WHO-EM/ARD/034/E

Country Cooperation Strategy for WHO and Jordan 2008–2013

Jordan

World Health Organization
Regional Office for the Eastern Mediterranean

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Abbreviations

BMI	Body mass index
CCA	Common Country Assessment
CCM	Country Coordination Mechanism
CCS	Country Cooperation Strategy
CEHA	Centre for Environmental Health Activities
CIP	Civil Insurance Programme
EC	European Commission
EMRO	Regional Office for the Eastern Mediterranean
FAO	Food and Agriculture Organization of the United Nations
GDP	Gross Domestic Product
GPW	General Programme of Work
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IT	Information technology
JD	Jordanian dinars
JPFHS	Jordan Population and Family Health Survey
JPRM	Joint Programme Review and Planning Mission
JUH	Jordan University Hospital
JUST	Jordan University of Science and Technology
ILO	International Labour Organization
KAH	King Abdullah Hospital
MDGs	Millennium Development Goals
MOF	Ministry of Finance
MOH	Ministry of Health
MOSD	Ministry of Social Development
MOU	Memorandum of Understanding
NA	National Agenda
NHSIS	National Health Statistical Information System
PHC	Primary health care
RMS	Royal Medical Services

Abbreviations

SO	Strategic Objective
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

Section 1

Introduction

Section 1. Introduction

The Country Cooperation Strategy (CCS) reflects a medium-term vision of WHO for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS aims to bring together the strength of WHO support at country, Regional Office and headquarters levels in a coherent manner to address the country's health priorities and challenges. The CCS process examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, determinants of health and national policies and strategies that have a major bearing on health. The exercise aims to identify the health priorities in the country and place WHO support within a framework of 4–6 years in order to strengthen the impact on health policy and health system development, as well as the linkages between health and cross-cutting issues at the country level. The CCS as a medium-term strategy does not preclude response to other specific technical and managerial areas in which the country may require WHO assistance.

The CCS takes into consideration the work of all other partners and stakeholders in health and health-related areas. The process is sensitive to evolutions in policy or strategic exercises that have been undertaken by the national health sector and other related partners. The overall purpose is to provide a foundation and strategic basis for planning as well as to improve WHO's collaboration with Member States towards achieving the Millennium Development Goals (MDGs).

This strategy document for 2008–2013 follows the previous CCS for Jordan, which covered the period 2003–2007. Its formulation is the result of analysis of the health and development situation and of WHO's current programme of activities. For its development, a national CCS team was formed representing officials from the Ministry of Health and High Health Council along with WHO staff from the country and regional offices and headquarters (Annex 1). During its preparation, key officials within the Ministry of Public Health and Population as well as officials from various other government authorities, United Nations agencies, nongovernmental organizations and private institutions were consulted. The critical challenges for health development were identified. Based on the health priorities of the country, a strategic agenda for WHO collaboration was developed. Clear guiding principles were used to identify the challenges as they relate to the context of Jordan, national and partnership frameworks, the prioritized areas of work and strategic directions.

The key challenges identified in Jordan's CCS 2008–2012 are focused on six areas: health system governance, human resources for health, health information and research, health financing, healthy lifestyle promotion and risk factor management, and emergency preparedness. Special emphasis is given to cross-cutting issues interlinking environment, poverty and gender as they influence the strategic directions and areas of priority.

Section 2

Country Health and Development Challenges

2.1 Geographic location and administrative structure

Jordan is a small country with a total area of 89 342 square kilometres. Three quarters of the total area of Jordan is sparsely populated desert. The country has limited natural resources and suffers from severe fresh water scarcity; it is ranked among the five most water-poor countries in the world.[1]

Jordan is a constitutional monarchy and has a parliamentary system composed of an elected lower house of representatives and an upper house appointed by the king. Administratively, the country is divided into twelve governorates, each run by a governor appointed by the king. Governors are the sole authorities for all government departments and development projects in their respective areas.

2.2 Population overview

Jordan is a developing country with an estimated population of 5.6 million.[2] 82.6% of the population is urban, with the majority (71.5%) concentrated in the country's three largest urban areas (15.7% of the total area of Jordan): central Amman, Zarka and Irbid governorates.

Jordan is in demographic transition, with a relatively high total fertility rate of 3.7, crude birth rate of 29 per 1000 population, death rate of 7 per 1000 population and an annual population growth rate of 2.3%. In 2004, 60.7% of Jordanians were under the age of 25 years and children below the age of 15 years constituted 37.3% of the population. Individuals 65 years and over made up 3% of the population and the dependency ratio was 68.2%.[3] Despite the declining fertility, the total population is expected to double within the next 30 years.

Migration from neighbouring countries is a strain on the social welfare sector; in addition to the estimated 1.7 million Palestinian refugees, there are also an estimated 450 000 to 500 000 displaced Iraqis in Jordan.

2.3 Economic and social development

The Human development report 2006 ranked Jordan at 86 out of 177 countries in terms of human development indicators, moving up from 90 in 2004. Jordan is a lower-middle income country with a per capita GDP of US$ 2542 for 2006.[4] In 2007, the unemployment rate was estimated at 14.3%, and was highest among women (25.4%) and young people (51.3%).

The National Poverty Alleviation Strategy (2002) indicates that up to a third of Jordanians live below the poverty line.[5]

1 United Nations. Common Country Assessment: Jordan 2006
2 Department of Statistics. Jordan in Figures 2006
3 Department of Statistics. Jordan in Figures 2005
4 Department of Statistics. Preliminary Estimates of the GDP for 2006
5 Ministry of Social Development. Poverty Alleviation for a stronger Jordan: a comprehensive national strategy, 2002

The official figure for income poverty stands at 14.2% and the national poverty line is JD 392 (US$ 554) per capita per year. In rural and urban areas, 18.7% and l2.9% of the population, respectively, live below the poverty line.[6]

In 2005, Jordan launched a National Agenda to achieve a set of ambitious macroeconomic and social development targets, i.e. reduction of unemployment and poverty rates.[7] Major highlights in the National Agenda health sector policy reform include: universal health insurance; efficiency and quality of public services; focus on preventive medicine and primary health care; emergency medical services; and human resources for health. The themes of the National Agenda feed into efforts to achieve the health-related national targets of the Millennium Development Goals (MDGs).

2.4 Health system

2.4.1 Governance

The Government of Jordan is committed to making quality health care services available and accessible to all citizens. The governance of the health care system in Jordan is vested in the Ministry of Health, mandated by the Public Health Law and other legislation to license, monitor and regulate all health professions and institutions in the country. Professional associations, other health councils and independent public organizations (Jordan Medical Council, High Health Council, High Nursing Council, Jordan Food and Drug Administration, Private Hospitals Association and others) participate with the Ministry of Health in regulating and monitoring functions.

Governance within the Ministry of Health is highly centralized, and the main challenges facing the Ministry are improving efficiency, cost containment and quality of patient care. A review of attempts to introduce decentralization in the Ministry of Health which were undertaken in the 1990s could assist in guiding the process, especially in light of the development of locality administration in Jordan. There is also a need to include representation from health-related sectors such as water, environment and population in the High Health Council.

2.4.2 Health care system organization

Public sector providers of care

The Ministry of Health is the major health care provider in Jordan and is responsible for all health matters in the country, including health promotion and protection, administration of the Civil Insurance Programme (CIP), organization and supervision of health services provided by both the public and private sectors, and establishment of educational and health training programmes. A list of health care providers by sector is given in Table 1.

The Royal Medical Services (RMS) provides health care and comprehensive health insurance to active and retired military personnel and their families.

