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Country Cooperation Strategy for WHO and Saudi Arabia 2006–2011

Saudi Arabia

World Health Organization
Regional Office for the Eastern Mediterranean

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World Health Organization
Regional Office for the Eastern Mediterranean
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Abbreviations

CCS	Country cooperation strategy
GDP	Gross domestic product
NHIS	National health information systems
UNDP	United Nations Development Programme
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
JPRM	Government/WHO Joint Programme Review and Planning Mission
PHC	Primary health care

Executive Summary

Saudi Arabia has witnessed a massive improvement in socioeconomic development in the past 30 years, with profound progress in health, education, housing and the environment. There is now an extensive network of modern roads, highways, airports, seaports, power, desalination plants and huge industrial complexes. There are a number of critical challenges facing health development:

- Financing health care services. This is one of the most important challenges facing the Ministry of Health. It is becoming increasingly difficult to continue funding the health service through the public sector as has previously been the case.
- Strengthening the organization of health services. It is evident that the traditional health system is failing to meet emerging needs. There is growing interest in separating the components of health care, namely, financing, provision, control and supervision.
- Health human resources. About four fifths of doctors and nurses, as well as more than half of the technicians, in Saudi Arabia are non-Saudis. Moreover, a sizeable proportion of Saudis working in the health field are engaged in administrative duties.
- Health information systems. Another challenge is establishing an efficient national health information system (NHIS).
- Noncommunicable diseases. Epidemiological data indicate an alarming increase in the incidence and prevalence of diabetes, hypertension, cancer and road traffic accidents.
- Communicable diseases. Generally the incidence of communicable diseases in Saudi Arabia is on the decline and to maintain this trend, there is a need to strengthen the surveillance systems as well as disease control activities for communicable diseases.
- Health promotion and improving environmental health. The rapid urbanization of the population, and the changes in lifestyle linked to diet change, modern transport and changes in youth culture, require changes in communities if healthier lifestyles are to be established. To address these issues the Government will need to expand its work in promoting healthy environments in schools, workplaces, cities and in the home.

The agenda for WHO technical cooperation with Saudi Arabia for the period 2006–2011 will be based on the following strategic directions:

1. Supporting the strengthening of national health systems.

- Organizational development of the Ministry of Health at central and regional levels (e.g. hospital autonomy, regulation capacities, quality assurance).

- Developing capacities in health economics, national health accounts and in analysis and review of national health financing options.
- Building up national human resources for the management and delivery of health services.

2. Developing national capacities for analysis, interpretation and response to health information.

- Health information systems. Supporting the development of information networks among health facilities at all levels in order to facilitate, enhance and optimize work flow.
- Burden of disease. Working with the Ministry of Health to strengthen its capacity for evidence-based decision-making, using analytical tools, and development of a health system observatory.

3. Prevention and control of communicable and noncommunicable diseases.

- Working with the Ministry of Health. Ensure capacities exist to maintain control of communicable diseases.
- Strengthening Ministry of Health programmes for preventing and treating noncommunicable diseases, and for reducing related disabilities.

4. Promoting the development of coherent and effective health care delivery.

- Development of primary health care.
- Supporting the Ministry of Health in developing cross-sectoral collaboration in health (e.g. across ministries and with the private sector), in particular with the Ministry of Education and the environmental health sector.

Section 1

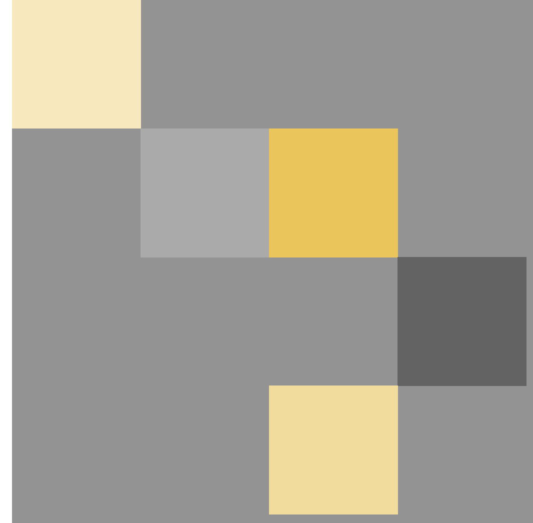
Introduction

Section 1. Introduction

The WHO country cooperation strategy (CCS) reflects a medium-term vision for WHO's technical cooperation with a given country and defines the strategic framework of the WHO secretariat for working in and with the country. The CCS process, in consideration of global and regional health priorities, has the objective of strengthening WHO support at country, Regional Office and headquarters level so that it addresses the country's health priorities and challenges in a more coherent manner. The CCS in the spirit of health for all and primary health care examine the health situation in the country from an approach that encompasses the health sector, socioeconomic status, the determinants of health, and national policies and strategies that have a major bearing on health. The CCS aims to identify health priorities in the country and provide a framework for support for 4–6 years to have an impact on national health policy and health systems development, and to strengthen the linkages between sectors and stakeholders at national level.

The CCS takes into consideration the evolution of national policies and strategies in health and health-related areas. The overall purpose is to provide a foundation for strategic planning as well as to improve WHO's contribution to the work of its Member States for achieving the targets of the Millennium Development Goals.

The CCS was formulated by engaging the three levels of the WHO secretariat in a consultation meeting involving the Ministry of Health, Ministry of Education, Ministry of Planning, United Nations Development Programme (UNDP), and agencies involved in subregional work, such as Arab Gulf Programme for United Nations Development Organizations (AGFUND), the Arab Red Crescent Society, and the Gulf Cooperation Council (see Annex 1). This CCS document has been compiled through joint effort between the Ministry of Health and WHO.



Section 2

Country Health and Development Challenges

2.1 Economic and social development

2.1.1 Socioeconomics

Saudi Arabia is a vast country, covering an area of 2.15 million km^2. It is known for its arid desert and its various highlands. The prevailing climate is hot and dry, with rainfall scarce except in the south-western and western coastal zones.

The country has witnessed a massive improvement in socioeconomic development in the past 30 years, with startling progress having been made in health, education, housing and the environment. There is now an extensive network of modern roads, highways, airports, seaports, power, desalination plants and huge industrial complexes. Saudi Arabia has modern hospitals, schools, universities, recreational and tourist facilities. The United Nations Development Programme (UNDP) annual global human development report 2002 still classes Saudi Arabia among countries with medium-term development, ranking it 71 globally; however a recent joint Ministry of Economy and Planning and UNDP report suggests that the country may soon be categorized as having high human development. Since 1970 a series of 5-year development plans have set national policy on economic and social affairs, and the current plan covers the period up to 2005. The Ministry of Planning also has defined a 2020 vision paper to guide development in Saudi Arabia, focusing on increasing jobs and per capita income, and reducing poverty. Table 1 indicates progress in the past 10 years.

The industrial sector is the dominant source of wealth, creating 51% of GDP with most of this from oil and gas mining; the service sector accounts for 43% of GDP and agriculture for 5%. Saudi Arabia has the largest reserves of petroleum in the world, and is the largest exporter. In the early 1980s the Government's budget went into major deficit, and since the 1990s the Government has been working to bring this back into balance, and to encourage private economic activity. It cut its foreign assistance, and has been looking to control its increasing domestic programmes, including the social sectors.

2.1.2 Demographics

Saudi Arabia has a population of 22.6 million, of which about 6 million are expatriate (Table 1).[1] The population is overwhelmingly young (Figure 1), with 45.7% female and 54.3% male due to the high number of male expatriates working in the country.

Mortality fell rapidly in the period from 1970 to 1990, and continues to improve (Table 2, Figure 2). In recent decades there has been a gradual shift from rural to urban living, which now includes over 85% of the population; the capital Riyadh has a population of 4.7 million.[2]

[1] Central Department of Statistics, 2003.

