Country Cooperation Strategy for WHO and Bahrain
2005–2010

Bahrain

World Health Organization Regional Office for the Eastern Mediterranean Cairo, 2006
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Executive Summary

The Country Cooperation Strategy (CCS) defines the strategic framework for WHO’s work with the Government of Bahrain in the next 6 years. It represents a vision and priorities that will guide WHO’s work with the country. The CCS is based on careful analysis of health and development issues and challenges, and governmental actions and expectations, and was developed in partnership with, and with the involvement of, stakeholders in the health care system in Bahrain.

While the CCS was developed to further support the development of the health care system in Bahrain, it also reflects WHO’s orientations and values as well as regional and global perspectives. A critical component of the CCS is greater prioritization of activities and more emphasis on strategic planning for health with role identification and clarification.

Bahrain enjoys an advanced level of health as manifested by its health status indicators. Bahrain’s national health strategy for the period 2002–2010 represents a framework for action that will help to develop the health system in the long term. After one year of implementation it is important to reflect and to integrate, review and modify to guide the longer-term process. The CCS at this time will have a great impact in this regard.

With political transformation in Bahrain, greater pressure will be placed on the public sector to achieve greater efficiency and responsiveness. A well-integrated strategy through the CCS will assist in the process of mobilization of resources in directions that will have more lasting impact on the general development and improvement of the health care sector in the country.

Changes in the environment surrounding the operation of the health system in Bahrain, such as World Trade Agreements, labour market reform and the increased orientation towards privatization dictate an improved performance at all levels, including local, regional and international levels. The CCS will assist in the achievement of the goal of improved WHO performance in the country, especially that WHO is the main international agency in partnership for health with the government of Bahrain.

The key challenges can be summarized as follows.

- With the proliferation of the private sector in its different forms (hospitals, general and specialized clinics, polyclinics in order and alternative medicine) regulation is essential. Regulation and accreditation is important to maintain the advanced health status of the population and to regulate the public–private health care relationship.

- With the continually increasing demand for health services and the escalation in costs, efficiency and alternative ways of financing are required to maintain and sustain health system development.

- With the political transformation in Bahrain, policy formulation, analysis and implementation will be in greater demand. Policies that foster the
implementation of various laws and ensure compliance with regulation and accreditation standards are critical.

Human resources planning has been a chronic issue. There is a pressing need to plan to match the required specialties with appropriate numbers and quality of human resources.

Improvement of the information system is needed to capture the information required for evidence-based planning and management.

With the change in the lifestyle of the population and demographic trends, noncommunicable diseases present a major health challenge for the country. Plans and actions to alleviate the burden of noncommunicable diseases on population health and on health resources are critical.

With the continuous development of health services, major developments have occurred in human resources, equipment and facilities. However, this has not been accompanied by similar developments in management, coordination and organization.

Although information is gathered on a regular basis from all business areas and published annually, this remains raw data that needs to be interpreted, analysed, used and complemented by health system research to be able to generate intelligence and evidence to support decision-making.

The CCS team held extensive discussions with key officials within the Ministry of Health as well as representatives of other government and private health care stakeholders, academia, professional organizations, civil society and officials from the Shura Council, the parliament, municipal councils and UNDP. A rapid review of the health sector situation was undertaken, identifying the major challenges facing health development in Bahrain. Then, based on these, the priority directions for WHO’s technical collaboration with the government of Bahrain were identified.

The strategic directions for the CCS for the next 6 years take into account the level of health status in Bahrain, the demographic transition, the epidemiology of prevailing and projected disease patterns, the National Health Strategy and the goal of the government of Bahrain to provide high quality health coverage to all people at an affordable cost, as well as the overall socioeconomic and political developments, particularly the transition period and the focus on diversification of the economy.

Four strategic directions were identified to build on the achievements and successes of the health sector in Bahrain and address the current challenges and future possible scenarios. In addition to supporting the Ministry of Health, the directions are selected to be sensitive to the new realities and support other major health partners in government, the private sector, civil society, nongovernmental organizations, professional organizations, educational institutions and UN agencies. Lastly, the strategic directions are formulated in accordance with WHO’s mandate, means and technical domain.
The four strategic directions are:

1. Sustain and build on the achievements of Bahrain’s health system through strengthening the role of the public sector and public–private partnership. The health system should improve its organization and management leading to increasing efficiency, quality, patient safety and responsiveness.

2. Address new evolving scenarios including the changing role of the Ministry of Health, dealing with the impact of globalization and managing partnership for health development.