[6] The Hashemite Kingdom of Jordan/ World Bank. Jordan Poverty Assessment. Main Report, Volume 2. December 2004

[7] Government of Jordan. National Agenda 2006–2015

Table 1. Providers of health care and eligible/beneficiaries in Jordan

Sector	Authority	Eligible/beneficiary	
Public	Ministry of Health (MOH)	Civil insurance	
		Any citizen, resident or visitor	
		Other insurance – MOU	
	Royal Medical Services (RMS)	Military insurance	
		Private customers (include visitors)	
		Other insurance – MOU	
	University hospitals and specialized centres	Jordan University Hospital	Their own constituency
		King Abdullah I Hospital (JUST)	Other insurance
		King Hussein Cancer Centre	Private customers
Private	Clinics	Private insurance	
	Hospitals	Private customers	
	Treatment abroad	Visitors, Other insurance	
International	UNRWA	Registered Palestinian refugees	
Nongovernmental organizations	National	Red Crescent Society	
	International	Clinics and hospitals	

RMS also provides services to uninsured patients referred from the Ministry of Health and the private sector on a fee-for-service basis. A new memorandum of understanding has been signed with universities to coordinate training and services. RMS has training institutions and a structured continuous professional development programme for its staff.

Jordan University Hospital (JUH) in Amman and King Abdullah I Hospital (KAH) at Jordan University of Science and Technology in Irbid provide high quality secondary and tertiary health care services. Patients of both hospitals are university employees and their families, students enrolled in the university, referrals from the Ministry of Health and RMS, or independent private patients. These hospitals serve primarily as teaching facilities for undergraduate and postgraduate training of health professionals. King Hussein Cancer Centre is the primary cancer treatment facility in the country.

Private sector

The private sector contains much of the country's medical expertise, in addition to high technological capacity and quality of services. It attracts a significant number of patients from neighbouring countries.

Nongovernmental and international organizations

The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) operates a health programme focused on the direct provision of essential health services to the registered Palestinian refugee population in Jordan.[8] Its services include school health, health education programmes and environmental health services in refugee camps. It currently operates 23 public health facilities inside and outside the camps. It also subsidizes secondary and tertiary care for refugees through contracts with the Ministry of Health, RMS and private hospitals. The major responsibilities of the Jordanian Red Crescent Society health facilities are to provide health during emergencies and for refugees in Jordan, such as some of the Iraqi population in Jordan.

2.5 Resources for health care

2.5.1 Health care finances

Jordan's total expenditure on health is among the highest in the Region, at 9.8% of GDP (compared to an average 5% in the Region). Jordanians spend an average of US$ 228 per capita per year on health (2005), compared to an average of US$ 91 in the Region. The contribution of social security to government expenditure on health in Jordan is negligible, when compared to its contribution in the Region and globally.[9] There are no estimates of the impact of catastrophic health expenditure as defined by WHO.[10]

The government share of total health expenditure has declined from 51% in 1998 to 41% in 2005 (including external sources and donors). This reinforces the growing importance of private sources, estimated at 59%. In the period 1998–2003, the financing share of the Ministry of Health from total government sources remained fairly stable (58%–60%). Meanwhile, secondary health care/hospitals absorb a disproportionately large share of public spending on health (76%), while the share of expenditure on primary health care has been steadily declining.[11]

Although pharmaceuticals account for 14% of the total public spending on health, they account for almost one third of the total health expenditure in Jordan, putting Jordan among the highest spenders on medicines in the world, estimated at more than 3% of GDP.

2.5.2 Human resources for health

Jordan fares well with regard to its health workforce and is a supplier of human resources for health to many countries in the region. It is almost self-sufficient in the pre-service health and medical education, and to a large extent in postgraduate major specialty training. Jordan is recognized in the Region as a training centre for health professions. However, Jordan lacks a comprehensive

8 UNRWA. Annual Report of the Department of Health, 2004
9 WHO. World Health Statistics, 2007
10 Ke Xu et al. Household catastrophic health expenditure: a multicountry analysis. Lancet, 2003, 362: 111–7
11 Ministry of Finance. Jordan Public Expenditure Review, 2006 (Arabic)

human resources for health plan and strategy to address both local and regional needs.

Overall, 13.5% of the Ministry of Health staff are physicians (all types including residents), 27.8% are nurses (all categories), 15% in administration and about 24% in ancillary services. However, nearly two thirds of the Ministry of Health doctors (64%) and the majority of registered nurses (86%) work in hospitals, leaving a small percentage to work in primary health care facilities. Meanwhile, 9% of total Ministry staff work in the central Ministry of Health, which is considered a significantly high percentage when compared to some other countries in the Region.[12] The public sector employs around 40% of all practising physicians in the country, 7% of pharmacists and 64% of nurses. The physician to population ratio is 24.5 per 10 000, higher than most other countries in the Region and other middle-income countries.

Human resource development assessments supported by WHO (1998) and USAID (2004) showed gaps in human resources management, including performance management, job descriptions, recruitment, hiring, firing, transfer and promotion. As well, there is no formal continuing education system and the relationship between health service provision and pre-service training institutions is not strong. Budget allocations for human resource development in the Ministry of Health and the private sector are minimal.[13]

2.5.3 Pharmaceuticals

Jordan produced only 25% of its pharmaceutical needs in 2003, yet it is an exporter of pharmaceuticals, and this industry is considered one of the promising industries in national economic development plans. The national medicine policy, developed in 2000 in collaboration with WHO and the World Bank and currently under revision, serves as a framework for future development and upgrading of the pharmaceutical sector. The Jordanian Food and Drug Administration is in charge of quality control of locally manufactured and imported medicine, medical supplies, drug registration, licensing and pricing.

2.5.4 Health information systems and health research

The National Health Statistical Information System (NHSIS) at the Ministry of Health is the focal point of health information in Jordan. Major constraints facing the NHSIS are lack of qualified human and financial resources, inadequate linkages between institutions, and lack of accurate data on health services and financing in the private sector. Furthermore, there is no national health research system in place. Main achievements of the NHSIS include the launch of the Ministry of Health website and establishing national registries for cancer.

Health education initiatives are currently taking place, mainly through the Ministry

[12] EMRO 2006. Regional Health Systems Observatory. Health System Profile: Jordan

[13] Ministry of Finance. Jordan Public Expenditure Study. Health Sector Draft Report 2004

of Health's department of health education. Recently, a partnership on health promotion was established called Our Health (Sehetna). A comprehensive review of current awareness-raising activities for behaviour-related disease is in order.

2.5.5 Health insurance

Currently, an estimated 65%–75% of Jordanians have some form of health insurance (civil, military, UNRWA, private) depending on the reporting authority. Any individual can utilize the Ministry of Health services and pay subsidized fees (15%–20% of cost). In this sense, the Ministry of Health provides a safety net for Jordanians who require health care and have no insurance.

The Civil Insurance Programme (CIP) covers all government employees and their dependents, the poor, the disabled, children under six years of age and blood donors. The plan is covering about 20% of Jordanians. RMS is the largest health insurer and covers 27% of the population, mainly military personnel and their dependents. UNRWA provides free primary health care to eligible Palestinian refugees in Jordan, and contributes to the cost of inpatient care. UNRWA is reported to cover 11.4% of the population. Health insurance by private insurance companies is available for people who want it.

The CIP has an optional subsidized health insurance programme for pregnant women and senior citizens. The CIP has offered health insurance to all Jordanian citizens (and residents) who are not covered by any health insurance. The National Agenda is targeting universal health insurance coverage by the year 2012. Discussions are currently under way to create an independent health insurance agency.

2.5.6 Health service delivery, coverage and utilization

Primary health care

Jordan has nationwide primary health care coverage, with about 2.4 primary care centres per 100 000 population and an average patient travel time of 30 minutes to the nearest centre. This represents a high density system by international standards, with 97% access estimated by the Ministry of Health in 2007.

