emirates



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Regional Office for the Eastern Mediterranean  
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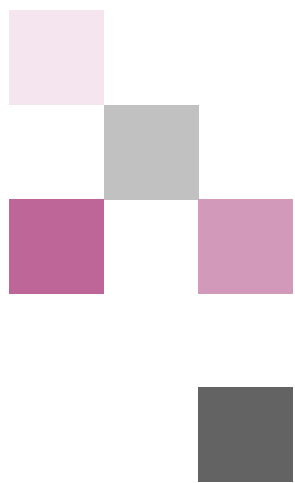
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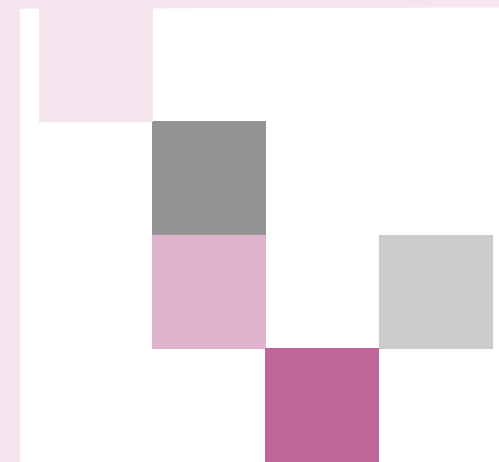
AED	Arab Emirate Dirham (1 US\$ = 3.6 AED)
CCS	Country cooperation strategy
DPT	Diphtheria, pertussis, tetanus
DTPS	District team problem-solving
GDP	Gross domestic product
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HRD	Human resources development
ICD	International classification of diseases
IMCI	Integrated management of childhood illness
JPRM	Government/WHO Joint Programme Review and Planning Mission
NHA	National health accounts
NCD	Noncommunicable diseases
NGO	Nongovernmental organization
PHC	Primary health care
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

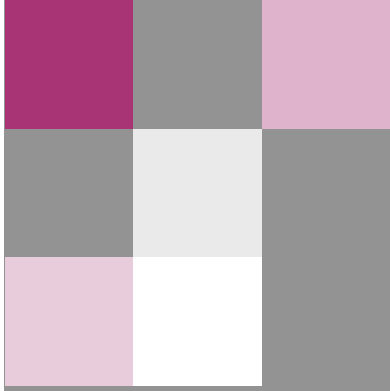
The CCS is intended to build on the current United Arab Emirates health-for-all strategy and act as a blueprint for gathering and using information for health to guide policy-makers and service providers of a future health system. Its main theme is the orientation or reshaping of health services so that improving people's health and quality of life becomes the primary and unifying focus of the work of health care policy-makers and providers.

Compared to other countries in the world, the level of health in the United Arab Emirates is considered good. Nevertheless, the Government is concerned over the cost of services, scarcity of choices available and quality of service. Health service in the country is provided by six different authorities, five of which are governmental and the sixth is provided by the private sector, with each authority having its own system and staff.

Health systems currently operate within an environment of rapid social, economic and technological change. Health systems are also nowadays under continuous scrutiny by planners, purchasers and users of the services. In order for the Ministry of Health in the United Arab Emirates to achieve the overall goals of good health, it is important to identify some of the critical health challenges facing health development. The critical health challenges are in the areas of: strengthening the organization of health services; health financing; health resources for health; and health education.

WHO collaboration with the United Arab Emirates will focus on strategic directions providing technical assistance in the following priority areas: strengthening institutional capabilities of the Ministry of Health; improving human resources; reduction of the burden of diseases, especially of noncommunicable diseases; improving intersectoral collaboration and community involvement and empowerment for the purpose of health development; and enhancing health research that will assist in health development through supporting related policies and capacity-building.





Section



Introduction



The CCS is intended to build on the current United Arab Emirates health for all strategy and act as a blueprint for gathering and using information for health to guide policy-makers and service providers of a future health system. Its main theme is the orientation or reshaping of health services so that improving people's health and quality of life becomes the primary and unifying focus of the work of health care policy-makers and providers.

The United Arab Emirates health for all strategy depends on the international WHO definition of health: A state of complete physical, social and mental well-being, and not merely the absence of diseases and infirmity. The strategy also stresses that enjoyment of the highest standard of health is a basic right for each citizen, and that ensuring good health for all citizens is essential for realizing welfare and prosperity.

This strategy also asserts health as the basis of realizing health for all in the twenty-first century, by defining it as basic health care based on scientific, practical and socially accepted grounds, using the appropriate techniques and making health care available for all nationals along with their total participation in providing and supporting the same.

Moreover, the United Arab Emirates strategy highlights the importance of adhering to and honouring cultural and religious norms within the various aspects of health services, which are based on consolidation, cooperation, efficiency,

justice sustainability and equity among the various national sectors.

Out of its realization of the strategy's importance, the Ministry of Health, the responsible authority, regulator and major provider of curative, preventive and promotive care in the United Arab Emirates, has provided and achieved remarkable health services for its 3 754 000 people. Despite the fact that much has been achieved, some challenges in services remain which must be addressed. In order to deal with these challenges, the close collaboration between the Government of the United Arab Emirates and World Health Organization (WHO) is to be strengthened and streamlined.

The Government is committed to the world declaration on health which calls on countries to confirm their commitment to the Constitution of WHO, which stipulates that health is a basic human right and an ultimate objective for social and economic development and that all countries be committed to reform their health systems in a suitable manner and take collective action against the dangers to health and to the well-being of the world community.

Planning for the WHO collaborative programme takes place every two years through the Joint Programme Review and Planning Mission (JPRM) exercise. It has been recognized by the World Health Assembly that the collaboration between the two partners should be intensified and based on strategic directions. This CCS was produced by a team from WHO Regional

Office for the Eastern Mediterranean and a national team of senior officials in the Ministry of Health, United Arab Emirates, to strengthen WHO's contribution to health development in the United Arab Emirates and to ensure greater responsiveness to country needs.

All in all, this document will provide a guideline for technical collaboration between the WHO Regional Office and the Government, which will contribute to the future advancement of health care in the United Arab Emirates.

