

Country Cooperation Strategy for WHO and Kuwait 2005–2009

Kuwait



World Health Organization
Regional Office for the Eastern Mediterranean

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for WHO and Kuwait
2005–2009

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Regional Office for the Eastern Mediterranean
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Contents

Executive Summary 5

Section 1. Introduction 11

Section 2. Country Health and Development Challenges 13

2.1 Socioeconomic and demographic overview 15

2.2 State of health and health care 16

2.3 Challenges, issues and constraints 18

Section 3. Development Assistance and Partnerships: Aid Flows, Instruments 21 and Coordination

Section 4. Current WHO Cooperation 25

4.1 Organization of health services 27

4.2 Emergency preparedness and humanitarian action 27

4.3 Evidence and information for policy 27

4.4 Promotion of healthy lifestyles 28

4.5 Nutrition and food safety 28

4.6 Child and adolescent health (including IMCI) 28

4.7 HIV/AIDS and sexually transmitted diseases 28

4.8 Noncommunicable diseases 29

Section 5. WHO Policy Framework: Global and Regional Directions 31

5.1 Operating framework 33

5.2 Country level functions 33

5.3 WHO-wide strategic directions 34

5.4 WHO global priorities 34

5.5 WHO regional priorities 35

Section 6. Strategic Agenda: Priorities Jointly Agreed for WHO Cooperation in and with Kuwait for the Next Five Years 39

6.1 National health priorities 41

6.2 Strategic directions for cooperation 41

Section 7. Implementing the Strategic Agenda: Implications for WHO Secretariat, Follow-up and Next Steps at Each Level 45

7.1	Implications for at Country level	47
7.2	Implications for at Regional level	47
7.3	Implications for WHO at Headquarters level	47
7.4	Requirements for CCS implementation	47

Annex 49

Executive Summary

The WHO Country Cooperation Strategy (CCS) with Kuwait is a reference framework for decisions influencing the country's health sector in the medium-term. In developing the CCS the country's needs and expectations with regional orientations and global priorities for public health are considered. The key principles that govern WHO's search for new strategic agendas at country level are to have greater focus on support in the country health sector; greater flexibility within precise boundaries for response; more emphasis on WHO's role as policy adviser and broker; wider partnerships and greater attention to partners' strategies and activities; maintenance of the visibility and credibility of WHO and differentiation of WHO's work and performance from that of the government; and guidance for achieving the health sector related Millennium Development Goals (MDGs).

According to 2003 estimates the total population of Kuwait is 2.484 million of which nationals constitutes about 37%. The population growth was estimated to be 3.36% in 2004. Kuwait is a small, rich, relatively open economy with 10% of world reserves of crude oil. Petroleum accounts for nearly half of GDP, 95% of export revenues, and 80% of government income. In 2003 the GDP per capita was estimated to be US\$ 18 100. The labour force is 1.3 million of which 80% are non-Kuwaitis. Unemployment was estimated to be 7% in 2002, mainly short-term. In 2003, the adult literacy rate was 91% with female literacy of 89%. Primary education is universal. Although women have full participation in

all aspects of socioeconomic activities, they have yet to be given the right to vote. Life expectancy at birth for the Kuwaiti population in 2003 was 78.7 years, the infant mortality rate was 9.4 per 1000 live births and the maternal mortality ratio 9.1 per 100 000 live births. Total population access to health services was 100% and there was no urban-rural gap.

In terms of health financing, the annual budget of MOH per capita in 2001 was US\$ 463, while the national health expenditure per capita was US\$ 578. The total expenditure on health was 3.5% of GDP. All Kuwaitis have access to primary health care services. There are 74 primary health care centres throughout the state across six health regions that provide polyclinic services.

In 2003, the human resources rates per 10 000 population were 19 for medical doctors, 3 for dentists, 2.6 for pharmacists, 40 for nurses and mid wives, 21 for hospital beds and 3 for primary health care units. In 2003 the percentage of infants immunized against DPT was 98%, poliomyelitis 98% and measles 99% with 100% vaccination coverage against HBV. Secondary care is provided through six regional hospitals, in addition there nine specialist hospitals with total of 4575 beds. These hospitals consume the largest proportion of the public health budget, despite moderate bed occupancy and high pressure on primary care services.