Jordanians make about 3.6 outpatient visits a year on a per capita basis, almost half of which occur at the Ministry of Health facilities and 40% at facilities operated by RMS, JUH, UNRWA and other organizations. Populations that are illiterate, poor or living in rural areas are more likely to use the Ministry of Health outpatient services.[14] However, weak or no reporting of the private sector may affect these figures.

The average cost per visit at primary health care centres is JD 4.5 (US$ 6.4). Determinants of the cost per visit are mainly volume of patients seen per day, type of facility and the nature of services provided. The highest cost per visit is seen in facilities with low volume of patients, village clinics and pre-natal/post-natal services facilities.[15]

[14] USAID Primary Health Care Initiative. Household survey 2001

[15] USAID Primary Health Care Initiative. Rationalization of staffing patterns and cost analysis of primary care services in Jordan 2000

Improvement of the quality of care, expansion of services, cost containment and activation of a referral system for the primary health care network are needed.

Secondary and tertiary health care

Jordan has 1.9 inpatient hospital beds per 1000 population.[16] About 12.3% of the population is admitted annually to hospitals, with an average length of stay of 3.2 days. The average overall hospital occupancy rate is estimated at 60.9%, with variation between the public and private sectors. JUH has the highest bed occupancy rate (75%), followed by RMS (74.3%) and Ministry of Health hospitals (65.8%).There is a significant excess in bed capacity, as indicated by low bed occupancy rates in the private sector (45.9%).

Medical tourism

Medical tourism contributes to the national economy, as the country receives more than 100 000 patients from neighbouring countries per year. The majority of these patients come from Yemen, Libyan Arab Jamahiriya, Palestine and Sudan, seeking specialized medical care in the private sector. In 2001 the private sector received about US$ 600 million in revenues from foreign patients. The Jordan national health accounts exercise reported that in 2001, 32% of hospital revenue was from medical tourism.[17]

Despite the country's success in attracting foreign patients, a number of issues need to be addressed, including the lack of coordinated marketing efforts, discrepancy between the quality of care provided and the charges incurred, recurrent malpractice issues and inadequate quality control. Launching of health care quality management and control would enhance the medical tourism sector. The Ministry of Health is seeking accreditation mechanisms to maintain adequate levels of competitiveness and is urging all hospitals to work towards achieving international quality indicators within an established time-frame.

2.6 Health status

2.6.1 Mortality trends

The crude death rate for 2005 was estimated at 7 per 1000 population (revised in light of 2004 census). Although death registration is mandatory by law, registration is not universal (estimated at 37%) and certification by cause of death is not completely accurate.[18] However, recent efforts have been effective in improving the mortality statistics in Jordan.

Mortality levels and trend analysis (Figure 1) indicate that cardiovascular diseases are the main cause of death, accounting for 38% of all deaths in 2004. Cancer ranks second (14%) and external causes including injuries (11%) ranks third.

16 Ministry of Health. Annual Statistical Report 2006
17 WHO Regional Health Systems Observatory 2006. Health System Profile: Jordan
18 WHO. World Health Statistics 2007

Antenatal care coverage has expanded, covering 99% of pregnant women in 2004, and all births (100%) are attended by skilled health personnel.[19] However, the quality of antenatal care and proper attendance of delivery, including caesarean section rates, are still in question.

The infant mortality rate has declined from 122 per 1000 live births in 1961 to 22 per 1000 live births in 2002. Under-five mortality has declined from 39 per 1000 live births in 1990 to 27 per 1000 in 2002. The decline is due to intensive focus on maternal and child health activities. The neonatal mortality (Figure 2) rate declined from 21 to 16 deaths per 1000 live births over the period 1985–2002; however, its contribution to overall infant mortality increased, from 63% in 1985 to 70% in 2002.[20] Therefore, to achieve the MDG target of two-thirds reduction in under-five mortality in Jordan, neonatal mortality, the major contributor to under-five mortality in Jordan, should be addressed.

2.6.2 Morbidity trends

Morbidity data

National morbidity data are not collected according to a standardized methodology and are not available in a comprehensive manner. Most of the available data relate to reportable diseases, and the majority of hospitals and health care facilities do not code or classify diseases. Admissions and discharges are properly categorized as system-related categories, and surgeries are only coded as major and minor. In 2006, diseases related to the respiratory system were responsible for 42% of health problems treated at the Ministry of Health primary health care facilities.[17] Data from Al Bashir

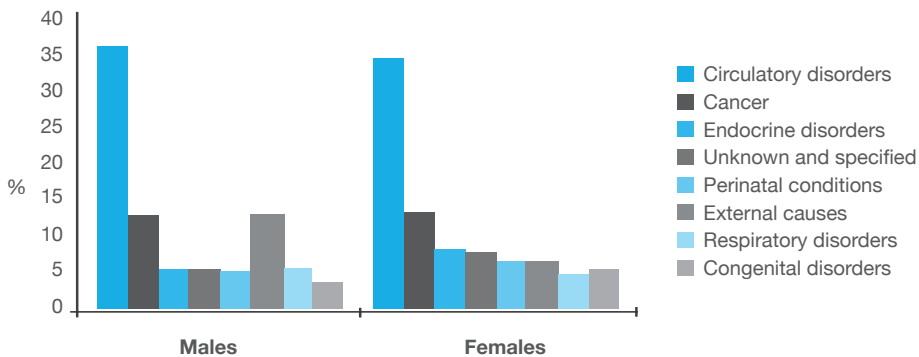

Figure 1. Leading causes of death in Jordan, by sex, 2004

Source: Ministry of Health Information Directorate, 2007

[19] Ministry of Health 2007. National Death Registry Report for 2004

[20] Department of Statistics. Jordan Population and Family Health Surveys, 1990, 1997, 2002

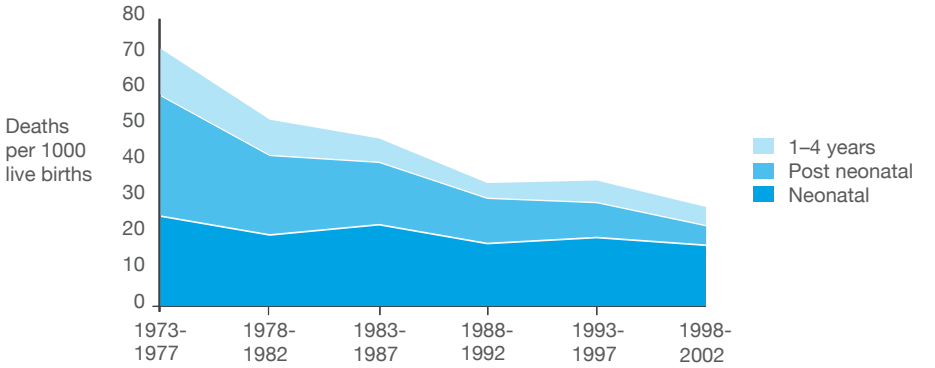

Figure 2. Trend in components of under-5 mortality, 1973–2002

Source: Department of Statistics. Jordan Population and Family Health Surveys, 1990, 1997, 2002

hospital (a tertiary hospital) confirm the importance of cardiovascular disease, renal failure, diabetes, pneumonia and asthma.

Communicable diseases

Although the disease profile in Jordan is changing, infectious diseases are still major causes of morbidity. Diarrhoeal diseases, acute respiratory infections and hepatitis are the leading causes of morbidity reported from health facilities in Jordan, especially among children. There has been a dramatic drop in the incidence of vaccine-preventable diseases. No cases of polio were reported in the country since the outbreak of 1991. Good surveillance and follow-up of all cases and contacts have resulted in a drop in tuberculosis rates from 7.3 per 100 000 in 1993 to 2.8 per 100 000 in 2004.[21] All malaria cases currently detected in Jordan are imported.