Section

# 2

Country Health and Development  
Challenges

### 2.1 Government and people

The United Arab Emirates was formed in December 1971, and joined the League of Arab States, the United Nations and its specialized organizations in the same month and year. It is a member of the Gulf Cooperation Council (GCC) and several other international organizations.

The estimated population is 3 754 000 (2002). Average life expectancy is 73 years, males 71.3 and females 75.1 years. The majority of the population are males who

represent 67.7% while females represent 32.3%, owing to the preponderance of male expatriates. It is remarkable that 68.8% of the total population are between the ages of 15 and 49 years (Table 1). The United Arab Emirates administratively comprises seven emirates: Abu Dhabi, Dubai, Ras al-Khaimah, Sharjah, Ajman, Umm al-Quwain and Fujairah. The city of Abu Dhabi is the capital (Table 2).

**Table 1. Demographic and socioeconomic indicators**

Demographic indicators	Value	Year
Population (million)	3.754	2002
Annual population growth rate (%)	1.39	2002
Total fertility rate (children/woman)	3.29	2000 (est.)
Average life expectancy (total) (years)	73	2002
Infant mortality rate	8.1	2002
Maternal mortality ratio	0.0	2002
Crude death rate	1.56	2002
Crude birth rate	15.48	2002
Still birth rate	7.14	2002
Male illiteracy rate (%) (10 years and over)	18.4	1995
Female illiteracy rate (%) (10 years and over)	12.1	1995
Per capita GDP at exchange rate (US\$)	25 614	2002
Total expenditure on health per capita (US\$)	767	2001

Source: Annual statistical report, United Arab Emirates, Ministry of Health, 2002.

**Table 2. Population of individual Emirates**

Emirate	Population
Abu Dhabi	1 470 000
Dubai	1 112 000
Sharjah	599 000
Ajman	215 000
Umm al-Quwain	59 000
Ras al-Khaima	187 000
Fujairah	112 000

Source: Annual preventive medicine report, United Arab Emirates, Ministry of Health, 2000.

## 2.2 Economic and social development

The United Arab Emirates is a small, high-income country with rich natural resources. United Arab Emirates is not only the world's fourth largest oil producer, but also is the richest state per head of population, and the new commercial hub of the Middle East. Few nations on earth have experienced more complete and far-reaching change over the past few decades than the United Arab Emirates. Yet only 50 years ago, when oil exploration started, there was no electricity, no plumbing, not a single public hospital or modern school, no bridges and only a handful of cars.

The United Arab Emirates has undergone major political and economic transition, and is characterized by its peace, stability and love for modernization. The Government continues to seek out the best technology in the world and facilitates investment measures in order to bring investors from all over the world. Therefore, policies and regulations were created to provide the

best investment climate, characterized by easing controls and improving the banking sector and foreign exchange regulations.

The continuous economic improvement and development is reflected in the country's indicators. The gross national income increased from 4.7 billion AED in 1972 to 229 billion AED in 2002, with an annual growth rate of 13.8%. The gross domestic product per capita reached 69 000 AED in 2002, the gross domestic product increased from 6.5 billion AED in 1972 to 260 billion AED in 2002, with an annual growth rate of 13%.

Non-oil sectors contributed 188 billion AED in 2002 compared to 2.4 billion AED in 1972, investment in all its forms increased from 1.7 billion AED in 1972 to 60 billion AED in 2002 in an annual growth rate of 12.6%. The Ministry of Agriculture and Fisheries spent 145 million AED, out of a total budget of 152 million AED in 2001, on projects related to drinking-water drilling wells and maintenance of dams. All the population has access to safe drinking-water and

sanitation facilities. The electricity and water supply sector is adopting projects that cost 2821 million AED. The transportation and communication sector spent 1870 million AED in 2002 on projects related to constructing new highways and roads, and maintenance of old ones, public housing assistance reached 640 million AED in 2002, public services, especially education, reached 240 million AED in 2002, and public health services reached 64 million AED in 2002. These services included construction of new hospitals, primary health care centres, dental clinics, etc., and insurance companies increased from 40 companies in 1975 to 313 companies in 2002.

Moreover, it is of importance to note the great consideration that is being paid by the Government towards the environment and its protection through enhancing agriculture, public gardens and environmental reservations.

The Government allocated all necessary funds to ensure good education for all citizens. The number of students increased from 481 thousand in 1995 to 564 thousand in 2000. The male (10 years and over) illiteracy rate is estimated at about 18.4% (1995), while the female (10 years and over) illiteracy rate is estimated at about 12.1% (1995). Dropouts from school still represent a problem, nonetheless, the number of dropouts decreased from 3.7% in 1995 to 1.9% in 2000. The United Arab Emirates is recognized for its great emphasis on and remarkable programme for abolishment of illiteracy for all citizens in general, and the elderly in particular.

In addition, the Ministry of Health has made remarkable achievements in the field of information technology, and e-government. International reports indicate that the government of the United Arab Emirates is being recognized for its distinguished programme of the e-government and occupied grade level 21 worldwide and grade level one among the Arab countries.

## 2.3 Health profile

### 2.3.1 Overview

Compared to other countries in the world, the level of health in the United Arab Emirates is considered good. Nevertheless, the Government is concerned over the cost of services, scarcity of choices available and of the service quality. Health service in the country is provided by six different authorities, five of which are governmental and the sixth is provided by the private sector, with each authority having its own staff and system.

Several sources of financing exist and each has various procedures for drawing up budgets, expenditure and control and auditing procedures have not been updated for a long time.

The Ministry of Health, as part of the state machinery, is in the process of obtaining ISO 9000 certification, which is expected to have a very positive impact on the quality of the health system management.

### 2.3.2 Health policies and strategies

There is a comprehensive health strategy, which needs revision and updating due to the political reforms under way in the country. The biggest change in policy is the withdrawal of the Ministry of Health from

direct health care delivery. In Dubai, where a Dubai government health system has existed for more than 30 years, Abu Dhabi Emirate has established a health authority to delivery. Nevertheless, the relationship between the different health care providers and the Ministry of Health needs greater clarification and streamlining.