[2] *The work of WHO in the Eastern Mediterranean Region, annual report of the Regional Director 1 January–31 December 2003.* Cairo, World Health Organization, Regional Office for the Eastern Mediterranean, 2004.

Table 1. Progress in economic and demographic indicators

Indicator	1993	2003
Estimated population (millions)	16.9	22.67
GDP per capita (US$)	6 680	8 066
Crude birth rate per 1000 live births	43.3	31.0
Average annual population growth rate	3.8	2.95
Total fertility rate	6.5	4.3
Life expectancy		
Male	68	70
Female	69	73

Source: Central Department of Statistics, 2003.

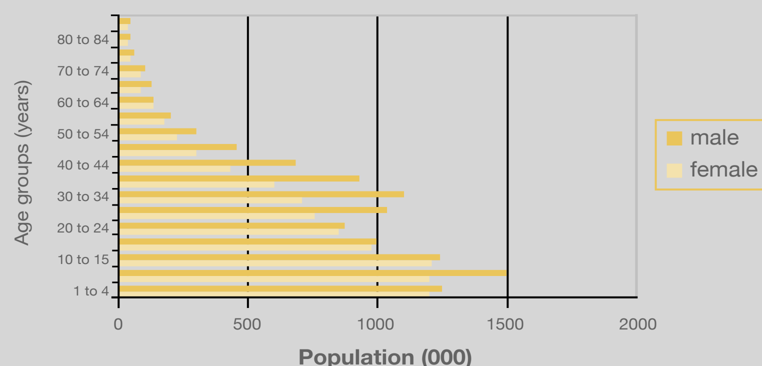


Figure 1. Population pyramid, Saudi Arabia 2002

Table 2. Summary mortality data, Saudi Arabia 2003

Indicator	2003
Crude death rate/1000 pop	2.5
Infant mortality rate/1000 pop	19.1
Under 5 mortality rate/1000 birth	22.4
Maternal mortality ratio/100 000 live births	14

Source: Ministry of Health, Saudi Arabia

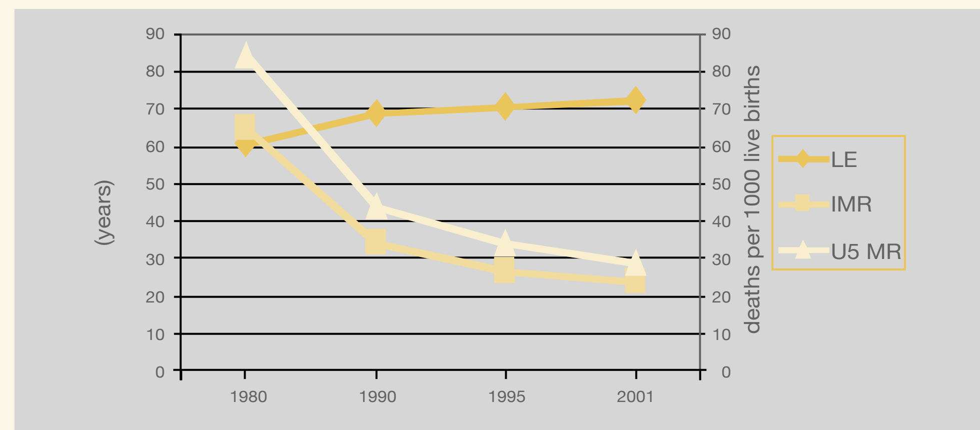


Figure 2. Life expectancy and under-5 and infant mortality, Saudi Arabia, 1980–2001

Source: Regional Office for the Eastern Mediterranean

2.1.3 Human rights

There has been considerable progress by the Government in this area, with the establishment of a Human Rights Society, under the Crown Prince, which includes prominent people from Government, business, religious institutions and academia. An orientation workshop has taken place with the assistance of the UN, and various programmes are underway to demonstrate best practice and establish human rights institutions in the country.

The initial focus has been on prisons and responding to individual complaints. Municipal elections are soon to be under way for the first time with the aim of local councils having a mixture of appointed and elected representatives. Women, however, will not be included as candidates and will not be eligible to vote at this stage.

2.1.4 Development indicators

The major improvements in health and human development have been in part accomplished through major advances in the broader determinants of human development. School enrolment is improving with 97.5% of males and 94.5% of females enrolling for primary education, and 92.8% and 88.2% respectively enrolling in secondary education. The adult literacy rate is 88% for males and 72% for females; youth illiteracy is 5% and 9% respectively. Average household income grew rapidly between 1970 and 1990 as the benefits of the oil industry were widely spread by the Government across the Saudi population. Over 95% of households have access to safe water, which in some parts of the country, particularly the capital Riyadh, is supplied through desalination plants along the coastline; figures for sanitation facilities suggest they are adequate across the population.[3]

[3] *World development report 2002, Deepening democracy in a fragmented world.* New York, United Nations Development Programme, 2002.

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2.2 Health profile

2.2.1 Burden of disease

There has been an increase in life expectancy in recent years; the overall burden of disease in Saudi Arabia has reduced markedly, with a large drop in mortality and morbidity from communicable diseases and huge drops in maternal mortality. Communicable disease and vector-borne outbreaks still occur, but these are no longer the major cause of ill health in Saudi Arabia. With increasing longevity and changes in lifestyle, there has been a consequent increase in patterns of disease with a marked increase in illnesses related to noncommunicable diseases, in particular cardiovascular disease and diabetes. Deaths from road traffic accidents have been increasing, and are now the largest cause of death in adult males aged 16 to 36 years (see Figure 3). These trends are expected to continue. However, a major obstacle to assessing the national burden of disease is a lack of reliable data from community and non-Ministry of Health health facilities; addressing this constraint is critically important for long-term planning by the Ministry of Health.

2.2.2 Health system

Ministry of Health

The safety and health of individuals, family and community are covered by Article 31, covering the Basic Governance System (Law) approved by royal decree. Health has featured in the 5-year development plans since 1970, and is seen to be a 'productive' sector, and a key part of the overall development of the country. The Ministry is headed by a Minister and two Deputy Ministers for Executive Affairs and for Planning and Promotion, and four assistant Deputy Ministers. The mission of the Ministry is: "The provision of comprehensive health care comprising preventative, curative and rehabilitative components commensurate with the Saudi Arabian culture, health ethics, citizens approval and having equitably distributed health services in addition to taking care of the health personnel in a means that will influence an acceptable performance". A 20-year health strategy has guided its work covering:

- health policies and health plans;
- regulation aimed at health services development;
- coordination with other government sectors that provide health services as well as the private sector;
- provision of primary health care throughout Saudi Arabia and prevention of epidemics;
- planning and implementing preventative programmes;
- providing basic treatment for diseases and injuries including emergency and first aid;
- training and education of health personnel in cooperation with other training and educational institutions;
- conducting research on existing health problems;
- developing health and medical information systems;
- coordination with health-related authorities concerning health parameters, such as the Ministry of Agriculture (malaria, brucellosis, schistomiasis), Ministry of Municipal and Rural Affairs (Environmental health awareness and concepts of health promotion), Ministry of Commerce and Industry (for matters related to the manufacture of drugs and products related to supply of medicines and safety of imported food, as well as encouraging the private sector to take part in providing health services).

A health act was sanctioned by royal decree to ensure comprehensive health care provision to the entire population in an equitable, accessible and organized manner. A health services council was created by the powers of this act; membership brings the Ministry of Health together with other government ministries and with the private sector to provide health services.