Jordan is a low prevalence country for HIV/AIDS, with an estimated prevalence of less than 0.01%[22]. As of December 2006, the cumulative number of HIV/AIDS reported cases in Jordan was 492, of which 35% were Jordanians (Ministry of Health data). The estimated number of people living with HIV is below 1000. Sexual contact is the main mode of transmission. Available data rely on passive case reporting, which may underestimate the true situation and overlook vulnerable groups. Several biological and behavioural surveillance activities were conducted on most-at-risk populations between 2006 and 2008. Besides sex workers, men having sex with men and injecting drug users, migrant workers and prisoners were also identified as high-risk populations. The Government of Jordan has developed a comprehensive multisectoral national HIV/AIDS strategy (2005–2009), including major awareness raising and focus on vulnerable groups. It is estimated that 100

[21] Ministry of Health, Disease Control Directorate. Report to the WHO Joint Programme Review Mission 2005
[22] WHO/UNAIDS. Report on HIV/AIDS 2006

HIV patients are in need antiretroviral treatment; the reported number of those receiving the treatment is 53, i.e. coverage of 53%.

Chronic and noncommunicable diseases, lifestyle and behavioural risk factors

Jordan is witnessing an increasing trend in the number and severity of noncommunicable diseases, particularly cardiovascular diseases, cancer, diabetes and chronic respiratory conditions. The major cardiovascular diseases prevalent in Jordan are hypertension, coronary heart disease and stroke. There is an increasing prevalence of risk factors when compared to 2004 data (see Table 2). A 2007 survey conducted among adult Jordanians 18 years or older found the prevalence of hypertension to be 26% (31% in males, 22% in females), diabetes 16%, impaired fasting glucose 24% (50% increase from 2005) and hypercholesterolaemia 34%. The prevalence of overweight (BMI ≥ 25 kg/m2) was 66% (63% in males, 70% among females). Levels of physical inactivity are high and estimates show moderate inactivity at 32% (improved from 50% in 2005). Almost 29% of the Jordanians smoke cigarettes regularly (50% males, 6% females) and another 9% smoke waterpipe. About 60% of smokers started smoking before the age of 18. [23,24]

Based on FAO statistics, the average daily per capita dietary energy supply increased by 25% during the period 1962–2002, with the carbohydrate share of the dietary energy supply decreasing (though it remains high, at 62%). The decrease was accompanied by an increase in the share of energy supply from fat. The protein share remained relatively stable, fluctuating around 10%. This increasing share of fat may contribute to the epidemiological shift towards noncommunicable diseases.[25]

The National Cancer Registry was established in 1996. The crude incidence rate for all cancers among Jordanians in 2004 was 67.1 per 100 000 population (63.9 for males and 70.5 for females). However, when rates are adjusted to the world standard population, gender differences disappear (age-standardized rates per 100 000: males 112.5 and females 112.6). The highest reported crude cancer incidence rate was observed in Amman governorate (112.9), followed by Irbid (61.8). The lowest (20.3) was observed in Mafraq. Reasons are attributed to lifestyle, but the method of registering the case is very important. Breast cancer ranked first among females, accounting for 32.9% of all female cancers, while colorectal cancer was the commonest among males, 14.1% of all male cancers. The majority of cancer cases are diagnosed in late stages of the disease.[26]

Accidents and injuries constitute the second leading cause of death in Jordan and have become an increasingly significant problem. In 2006, the Jordan Traffic Institute

[23] Ministry of Health. Main results of behavioural factors and risk factors of chronic diseases in Jordan (released 22 November 2007)
[24] Ministry of Health and USAID 2006. Jordan behavioural risk factor survey for 2004–2005
[25] FAOSTAT data 2005. Available at http//faostat.fao.org/faostat/collectives
[26] Ministry of Health 2007. National Cancer Registry. Incidence of Cancer in Jordan 2004

Table 2. Prevalence of risk factors among adult Jordanians (18+), 1996, 2004 and 2007

Risk factor	1996	2004	2007
Hypertension %	32	29.1	26
Diabetes %	7	13.2	16
Impaired fasting glucose %	NA	NA	24
Hypercholesterolaemia %	NA	22.1	34
Overweight (BMI ≥ 25 kg/m2) %	NA	73	66
Moderate physical inactivity %	NA	51	32

Source: Jordan behavioural risk factor surveys, 1996, 2004 and 2007

reported 98 055 road traffic accidents, resulting in 18 019 injuries and 899 deaths.[27] Injuries occurred more commonly in the age group 15 to 30 years and deaths in the age groups of 0 to 11 years and 50 years or more. Occupational accidents amounted to 112 859 in 2004, resulting in an estimated loss of 97 522 working days.

Osteoporosis is another emerging health problem in Jordan. A study conducted on 821 post-menopausal Jordanian women aged 50–89 years showed an overall prevalence of 23% when all skeletal sites were combined.[28]

Hereditary diseases are fairly common in Jordan and are closely associated with consanguineous marriage. The high consanguinity rate (50% of all marriages) contributes to the increase of autosomal recessive disorders.[29] Thalassaemia is the commonest screenable hereditary disease with a carrier rate of 3.4%. There are more than 1000 cases of thalassaemia registered at the Ministry of Health hospitals, with patients on a regular treatment regimen. The annual cost of treatment is estimated at about JD 7 million (US$ 9.9 million). Premarital screening for thalassaemia and some other hereditary diseases is now mandatory by law and is provided free of charge in Ministry of Health centres.

2.6.3 Nutritional disorders

The latest estimates of reported malnutrition among children under five years of age include stunting at 9%, underweight at 4% and wasting at 2%. Although these estimates reflect good general nutrition among children under five years, there are some regional variations mainly favouring the northern part of Jordan and reflecting the strong influence of certain socioeconomic determinants.[30]

27 Royal Hashemite Court, Department of Research and Public Opinion 2006. Traffic Injuries 2006

28 Masri B et al. The First National Osteoporosis Record 2005

29 Khoury SA, Massad D. Consanguineous Marriage in Jordan. American journal of medical genetics, 1992; 43:769–75

30 Department of Statistics and ORC Macro 2003. Jordan Population and Family Health Survey 2002

Anaemia is a public health problem. A national survey on iron deficiency anaemia, conducted in 2002, showed that anaemia affected 32% of women in reproductive age and one fifth of children under five years, with variations between governorates. Iodine deficiency disorders were a problem in early 1990s.[32] The problem was addressed through a universal salt iodization programme launched in 1995. Evaluation in 2000 and 2002 showed that 98% of households are consuming iodized salt effectively.

2.6.4 Reproductive health

Coverage indicators for maternal health have improved in Jordan. However, only 50% of pregnant women are covered by two or more doses of tetanus toxoid, mostly due to an increasing number of pregnancies and deliveries being attended in the private sector.[33] Antenatal clinics distribute iron and folic acid supplements. However, the percentage of women receiving postnatal care remains low. In 2002 the Jordan Population and Family Health Survey reported that 65% of mothers examined immediately after birth do not return for postpartum examination. The public sector, UNRWA, nongovernmental organizations and the private sector offer family planning services. In 2005, the modern contraceptive prevalence rate was around 43%.