With the decrease in the incidence of communicable diseases and the increase in

life expectancy, the burden of disease has shifted towards noncommunicable diseases and injuries. Trends are showing steady increases in the incidence of coronary heart disease, cancer and accidents and injuries. In addition to this noncommunicable disease risk factors are showing alarmingly high prevalence; for example, diabetes, obesity, dyslipidaemia and physical inactivity. Mental disorders also represent a major public health problem, in particular among non-Kuwaitis.

Despite achievements, Kuwait is facing many challenges in the health sector: a) high expectations among a literate and educated public for quality services; b) increasing prevalence of noncommunicable disease, in particular, cancers, coronary heart diseases and mental health disorders; c) investment in curative rather than preventive services; d) need for capacity-building and real and substantial investment in public health and primary care capacity, both in term of quantity and quality of practitioners; e) continued reliance on non-Kuwaiti health professionals to support the expanding health system; f) escalating costs of health services due to the expansion of population coverage, medical advances and unmet demands; g) need to determine the best and the most cost-effective way to fund the health and health care services taking into account the high percentage of the non-Kuwaiti population and the exceptionally high non-Kuwaiti workforce; h) need for investment in quality of care to reduce the unit costs in the medium and long term, increase patient, public and professional satisfaction and minimize litigation; and i) urgent need to invest in management capacity development through training and

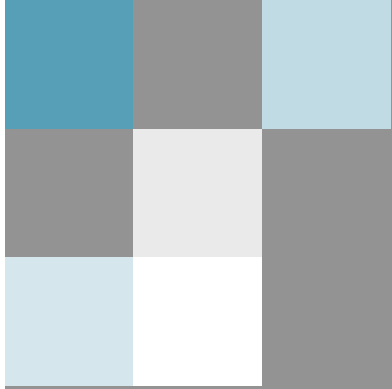
a leadership programme.

Kuwait does not depend on external assistance for the financing of its health sector. Kuwait is a net donor of funds for supporting the health sector of other Islamic countries in the Region. WHO provides technical assistance to the Ministry of Health through policy advice, capacity development of its staff, and review of the national policies, strategies and programmes. The principal instrument for providing such assistance is the biennial Joint Programme Review and Planning Mission (JPRM) exercise. The JPRM for 2004–2005 focuses on the following areas: i) organization of health services ii) emergency preparedness and humanitarian action; iii) evidence and information for policy; iv) promotion of healthy lifestyles; v) nutrition and food safety; vi) child and adolescent health (including IMCI); vii) HIV/AIDS and STD; and viii) noncommunicable diseases;

In today's Kuwait there are new sets of challenges and the CCS team identified 10 priority areas that need to be addressed in order to continue with the level of success achieved so far. The WHO will work closely with the Ministry of Health to address these priorities. These are: i) supporting health promotion; ii) noncommunicable disease prevention and care; iii) strengthening the primary health care services; (iv) strengthening the mental health services; (v) organizational development and management of the health system; vi) Evaluating the health financing and regulations; vii) Promoting “quality” of care; viii) strengthening the health information system; and ix) increasing capacity in medicines management.

WHO does not have a country office in Kuwait. Country level support is provided through a Regional Office staff who fulfils the responsibility of the Desk Officer for Kuwait on a part time basis. Although the current arrangement works well, given the ambitious agenda there will be a greater need for technical support through short-term consultants, training programmes for health professionals, dissemination of information on key issues, and organization of study tours. The Regional Office and headquarters would primarily be responsible for the following: a) prompt and effective provision of technical support; b) sharing of

regional experiences (technical cooperation among developing countries), resources (WHO collaborating centres, regional centres of excellence) and development of guidelines and protocols; c) capacity-building at regional and headquarters levels; d) monitoring and evaluation of priority programmes; e) coordination of support with headquarters and the desk officer; and f) standard setting and a clearing house for information and publication. Financial resources are needed to support the areas of intervention identified in the CCS, which will primarily be met from the country's resources.



Section



Introduction



The WHO Country Cooperation Strategy (CCS) with Kuwait is a reference framework for decisions influencing the health sector in the medium-term. In developing the CCS the country's needs and expectations, together with regional orientations and global priorities for public health are considered. The key principles that govern WHO's search for new strategic agendas at country level are to have greater focus on what to support in the country health sector; greater flexibility within precise boundaries for response; more emphasis on WHO's role as policy adviser and broker; wider partnerships and greater attention to partners' strategies and activities; maintenance of the visibility and credibility of WHO and differentiation of WHO's work and performance from that of the government; and guidance for achieving the health sector related Millennium Development Goals (MDGs).