Health financing

The Ministry of Health budget represents 6.8% of government expenditure.[4] This is an average expenditure of US$ 171 per capita, up from US$ 112 in 1993. Total expenditure on health is 4.6% of GDP.[5] Of this, 74.6% is from government and 25.4% from private expenditure. The Government is considering the different options for financing health in the future, and is making membership of an employer or private sector insurance scheme mandatory for expatriate workers; this is seen as a first step in developing the insurance sector. The aim is to reduce the financial load on the Government, but final decisions on the most appropriate options have yet to be made. A critical first step, however, is to develop robust National Health Accounts (NHA), covering all

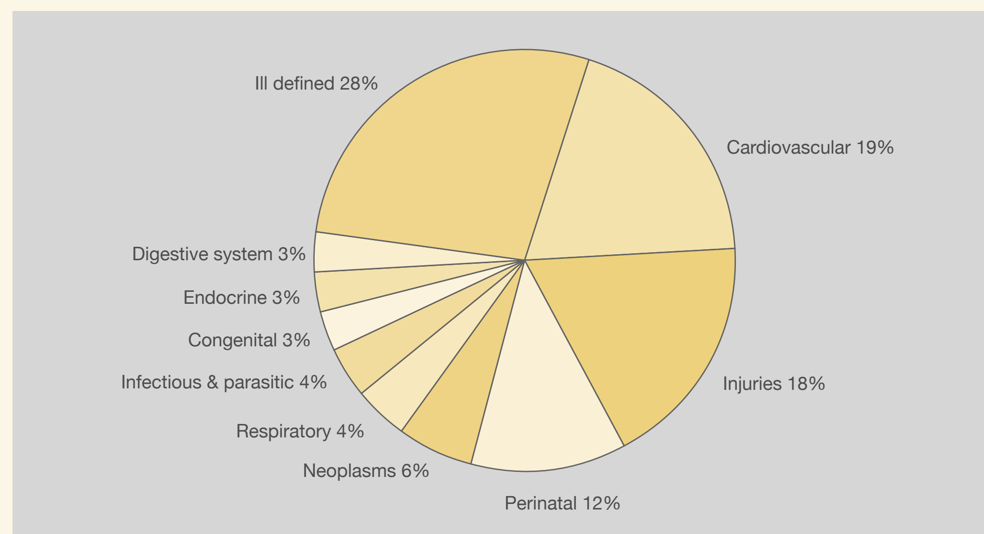

Figure 3. **Deaths in Ministry of Health hospitals, 2002**

Source: Ministry of Health, Saudi Arabia, 2002

[4] Ministry of Health. *Annual health report.* Saudi Arabia.

[5] *The work of WHO in the Eastern Mediterranean Region, annual report of the Regional Director 1 January–31 December 2003.* Cairo, World Health Organization, Regional Office for the Eastern Mediterranean, 2004.

revenue and expenditure for health in both public and private sectors, and to perform a costing analysis of existing health services. A NHA unit has now been established in the Ministry of Health to perform this work.

Primary health care

The current level of health services for the population is shown in Table 3. Free curative, preventive, promotive and rehabilitation services are available in 1850 primary health care (PHC) units across the country. About 83% of public sector attendances occur in PHC clinics. Three types of PHC centre exist covering populations of up to 500, 5000, and 25 000; however, some clinics, particularly those in city areas can sometimes be overloaded and may serve populations of up to 100 000. Some areas are very remote, and an estimated 900 additional PHC centres are required if an equitable service is to be delivered. Large investments are planned with the Ministry of Economy and Planning.

PHC practitioners are largely expatriate, with an equal gender ratio and with PHC clinics designed to allow separate services for men and women. The expatriate workforce does, however, bring its own problems including poor communication on health issues, cultural differences and a very high turnover.

Most services have developed from vertical programmes, and attempts are now under way to provide more coherent family practioner practices at the PHC level. Family medicine is being developed as a clinical speciality, and ‘mini-clinics’ have been established for chronic disease care. Oversight and quality of care is provided by a well developed system of quality assurance, managed by 20 Regional Health Affairs Directorates, under the Ministry of Health. These directorates are responsible for the management of all Ministry of Health services, using technical and managerial guidance from the centre.

Table 3. Health human and material resources

Indicator	Rate per 10 000 population
Physicians	15.3
Dentists	1.8
Pharmacists	2.6
Nurses	32.3
Health technicians	18.5
Hospital beds (total)	22.4
Ministry of Health	13.5
Private	4.4
Health centres	1.15

Source: Ministry of Health, Saudi Arabia, 2003.

Hospital care

Most secondary care is provided at district level in general hospitals managed by the regional directorates. Specialist public sector and private hospitals are growing in number and are available in the major cities; public sector hospitals currently absorb 60% of the Ministry of Health budget. The traditional role of the Ministry of Health is likely to change, as it is currently examining options for increasing the managerial independence of public sector hospitals as part of a general move towards the Ministry of Health being a purchaser of services, with responsibility for overall policy and monitoring of performance. Privatization of some health facilities may be considered in the future when insurance schemes are sufficiently well developed.

Human resources

Of all staff providing health service delivery, 61% are expatriate workers; this brings instability, due to the reasons stated above, and the Government now has ambitious plans to increase the level of Saudi nationals providing health services. Targets for this have been developed (Table 4), and support from WHO has been requested. The Ministry of Health has 43 colleges and institutes for developing health staff covering all specialities; all areas need to be expanded to meet the targets. Particular priorities are developing capacities in teaching staff, health administration, human resources management, health insurance administration, health centre management, quality assurance, leadership development and nursing administration. The detailed plans of the Ministry of Health will need to be reviewed more closely by WHO to clarify how it can best provide support.

Health information management

The Ministry of Health houses a health information centre for pooling essential health and health service information from local, regional and central levels. There has been a considerable effort made to improve these systems and a new information system is about to be launched that will link

Table 4. Health human resources planning

Category	8th plan (2005–2010)		9th plan (2010–2015)		10th plan (2015–2020)	
	Total	% Saudi	Total	% Saudi	Total	% Saudi
Physicians	38 104	23	42 300	28	46 846	33
Dentists	4 572	53	5 076	61	5 739	67
Pharmacists	10 830	33	12 269	42	13 315	49
Nurses	76 573	31	86 756	38	96 131	44
Health technicians	51 049	62	57 837	72	64 087	81
Total	18 128	39	204 238	47	226 118	53

Source: Ministry of Health, Saudi Arabia, 2003.

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all PHC centres with the Ministry of Health. However, problems still exist related to lack of linkages between hospitals and other health institutions and the absence of data from the private sector or other government hospitals outside the Ministry of Health (e.g. Military and National Guard). Current information is heavily focused on activity data with little information on morbidity. A critical step in improving this situation is the development of systems and studies to assess the burden of disease, in order to guide future planning of the health sector.

The Ministry is investing in information and communication technology (ICT), but a comprehensive strategy for the entire public sector has yet to be agreed. Proper use of information and communication technology for data management remains limited. The Ministry of Health is planning pilots in health telematics, particularly important for linking hospitals and rural primary health care facilities.

Research and quality assurance

Research and quality assurance are recognized as being crucial for the development of the health system, but no Ministry of Health explicit research strategy currently exists and support for this has not yet come from WHO. High quality public health and medical research is, however, available. Quality assurance is well established in the Ministry of Health PHC sector.

Other government ministries providing health services

In addition to services provided by the Ministry of Health, the Ministry of Defence, the National Guard, and the Interior Ministry also provide comprehensive curative health care services in some of the major cities. These are run on a private sector basis on a predominantly fee-for-service basis, except for the small number who can afford the currently high premiums of private health insurance.

Private sector

Health services are also provided through the private sector in the form of private hospitals and private practitioners. Private health insurance is available through insurance firms covering different services. Regulation of the private sector is the responsibility of the Insurance Corporation, a parastatal body (cooperative insurance council), accountable to the Minister of Health. The main legislation currently in place to cover the private sector deals with all health and health-related sectors.