2.6.5 Environmental health

Water, sanitation and waste management

In 2004, 97% of the Jordanian population had access to piped water supply.[34] However, intermittent supply and inadequate distribution systems are major problems. Acute water scarcity is aggravated by relatively high population growth. The available water from the existing renewable sources per person per year is projected to fall from 159 centimetres in 2003 to about 90 centimetres by 2025. Water scarcity is exacerbated by pollution of water sources caused by inadequate and inefficient management of domestic wastewater, uncontrolled disposal of industrial waste, leakage from solid waste landfills and seepage from excessive use of fertilizers and pesticides. While 60% of the population has access to improved sanitation (unrealistically reported at 93% in some references), wastewater collection and treatment systems are overloaded and effluent from them does not meet national standards. Solid waste collection, which covers 75% of Jordanians and more than 90% of the population of greater Amman, seems to be satisfactory. Nevertheless, the design and operation of most of these disposal sites need improvement not to contribute to pollution.

Emissions of five principal air pollutants (suspended particulate matter, sulfur dioxide, nitrogen dioxide, carbon monoxide

[32] Ministry of Health 1993. National Research Committee on Iodine Deficiency Disorders in Jordan. Report prepared for WHO and UNICEF

[33] Ministry of Health 2007. WHO/UNICEF joint reporting on immunization for 2006

[34] UNDP. Human Development Report 2006

and lead) have all increased significantly in Jordan in the past two decades. Specific measures for regulating polluting industries and decreasing automobile emissions are currently being considered.

Food safety

Overall, the reported incidence of foodborne diseases in Jordan is decreasing; however, strong publicity given to mass food poisoning accidents has put the issue in the public eye. Limited data are available to assess the burden of illness resulting from foodborne pathogens. The Jordan Food and Drug Administration, established in 2003, is the agency officially mandated to regulate and supervise food safety activities, for both imported and locally produced food, including ensuring the enforcement of food legislation. Food safety activities have proven to be inadequate, as evidenced by the recurrent outbreaks of food poisoning in mayonnaise and shawarma.

The government has recognized the true extent of health and economic consequences of food-borne diseases.[35] Constraints to food safety include limited human resources, inadequate consumer awareness, overlap of responsibilities across the food chain, lack of regulation of street foods and food handlers, lack of multidisciplinary inspection teams and limited laboratory services. The Ministry of Health is responsible for the surveillance of foodborne diseases, notification of individual cases and outbreak reporting system. Foodborne diseases include cholera, bloody diarrhoea, food poisoning, hepatitis A, brucellosis, typhoid and paratyphoid fever.

There is a clear need to reinforce consumer protection laws, improve coordination between various sectors, increase food safety budget and drastically improve monitoring and inspection. More emphasis is needed on the control of water used for irrigation of vegetables eaten uncooked and on safety standards in slaughterhouses, butcher shops and public places selling or serving food.

Another issue of concern is pesticide residue in the agricultural products of Jordan. Records indicate that for 2002, about 6% of tested samples had pesticide residue greater than the maximum allowable limit and 19% had residue within acceptable limits. An integrated strategy for monitoring use of pesticides in agriculture is urgently needed. There is a need for collaborative efforts of all concerned parties, including ministries of environment, health, agriculture, and water and irrigation.

2.7 Major challenges

The main challenges of health sector in Jordan fall within the following two clusters: health system (governance, financing, human resources, evidence and research); and epidemiological transition (chronic and noncommunicable diseases, lifestyle and behavioural risk factors).

[35] WHO in collaboration with the Ministry of Health carried out a population survey in 2003–2004 to study the burden of illness due to salmonella, shigella and brucellosis. The study indicated a large burden of foodborne pathogens and highlighted the magnitude of under-reporting and under-diagnosis of foodborne illness at all stages of the surveillance system

Specific challenges include the following.

- Lack of systematic burden of disease assessment
- High expenditure on health as a percentage of GDP (9.4%, with 41% out of pocket)
- Relatively high percentage of total health expenditure on pharmaceuticals (30%)
- Lack of universal health insurance coverage
- Lack of evidence-based health system performance
- Weak health system research
- Variable quality of health services
- Concerns on equity of the health system
- Incomplete role and regulation of the private sector (domestic, medical tourism, pharmaceutical sector)
- Need for more attention to environmental health and food safety

2.8 Enabling factors

- Achievement of good health status and good health services in comparison with other countries of similar socioeconomic status
- Well established primary health care network (referral system limited to public sector
- High level political commitment, reflected in the national agenda.
- Functioning High Health Council
- Clear government policy on equity for health
- Presence of legislation and public health laws
- National health strategy being re-drafted
- Presence of strategies and plans for the health-related sector
- Availability of quality health workers
- Relatively high population coverage for health insurance (2/3 of population)

Section 3

Development Cooperation and Partnerships

3.1 Overview

Historically, foreign aid has played a vital role in the economic development of many developing as well as low-middle income countries, and Jordan stands at no exception. For many years, Jordan has received assistance from bilateral and multilateral donors who constitute an integral source of its development funding.

In 2006, Jordan's general budget achieved good results with the overall budget deficit declining from 5% of GDP in 2005 to 3.8% in 2006.[36] Current expenditures rose by 7.3% as a result of the increase in international oil prices, which was clearly reflected by the cost of fuel subsidies amounting to JD 215.7 million (US$ 304.7 million). Capital expenditures rose by 25% as a result of implementing a large number of developmental projects across the country.

During 2006, the total amount committed by the donor community was US$ 675 million. The committed grants reached US$ 485.4 million, representing about 72% of total foreign assistance, and the loans reached US$189.6 million, representing about 28% of total assistance (Figure 3).

In 2006 the support from bilateral donors amounted to US$ 432.6 million, representing 64% of total assistance, whereas the total amount received by multilateral donors amounted to US$ 242.4 million, representing 36% of total assistance.[37]

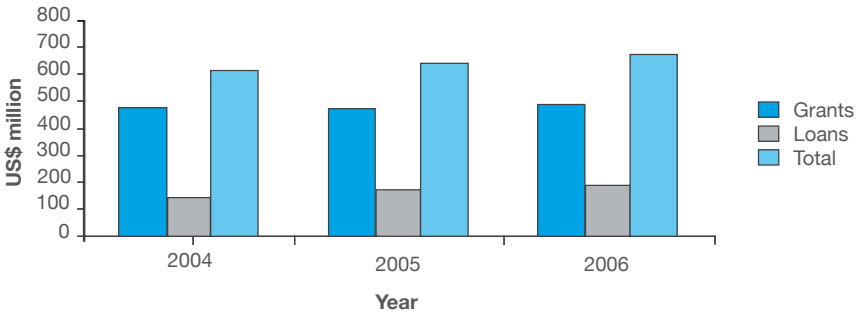

Figure 3. Foreign aid to Jordan 2004–2006*

Source: Ministry of Planning and International Cooperation Foreign Assistance to Jordan 2006
*Oil grants are not included

[36] Ministry of Planning, Jordan (website)
[37] Ministry of Planning and International Cooperation. Foreign Assistance to Jordan 2006

3.2 United Nations system

Since 1952, the United Nations system has continued to provide technical support to Jordan. In 2006, UN programmes (UNDP, UNIFEM and UNODC) committed a total of US$ 1.77 million, while the World Bank committed to a total of US$ 20.85 million. UNDP support for health and related areas is limited to collaboration with the Department of Statistics and collaboration with interagency projects led by WHO, such as HIV/AIDS prevention, media and health, and healthy villages. UNICEF's scope of work is centred on areas relating to nutrition, primary health care and healthy lifestyle promotion. UNFPA is committing resources to address integration of reproductive health into primary health care and contributes to improvement of vital statistics and vital registration.