Kuwait's achievements are so far relatively comparable to average European standards of health and health care. This high level of health status and good standard of and accessible health care services was achieved through the generous welfare system and education attainments developed since independence in 1961. Great strides have been made in health since 1910 when curative health services were provided by American missionaries. In the early 1930s the Municipal Department was established and assumed responsibility for upgrading Kuwait's public health. This improvement was demonstrated in the programmes to clean areas of the country, and projects to provide needed drainage were undertaken

as well as health awareness and vaccination campaigns. In 1936 the Health Department was established and during the 1950s Kuwait witnessed an overall health renaissance marked by rapid progress in the construction of hospitals and health care units.

WHO's global strategic objectives are: reducing excess mortality, morbidity and disability, promoting healthy lifestyles and reducing risk factors, developing health systems, and framing policies that are enabling the development of the health sector. The areas identified for WHO cooperation with Kuwait to build on include:

- providing advice to influence development of policy that aims to improve further the health of the population of Kuwait, its implementation and the best possible monitoring system;
- sharing advances in health system development and providing policy options; standards; advocacy;
- encouraging and supporting advance training in all areas where development is needed;
- supporting relevant research and development that have impact on the population's health;
- supporting the implementation of national priority programmes based on population needs.



Section

2



Country Health and Development
Challenges

2.1 Socioeconomic and demographic overview

Population

Kuwait occupies the north-eastern corner of the Arabian Peninsula. It is bound to the east by the Persian Gulf, to the south-west by Saudi Arabia and to the north and the east by Iraq, with a total land area of 17 818 km². The climate is intensely hot in summer with a short cool winter.

Total population of nationals and nonnationals (2003) is estimated at 2 484 334 (nationals constitute about 37% of the total population).¹ Population growth is estimated at 3.36% (2004). The population is distributed in 6 governorates, with highest density in Hawelli (686 421 persons which represents 27.6% of the total population). Kuwait is nearly completely urbanized with 97% of its population living in urban area, with universal access to safe water and sanitation.

Economy

Kuwait is a small, rich, relatively open economy with proven crude oil reserves of about 98 billion barrels: 10% of world reserves. Petroleum accounts for nearly half of GDP, 95% of export revenues, and 80% of government income. Kuwait's climate limits agricultural development. Consequently, with the exception of fish, it depends almost wholly on food imports. In 2003 GDP per capita was estimated at US\$ 18 100.

Employment

Kuwait is a country with a small population, which gives good opportunity for employment. The labour force is 1.3 million of which 80% are non-Kuwaitis. Unemployment was estimated to be 7% in 2002, mainly short-term.

Education

Great emphasis has been placed on education as a means for economic development. Adult literacy rate is 91% (2003) and female literacy rate 89%. Primary education is universal with 100% secondary level enrolment also for both males and females.

Women's development

With the high literacy rates in Kuwait, women have full participation in all aspects of socioeconomic activities, in both the public and private sectors. However, women have yet to be given the right to vote.

Food and nutrition

Food is available in abundance and is affordable to all sections of the population. However, there is evidence of under-nourishment, and some studies have reported a significant evidence of anaemia, especially among young girls. Overweight and obesity are significant health risk factors in Kuwait with a high prevalence especially among the Kuwaiti population.

¹ Data sources: Demographic and health indicators for countries of the Eastern Mediterranean 2004. Cairo, World Health Organization, Regional Office for the Eastern Mediterranean, 2004.

2.2 State of health and health care

Main health status indicators

According to the Ministry of Health, life expectancy for the Kuwaiti population (no available data for non-Kuwaiti) at birth is 78.7 years, for males 77.8 and for females 79.9 (2003). Infant mortality rate is 9.4 per 1000 live births (2003), and under-five mortality rate 11.8 per 1000 live births for males and 10.9 per 1000 live births for females.

Maternal mortality per 100 000 live births was 9.1 in 2003, crude birth rate 17.7 per 1000, crude death rate 1.8 per 1000 population, and the total fertility rate 2.2. Total population access to health services was 100% in 2003. There is no urban–rural gap since over 95% of the population is urban.