The Ministry of Health budget as a percentage of the Government budget has remained constant: 7.7% in 1982/1983, 7.6% in 1996/1997, and 7.7% in 2001. The per capita share of the Ministry of Health budget is estimated as 0.6% of GDP (2002). The per capita expenditure on health reached US\$ 767 in 2002.

The State is thoroughly revising the delivery system and studying health insurance schemes to replace the current fees-for-service mode. A proposal was prepared by the Ministry of Health and is under review.

Decentralization is of long standing history, as the State is based on federalization with broad power sharing. Within the health system, the Ministry of Health looked at power sharing from the point of view of primary health care. The Primary Health Care Services Promotion Committee (PHCSPC) defined decentralization as the delegation of some powers and granting of some autonomy to the regions, with the insurance of supervision, follow-up and assessment by the central administration. A positive aspect of decentralization is the increase of quality health services and the augmentation of the satisfaction of the service beneficiaries. The administrative structure of the Ministry of Health, which includes the medical regions, might facilitate the decentralization process. This

will require amendments to the legislation and laws, some of which are related to the Ministry of Health while others are outside the control of the Ministry of Health and pertain to other ministries. The technical and administrative potential and resources must also be available.

The Committee agreed that the delegation of power should include two aspects: 1) complete financial powers by giving the regions an approved federal budget; and 2) administrative powers including the power to choose and employ personnel. The central administration will be responsible only for the conclusion of contracts deducted from the regions' budgets.

Regionalization was defined by the PHCSPC as the old medical districts, which is an administratively defined region whose population varies between 25 000 and 600 000. There are currently nine districts (Articles 40 and 41 of the Organizational Chart of the Ministry of Health pursuant to Cabinet Resolution No. 11 of 1989). These districts enjoy some administrative and financial powers, whereas there are at least two levels of service: primary and secondary (specialized) care.

### 2.3.3 Health care delivery system

According to the Annual Statistical Report 2002, the United Arab Emirates has 15 hospitals in urban areas, which represents 57.7% of the total number of hospitals in the country, and 11 hospitals in rural areas, which represents 42.3% of the total hospitals in the country. In addition, there are 106 primary health care centres distributed between urban and rural areas, in a proportion of 33% (35 centres) and 67% (71 centres), respectively.

The Ministry of Health provides an average of one centre for every 35 415 of the population. Also, the Ministry of Health provides nationwide 11 centres for school health, which supervise 642 clinics in schools, 9 centres for preventive medicine, and 10 centres for maternity and child care. In addition, the Ministry of Health provides 92 dental clinics nationwide.

The number of beds in non-private hospitals reached 4100 in 2002. It is estimated that there is one bed for every 915 people. The average bed occupancy rate for hospitals ranges from 57% to 90%.

The Ministry of Health, with comprehensive coverage to all the population, is extending its services to small communities scattered around the major settlements. The major areas of strategy in this sector are revision of the family care system, accreditation and strengthening the referral system.

Almost all levels of health services are decentralized. All hospitals are either managed by medical districts or independent authorities. With rapid changes, the management of the system poses some difficulties to be addressed by the Ministry of Health.

### 2.3.4 Health information system

Building and maintenance of the national health information system is a strategic objective to support and enhance the country cooperation strategy and all its strategic elements, including disease surveillance, trend analysis and burden of disease studies, health systems development, health and biomedical research, decentralization, privatization and public-private partnership, and health promotion and healthy lifestyles.

The strategy recognizes that health care is increasingly becoming an information-driven service, and information is a major resource crucial to the health of individual citizens, the population in general, and to the success of any health care institution. Efforts and feasibility studies about digital infrastructure have been initiated. The planned system is moving towards digital formats to capture, record, retrieve, analyse and communicate data dynamically.

### 2.3.5 Human resources

The number of medical doctors reached 2304 in the public sector, with an average of 1 doctor for every 1629 people and 1 nurse for every 650 people. Technical and administrative resources are represented by 12 100 people nationwide.

The number of physicians reached 2304, nursing staff 5779 and technicians 12 100 in 2002. Specialists increased from about 31% of total physicians in 1990, to 37% in 2002, which shows the inclination towards appointment of specialists and consultants at the expense of practitioners and family physicians.

Despite the fact that a remarkable increase took place in the number of workers in the Ministry of Health, there is still a shortage in availability of trained local physicians and nurses.

### 2.3.6 Morbidity and mortality trends

#### Maternal and child health

Changes in the provision and impact of health services are reflected by a number of key indicators as estimated in 2002: infant mortality rate 8.12, neonatal mortality rate 5.5, under-five mortality rate 10.1 and

maternal mortality ratio 0.0 (2003). The low mortality rates are mainly due to excellent maternal health services and facilities and attendance of 98% of deliveries by trained health personnel. Figures for the level of contraceptive use in the United Arab Emirates are unavailable.

The strategies recommended by WHO have resulted in an eradication of poliomyelitis. United Arab Emirates is still working towards the elimination of measles and expects a favourable chance of achieving elimination by 2005 due to the high coverage rates with measles vaccine (at about 96%) and the significant reduction in measles incidence.

The incidence of the other immunizable childhood diseases has sharply declined due to sustaining maximum immunization coverage, and continuing provision of relevant information to the public through organized health education activities. Rubella has been recorded for many years and reported cases have been declining steadily.

#### HIV/AIDS and other sexually transmitted diseases

According to WHO, United Arab Emirates and neighbouring countries have among the lowest number of reported HIV/AIDS cases in the world. Cultural, social and behavioural norms may have contributed to keeping infection at these low levels. However, another contributing factor is the AIDS control programme, one of the first of its kind in the Region. The programme was initiated in the late 1980s and concentrated on early case detection (by including all expatriates entering the country for work, or renewal of visa, all new marrying males,

on university entrance, employment or army recruitment, etc.), follow-up of patients for counselling and compliance, health education campaigns and other strategies.

The number of reported cases of syphilis was 560, gonorrhoea 117 and other sexually transmitted diseases 43 in 2003.