Public health programmes

Communicable disease control and surveillance. There has been major progress in the control of communicable and parasitic disease in recent decades (Table 5). Most vector-borne diseases have been dramatically reduced, notably schistosomiasis (from 16.2 per 100 000 in 1993 to 5.5 per 100 000 in 2003), cutaneous leishmaniasis (from 60.3 per 10 000 to 2.1) and visceral leishmaniasis (from 1.05 to 0.17). Some problems remain, in particular the following:

- Malaria: endemic areas still exist in the south in border areas with Yemen, covering about 5% of the population. In 2002, there were 2612 confirmed cases, of which about half were locally transmitted. A joint Saudi–Yemeni coordination committee exists for malaria/vector control, and WHO has been requested to guide Saudi Arabia work in this area.
- Tuberculosis: in 2002 there were 3271 cases, 70% of which were pulmonary, suggesting an incidence of 10.2 per 100 000. Most cases (62%) of pulmonary tuberculosis are in the 15–44 age groups, and 25% are located in Riyadh. All cases are included in the national programme for DOTS; tuberculosis treatment is only available in the public sector. Problems remain with private and non-government providers, particularly in proper use of diagnostics, and in getting PHC centres to provide early diagnosis and treatment.
- HIV: trends in prevalence is increasing in spite of the great effort exerted by the Ministry of Health and other related ministries. The Government has recently released figures showing that since 1984 there has been a cumulative total of over 7000 cases of HIV/AIDS, of which about 1100 are indigenous cases.[6] The full range of treatment is available in three specialist centres based in Riyadh, Jeddah and Daman. HIV coordinators in every regional directorate coordinate the Ministry of Health prevention, treatment and care programmes. The focus is on developing dialogue with schools, religious leaders and the general public, introducing syndromic management for sexually transmitted diseases into PHC centres, and working with vulnerable groups.

Child health. Child health care indicators show a marked decline in child mortality, mainly owing to the reduction in incidence

Table 5. Communicable disease incidence rates 1993–2003

Disease	Incidence per 100 000 population	
	1993	2003
Diptheria	0.05	0.04
Pertussis	0.2	0.2
Tetanus (per 1000 live births)	0.2	0.04
Poliomyelitis	0.01	0.00
Measles	82.2	1.45
Malaria	108.6	56.0
Tuberculosis	14.7	10.2
Hepatitis B	17.0	11.4

Source: Ministry of Health, Saudi Arabia, 2003.

[6] Ministry of Health, Saudi Arabia, 2004.

of communicable diseases as a result of high immunization coverage, improved nutrition, adequate safe water and sanitation, and reduction of acute respiratory illnesses. Extended Programme on Immunization (EPI) coverage is high, although persistent problems remain, in particular occasional outbreaks of measles, with 1208 cases in 2003 due to non-immune groups who had missed vaccination;[7] this has been rectified by changing the vaccine schedule and carrying out MMR vaccine campaigns in secondary schools. Saudi Arabia still has the highest infant and child mortality figures among the member states of the Gulf Cooperation Council (Table 6). Malnutrition is still a problem with 3% of children reported malnourished;[8] in 1995 only 31% received exclusive breastfeeding.[9] However, the increasing problem now is that of obesity, which affects about 30% of children.

Maternal and reproductive health. Maternal mortality declined from 18 per 100 000 live births in 1993 to 14 in 2003 with 91% of births attended by a skilled professional, the majority of which (86%) were in public facilities;[10] 66% of pregnant mothers received full immunization of two doses of tetanus toxoid in 1998.[11] Approximately 90% of pregnant mothers receive at least one antenatal check up by a skilled professional (1996).

Contraceptive prevalence was 21% in 1996, with 69% using contraceptive pills and 24% IUDs.[12] No data exist on the unmet demand for contraception. The total fertility rate fell from 6.5 in 1993 to 4.3 in 2003. The mean age of marriage for females is 21.7 (25.6 for males). The Government is in the process of developing a national population policy.

Noncommunicable diseases. In response to the marked increase in noncommunicable diseases over the past decade, (Table 7), the Ministry of Health established a noncommunicable diseases unit in 2003. Many programmes are now under way, covering the following:

- Diabetes mellitus has been the first priority, given the alarming increases; recent studies suggest a prevalence of over 15% in adults. A diabetes centre has been established in each region to mainstream diabetic care at all levels of the health system, with the explicit aim of reducing future diabetic complications, currently projected to take up 40% of hospital services in future decades.
- Genetic diseases are a priority, given the high level of genetic blood disorders in the country. All couples are now screened for thallassaemia and sickle cell disease through 120 centres established by the Ministry of Health, and those who are positive are provided with counselling and advice regarding marriage; a follow up programme is also under way. More screening is now taking place in schools prior to engagements. Neonatal screening for metabolic disorders has also been developed together with other countries in the Gulf Cooperation Council.
- Noncommunicable diseases STEPwise surveillance is being developed with support from WHO; a unit for this has been established in the Ministry of Health, and WHO guidance has been adapted for local usage. This will need to be further amended to include mental health and injuries. All data are to be processed and be made available to regional directorates.
- Cancer registration is well established, and a Gulf Cooperation Council programme has been under way since 1997. In Saudi Arabia, neoplasms accounted for 5% of hospital reported deaths. The most common cancer in males is leukaemia, and in females breast cancer. A national committee oversees the development of services, education campaigns, screening services and palliative care.
- Smoking remains a major problem with 20% of the adult population smoking (males over 15 at 38%, and females 2%). A major national anti-smoking campaign is under way and the first city (Al Bukharia in Al Qasseem) in the Healthy Cities project (20 cities are currently taking part in the initiative) is now smoke-free in public places.
- Injuries are a significant public health problem in Saudi Arabia. Problems of data quality, lack of intersectoral coordination and shortages of both financial resources and trained personnel hinder the development of injury control activities.

Table 6. Child mortality in the member states of the Gulf Cooperation Council

Country	UAE	Bahrain	Qatar	Oman	Kuwait	Saudi Arabia
Infant mortality	8.1	7	8.7	16.2	9.6	19.1
Under-5 mortality	28	30	15.7	35	11.2	34

Table 7. Trends in noncommunicable diseases (inpatients)

Disease	1994	2002
Hypertension	644 353	1 055 583
Renal failure	4 884	7 719
Diabetes mellitus	1 019 652	1 596 927
Road traffic injuries	504	28 372

Source: Hospital admissions records.

[7] *The work of WHO in the Eastern Mediterranean Region, annual report of the Regional Director 1 January–31 December 2003.* Cairo, World Health Organization, Regional Office for the Eastern Mediterranean, 2004.
[8] World development indices, 2000.
[9] Saudi family health survey, 1996.
[10] Ministry of Health. *Annual health report,* Saudi Arabia, 2003.
[11] World Bank review, 1999.
[12] Saudi Arabia family health survey, 1996.

- Saudi Arabia is facing a major problem due to road traffic accidents. It is estimated that of all the deaths that occur in Ministry of Health hospitals, more than 80% are due to road traffic crashes.[13] According to figures released by the Traffic Department, 4848 people died in crashes in 2000,[14] and 267 772 others were injured during the same period. It is estimated that road accidents also result in SR 7 billion in losses to the economy ever year. One person is killed and eight are injured every 2 hours on the roads. The frequency and incidence among the expatriate population is even higher. Both the prevalence and incidence of road traffic accidents increases during the holy month of Ramadan and during the season of *hajj*. As well as the humanitarian suffering, the economic impact has been estimated at about US$ 65 billion, or 1–2% of GNP. This problem was highlighted during World Health Day, and WHO technical guidance is being adapted to help guide the national programme. Data on levels of domestic violence are not available.
- Nutrition is overseen by PHC and preventive health programmes. Saudi Arabia is experiencing a double problem, of undernutrition in some groups and obesity in others. A particularly important problem is the low level of breastfeeding, with as many as 80% of children weaned by 1 month, a practice encouraged through commercial promotion of milk substitutes. To address this problem the Government is introducing a national code, has restricted milk substitute advertising, and has started a 'baby-friendly hospital' initiative in nine hospitals. WHO support has been requested in addressing iron fortification of flour.
- Mental health and substance abuse are among the major health problems, which are of great concern to the Government. Since the early 1980s a network of mental health care services was set up in the form of small hospitals across the country. A national mental health programme was established in 1989, which included making essential mental health services available in PHC. Drug abuse is a small but significant problem and relevant health promotion services have been introduced through the school health services.