Health expenditure

Although a full National Health Account study has not been undertaken in Kuwait, WHO reports show government allocated 6.9% of the budget to the Ministry of Health in 2002. The expenditure of the Ministry of Health as percentage of GNP was 2.1% in 2001. While the annual budget of the Ministry of Health per capita in 2001 was as US\$ 463, national health expenditure per capita was US\$ 578. However, total expenditure on health as a percentage of GDP was 3.5. Private health expenditures represented 21.2% of total health expenditure, giving a mixed health economy of 80:20 public/private. Private expenditure is mainly out-of-pocket expenditure.

Primary health care and human resources for health

Both the public and private sectors provide health and medical care, with primary health care being provided by the public sector. All Kuwaitis have access to primary health care services. There are 74 primary health care centres throughout the state across 6 health regions that provide polyclinic services. According to the Ministry of Health data, antenatal care is provided to 100% of pregnant females, trained health personnel attend all births and around 98% of children are fully vaccinated. In 2003, the human resources per 10 000 population were: 19 medical doctors, 3 dentists, 2.6 pharmacists, 40 nurses and midwives and 21 hospital beds. These are for PHC units per 10 000. Table 1 gives the breakdown of health human resources in Kuwait, and distribution by Kuwaiti and non-Kuwaiti population.

Immunization

In 2003 the percentage of infants immunized against DPT was 98%, poliomyelitis 98% and measles 99% with 100% vaccination coverage against HBV (Table 2). These high coverage rates can be attributed to the efforts of the Ministry of Health in reaching mothers, better provision of knowledge and improved awareness of the public on diseases.

Hospitals

Secondary care is provided through six regional hospitals with 2500 bed capacity. In addition to this there are 9 specialist hospitals, including maternity, infectious diseases, mental health and cancer hospitals, bringing the total beds available to 4575, with total bed occupancy around

Table 1. Health human resources profile, Kuwait, 2003

Cadre	Kuwaitis	Non-Kuwaitis	Total
Physicians	1 718 (40%)	2 537 (60%)	4 254
Pharmacists	152 (29%)	380 (71%)	532
Managers	6 622 (91%)	669 (9%)	7 291
Technicians	4 245 (62%)	2 650 (38%)	6 895
Nurses	984 (11%)	8 013 (89%)	8 997
Support staff	511 (69%)	229 (31%)	740
Ancillary staff	82 (11%)	693 (89%)	775
Total	14 314 (49%)	15 171 (51%)	29 485

Source: Ministry of Health Kuwait

Table 2. Some population indicators, Kuwait 2002–2003

Population with safe drinking-water	2002	100%
Population with adequate excreta disposal facilities	2002	100%
Population with local health care	2002	100%
Deliveries attended by trained personnel during pregnancy	2002	100%
Infants attended by trained personnel	2002	100%
Infants fully immunized against		
Tuberculosis	2003	100%
Poliomyelitis	2003	98%
DPT	2003	98%
Measles	2003	99%
Hepatitis	2003	100%

Source: Ministry of Health Kuwait

60%. These hospitals consume the largest proportion of the public health budget, despite moderate bed occupancy and high pressure on primary care services.

Communicable diseases

Substantial epidemiological transition has occurred in regard to infectious and communicable diseases. This is attributed to socioeconomic development and rapidly

changing lifestyles. There were no reported cases of cholera, diphtheria, polio and tetanus in 2000. The reported number of malaria cases was 233 in 2001. There were 111 reported cases of tuberculosis in 2001.

Noncommunicable diseases

With the decrease in the incidence of communicable diseases and the increase in life expectancy, the burden of disease has shifted towards noncommunicable diseases and injuries. Trends show steady increases in the incidence of coronary heart disease, cancer and accidents and injuries (mainly road traffic accidents). In addition to this many risk factors are showing alarmingly high prevalence, for example, diabetes, obesity, dislipidemia and physical inactivity. Various national groups and communities have been set up to tackle these problems. Mental disorders also represent a major public health problem, in particular among non-Kuwaitis. The extent of somatization is not known, but it is expected to be high in such a mixed population.

2.3 Challenges, issues and constraints

Despite the admirable achievements in socioeconomic development, health status and provision and access to public services, Kuwait is facing many challenges in the 21st century which may impinge on the health of the population if serious and systematic steps are not introduced as soon as possible.

- ❖ Public expectations: The very high expectations among a literate and educated public for higher quality

services, accessible to where they live, and that meet all their needs (for example a range of what is called secondary services provided in primary care settings) pose a major challenge to health policy makers.