#### Communicable diseases

Communicable diseases still pose a problem to the United Arab Emirates despite the fact that the incidence of many communicable diseases has declined sharply in recent years. Plans are still ongoing to control, eliminate and/or eradicate such diseases in the country. Viral hepatitis, tuberculosis and meningococcal meningitis are still considered an important public health problem. The United Arab Emirates is free of malaria transmission. A comprehensive strategy for the control of malaria was undertaken in collaboration with partners, such as municipalities, Ministry of Agriculture and the private health sector. There are still sporadic cases of typhoid fever and leprosy. The reported leprosy cases are predominantly imported and cases detected by the national screening programme are immediately deported.

#### Noncommunicable diseases

The main noncommunicable diseases are cardiovascular diseases, cancers, diabetes and chronic obstructive pulmonary diseases. In recent years noncommunicable diseases, notably cardiovascular diseases, cancers and diabetes, as well as accidents, have been the leading causes of mortality (Table 3).

**Cardiovascular diseases.** In the absence of a cardiovascular disease registry and/or reliable morbidity statistics, it may be difficult to draw firm conclusions on cardiovascular diseases morbidity. However, national data strongly indicate that cardiovascular diseases continue to be the leading cause of death with acute myocardial infarction representing 28%, cerebrovascular disease 16.2%, hypertensive disease 13.0%, and ischaemic heart disease 12.3% of mortality from cardiovascular diseases. Deaths due to cardiovascular diseases are reported among more males than females across all age groups. In addition, over 90% of such deaths occur over the age of 45 years. The Ministry of Health is working towards a well defined prevention and control plan for cardiovascular diseases.

**Accidents** are a major health problem. They have been ranked as the second leading cause of death in the country. In 2003, 1014 deaths were attributed to accidents. The predominant cause of death was road traffic accidents, which accounted for 70.5% (620 cases) of all accidental deaths. Males accounted for 88.5% of these deaths.

**Cancer** is the third leading cause of death accounting for 468 deaths in 2000, or 8.6% of total deaths. In 2003, it accounted for 525 deaths. Cancer trends closely follow global trends. Cancers of the lung and breast are the leading cancers among males and females, respectively. Stomach cancer is the second most common cancer in males compared with cervical cancer in females. The United Arab Emirates has cancer control and prevention activities (Table 4).

**Congenital anomalies** have ranked as the fourth leading cause of death in recent years. The number of reported deaths in 2003 was 274, which represents 4.68% of all deaths. Deaths among children below 15 years constituted 90% of all congenital anomalies deaths.

**Diabetes mellitus** is a significant cause of mortality and morbidity. Deaths attributed to diabetes accounted for 2–3% of all deaths in the past 10 years. Almost all deaths were reported among persons 45 years and older. The number of reported cases in 2003 was 175. A recent joint WHO/United Arab Emirates study, showed that the prevalence of diabetes is approximately

Cause	Percentage
Cardiovascular diseases	28.7
Road traffic accidents	15
Cancers	8.6
Congenital anomalies	4.7
Diabetes mellitus	2–3

Source: Ministry of Health strategic plan (2000–2010), United Arab Emirates, Ministry of Health, 2000.

**Table 4. Cancer control programmes**

Breast cancer screening programme

Early detection of cervical cancer

Early detection of colorectal cancer

Early detection of prostate cancer

Source: Ministry of planning website ([www.uae.gov.ae/mop](http://www.uae.gov.ae/mop)), United Arab Emirates.

17%, and this could serve as a preliminary baseline on which to build a solid database to guide the national plan.

### 2.3.6 Lifestyle and environmental factors

Tobacco consumption still poses a problem. According to a recent study, 24.3% of males aged 13–15 years were current smokers, 42% of males aged 17 years were current smokers, and 20% of adult males were current smokers. Female current smokers aged 13–15 years represented 2.9%, while adult females represented <1.0%. Shisha (argelie) is widespread and daily use has significant health implications. The United Arab Emirates has an anti-tobacco programme which has four components: legislation, smoking cessation units, a community-based component, and a school-based component.

### 2.3.7 Environmental health

The rapid growth and urbanization of the United Arab Emirates is leading to environmental degradation and negative impacts on the health of the people. Rapid growth is causing air quality to become poor in the large cities due to motor vehicles and industrial emissions. The health impact can be seen by the fact

that the incidence of respiratory diseases has increased in the past 10 years. There is a need for community-based initiatives for integrated development programmes, such as Healthy cities and the Healthy Environment for Children Alliance, as well as the need to strengthen the district health system and legislation.

### 2.3.8 Health education

The health education component of all prevention and control measures is multifaceted, targeting different groups of the population including different methodologies (conferences, courses, lectures and workshops, national awareness weeks e.g. Cancer National Awareness Week, outreach activities, sporting events, publications and media use). It is important to note that there is no reference centre for health education in the community nor a radio and television production unit which broadcasts awareness programmes via the various media channels. Because of the diversity of nationalities and languages public communication is a challenge.

## 2.4 Key issues and main challenges

Health systems currently operate within an environment of rapid social, economic and technological change. Health systems

are also nowadays under continuous scrutiny by planners, purchasers and users of the services. In order for the Ministry of Health to achieve the overall goals of good health, it is important to identify some of the critical health challenges facing health development.

The critical health challenges include the following.

### 2.4.1 Strengthening the organization of health services

The current and future trends of services organization pose great challenges to the leadership role to be played by the Ministry of Health in stewarding, regulating and monitoring the overall performance of the system. There is a weakness of the central health body in carrying out planning, coordination, monitoring and evaluation in all health issues. Hospital management (personnel, materials, patient safety and risk management) and autonomy are still weak due to lack of skilled and educated managers and absence of national guidelines. There is an evident lack of scientific research as an integral part of national health development.

### 2.4.2 Health financing

The largest part of the budget specified for health goes to the second and third levels of the curative services, whereas little goes to the preventive and the primary health care services, with growing patient expectations, health transitions and increase in price of medical services and medicine. Laws pertaining to financial, administrative and purchasing procedures must be reviewed, and more authority must

be granted to officials to distribute resources as per the current requirements instead of the method set forth in the budget.