Health promotion and school health programmes

A comprehensive programme covers environmental health, Healthy Cities, occupational health, food and water safety and chemical and radiation safety. The Healthy Cities project was started in 1998, and now covers 20 cities focusing on health in schools, the workplace and hospitals, and on the city environment for physical activity. Women's participation in community-based initiatives is promoted.

The school health programme provides a comprehensive service, covering 30 000 schools, focusing on health education, health services and mental health. A health-promoting school programme, linked to the Healthy Cities project, promotes a healthy environment in 30 schools; an evaluation is planned shortly. Other work includes focusing on teachers as health guides, improving dietary habits in school, promoting physical activity (although this programme is so far limited to females) and improving the understanding of reproductive health matters. The curricula as a whole have been reviewed in recent years for consistency and phasing of messages through the school years. Given that these programmes are critical to the long-term reduction of noncommunicable diseases, it will require further support and expansion, with close coordination with the Ministry of Health.

Health of pilgrims

Each year about 1.3 million pilgrims visit Saudi Arabia for the hajj. The large numbers, their high density and the high proportion of elderly people brings public health challenges relating to access to nutrition, sanitation, communicable disease outbreaks, accidents, heat exhaustion and precipitation of chronic illness, such as coronary heart disease. Various measures have been put in place to address these challenges, for example, meningitis prevention measures. Many countries supply their own medical missions during the hajj, but most of the work in promoting and protecting health is borne by the Ministry of Health.

Health of vulnerable groups

Expatriates currently receive free preventative and emergency health services under the Ministry of Health, but regular health care has to be paid out-of-pocket or through private health insurance schemes. While some are well paid and can afford this, many are provided with small salaries and are vulnerable to illness and lack of basic health care. Soon all expatriates will have to be covered by health insurance in order for residence to be continued. The impact on this group is as yet unclear and some of the poorest could have their overall health significantly threatened; the situation should be carefully monitored. Before entry into the country, potential expatriates undergo extensive screening, including screening for HIV, resulting in exclusion for those who are HIV-positive.

2.3 Summary of critical challenges

2.3.1 Financing health care services

This is one of the most important challenges facing the Ministry of Health. It is becoming increasingly difficult to continue funding the health service through the public sector as has previously been the case. This problem is compounded by many factors, such as the increasing proportion of the dependent population, including the elderly. Saudi Arabia is witnessing rapid transition in the pattern of diseases from communicable diseases to expensive noncommunicable diseases. The high prevalence of diabetes mellitus, hypertension and cardiovascular diseases, as well as the increase in the incidence of cancer, demand not only an increase in expenditure in the health services currently provided, but also will inevitably require much greater expenditure in the future as a result of the costly complications of these diseases.

[13] *(http://www.ameinfo.com/49959.html, accessed 22 June 2005).*
[14] *Statistics of road accidents in Saudi Arabia. The Saudi Arabian Information Resource, 2002 (http://www.saudinf.com/main/y3795.html, accessed 23 June 2005).*

A recent study concluded that the expenditure of health services would double within the next two decades.[15] Accordingly, the Ministry of Health needs to identify alternative sources for funding. In the absence of a tax system in Saudi Arabia, health insurance is being seriously considered to meet the increasing demand for acceptable health services. However, the proposed reform would require a better understanding from the public and decision-makers of issues such as national health accounting, cost analysis of expenditure in the medical services, in addition to other issues pertinent to health insurance, such as legal aspects and policies.

The Ministry of Health would benefit and learn from the experiences of other countries who have implemented similar programmes concerning the privatization of medical services. Nevertheless, the Ministry of Health is aware that unbalanced implementation of such a programme could limit the access of poor Saudis to acceptable health services, especially those living in remote areas, and the vulnerable and disadvantaged sectors in the population. The proposed social health insurance scheme would be implemented in phases, starting with expatriate workers. WHO is expected to provide technical support in related activities.

2.3.2 Strengthening the organization of health services

It is evident that the traditional health system was failing to meet emerging needs. There is growing interest in separating the components of health care, namely, financing, provision, control and supervision to ensure the best possible outcome for expenditure in the field of health. Health providers other than Ministry of Health are expected to join in this proposed change. There is a need to promote autonomy of major hospitals by introducing a corporate system.

2.3.3 Health resources

There is a need for qualified and well-trained manpower. About four fifths of doctors and nurses, as well as more than half of the technicians in Saudi Arabia, are non-Saudis. Moreover, a sizeable proportion of Saudis working in the health field are engaged in administrative duties. The shortage in Saudi cadre is further compromised by their concentration in urban areas, which has resulted in a disproportionate distribution of health personnel within Saudi Arabia. For successful saudization proposals, there is a need to invest in medical education and allied health disciplines in both the public and private sectors. There is also a need for further training of Saudi doctors and nurses to further upgrade the quality of health services provided. In addition there is need for a long-term plan for manpower development; capacity-building should be based on defined needs and plans and not on an ad hoc basis. It is believed that lack of quality training, including training in leadership and management of health services explains why there are relatively unsatisfactory outcomes in the different programmes, in spite of the expenditure given to this sector.

[15] Al Humaidy, AR. *Distribution of health resources in the* Ministry of Health. Ministry of Health, Bureau of Health Economics, 1423 AH. (Arabic).

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2.3.4 Health information systems

Another challenge is establishing an efficient national health information system (NHIS). Previous efforts geared at accomplishing this goal have not been successful. The available data for morbidity and mortality are not considered very accurate. The role of a satisfactorily updated NHIS would of great value in providing good data for decision-making (evidence-based decisions). Improvements in telecommunications in health facilities are expected not only to support the efficiency of the NHIS, but also to play an important role in improving medical services in rural areas, reducing the number of referrals to tertiary medical facilities.

The expected change in systems related to health care services delivery and the epidemiological transition in the pattern of disease call for further technical development in optimal utilization of health information for decision-making. It has become necessary to redefine priorities in the field of health, support capacity-building and research. It is expected these activities will eventually ensure equity and quality of the health services provided. There is need to develop sensitive and appropriate indicators for monitoring performance of health system in Saudi Arabia. Moreover, a strong health information system would also reduce wastage of resources (equipments, materials and drugs).

2.3.5 Noncommunicable diseases

Epidemiological data indicates an alarming rise in trends relating to incidence and prevalence of diabetes, hypertension, cancer and road traffic accidents. The projection of needs for specialized medical services related to the forecasted number of complications as a result of these diseases is disturbing. There is a need to strengthen health programmes on primary prevention as a way to increase the awareness among the general population and promote and support community-based programmes on healthy lifestyle and behaviour, such as anti-smoking programmes, balanced diet and exercise. It is expected some time will be needed to register significant changes in behaviour and attitudes of the public. In the meantime, there is a need to ensure procurement and access to affordable and appropriate treatment. The Ministry of Health has already established many health committees and is currently preparing plans to deal with these emerging diseases through the National Cancer Prevention Programme and the Saudi Multi-sectoral Safety Programme among others.

Other noncommunicable health problems of growing interest include reproductive health services and mental health. Collaborative efforts between the Ministry of Health and other stakeholders e.g. the Ministry of Education, and other governmental and nongovernmental institutions would be desirable.