- ❖ Demographic changes: It is projected that the Kuwaiti population over the age of 60 years will increase to 8% of the population by 2030 and to 25% by 2050. The prevalence of chronic disease, therefore, will increase, in particular cancers, coronary heart disease (angina, myocardial infarction, arrhythmias and heart failure) and mental health disorders.
- ❖ Investment in curative rather than preventive services: Despite the substantial improvement in health, the focus is still on programmes to expand hospital services in both the public and private sector. This is a costly in the long term. The priority should be focused on reducing ill health and the burden of diseases through programmes that secure the health of the whole population. This cannot be achieved without shifting resources from curative to public health activities, including prevention of noncommunicable diseases and reduction of risk factors.
- ❖ Burden of noncommunicable diseases: WHO predicts that noncommunicable diseases will constitute more than 60% of burden of disease in the Region by 2020.² Current data show that Kuwait is already at this stage with trends showing

steady increases in coronary heart disease, cancers, accidents and mental ill-health. Indeed, some of the risks to health are already very high, including overweight and diabetes.

- ❖ Capacity-building (public health, primary health care): Kuwait will not be able to cope with the changing patterns of the disease burden (noncommunicable diseases) without real and substantial investment in public health and primary care capacity, both in terms of quantity of practitioners and quality of such practitioners.
- ❖ Human resources development/ standards: Kuwait is still relying, and will continue to rely for many years to come, on non-Kuwaiti health professionals to support the expanding health system. The variation in quality is huge and a system of recruitment to minimize variation is urgently needed. It will be some time before such a variation can be overcome.
- ❖ Cost of health services: The costs of health services in all countries, including Kuwait, are escalating. This is not because of the increase in unit costs, but is due to the expansion of population coverage due to medical advances and unmet demands. A political decision is needed on the best and the most cost-effective way to fund the health and health care services

in Kuwait. Furthermore, any decision should take into account the very high percentage of the non-Kuwaiti population (63%) and the exceptionally high non-Kuwaiti workforce (80% of the total workforce).

- ❖ Quality of health service: Investment in quality will reduce the unit costs in the medium and long term, increase patient, public and professional satisfaction and certainly will minimize litigations. Patient and public safety is paramount in any good health system.
- ❖ Health service management: The quality of the health system is always linked to its leadership and the management capacity to deliver services that meet the needs of the population and that use the resources available in the most cost-effective ways. Health systems are organic bodies and changes are inevitable in responding to changing population needs and medical advances. There is urgent need to invest in management capacity development through training, leadership programmes and selection of health leaders who can deliver the health priorities for Kuwait (see 2.3 below) and meet the many challenges of the 21st century. It is essential to stress once again that without good information and flow of timeless information within the health system, services cannot be managed and developed effectively.

² The World Health Report 2002. Reducing risks, promoting healthy life. Geneva, World Health Organization, 2002.



Section

3



Development Assistance and Partnerships:
Aid Flows, Instruments and Coordination

Section 3. Development Assistance and Partnerships: Aid Flows, Instruments and Coordination

Kuwait does not depend on external assistance for the financing of its health sector. Kuwait is a net donor of funds for supporting the health sector of other Islamic countries in the Region.

Section

4

Current WHO Cooperation



WHO provides technical support to the Ministry of Health through policy advice, capacity development of its staff, and review of the national policies, strategies and programmes. The principal instrument for providing such assistance is the biennial Joint Programme Review and Planning Mission (JPRM) exercise. The most recent JPRM was for the period 2004–2005.

The current joint programme workplans are focused on the following areas:

4.1 Organization of health services

Healthy policy and strategic planning

The programme objectives are to foster the use of economic analysis in order to improve equity and efficacy of the health system, and to build the required capacity to best use economic tools.

Medical accreditation and quality assurance

Kuwait has ratios of health professionals to population higher than the regional average in all categories except for pharmacists. There is an excellent national system of continuing professional development (CPD) for all categories of the health workforce. The outcomes of the Arab Centre for Medical Literature (ACML) have been widely used and have made an impact on teaching. Continuing education activities are being linked with the process of promotion, re-licensing and recertification for all categories of health professionals. Partnership between health services and medical education is

being strengthened through a thorough revision of the curriculum in the Faculty of Medicine and other colleges. A system of accreditation of medical education is being implemented.