In 2007, the UN system finalized the United Nations Development Assistance Framework (UNDAF) for Jordan for the period 2008–2012. The UNDAF was prepared on basis of the Common Country Assessment (CCA). The UNDAF is the strategic tool for cooperation between Jordan and the UN system for the period 2008–2012. The UNDAF is based on national priorities as identified by National Agenda, as well as the Millennium Development Goals (MDGs). Programmes emerging from the UNDAF will address all MDGs and will contribute to the achievement of the three following UNDAF outcomes by 2012.

- Quality of and equitable access to social services and income generating opportunities are enhanced with focus on poor and vulnerable groups
- Good governance mechanisms and practices established towards poverty reduction, protection of human rights and gender equality in accordance with the Millennium Declaration
- Sustainable management of natural resources and the environment

The UN agencies have identified a number of areas where two or more agencies can combine efforts and map out joint programming initiatives for achieving the agreed upon objectives. The total budget estimated for implementation of the UNDAF (2008–2012) is US$ 45.9 million. The core resources needed from agencies' budgets are US$ 13.7 million (29.8%), in addition to resources that will need to be mobilized from partners, estimated at US$ 32.2 million (70.2%).

3.3 Donors/lenders group

The donors and lenders group is an informal consultative body consisting of heads of missions of donor and lender countries and representatives of UN agencies. The group is chaired by one of its member from the heads of diplomatic missions and rotation is carried out every six months. The Resident Coordinator's Office acts as the secretariat for the consultative group. The donors/lenders group has been functioning since 2000. One

of the objectives of the group is to improve harmonization and identify constructive synergies among donors/lenders and UN agencies. The group has six subgroups for education, environment, governance and public sector, private sector development, water and social development.

3.4 Donor support for health

In the past two years, the health sector was the third largest recipient of donor funds in Jordan, after direct budget support and the water sector. Total foreign assistance committed by donors and financing institutions for the health sector was US$ 94.04 million in 2005 and US$ 118.3 million in 2006. These amounts, respectively, constituted 15% and 17.5% of the total foreign assistance to the country.

For many years, USAID has been a leading donor to the health sector and has been diligently working with the Ministry of Health and other health related ministries. Areas of support were centred towards population policies and strategies, management of information systems, reproductive health, quality assurance, and strengthening of epidemiological surveillance system for diseases. Other donors are the European Union, Governments of Germany and Japan, Saudi Development Fund, Islamic Development Bank, Arab Fund for Economic and Social Development, OPEC Fund for International Development, the World Bank, and Governments of Norway, Spain, Greece, Switzerland, Canada, Korea, Italy and China.

3.5 Coordination with UN agencies

The WHO office in Jordan has excellent communications and collaboration with all UN agencies. WHO participates actively in various meetings of UN agencies and in the CCA and UNDAF processes. It undertook leadership of the UNDAF thematic group on sustainable management of national resources and environment. It also chaired the UNAIDS thematic group for the past five years and chaired the UNDP MDG Achievement Fund Thematic Window for Youth, Employment and Migration in 2007.

The WHO office also has a close relationship with many governmental, nongovernmental, educational and private sector organizations in Jordan. WHO is playing a vital role in assisting the national committees for violence and injury prevention, tobacco control and healthy lifestyles promotion while ensuring a stronger UN presence with involvement of various UN agencies. WHO has actively sought collaboration with UNICEF and UNFPA in the areas of Integrated Management of Childhood Illnesses, road safety, tobacco control, violence, youth and reproductive health. Moreover, WHO is collaborating with UNHCR, UNICEF, UNFPA and the International Red Cross and Red Crescent Society to provide health services for Iraqi refugees in Jordan. WHO is an active member in the Country Coordination Mechanism (CCM) which is led by the Ministry of Health.

Section 4

Current Country Programme

4.1 Brief historical perspective

In 1985, the WHO country office was established in Jordan in to provide technical support to the Ministry of Health and other health related ministries and sectors. Apart from the WHO Representative's office, Amman hosts the WHO Centre for Environmental Health Activities (CEHA) for the Eastern Mediterranean Region. CEHA staff provide technical support to the WHO office in specific areas relating to water, sanitation, chemical safety and other environmental health activities. As well, the United Nations Relief and Works Agency for the Palestine Refugees in the Near East (UNRWA) is located in Amman. The UNRWA Director of Health for the five areas of operation is a WHO-seconded senior staff.

4.2 Key roles and areas of work

4.2.1 Roles

WHO provides technical and financial support and collaborates with the Ministry of Health, other governmental sectors, nongovernmental organizations, medical and allied sciences institutions and WHO Collaborating Centres. The collaborative programme covers: technical advice, provision of experts/consultants, organizing fellowships/study tour to train nationals, providing supplies and equipment, and supporting operational research and information and knowledge exchange.

WHO has played a key and vital role in the development of CCA and UNDAF in 2005–2007, chairing the health working group, and participated in the poverty and education working groups. WHO is fully involved in the development of national health plans, strategies and major national health activities and is currently the lead UN agency for health development in the country. WHO has played a key supporting role in the development of major national plans and strategies such as the National Agenda, the national health strategy, and the national strategy on HIV/AIDS, the school health strategy, and the national food and nutrition policy. Furthermore, the WHO office has been acting as back-up hub for neighbouring countries such as Lebanon, Iraq and the occupied Palestinian territory during emergencies and has facilitated many administrative procedures.

4.2.2 Areas of work

Avian influenza

WHO has assumed the role of reference point for avian influenza and enjoys a very close relationship with FAO in assisting the country in preparedness and response to avian influenza. WHO also has assisted the office of the UN Resident Coordinator and UNCT in preparing, implementing and monitoring the UN Contingency Plan on pandemic influenza for UN staff in Jordan and Iraq.

Community-based initiatives

As part of the UN drive towards interagency collaboration, the WHO Office in Jordan cooperates with the UNIFEM Regional Office for Arab States on health and gender issues,

including awareness on reproductive health, sexual health rights, early detection of breast cancer and prevention of obesity and smoking. These efforts are part of existing projects implemented by both organizations in Jordan and the region: WHO's healthy villages project and UNIFEM's village project, which are aimed at poverty reduction and community empowerment for health and local development. Additionally, WHO is closely collaborating with UNRWA in the development of healthy villages and healthy lifestyle promotion in refugee camps.

HIV/AIDS

WHO has been the chair of the active UN theme group on HIV/AIDS since 2001. The group, which includes national AIDS programme management and nongovernmental organizations, USAID and other donors, has played a crucial role in accomplishing the three "ones" (one national framework, one national authority and one monitoring and evaluation system). This theme group was noted in the mid term review report of the UNDAF 2003–2007 as a huge and unprecedented success in the UN system

The country office in collaboration with the Regional Office, headquarters and the Global Fund to fight AIDS, Tuberculosis and Malaria has assisted the Ministry of Health in developing successful proposals for Global Fund support for both HIV/AIDS and tuberculosis programmes.

Partnerships with other ministries and agencies

Relationships with some ministries and with civil society and nongovernmental organizations are not sufficiently strategic or solid. WHO has facilitated a successful partnership among concerned stakeholders on tobacco, road safety and HIV/AIDS. Partnership building is expanding to include the High Health Council, Ministry of Environment, Ministry of Transport, Ministry of Interior, Ministry of Agriculture, Ministry of Education and Civil Defence.

There are five WHO collaborating centres in Jordan: National Blood Bank; National Centre for Diabetes, Endocrinology and Genetics at the University of Jordan; Faculty of Nursing at the Jordan University of Science and Technology; King Hussein Cancer Centre; and National Council for Family Affairs. The role of collaborating centres needs further strengthening.