### 2.4.3 Health resources for health

There is need for qualified and well trained human resources. Most doctors and nurses, as well as technicians, are not nationals. A sizeable proportion of national personnel working in the health field are engaged in administrative duties. Innovative ways and means need to be found to increase the number of nationals in the health sector. Employment is difficult and the official rules and regulations are lengthy even when a vacancy is available: training programmes are not persistent and lack the necessary funds; career development activities are uncoordinated and ad hoc; and there is no systematic performance appraisal.

### 2.4.4 Health education

Although health education has been recognized as an essential element to support health care services, it still lacks proper definition of why, where, what, how and who. Although isolated and uncoordinated activities for utilization of health education exist, there is no attempt at joining forces in a well studied programme. The information and telecommunication infrastructure in health care institutions is weak. Most hospitals, primary health care centres, medical colleges and other health facilities do not have the necessary infrastructure to deploy e-health solutions due to the low penetration rate of the internet in health care institutions. Health information on the internet and the use of the internet for delivery and promotion of health care services are still very much underutilized.



Section

# 3

Development Assistance and Partnerships:  
Aid Flow, Instruments and Coordination

### 3.1 Overall trends in aid flows

The development assistance in the United Arab Emirates is generated from its own Government. However, WHO in collaboration with the Ministry of Health has made remarkable achievements in areas of coordination, joint planning, transparency, information sharing and some other logistic and administrative measures. In addition, there is collaboration between Ministry of Health, UNDP and UNICEF. The functions of these United Nations agencies are primarily an exchange of ideas and technical assistance for areas such as social and economic development, services, education, health and management.

Through its central coordinating role in the United Nations system, UNDP has access to the international experience and expertise of over 100 United Nations organizations and agencies and other international institutions. By helping to bring this wealth of expertise to the country, UNDP provides technical cooperation in building the human resources, institutions and policies that help shape the future of the United Arab Emirates and its people. UNDP activities in the United Arab Emirates reflect current national development priorities, namely: institutional and human resources development; international trade and integration into the global economy; and protection, management and regeneration of natural resources and the environment.

UNDP gives particular emphasis to the role of women and mobilizing information and communication technology for

development. Through the global UNDP network and the United Nations system as a whole and with international development partners, UNDP provides the following core services: policy advice and technical support; capacity development of institutions and individuals; advocacy, communication and public information; promoting and brokering dialogue; and knowledge networking and sharing of good practices.

### 3.2 Assistance to the health sector

There are a lot of funding and benevolent and charity agencies in the country. The major governmental organizations are the Red Crescent, Women's Organization, Marriage Fund, Zayed and Makhtoum Charities. Each Emirate has various charity organizations. The funds for all of these organizations come from governmental sources, charity or special funds of the rulers.

### 3.3 Mechanisms for donor coordination

The Ministry of Health has little information about the flow of funds, either externally or internally. All of these funds are created for welfare purposes of the population. Each organization has its own regulations and laws. The external flow of funds is not documented, but the impression is that there are widespread activities involving all types of support, mainly from Arab and Islamic countries.

Section

# 4

Current WHO Cooperation



### 4.1 WHO country office

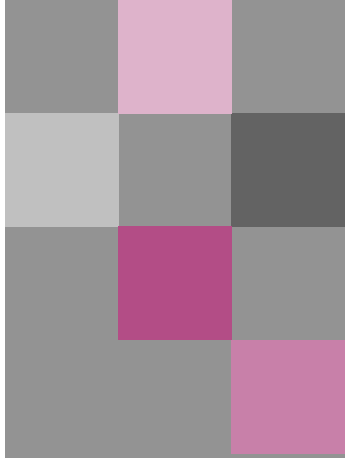
There is no WHO country office in the United Arab Emirates. However, WHO's presence has been strengthened through the office of the Foreign Relations and International Health Department in the Ministry of Health.

### 4.2 Current country programme

The Regional Office established a planning and consultative process with the Ministry of Health through the Joint Programme Planning and Review Mission (JPRM). According to the guidelines for the preparation of the JPRM for the biennium 2004–2005, the JPRM aims at ensuring that the collaborative programmes are in line with the national health policy and will strengthen the national capacity for achieving the health goals and aspirations. The biennial programme budget is about US\$ 120 000 and activities are defined according to the JPRM. Moreover, capacity-building activities through participation of Ministry of Health officers and directors in intercountry, regional or global meetings or training courses are often funded by the Regional Office or headquarters. Over 100 officers and directors, mainly from Ministry of Health institutions, attended WHO sponsored meetings outside the United Arab Emirates in 2002–2003.

Areas of collaboration between the Ministry of Health and the Regional Office have been identified through the JPRM as follows:

1. control of communicable diseases: HIV/AIDS, malaria, measles elimination, poliomyelitis eradication, tuberculosis;
2. health promotion and healthy lifestyles: mental health, substance abuse, nutrition and food safety, breast cancer screening, child and adolescent health, reproductive health and community-based rehabilitation;
3. nursing and paramedical resources;
4. national system for accreditation of health services;
5. evidence-based medicine;
6. training in quality management in blood banks; and
7. fellowships for human resources.



Section

# 5



WHO Policy Framework: Global and Regional  
Directions

### 5.1 Operating framework

Health systems in developing countries are becoming more complex. The role of the state in provision of health care is diminishing rapidly, with the private sector and civil society becoming active and important players. Also, globally, a number of development organizations and financial institutions have become heavily involved with health development activities in developing countries. It was, therefore, timely for WHO to respond to this changing environment by calling for new ways of working with its Member States.

WHO has adopted a broad approach to health within the context of human development with a particular focus on the links between health and poverty reduction. It is assuming a greater role in establishing wider national and international consensus on health policies, strategies and standards, through managing the generation and application of research, knowledge and expertise. At the country level, through the CCS process, it is envisaged that:

- WHO collaboration will be more strategic and focused on fewer priority areas, which will be an amalgam of global, regional and national priorities;
- increased emphasis will be given to WHO's role as a policy adviser and broker;
- opportunities will be sought for increasing and strengthening partnerships with other international and national agencies, including

nongovernmental organizations working in the field of health;

- innovative approaches will be sought to increase the effectiveness of WHO support;
- attempts will be made to ensure the utilization of the knowledge and skills present in the country for WHO's normative work.