Infection control in secondary and tertiary care

The Ministry of Health is strengthening its programmes in quality of care through training programmes for medical and paramedical staff among hospitals.

Health laboratory support and health technologies

The public health laboratories are introducing quality assurance, including standard operating procedures, job descriptions, quality control and internal calibration, bio-safety measures, proper inventory and recording. The national public laboratories of Kuwait are strengthening and developing chemical and microbiological blood safety testing.

4.2 Emergency preparedness and humanitarian action

National emergency preparedness is being updated and strengthened, particularly through capacity-building. The number of staff trained in management and care of patients during disasters is being increased.

4.3 Evidence and information for policy

Considerable progress has been achieved in improving the quality of the National Health Statistical Information

System (NHSIS) in Kuwait. Many areas of progress have been made and reviewed by WHO Staff and consultants. Strengthening human resources in the area of burden of disease estimation has been achieved through participation of nationals in the Global Burden of Disease Workshop 2002, and WHO will continue to support this initiative.

4.4 Promotion of healthy lifestyles

Kuwait needs to integrate health promotion into strategies and plans with broader determinants of health and to reduce risks to people's health through gender sensitive life course approach. In Kuwait, young people are vulnerable to a wide range of unhealthy lifestyles. Understanding risk factors, especially during adolescence, is important to the development and implementation of school, as well as out-of-school, health education programmes.

In **occupational health**, the focus is on safety promotion through strengthening of national capabilities for safe management of chemicals; establishing and strengthening of risk reduction programmes; developing chemical emergency preparedness and response; information exchange on toxic and chemical risks; harmonization and labelling of chemicals; risk assessment of chemicals, and advocating occupational health for all. Cooperation with WHO is of great importance in building national capacities, achieving better access to adequate occupational health services and enabling appropriate access to safe and healthy environment and work conditions.

WHO is supporting the Kuwait national programme to ensure **health care management** for the elderly is integrated

into primary health care, and to develop, review and update a national strategy for health of the elderly.

4.5 Nutrition and food safety

Kuwait is almost exclusively dependent on food imports. Total dietary energy supply has significantly increased and is now equivalent to that of most developed countries. The traditional diet has almost disappeared and has been replaced by more ready-to-eat foods. These new dietary habits have been found to lead to low intake of various essential nutrients and even to deficiencies, particularly of iron, vitamin A and vitamin C.

4.6 Child and adolescent health (including IMCI)

A national plan of capacity-building for IMCI is being implemented.

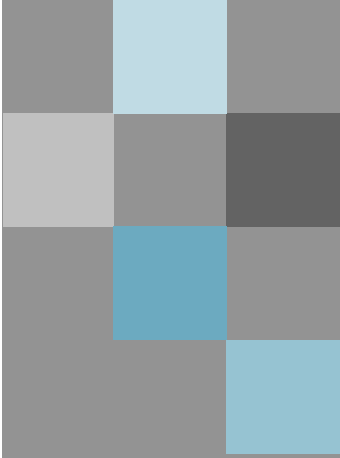
4.7 HIV/AIDS and sexually transmitted diseases

Heterosexual transmission represents the most prevalent mode of transmission (65%) of HIV/AIDS. Targeted prevention addressed to particularly vulnerable groups needs is being developed in conjunction with advocacy to ensure enabling policies. A national strategic plan has been developed.

4.8 Noncommunicable diseases

The national data on noncommunicable diseases and noncommunicable diseases risk factors are not complete. There are good services for management of noncommunicable diseases and the Ministry of Health is aiming to integrate management of noncommunicable

diseases into primary health care, and is planning to start a STEPWISE surveillance system for noncommunicable diseases and noncommunicable diseases risk factors. National plans for noncommunicable diseases are available. The Regional Office considers Kuwait as a demonstration area for diabetes. A population-based cancer registry is being completed.



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 Kuwait for
2005–2009

Section 6. Strategic Agenda: Priorities Jointly Agreed for WHO Cooperation in and with Kuwait for the Next Five Years

6.1 National health priorities

The improvement in the population's health in Kuwait, and in particular among the Kuwaitis, is the pride of all those involved in the planning, decision-making and delivery of services to meet the population needs. However, populations and their needs are changing, hence the priorities and the challenges. In today's Kuwait there are new sets of challenges and health professionals working with the WHO team that visited Kuwait in July 2004 identified 10 priority areas that need to be addressed in order to continue with the level of success achieved so far.