2.3.6 Communicable diseases

Generally the incidence of communicable diseases in Saudi Arabia is on the decline. To maintain this declining trend, it is necessary to strengthen the surveillance systems, as well as disease control activities for communicable diseases, especially those related to control of vector-borne diseases such as malaria, Rift Valley fever and dengue fever in southwestern Saudi Arabia

along the borders with Yemen. Coordinated cross-border activities are essential as is the need to continue sharing relevant data on these diseases openly. The annual mass gathering during the pilgrimage to Mecca *(hajj)* necessitates the strengthening of the ongoing surveillance of epidemic-prone diseases, such as meningococcal disease, influenza and others.

2.3.7 Health promotion and improving environmental health

The rapid urbanization of the population, and the changes in lifestyle linked to changes in diet, modern transport and changes in youth culture, require a shift in the thinking of communities if healthier lifestyles are to be established. To address these issues the Government will need to expand its work in promoting healthy environments in schools, workplace, cities and in the home.

Section 3

Development Assistance and Partnerships: Aid Flow, Instruments and Coordination

3.1 United Nations Development Programme

The presence of UNDP is unique in that it is both to help take forward the UN's work as a whole, as well as to provide technical support to Saudi Arabia. This is particularly important for Saudi Arabia's role in supporting development activities in countries or areas with complex disasters or in post-conflict situations in the region. Similarly, UNDP would expect WHO's role to be different in also enabling Saudi Arabian resources and expertise to be made use of in other parts of the Region. UNDP and WHO have an excellent relationship, and have recently collaborated with UNAIDs to break down the reluctance for public discussion about HIV/AIDs. Collaboration is also important in the field of the Millennium Development Goals (MDGs), for which national monitoring systems are being institutionalized within the country, and also within the arena of human rights, which have seen major breakthroughs recently in the country.

3.2 Executive Board of the Health Ministers' Council for Gulf Cooperation Council states

The Executive Board of the Health Ministers' Council covers the six Gulf Cooperation Council states, with a secretariat based in Riyadh. The Council performs research and public health advocacy, and works closely with WHO to pursue its positions and resolutions with the Gulf Cooperation Council Ministries of Health. The Council has just signed a Memorandum of Understanding with WHO to guide the collaboration. Central to this will be to improve communication and coordination with the Regional Office through the WHO country office.

3.3 The Arab Red Crescent Organization

The Arab Red Crescent Organization is a Saudi-based secretariat whose role is to coordinate the Arab national organizations, and to help them mobilize resources when crises occur. They have a total of 20 members in the Region, and have just agreed a Memorandum of Understanding with WHO to work together in crises and develop some joint programmes, such as the upcoming programme on mental health in crises. They have just completed a strategy for the next 6 years which focuses on:

- law and human rights;
- health care in crises;
- building capacities of national societies;
- responding to emergencies.

3.4 Collaborating centres and Saudi Arabian expertise

Saudi Arabia currently only has three collaborating centres to promote the exchange of expertise within the Eastern Mediterranean Region. These are:

- King Faisal Specialist Hospital and Research Centre: blood safety

- WHO Collaborating Centre for Haemoglobinopathies, Thalassaemias and Enzymopathies, King Saud University: blood diseases
- WHO Collaborating Centre for Prevention of Blindness: eye specialists

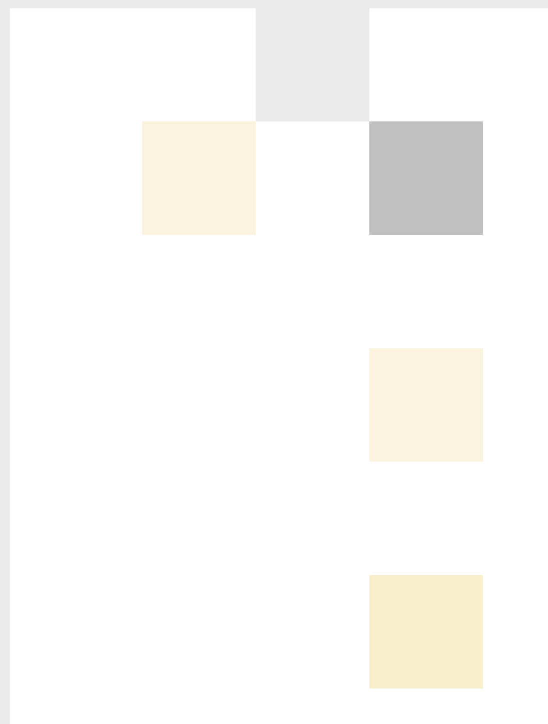
Given the degree of high quality specialist expertise in the country, and the broader needs within the Region, Saudi Arabia is well placed to expand this list of collaborative centres. This will raise the profile of the centres themselves, and lead to a useful sharing of expensive resources with other countries in the Region.

3.5 Arab Gulf Programme for United Nations Development Organizations (AGFUND)

This agency provides support for projects aimed at reducing poverty; it has several projects with WHO around the globe. Its headquarters are based in Riyadh, and many of its areas of interest overlap with WHO, in particular, communicable disease control, environmental health, health management, emerging diseases (e.g. HIV/AIDs) and school health, the latter being particularly important. It also supports the Health Academy, an e-health initiative managed in Geneva.

3.6 'Friends of WHO'

WHO is exploring, together with the Ministry of Health, the setting up of a group within Saudi Arabia who are interested in providing resources for health and development elsewhere in the Region, and perhaps globally. The WHO country office is in an ideal position to facilitate such interest to ensure it is invested in initiatives which are based on clear evidence of success.



Section 4

Current WHO Cooperation

WHO's programme of technical cooperation with Saudi Arabia is of long standing although no WHO representative was available to lead the programme for four years prior to 2003. This gap has meant that some of the existing programme was developed without facilitation. The biennial programme covers 35 programme areas, with funds distributed as shown in Figure 4. The large amounts for malaria and vector control underline the importance given to the control of the cross-border vector-borne disease problems in the south of the country. The country office consists of an administrator, two assistants, one of whom manages the library and distribution of WHO publications, and two drivers.

In taking forward the country cooperation strategy, and the expectations of both the Government of Saudi Arabia and WHO, the following challenges will arise:

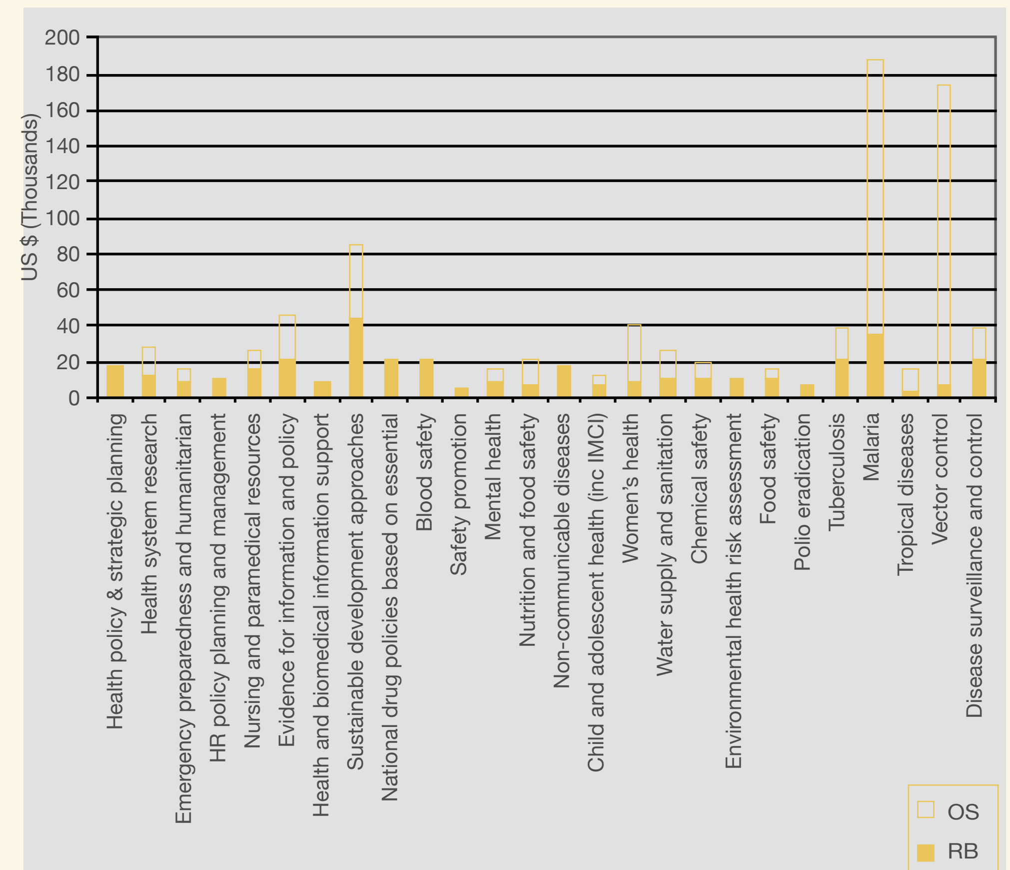


Figure 4. **Government/WHO Joint Review and Planning Mission financial plan**

1. The number of programmes currently being administered is too wide to allow significant impact; future programmes should be more focused, with fewer programme areas, and be better integrated to support national objectives.
2. The content of the existing JPRM does not match the demands currently being made on WHO, and this will need to be radically revised if the demands on WHO are to be met.3. There is a considerable level of expertise and resources in the country that could support health and development in other Member States in the Region as well as serving the technical support needs of the country. The WHO country office could facilitate this, but must have the local capacity to do so.
4. During the CCS consultation, it was clear that WHO support is valued in Saudi Arabia, but that there are areas that need improvement, in particular:
    - communication with those dealing with the Regional Office through better coordination by the country office.
    - responsiveness to requests for support or guidance, and avoiding the delays which sometimes happen.
    - ensuring that the quality of support is appropriate for Gulf Cooperation Council countries, given that technical support needs for poorer developing countries are very different from the wealthier Member States, with more sophisticated health systems.
    - working with the Regional Office and headquarters to identify technical support beyond the Region, particularly in areas where experience from established and well developed health systems is required.
5. To serve both national needs and perform its regional or subregional role, the capacity of the WHO country office is currently inadequate, and will need to be strengthened.

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:

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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 Saudi Arabia

6.1 Framework for supporting national health priorities

Consultations between the WHO team and the Ministry of Health leadership and stakeholders revealed that future joint plans, technical assistance and collaboration should cover the following strategic directions:

- supporting the strengthening of national health systems;
- developing national capacities for analysis, interpretation and response to health information;
- prevention and control of communicable and non-communicable diseases;
- promoting the development of coherent and effective health care delivery.

6.2 Strategic directions

6.2.1 Supporting the strengthening of national health systems

Organizational development of the Ministry of Health at central and regional levels (e.g. hospital autonomy, regulation capacities, quality assurance)

The intention of the Ministry of Health towards implementation of health insurance will mean a separation between provision and regulation of health services and will require new capacities to be strengthened in the Ministry of Health. WHO will support in undertaking assessments of the health sector to define the tasks and necessary work plans to take this forward.

The new tasks will require leadership in evidence-based policy development, strategic thinking in planning and management, regulation, coordination and partnership, and quality assurance. There is also a need to develop analytical tools to support policy making and priority setting, such as costing and cost–effectiveness analysis. WHO will also support filling in the gaps in the managerial capacities of hospitals and mid-level managers.

Developing capacities in health economics, national health accounts and in analysis and review of national health financing options

Health financing has become a concern to the Ministry of Health in recent years due to the ever-increasing cost of services from: 1) the changing epidemiological pattern of diseases with rising life expectancy and increases in chronic diseases; 2) increased dependence on high technology; 3) increased provision of health services to a growing population and rising demands on health services by communities.

Services are largely being financed by government revenues, which are unlikely to increase sufficiently to cover the expected doubling of health service cost over the next 20 years. The Ministry of Health has therefore begun to review its options of financing and generally is heading towards health insurance options.

WHO will collaborate closely with the Ministry of Health to understand better the options for more robust financing of health care by expansion of social health insurance,

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together with the private sector, with the aim of achieving universal health insurance coverage. To prepare for this the country should start the national health accounts process and work for institutionalization and ownership of NHA analysis as a normative function. This will help in selecting, from the various options for the expansion of health insurance coverage. There will also be a need to promote cost control and cost containment policies in order to improve the efficiency of the system.

Building up national human resources for the management and delivery of health services

Saudi Arabian health services have relied heavily on expatriate professionals in the running of services during the past four decades. Huge efforts had been initiated to educate and train nationals, although despite the expansion in health-related education, it is assumed that at the current pace not even 40% of needs will be covered in 20 years.

There are clearly inadequate capacities in some areas, and this is made worse by a sizeable portion of Saudi physicians and nurses (23% and 31% of their workforce respectively) undertaking managerial and administrative responsibilities rather than utilizing their technical expertise. Nevertheless there is also a distribution problem as most Saudi staff are stationed in hospitals in urban areas.

WHO will work closely with the country to accelerate development of human resources for health at various phases, particularly in policy, planning and management, strengthening human resources development functions in the Ministry of Health, and promoting tools for strategic planning of human resources development using projections, scenarios and other predictive techniques.

6.2.2 Developing national capacities for analysis, interpretation and response to health information

Health information systems

The health data currently collected are often unreliable with minimal utilization of information for setting priorities, research purposes or evidence-based decision-making. In the absence of proper burden of disease studies, priority setting is ill-informed. There is no coordination to make use of data collected by various health providers (national guard, private sector, etc.) other than the Ministry of Health. Telecommunications are not adequately used to improve the efficiency of the system (e.g. pre-referral consultations or staff training purposes). WHO support the Ministry of Health in developing its information networks among health facilities at all levels in order to facilitate, enhance and optimize work flow.

Burden of disease

WHO will work together with the Ministry of Health to strengthen its capacity for evidence-based decision-making, using analytical tools. Burden of disease (BOD) surveys are an essential step to guide health policies and cost-effective decision-making in controlling the three major categories of BOD, i.e. noncommunicable diseases (including maternal and mental disorders); communicable diseases and injuries.

WHO will support Ministry of Health to develop a health system observatory to be the national resource institution for collecting, reviewing, verifying, and evaluating data, as well as documenting, disseminating, and releasing formal national figures on the BOD.[16]

6.2.3 Prevention and control of communicable and noncommunicable diseases

Working with the Ministry of Health to ensure capacities exist to maintain control of communicable diseases in Saudi Arabia

Political commitment and technical support for strengthening surveillance and epidemic preparedness and outbreak management in Saudi Arabia needs to be augmented. Saudi Arabia will incorporate as appropriate the WHO regional strategic plans (prevention and control of emerging and re-emerging diseases; strengthening of surveillance, prevention and control; and prevention and control of epidemic disease) into its national surveillance plan. This plan will also strengthen the national surveillance and response systems, and strengthen national laboratory capacity to detect priority pathogens.

Strengthening Ministry of Health programmes for preventing and treating noncommunicable diseases, and for reducing related disabilities

Patterns of morbidity and mortality in Saudi Arabia are dominated by noncommunicable diseases and injuries. The main causes of death, as reported nationally, are cardiovascular diseases, road traffic injuries, diabetes and cancer. There are several programmes which deal with lifestyle and behaviour covering obesity, tobacco consumption, road traffic accidents and physical exercise. The healthy cities programme in 20 cities will enforce these approaches of protection and promotion. WHO will support the Ministry of Health in strengthening the existing protection and promotion programmes and support the development of new policies and programmes as appropriate.

Considering the crucial role of PHC in bringing these efforts near to the community, efforts will continue to execute these national plans through understanding burden of disease and promoting risk reduction at community level. Mapping of major causes of morbidity, disability and mortality in each catchment area will be developed to guide the allocation of resources and technical support, and to monitor progress, quality and performance.