Crisis management and involvement in the Iraq influx into Jordan

WHO is working with UNHCR, UNICEF, UNFPA and other partners in coordinating and harmonizing health support. WHO played a major role in the preparation of the ministerial consultation to support displaced Iraqis which convened in Damascus, Syrian Arab Republic, on 29–30 July 2007 and resulted in a common action framework for all partners working for the health of displaced Iraqis in Jordan, Syrian Arab Republic and Egypt. WHO is also supporting UNHCR activities in health, including psychosocial support to vulnerable displaced groups. Furthermore, WHO is leading the UN system in preparing medical evacuation plans for Jordan and logistical support for WHO staff in Lebanon and Iraq.

It is anticipated that more efforts will be needed for support to displaced Iraqis and

for assisting neighbouring countries.

4.3 Existing resources

In addition to the WHO Representative, the WHO office in Jordan includes the following fixed term staff.

- National programme officer (health system)
- National programme officer (health protection and promotion)
- One national senior administrative staff (office director)
- One national IT assistant
- One national clerk
- One national secretary
- Two drivers

The current country office is accommodated by the Government of Jordan in a rented three-story building. Only one and half floors are used by WHO. Recently the Government of Jordan offered land (2500 square metres) in the middle of Amman city for construction of a new office building. Construction is expected to start by mid 2008.

4.4 Country programme budget

The WHO country budgets for the bienniums 2006–2007 and 2008–2009 were US$ 790 000 and US$ 795 000 respectively (Figure 4). The regular budget comprised about 20%–50% of the total programme budget while extrabudgetary sources ranged widely, from US$ 606 500 to US$ 4 254 000. A breakdown comparison of the distribution of the WHO regular budget in order in the past two bienniums across priority areas is shown in Figure 4. The priority areas identified were communicable diseases, noncommunicable diseases, emergency preparedness, health systems strengthening, health promotion and protection and sustainable development.

4.5 Challenges

- Harmonization with the National Agenda. The National Agenda, launched in 2005, sets the framework for development and has been used as a reference in the CCS process. WHO collaboration and the implementation of the CCS should be harmonized with the main National Agenda themes of poverty reduction; sustainable environment; education; training and youth employment; population and health; public and private sector development; and equity and equality issues, including gender
- Refocusing. There is need for more emphasis on health system strengthening and on the prevention and treatment of noncommunicable diseases
- Focus on major strategic initiatives and sustainability. The major emphasis should be on key strategic issues that support building national capacity and facilitate sustainability, such as integrated human resources development for health, building local capacity and institutional strengthening
- Partnership with national stakeholders outside the Ministry of Health. The Ministry of Health continues to be WHO's main counterpart; however, partnership with other national collaborators should be strengthened.

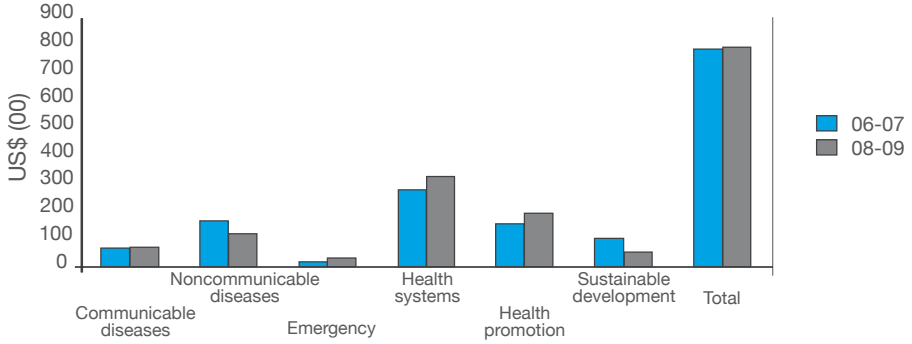

Figure 4. Distribution of regular budget among different programes for 2006–2007 and 2008–2009 bienniums

4.6 Strengths and weaknesses of WHO cooperation

4.6.1 Strengths

- Motivated and qualified staff
- Responsive and committed team
- High credibility and visibility
- Main source of health information in Jordan
- Catalyst for strategic change
- Strong advocacy role with highest political support
- Strong technical support
- Good follow-up with the Regional Office and headquarters on ongoing activities
- Lead in UNCT thematic groups (HIV/AIDS, environment and avian influenza)

4.6.2 Weaknesses

- Insufficient number of professional and support staff to respond to overwhelming demand
- Inadequate IT infrastructure and support
- Overemphasis on support for routine activities
- Too many programmes with less focus on strategic impact
- Limited cooperation with other health-related sectors
- Inadequate focus on key national strategic priorities
- Little correlation between the CCS and JPRM 2004–2007

Section 5

Strategic Agenda for WHO Cooperation

Section 5. Strategic Agenda for WHO Cooperation

5.1 Introduction

The General Programme of Work is a requirement specified in Article 28(g) of the WHO Constitution. The General Programme of Work analyses current health challenges in light of WHO's core functions and sets broad directions for its future work. The core functions as stated in the Eleventh General Programme of Work, covering the period 2006–2015, are as follows.

- Providing leadership on matters critical to health and engaging in partnership where joint action is needed
- Shaping the research agenda, and stimulating the generation, dissemination and application of valuable knowledge
- Setting norms and standards, and promoting and monitoring their implementation
- Articulating ethical and evidence-based policy actions
- Providing technical support, catalysing change and building sustainable institutional capacity
- Monitoring the health situation and assessing health trends

The analysis in the Eleventh General Programme of Work reveals several areas of unrealized potential for improving health, particularly the health of the poor. The gaps are identified in social justice, in responsibility, in implementation and in knowledge. WHO's response is translated into priorities in the following areas according to its results-based management framework.

- Providing support to countries in moving to universal coverage with effective public health interventions
- Strengthening global health security
- Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health
- Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health
- Strengthening WHO's leadership at global and regional levels and by supporting the work of governments at country level

The Medium-term strategic plan 2008–2013—an integral element in WHO's framework for results-based management—translates the Eleventh General Programme of Work's long-term vision for health into strategic objectives, reflects country priorities (particularly those expressed in country cooperation strategies) and provides the basis for the Organization's detailed operational planning. The strategic objectives provide clear and measurable expected results of the Organization.

The structure of WHO's Secretariat assures involvement with countries.

Headquarters focuses on issues of global concern and technical backstopping for regions and countries. Regional offices focus on technical support and building of national capacities. WHO's presence in countries allows it to have a close relationship with ministries of health and with its partners inside and outside government. The Organization also collaborates closely with other bodies of the United Nations system and provides channels for emergency support.

In developing strategic priorities for collaboration between WHO and the Government of Jordan during the mid-term period 2008–2013, special care has been taken by the CCS mission to ensure that these priorities are in line with the Organization-wide priorities and overall strategic directions during the same period.

5.2 Framework for collaboration

The development of the strategic directions for WHO collaboration with Jordan during 2008–2013 involved a comprehensive consultative process. The overall approach included as many stakeholders as needed to ensure intersectoral and intrasectoral integration and coordination, leaving room to identify or revise roles and expectations to help ensure harmonization and aid effectiveness.

Extensive technical discussion, consultations and group work allowed the CCS team to address the issues within a framework of cooperation between the WHO and the Government of Jordan. The CCS team focused on the development of the strategic directions. During the development process, certain guiding principles were used to identify challenges related to the priority areas.

- Alignment with national priorities
- Harmonization with programmes of other partners
- Linkage with WHO global and regional priorities
- Contribution to MDGs and related health goals
- Equity and social protection
- Gender equity, human rights and health security
- Strengthening technical and evidence-based practice and management
- Partnership
- Sustainability

The direction of WHO cooperation with Jordan during 2008–2013 will not deviate radically from previous strategies, which have resulted in the stable and steady improvement in health status and development of the health system. However, WHO collaboration will focus primarily on the health system (governance, financing, human resources, evidence and research) and challenges of epidemiological transition (chronic and noncommunicable diseases, lifestyle and behavioural risk factors).