WHO will work closely with the Ministry of Health to address these priorities. This work will be through joint programmes, technical support, capacity-building and training opportunities.

The ten priority areas identified are:

1. Health promotion
2. Noncommunicable diseases prevention and care (plus noncommunicable diseases risk factors surveillance)
3. Primary health care
4. Mental health
5. Organizational development and management of the health system
6. Health system finance and regulations
7. Quality (clinical and services)
8. Needs of the growing elderly population
9. Health information and information technology

10. Medicines management.

6.2 Strategic directions for cooperation

6.2.1 Supporting health promotion

WHO support will focus on support for standard setting and strategy development for health promotion through conduct of needs assessments for protection and prevention activities that improve health and identify risks to ill health both in the population and for high-risk groups; development of health promotion models that fit the culture of Kuwait and meet the population needs; and development of a performance management framework as part of the system development.

6.2.2 Noncommunicable diseases prevention and care (including noncommunicable disease risk factor surveillance and control system)

- Set up noncommunicable disease management programmes in primary care settings.
- Establish clear standards and guidelines for noncommunicable disease management including shared care guidelines (with Gulf Cooperation Council countries, the WHO and other countries).
- Shift resources from curative to preventive and protection services.

- ❖ Develop specific services to tackle risk factors (e.g. preventive cardiology).
- ❖ Target high-risk groups (schoolchildren, young people, immigrant workers etc).
- ❖ Identify health protection as a specific identity (immunization, disease surveillance and control system, HIV control etc).
- ❖ Define and address the needs of immigrant workers. Investment in their health will yield better productivity and less transfer of health problems to the Kuwaiti population.
- ❖ WHO will support:
 - ▶ Integration of noncommunicable disease management in primary care settings;
 - ▶ Capacity-building to deliver health improvement through public health approaches.

6.2.3 Strengthening the primary health care services

- ❖ Strengthen the role of public health at primary care level (legislation, training, incentives)
- ❖ Develop the specialization role with regard to primary health care practitioners.
- ❖ Address variation in clinical practice (clinical quality)
- ❖ Address health inequities among different communities. Develop an option appraisal on the best possible system for the care of the elderly. Such a system should focus on prevention of risk factors in this age group (e.g. prevention of falls, osteoporosis etc)

- ❖ Ensure that primary health care plays its role in managing chronic conditions in or near to patients' homes.
- ❖ Allocate/shift resources for such services.
- ❖ WHO will support:
 - ▶ Review of the values, functions and delivery of primary care services to respond to the changing needs of the population;
 - ▶ Exploration of some of the European models of integrated primary care which may be suitable to the advanced status of Kuwait health services;
 - ▶ Re-emphasis of the role of professionals in primary care as specialists in general medical services (of the same status as consultants in other specialities)
 - ▶ Development of services based on evidence and a case/care management philosophy.

6.2.4 Strengthening the mental health services

- ❖ Increase community awareness about mental health problems and reduce the stigma.
- ❖ Review the current mental health services.
- ❖ Based on the above review, develop a service based on population needs rather than historical development.
- ❖ WHO will support:
 - ▶ Review of current services.

- ▶ Bridging of gaps in current service provision and in particular:
 - ▶ developing models for mental health promotion suitable to the Kuwait culture
 - ▶ more emphasis on the role of primary care, especially in dealing with daily living problems of people with mental disorders and common mental disorders
 - ▶ mental health needs of expatriate populations
 - ▶ capacity-building to deal with the common mental disorders rather than the narrow focus on SMI.
 - ▶ Measures to address the escalating problems of drug abuse.

6.2.5 Organizational development and management of the health system

- ❖ Re-define the health system (population approach, proactive rather than reactive, population needs rather than demands).
- ❖ Devolve 60%–80% of the budget, budgetary control and decision-making to the local level (the six health areas and various settings).
- ❖ Train key people in leadership programmes (both medical, nursing and other health professionals).
- ❖ Strengthen national standard setting and national inspection and performance management.
- ❖ WHO will support:
 - ▶ Development of a leadership programme for mid-level and senior health managers and professionals;

- ▶ De-centralization of finance and management to the six health areas, and accountability through a clear and defined management performance and accountability framework;
- ▶ Review of the management structure of the whole organization in the light of the de-centralization mentioned above;
- ▶ Increased public and patient participation and involvement in planning and management of the health system.