### 5.2 Country level functions

To carry out WHO operations at the country level four WHO functions have been identified:

- catalysing the adoption and adaptation of technical strategies; seeding large-scale implementation;
- supporting research and development; monitoring health sector performance;
- information and knowledge sharing; providing generic policy options; standards; advocacy;
- providing specific policy advice; serving as broker; influencing policy, action and spending.

It should be noted that the sequence in which the above functions are listed is not an indication of their priority. In fact, the relative importance of these functions would vary from country to country depending on its state of development and strategic priorities identified for collaboration with WHO during the process of formulation of CCS.

### 5.3 WHO-wide strategic directions

WHO's current (2002–2005) General Programme of Work lists the following four inter-related strategic directions to provide a broad framework for focusing WHO's technical work.

- ❖ Strategic direction 1: reducing excess mortality, morbidity and disability, especially in the poor and marginalized populations.
- ❖ Strategic direction 2: promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, 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.

### 5.4 WHO global priorities

Based on the analysis of major challenges in international health, WHO has established a set of global priorities. The selected global priorities as stated in the General Programme of Work for 2002–2005 are as follows:

1. Malaria, tuberculosis and HIV/AIDS: these three major communicable diseases pose a serious threat to health

and economic development and have a disproportionate impact on the lives of the poor.

2. Cancer, cardiovascular diseases and diabetes: there is a growing epidemic of these diseases in the poor and in transitional economies.
3. Tobacco: is a major killer in all societies and rapidly growing problem in developing countries.
4. Maternal health: the most marked difference in health outcomes between developed and developing countries show up in maternal mortality data and it is difficult to reduce maternal mortality without a well-functioning health system.
5. Food safety: poses a growing public health concern with potentially serious economic consequences.
6. Mental health: five 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.
7. Safe blood: is both a potential source of infection and a major component of treatment, and crucial in the fight against hepatitis and HIV/AIDS.
8. Health systems: development of effective and sustainable health systems underpins all the other priorities; demand is substantial from Member States for support and advice on health sector reform.
9. Investing in change in WHO: is a prerequisite for WHO to become a more efficient and productive organization

and one capable of response within an increasingly complex environment. The development of new skills, systems and process is central to the effective management of WHO's core functions.

### 5.5 WHO regional priorities

The Eastern Mediterranean Region has the demographic profile of a developing region. It is a low–middle income region. Poverty and unemployment affect a large number of people. Communicable diseases are still prevalent in the least developed countries and tuberculosis, malaria and HIV/AIDS are major killers. A number of countries in the Region are in a state of conflict and emergency. Malnutrition is still a significant problem in some countries. Water scarcity is a region-wide challenge. Also, the lack of adequate safe water supply and proper sanitation are major health hindrances in the least developed countries, which constitute a large percentage of the population in the Region. Similarly, rapid urbanization and increase in car ownership have resulted in severe air pollution in major cities of the Region. Solid waste management, particularly of hazardous and medical wastes, is particularly weak in a significant number of countries of the Region.

An epidemiological shift is being witnessed in the Region. Currently, due to changes in lifestyles, noncommunicable diseases constitute 40% of the disease burden. It is projected that by 2020 the share of the burden for noncommunicable diseases will increase to 60%. This is creating a double burden of both communicable and noncommunicable diseases. Maternal mortality is still

unacceptably high in some countries. The average maternal mortality ratio for the Region in 2001 was as high as 330 per 100 000 live births, while over 60% of infant deaths occur in the neonatal period in most countries. Foodborne diseases are also on the rise and represent a major public health challenge. The rapid change in lifestyles in many countries is having a clear impact in terms of stress and mental health-related conditions.

The health system, including governance, quality assurance, service delivery, health regulation, and medical technologies and medicine, needs major strengthening in almost all countries. Health financing is a major emerging issue in the Region. In lower income countries most health expenses are borne by people. The middle-income countries have a mix of private and public sector. In these countries, in some instances, there is a surplus of trained human resources, such as physicians. In high-income countries the major share of health expenditure is borne by governments. The health information system in almost all countries needs to be strengthened. The nursing picture is rather gloomy, both in terms of adequate numbers in poor countries and career structure.

In light of the above situation, the Regional Office has identified certain priority areas for its collaboration with Member States. These were spelled out in the programme budget for the period 2004–2005 which was endorsed by the Regional Committee for the Eastern Mediterranean at its Forty-ninth session held in October 2002 (EM/RC/49/R.2). The priorities include the following.

## Health protection and promotion

- ❖ Promotion and development of healthy lifestyles through programmes such as the Tobacco Free Initiative, healthy communities, villages and cities, action-oriented school health activities, health of special groups and health education.
- ❖ Strengthening of national and regional initiatives to improve nutritional status through raising awareness of individuals and the community and control of micronutrient deficiencies.
- ❖ Integration of health promotion aspects with clinical approaches at all levels of the health care system, such as in the example of the regional initiatives to integrate at the primary health care level maternal, child and adolescent health, prevention and control of noncommunicable diseases and mental health activities.
- ❖ Promotion and strengthening of environmental health initiatives, particularly those relating to water safety and security, environmental health impact assessment, food safety and healthy environments for children and development of intersectoral activities in this respect.

## Community development

- ❖ Addressing the underlying determinants of health and poverty as essential to ensuring sustainable development and sustained health improvements in the long term. Community-based initiatives such as basic development needs (BDN), healthy cities, healthy villages and

women in health and development are among the priorities adopted by countries. In all these initiatives special emphasis is given to strengthening and enhancing the role of women as major stakeholders in achieving and sustaining the desired health and development goals.