Furthermore, the prioritized strategic directions are consistent with national priorities and WHO's mid-term strategic plan 2008–2013) of the Eleventh General Programme of Work (2008–2017) as well as with the regional priorities.

5.3 Strategic directions for cooperation

1. **Strengthening health sector governance and health system policy development and management**

- Developing health policies and strategies to be incorporated in all sectors for improving health
- Strengthening capacity for effective decentralization, especially quality, equity and the primary health care referral system
- Building capacity to enhance partnership among all stakeholders for health and effective intrasectoral and intersectoral collaboration
- Strengthening regulation of the private sector to ensure the quality of care and patient rights
- Promoting cost containment and rational use of health technologies to prevent the unnecessary escalation of health care costs, particularly in relation to growing medical tourism
- Strengthening regulation of the pharmaceutical industry and rational use of medicines

2. **Strengthening comprehensive national health human resource development, planning, production and utilization**

- Developing an integrated national health human resources development plan
- Establishing a functional coordinating mechanism to bring together all stakeholders
- Setting up a national accreditation system for health professions education
- Formulating policies for retention, management and performance-linked continuing professional development

3. **Strengthening information research and knowledge management**

- Strengthening an integrated national health information system for evidence-based policy formulation, decision-making, monitoring and evaluation
- Strengthening the national health research system
- Strengthening knowledge management and sharing

4. **Developing a fair sustainable health financing system covering the entire population**

- Developing a national health financing policy based on social health insurance
- Developing a fair financing system for equitable contribution and reduction of catastrophic health expenditures
- Institutionalizing the national health account and analysis

5. **Supporting policy, programmes and coordinating mechanisms for integrated health promotion and protection, risk factor management and injury prevention**

- Developing a national strategy for health promotion addressing lifestyle-related risk factors and their management
- Continuing support for road traffic accident and injury prevention
- Re-orienting human resources development to develop the required health workforce for health promotion and risk factor management
- Networking and improving intrasectoral and intersectoral collaboration
- Strengthening noncommunicable disease and risk factor surveillance
- Strengthening maternal mortality surveillance

6. **Strengthening national emergency preparedness plans and strategies based on hazard mapping and risk assessment**

- Developing a unit for health emergency preparedness in the Ministry of Health
- Building the capacity of Ministry of Health staff in early preparedness and response based on hazard mapping, and developing a national strategy for health emergency and preparedness
- Upgrading a legal framework and contingency plans

7. **Providing advocacy and technical support for health protection, especially environmental health and food safety through assessment, capacity building and coordination**

- Ensuring drinking-water security in overall development
- Strengthening health, environment, food and life style information systems, especially at city level
- Promoting dialogue on population, water scarcity and health

8. **Monitoring achievements on communicable disease control, including the surveillance system**

Section 6

Implementing the Strategic Agenda: Implications for WHO

Section 6.Implementing the Strategic Agenda: Implications for WHO

6.1 Overview

The implementation of the CCS puts additional demand on WHO not only to maintain its active and effective role but also to provide additional support as identified in the strategic directions. Table 4 shows the strategic directions versus the existing programmes and required staff.

Table 4. Strategic directions, existing workplans and resources needed

Strategic direction	Workplan title	Resources needed
1. Supporting appropriate evidence-based health system policies and strategies to be incorporated in all sectors for improving health › Strengthening capacity for effective decentralization › Building capacity for partnership and systematic intrasectoral and intersectoral collaboration	Governance Evidence and information for policy Health policy and strategic planning National medicine policies based on essential medicines Quality control and quality assurance (patient safety initiative and health district empowerment) School health strategy and accreditation guidelines	Health system strengthening officer One support staff
2. Strengthening comprehensive national health human resource development, planning, production and utilization › Developing an integrated national health human resources development plan › Establishing a functional coordination mechanism to bring together all stakeholders › Setting up a national accreditation system for health professions education › Formulating policies for retention, management and performance-linked continuing professional development	Human resources policy planning and management (human resources development) Nursing development and leadership for change programme	Health system strengthening officer Consultant

Strategic direction	Workplan title	Resources needed
3. Strengthening information research and knowledge management - Strengthening an integrated national health information system for evidence-based policy formulation, decision-making, monitoring and evaluation - Strengthening the national health research system - Strengthening knowledge management and sharing	Evidence and information for policy National health priorities identification National burden of disease estimation including strengthening ICD10 and mortality systems Governance mechanism MDG monitoring and monitoring of the UNDAF results matrix	Health system strengthening officer Collaborating network Independent research for policy
4. Developing a fair sustainable health financing system covering all population - Development of a national health financing policy based on social health insurance - Promoting fairness in financial contribution and reduction of catastrophic health expenditures	Health insurance programme and health care financing National programme on rational use of medicine Supporting Medicines Transparency Alliance pilot activity in Jordan	Health system strengthening officer Consultant

Strategic direction	Workplan title	Resources needed
5. Supporting policy, programmes and coordinating mechanisms for integrated health promotion and protection and risk factor management - Developing a national strategy on healthy lifestyles and risk factor management - Re-orienting human resources development to develop the required health-force for health promotion and risk management - Networking intrasectoral and intersectoral activities	Promotion of healthy lifestyles, nutrition and rehabilitation Genetic disorders and emerging priorities Mental health including substance abuse Noncommunicable diseases including blindness and deafness Health of special groups: school health, occupational health and health of the elderly Child health including integrated management of childhood illness Food safety and nutrition Violence and injuries Women's health Sustainable development approaches: healthy villages Assessment of risk factors for noncommunicable disease AIDS and sexually transmitted infections	Health promotion officer Media and communication national officer Administrative support staff

Strategic direction	Workplan title	Resources needed
6. Strengthening the national emergency-preparedness plans and strategies through preparation of hazard mapping, risk assessment, and updating legal framework and contingency plans › Preparation of hazard mapping and risk assessment › Updating legal framework and contingency plans › Building capacity of Ministry of Health staff in early preparedness and response	Emergency and disaster management Pandemic influenza UN Contingency Plan monitoring	Emergency national officer
7. Enhancing the national environmental health protection through assessment, capacity building and coordination	Environmental health including food safety	CEHA and national programme officer Administrative support staff

6.2 Country level

Human resource needs

- Fixed term post for a national health system strengthening officer
- Fixed term post for a national health promotion and protection officer
- New post for a national crisis management, emergency preparedness officer
- New post for a media and communication national officer
- Two posts for administrative support staff

Logistical and administrative needs

- Moving the WHO offices to a more spacious and secure premises
- Improving the communication system

6.3 Regional level

- Participation and substantive involvement in planning, provision of prompt technical support for mobilization and implementation of strategic directions
- Prompt and effective provision of technical support
- Monitoring and evaluation
- Sharing of regional experiences, resources and regional work plans
- Capacity building in terms of staff development
- Support for development of project proposals and backstopping for resource mobilization

6.4 Headquarters level

- Prompt and effective provision of technical support
- Monitoring and evaluation
- Sharing of global experiences
- Standard setting and clearinghouse for information and publication
- Necessary financial support through additional budget allocations (to be reflected in operational plans) and extrabudgetary resources
- Coordination of support with the Regional Office and country office

Annexes

Annex 1

Members of the CCS Team

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Dr Saher Shuqaidef, Short-term Consultant

Dr Sana Naffa, National Programme Officer

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Ministry of Health

Dr Ruwaida Rashid, Director of Women and Child Health Directorate

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Dr Abdul Razaq Al Shafei, Director of Health Economics Directorate

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