6.2.6 Evaluation of health financing and regulation

- ❖ Strengthen public health functions and capabilities and give the public health human resources the status they deserve.
- ❖ Re-define the health care system (see 6.2.5).
- ❖ Assess people's expectations (and needs).
- ❖ Conduct option appraisal and cost analysis of different proposed systems.
- ❖ Invest in a health economist post.
- ❖ Re-consider the privatization agenda and assess the possible impacts in the medium and long term.
- ❖ WHO will support:
 - ▶ Implementation of the WHO strategy document on "Strengthening public health functions and capabilities in Eastern Mediterranean Region", endorsed by the Regional Committee and Ministers of Health;

- ▶ A national health accounts study;
- ▶ Capacity-building in costs and cost analysis;
- ▶ The process of recruiting a health economist;
- ▶ Updating of health legislation to bring it into line with international trade agreements and human rights laws.

6.2.7 Promoting “Quality” (both clinical and services)

- Invest in a modern health information system that meets the needs of the health service in the 21st century.
- Develop training programmes to enable managers and health professionals to run such a system, and collect and analyse data.
- WHO will support:
 - ▶ Development of an integrated health information system that meet the needs of the 21st century;
 - ▶ Building of health information capacity, collection of accurate and timely data and interpretation to support management and clinical decisions as well as patient flow.
- Strengthen and improve the quality of primary health care services (including the integration of noncommunicable disease management into primary health care).
- Develop a system for clinical and service quality that balances between individual and collective responsibilities.
- Mandate professional development and continuing professional (medical and other) development.
- Incorporate quality as part of clinical practice (e.g. job plans, appraisals, clinical audit etc).
- WHO will support development of an integrated clinical quality system with particular emphasis on:
 - ▶ development of policies and control systems;
 - ▶ development of risk assessment and management at all levels, including primary health care;
 - ▶ development of an integrated clinical audit process as part of good clinical practice;

- ▶ development of outcome measurements;
- ▶ regular measurement of public opinion and patient satisfaction.

6.2.8 Strengthening the health information system

- Invest in a modern health information system that meets the needs of the health service in the 21st century.
- Develop training programmes to enable managers and health professionals to run such a system, and collect and analyse data.
- WHO will support:
 - ▶ Development of an integrated health information system that meet the needs of the 21st century;
 - ▶ Building of health information capacity, collection of accurate and timely data and interpretation to support management and clinical decisions as well as patient flow.

6.2.9 Increasing capacity in medicines management

- Develop training programmes for all medical practitioners on management of medicines.
- Develop national and local formularies.
- Incorporate medicines management in clinical quality programmes.
- WHO will support training programmes to all medical practitioners at all levels in good prescribing, evidence-based prescribing, clinical guideline development, implementation and monitoring.

Section

7

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

7.1 Implications for WHO at country level

WHO does not have a country office in Kuwait. Country level support is provided through a Regional Office staff who fulfils the responsibility of the Desk Officer for Kuwait on a part time basis. Although the current arrangement works well, given the ambitious agenda identified in Section 6 there will be a greater need for technical support through short-term consultants, training programmes for health professionals, dissemination of information on key issues, and organization of study tours.

7.2 Implications for WHO at regional level

The Regional Office would primarily be responsible for the following:

- Prompt and effective provision of technical support
- Sharing of regional experiences (technical cooperation among developing countries), resources (WHO collaborating centres, regional centres of excellence) and development of guidelines and protocols
- Capacity-building at regional level
- Monitoring and evaluation of priority programmes
- Coordination of support with headquarters through the Kuwait desk.

7.3 Implications for WHO at headquarters level

- Prompt and effective provision of technical support
- Capacity-building at headquarters level
- An effective mechanism for monitoring and evaluation
- Standard setting and clearing house for information and publications
- Coordination of support with the Regional Office.

7.4 Requirements for CCS implementation

Financial resources needed to support the areas of intervention identified in the CCS will primarily be met from the country's resources.



CCS Mission team

The CCS process for Kuwait started in mid 2004 with a preliminary situation analysis conducted in parallel at country, regional and headquarters levels. The WHO Team, including an external consultant from the UK (Professor S. Rawaf) visited Kuwait in July and met with a wide range of people across the health sector.