- ❖ Efforts to facilitate achievement of the Millennium Development Goals, aiming to halve the number of people living in absolute poverty by the year 2015. This will include the development of various policies and plans such as Poverty Reduction Strategy Papers, to create supportive political, physical and economic conditions for all segments of the population to produce a positive impact on the overall quality of life. Concerted efforts are being made to make health systems better oriented to the needs of the poor by giving greater attention to promoting health throughout the life span, and reducing inequities in health status.

## Disease control

- ❖ Improvement of epidemiological profiles using quantitative methods, such as burden of disease assessment and forecasting techniques. Efforts should be made to strengthen national and regional capabilities in epidemiology and national information systems through developing national and subnational registries for priority health problems. Efforts should also be made to benefit from epidemiological research studies in designing health policies and strategies. Priority diseases that are

the main contributors to the disease burden and at the same time are amenable to intervention strategies will be identified.

- ❖ An integrated approach in communicable disease control programmes through ensuring political commitment, integrating cross-cutting control activities, scaling-up disease-specific control activities, and developing synergy of managerial processes.
  - ▶ Essential packages of services for prevention and control of priority diseases and indicators to monitor and evaluate these programmes will be developed.
  - ▶ Integration of cross-cutting control activities will cover at least communicable disease surveillance, epidemic preparedness and response including developing early warning and surveillance systems, infection control and containment of antimicrobial resistance, integrated human resource development, health education and advocacy, and operational research.
  - ▶ Scaling-up of disease-specific activities includes immunization programmes, tuberculosis control, malaria control, HIV/AIDS/STD prevention and control, elimination and eradication of specific diseases.
- ❖ Immunization programmes maintained and strengthened, with particular focus on countries that have lower immunization coverage and problems in certification of poliomyelitis

eradication. The Regional Office will pursue its policy aimed at achieving self-sufficiency in vaccine production.

- ❖ Integrated management in control of noncommunicable diseases. Particularly attention will be paid to quality assurance programmes and to emerging needs, such as palliative care for cancer patients and health of the elderly.

## Health systems and services development

- ❖ Promotion of a culture of strategic thinking in decision-making, using evidence-based policies and strategies, and development of important components of the stewardship function, such as regulation, public-private mix management, coordination, etc.
- ❖ Strengthening decentralization of health systems through capacity-building and technical expertise, and supporting district health systems through institutionalization of the district team problem-solving approach and development of sustainable management through national management effectiveness programmes.
- ❖ Improving quality in health service delivery through implementation of a programme of continuous quality improvement based on quality standards for individuals, departments and organizations against which performance will be measured.

- ❖ Support to accreditation initiatives, such as multidisciplinary assessments of health care functions, organizations and networks, as an important approach for improving the quality of health care structures.
- ❖ Enhancing national information systems in order to provide necessary data on spending on health, particularly on private services, making use of household expenditure and utilization surveys and national health accounts analysis.
- ❖ Testing of the WHO framework and tools for health system performance assessment and development of an observatory in the Regional Office to assess, manage and monitor health sector reforms.
- ❖ Development and decentralization of laboratory activities, health imaging technology, blood safety and blood transfusion.
- ❖ Strengthening of the essential drugs programme and ensuring use of essential drugs lists by most countries while promoting rational drug use and traditional medicine.
- ❖ Improvement of coordination for human resources development and promotion of continuing education for health personnel at the various levels of the system. Efforts will focus on developing innovative approaches for human resources development, including community-oriented health personnel education.

Section

6

Strategic Agenda: Priorities Jointly Agreed  
for WHO Cooperation in and with  
United Arab Emirates

## Section 6. Strategic Agenda: Priorities Jointly Agreed for WHO Cooperation and with United Arab Emirates

### 6.1 National health priorities as identified by the Ministry of Health

- Provision of quality, comprehensive, primary and specialized care to all residents of the United Arab Emirates;
- Increasing life expectancy by reducing mortality and morbidity rates;
- Elimination or reduction of the occurrence of infectious disease to minimal levels, especially childhood diseases targeted in the immunization programme, as well as other important diseases;
- Early detection and timely treatment of prevalent chronic diseases;
- Implementation of programmes targeting specific populations or ages, such as mothers, children below 5 years, schoolchildren, youth, in addition to the elderly and persons with special needs;
- Establishment of a standardized information and data management system for evaluation and planning purposes in addition to a programme for health human resources development and training in specialized technical institutions.

### 6.2 Strategic directions for cooperation

#### 6.2.1 Strengthening institutional capabilities of the Ministry of Health

- Strengthening Ministry of Health leadership in evidence-based policy development, strategic thinking in planning and management, regulation, coordination and partnership, and quality assurance:
  - ▶ undertake national studies using standard analytical tools to support policy-making and priority-setting: national burden of disease assessment; institutionalization and ownership of national health accounts analysis; costing and cost-effectiveness analysis studies, including the identification and costing of essential interventions; and scenario development for strategic planning (human resources development, certificates of need, etc.);
  - ▶ supporting the national health information system and promoting population-based surveys to improve informed decision-making;
  - ▶ rationalizing the use of technology, including assessment and selection of biomedical equipment and procedures.
- Improving services and financing of health care through expansion of social health insurance, particularly

in the private sector, with the aim of achieving universal health insurance coverage for both national and expatriate communities:

- ▶ supporting selection from various options for expanding health insurance coverage, including capacity-building and necessary technical expertise (actuarial studies, management information systems, payment methods, etc.);
- ▶ promoting cost control and cost containment policies in order to improve the efficiency of the system:
- ❖ Improving the organization and regionalization of service delivery with particular focus on strengthening decentralization, implementing and strengthening the referral system and implementing quality assurance protocols:
  - ▶ conducting an in-depth review of the organization of service delivery based on primary health care;
  - ▶ assessing and supporting health system decentralization, including the referral system;
  - ▶ support to the strengthening of hospital-based care in areas of hospital autonomy, risk management approaches and tools, hospital management instruments, including accreditation, patient and facility safety and continuing professional development programmes;
  - ▶ strengthening the district health system through capacity-building and provision of necessary planning and management tools, including

district team problem-solving approaches;

- ▶ technical support to develop a national health disaster plan and strengthen emergency services.