6.2.4 Promoting the development of coherent and effective health care delivery

Supporting the development of primary health care

The Government has adopted the primary health care approach as the guiding principle to cater for the needs of

[16] "An observatory is a 'situation or structure commanding a wide view, with the ability to observe from an elevated position'. This means the creation of a function with the capacity to 'observe' the health, social and economic information available in the country: who is collecting it and how, who needs to gain access to it, and who has the potential to contribute. The observatory will also be an active network, made up of all the people who supply information to inform public policy, putting them in touch with each other and disseminating their work".
The South West Public Health Observatory (http://www.swpho.org.uk).

the population; 83% of consultations in the Ministry of Health were at the PHC level in 2003 with a 3–4% referral rate. For about 40% of the population PHC is the only health care provider. The planned investments in communication and information networks will improve decision-making, and will make data more reliable. The PHC system is facing enormous challenges, and these changes are a practical entry point for further improvements.

The extensive chain of PHC facilities (more than 1800) is in need of strengthening, particularly in terms of management capacities to better respond to the new tasks and competencies. The Ministry of Economics and Planning has already agreed to a massive increase in PHC investment, providing a major opportunity to improve the health of the population.

WHO will support the Ministry of Health to develop its plan of building a cadre of family physicians and also the 'family medicine' postgraduate programme through building on experience inside the country and externally. WHO will encourage the stability in the existing national and expatriate health professionals by helping the Ministry of Health to develop policies to improve PHC working conditions and build performance incentives in future insurance schemes.

Given the anticipated increase in competition from the private sector after adoption of insurance schemes, the public sector PHC service will need systems for constantly enhancing performance of its work force and overall structure. WHO will work with the Ministry of Health to improve licensing and re-licensing and accreditation of both PHC facilities and personnel. WHO will also support the periodic evaluation of the PHC system to learn lessons for continuous improvement.

Supporting the Ministry of Health in developing cross-sectoral collaboration in health (e.g. across ministries and with the private sector)

The population under 15 years of age accounts for 40% of the general population, and is a key target group for improving the nation's health. The big chain of school health facilities, health personnel, health-trained teachers and committees at school level provide opportunities for collaboration on national and local health programmes, and provide an essential link with communities on health matters. Much innovation and good practice is under way, and WHO will help strengthen and develop means of tighter collaboration and coordination between the two ministries both at central policy and regional and local levels.

With the increased diversification of health risks, approaches and players, the guiding principles of a PHC approach on intersectoral collaboration remains a necessity to protect the health of the population. In this respect, WHO will work in close collaboration with the country to assist and strengthen the different coordinating bodies, councils, committees and regional organizations to reach attainment of their intended goals.

Environmental hazards have witnessed an increase in Saudi Arabia in recent years due to the rapid changes that have taken place in lifestyle, in the development of cities and in urban settlements, and industrial coastal oil spills. Also regionally, Saudi Arabia has had two neighbours engaged in war with major weaponry which has led to major security concerns.

Country Cooperation Strategy for WHO and Saudi Arabia

In this respect, WHO will work in close collaboration with the Ministry of Health and other ministries councils, committees, and regional organizations to build on existing strategies to develop healthier cities, schools, industry and workplaces and support established bodies in close monitoring, controlling and evaluation of programmes.

7

7.1 WHO country office

The country office will need to be strengthened to support the expectations detailed in the country cooperation strategy. The following points should be considered:

- Proximity to the Ministry of Health: the current arrangement is good for the UN country team, but at the expense of relations with the Ministry of Health.
- Connectivity: current standards are very much lower than required for modern day use of the internet and conferencing facilities.
- Web-based resources: WHO Saudi Arabia does not have a website or any way for an outside agency to access WHO materials and information that are focused on Saudi Arabia. This needs to be addressed, and, if managed properly, would help in the dissemination of technical guidance which is in high demand.
- Staff capacity: if the Saudi Arabian programme is to be adjusted in line with the CCS, the capacity of the country team will need to be reviewed. As well as coordinating increasing technical support from the Regional Office and beyond, the country team should also be able to mobilize expertise and resources from Saudi Arabia for other Member States. The office should undergo re-profiling in line with regional and headquarters guidance on human resources.

7.2 WHO Regional Office and headquarters

There are several implications for the Regional Office and WHO headquarters, if the CCS is to be fully implemented:

- As stated above, the Regional Office should provide support, with headquarters assistance if necessary, on re-profiling the country team.
- The Regional Office will need to work with headquarters to respond to the more urgent requests raised during the CCS mission and during the recent visit of the Director-General. In particular those covering:
  - cross-border control of vector-borne diseases;
  - national health accounts;
  - building management capacities in the Ministry of Health;
  - health promotion in schools.
- The upcoming JPRM review will provide an opportunity for WHO and the Ministry of Health to re-programme existing funds to provide technical support along the lines of the CCS strategic agenda. The JPRM would benefit from having some of those involved in the CCS to help the WHO Representative's Offices make the necessary changes.
- The strong call for WHO to support the strengthening of health systems, and the limited consultation possible in the CCS mission, suggests that the health

systems group in the Regional Office might need to consider a follow-up mission to extend the consultation to other stakeholders and to formulate the WHO programme of support.

- The Regional Office knowledge management group should work with the existing country team to develop a website for disseminating WHO technical information to public health agencies within Saudi Arabia.
- The Regional Office should involve the country team in all communications with subregional groups based in Riyadh to ease communications, and ensure proper follow-up; this will be important for the Executive Board of the Health Ministers' Council for the Gulf Cooperation Council states.

7.3 WHO friendship committee

The WHO Representative has already started discussions with the Ministry of Health and others in Saudi Arabia on the setting up of a group to oversee the mobilizing of technical and financial resources for supporting health and development needs elsewhere in the region, and possibly beyond. This will need support from the relevant groups in the Regional Office and WHO headquarters. Financial support would probably be best directed initially at countries in crisis or in post-conflict situations, and at cross-border problems, such as control of vector-borne diseases; in addition, more global issues may be able to be supported.

Annexes

Annex 1
Persons met during the CCS consultation process

Ministry of Health

Dr Mansour El Hawasi, Deputy Minister for Executive Affairs

Dr Yagoub Al Mazrou, Assistant Deputy Minister for Preventive Medicine

Dr Othman Al Rabea'a, Adviser to H.E. Minister of Health

Dr Mohamed O. Ba Suleiman, Director-General Health Centres

Dr Mohamed H. Jefry, Director-General Infectious and Parasitic Disease

Ministry of Education

Dr Suleiman Al Shehry, Director-General Health Services (Girls)

Ministry of Economy and Planning

Dr Ahmed El Hakami, Deputy Minister of Planning

The Arab Red Crescent Society

Dr Abdullah El Hazza', Secretary-General

UNDP

Dr El Mustafa Binlamlih, Resident Coordinator, UNDP Resident Representative

Dr Montaser Uklah, Deputy Resident Representative

Executive Board of the Health Ministers' Council for the Gulf Cooperation Council States

Dr Tawfik A. Khoja, Director-General, Health Ministers' Council for the Cooperation Council States

AGFUND

Mr Jebrin Al Jebrin, Director of Projects

Mr Zuhair Mehyo, Projects Adviser

Mrs Maha Aal El Sheik, Projects Associate

Annex 2
List of CCS team members

Dr Awad Mukhtar, WHO Representative in Saudi Arabia

Dr Amr Mahgoub, Regional Adviser, Health Management Support, Regional Office for the Eastern Mediterranean

Dr Hassan El-Bushra, Regional Adviser, Surveillance, Forecasting and Response, Regional Office for the Eastern Mediterranean

Dr Robert John Fryatt, Public Health Officer, Sustainable Development and Healthy Environments/Cooperation and Country Focus, WHO headquarters