### 6.2.2 Improving human resources development

- ❖ Strengthening of human resources development functions in the Ministry of Health (planning department) with particular emphasis on nursing, primary care and public health professionals;
- ❖ Promotion of tools for strategic planning for human resources development and management using projections, scenarios and other predictive techniques;
- ❖ Establishing a national system of career development for health professionals;
- ❖ Strengthening the partnership between health care providers, professional associations, universities and other training institutions.
- ❖ Supporting development of human capacity in the field of health management, administration and financing through:
  - ▶ developing human resources;
  - ▶ promoting cost control and effectiveness, and monitoring public and private health expenditures in order to monitor utilization of health services;
  - ▶ supporting the current efforts of ISO 9000 certification, performance-based budgeting, e-government.

### 6.2.3 Reduction of burden of diseases, especially noncommunicable diseases

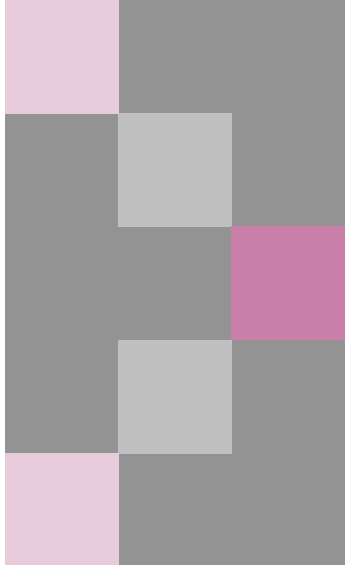
- ❖ Strengthening and supporting a stepwise surveillance system based on monitoring of risk factors, morbidity and mortality for noncommunicable diseases;
- ❖ Supporting the development of multisectoral strategies to prevent and control common noncommunicable diseases at the primary, secondary and tertiary prevention level;
- ❖ Enhancing management of noncommunicable diseases through primary health care interventions: improve healthy nutrition, promote physical exercise, control tobacco smoking, and promote safety in general and road safety in particular;
- ❖ Enhancing health education and promotion;
- ❖ Strengthening the laboratory network to support the surveillance system for the monitoring of communicable and noncommunicable diseases, including establishment of a reference laboratory;
- ❖ Assessing the burden as well as the epidemiological and clinical characteristics of mental health problems with a view to developing appropriate control strategies;
- ❖ Improving data collection on maternal health, with special focus on maternal morbidity.

### 6.2.4 Improving intersectoral collaboration and community involvement

- ❖ Strengthening healthy settings approaches, including healthy cities, health-promoting schools, healthy workplaces, and health-promoting hospitals.

### 6.2.5 Enhancing health research

- ❖ Promotion of culture of research and development in the health system;
- ❖ Capacity-building in research and development;
- ❖ Improving the linkage between research and policies based on evidence.



Section

# 7

Implementing the Strategic Agenda:  
Implications for WHO Secretariat, Follow-up  
and Next Steps at Each Level



Implementation of the Country Cooperation Strategy will be an integral part of the collaborative work between the Ministry of Health in the United Arab Emirates and WHO. The CCS will strengthen the nature of the work between the WHO and the Ministry of Health and contribute greatly to national health development.

### Country level

- ❖ Emphasis on standardized data collection to be used for policy inputs;
- ❖ Stronger human resources and institutional capacity development;
- ❖ Stronger advocacy, communication and public information;

### Regional level

- ❖ Efficiency in providing technical support without delay;
- ❖ Sharing of expertise;
- ❖ Sharing of resources (publications, documents, protocols, strategies, guidelines, experiences);
- ❖ Mobilizing information and communication technology;
- ❖ Promoting and brokering dialogue;
- ❖ Coordination of collaborative work among countries of the Region;
- ❖ Knowledge of networking and sharing of good practices.

### Headquarters

- ❖ Providing technical cooperation in building human resources, institutions and policies;

- ❖ Coordination between Regional Office and country representative;
- ❖ Source of integral information related to identified priority areas.

### Requirements for CCS implementation

The CCS comes at an important moment in state health system development. The changes being introduced in the country, including decentralization, privatization and health insurance, that might reflect positively on the health services and place extra demand on the work of WHO and the Ministry of Health must be proactive, with an ability to provide guidance and help with technical support for leadership, training, guidance and follow-up of the steps taken throughout the implementation of this strategy. This means that the liaison office (International Health Relations and Foreign Affairs) must be able to respond to, support and follow up the changes and take an active part in the advocacy programme for these changes.

Such an ambitious CCS will require funding beyond the regular budget. It is recommended by the team that securing extrabudgetary resources through a Funds-in-Trust approach will help to overcome the obstacles in timely response and support to emerging challenges.

## Annex 1 Process of CCS

The Ministry of Health of the United Arab Emirates initially developed a draft background document, which was reviewed by the Regional Office for the Eastern Mediterranean, before the WHO team went to Abu Dhabi for the period between 3–17 July 2004. The joint team comprised of Mr Abdel Hamoud, Head of Department of International Relations, MOH and Dr Khodr Awad, WHO, Country Cooperation Strategy, and Dr Said Arnaout, Regional Adviser for the Health of Special Groups and Dr Amr Mahgoub, Regional Adviser for Health Management Support. In Abu Dhabi, the team met with the following departments:

- ❖ Department of Statistics and Planning
- ❖ Nursing Department
- ❖ Primary Health Care Department
- ❖ Curative Medicine Directorate
- ❖ Dentistry Department
- ❖ Preventive Medicine Directorate
- ❖ Occupational Health Department
- ❖ Health Education Department
- ❖ School Health Department
- ❖ Blood Bank
- ❖ Technical Services Department
- ❖ Administration Department
- ❖ X-Ray Department

- ❖ Complementary Alternative Medicine Department
- ❖ Accounting Department
- ❖ Private Medical Profession Department
- ❖ Quality (ISO) Department

The meetings resulted in the raising and highlighting of various issues which were included in the second draft of the CCS document. This version was then circulated and finalized between the team members and delivered to the programme planning, monitoring and evaluation team.