3. Address new epidemiological realities and promote behaviours conducive to better health.

4. Sustain the national programmes of communicable diseases control with specific focus on the surveillance system for emerging and reemerging diseases.
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Section 2

Country Health and Development Challenges
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2.1 Economic and social development

2.1.1 Overview

Bahrain is a small Arab country that continues to develop with a configuration similar to those of industrialized countries. It is an archipelago of 33 islands situated halfway along the west coast of the Gulf, covering an area of around 707 km². Around 11% is reclaimed from the sea. With a population of 707,160 and a population growth of 2.7% (2001), Bahrain is among the most densely populated countries. Bahrain gained independence from the British in 1971, and over the past four decades has witnessed leaps in its development. It has established itself as a commercial centre in the Middle East, and transferred its economy into a service economy. It has a number of well established, non-oil dependent industries, as well as the infrastructure needed to sustain these industries. The per capita GDP of Bahrain is US$ 15,572\(^1\) and the adult literacy rate is 87.7.\(^2\)

2.1.2 Economic and social development

Economy

Because of its strategic location, Bahrain was at the confluence of the ancient trade routes between east and west. With the discovery of oil in the early 1930s, Bahrain’s economy was transformed and wealth and prosperity were brought to the nation. However, Bahrain cannot continue to depend totally on oil. Oil refining, which is the first and foremost of the industries in Bahrain, processes local oil as well as oil from Saudi Arabia, transported through pipelines. The income from this refining is already more important than the country’s own oil production. Petroleum production and refining account for about 60% of exports, 60% of government revenues and 30% of GDP.

To facilitate sustainable development in the long term and with the depletion of oil production, the government took early steps to diversify the economy. Today, the economic base of Bahrain includes oil and petrochemicals, manufacturing such as aluminium, dry dock for supertankers, banking, oil financial and commercial services. With its highly developed communication and transport facilities, Bahrain is home to numerous multinational firms with business in the region, and its central location have also made it a favourable transit spot for many airlines to numerous western and eastern destinations.

According to the Ministry of Finance, provisional data from the national accounts in 2003 indicate economic growth of 6.8% compared with 5.2% in 2002, while GDP at constant price increased to BHD 307,107 million in 2003 and 323,757 million in 2004 from 286,605 million in 2002. Growth is ascribed to the improvement in most of

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\(^1\) Health statistics, Ministry of Health, 2004
\(^2\) Census 2001
the non-oil economic activities. The GDP increment in 2003 was a result of increases in the world oil price and improvement in the performance of the financial sectors in the country.

Further development is expected through the Economic Development Board (EDB), which was established in 2002 with the goal of escalating economic growth in the country through promoting Bahrain as the venue of choice for international investors looking to establish their operations in the Middle East. The EDB is proposing investment in six major areas; health tourism is one of these areas.

Bahrain is signatory to the Agreement of the World Trade Organization with all the implications that has for the economy, people and society.

Sociopolitical context

The estimated 2004 population was 707,106 as compared to 561,872 in 1994 (Table 1). Of this figure 38% are non-Bahrainis. Based on the estimates of the 2001 and 1991 censuses, the annual percentage change for non-Bahrainis has reached 2.7% compared to 2.4% for Bahrainis, with a total annual change of 2.5%. This might represent a demographic challenge in the future. Similar to other Gulf Cooperation Council (GCC) countries, Bahrain has a relatively young population with two thirds of its residents in the age group of 15–64 years; a noticeable increase in this category has been in the working-age group of non-Bahrainis. Population growth for the age group of 65 and older has been maintained at a low proportion, 2.5% in 2003 compared to 2.2% in 1993.

Bahrain's government is a constitutional hereditary monarchy. In February 2002, the political system was revised towards a more democratic process through the National Charter, which was approved in a referendum in February 2001. The new charter revitalized the Bahrain constitution that was suspended in 1975. With the National Action Charter, elected municipal councils and a new National Assembly evolved with a bicameral system of both an elected Chamber of Deputies and an appointed Consultative Council. The elected

<table>
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<tr>
<th>Table 1. Demographic and socioeconomic indicators (2004)</th>
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<tbody>
<tr>
<td>Total population</td>
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<tr>
<td>Bahrain (%)</td>
</tr>
<tr>
<td>Non-Bahrain (%)</td>
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<tr>
<td>Population below 15 years (%)</td>
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<td>Population 15–64 years (%)</td>
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<td>Population 65+ years (%)</td>
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<tr>
<td>GDP per capita (US$) (%)</td>
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<td>Unemployment 15+ years (%)</td>
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Source: Health statistics, Ministry of Health 2003–2004
Chamber of Deputies will have the power to propose and modify laws, but promulgation requires the approval of the appointed Consultative Council.

For several consecutive years Bahrain ranked number one on the Human Development Index among Arab countries. The Human Development Report 2004 classified Bahrain among the high human development group, ranked 40 out of 174 countries. A major contribution to this position is the high literacy rate, 98.6% for youth aged 15–24, and life expectancy at birth of 73.8 years for both sexes, GDP per capita of US$ 15,572 and GDP per capita annual growth rate of 1.5 (2002 data).

Women's development

Women in Bahrain have always played a prominent role in society. The first girl's school in the Gulf region was established in Bahrain in 1928. Women's associations have been in place since the 1950s, contributing to the creation of a civil society qualified to play a leading role in enhancing awareness of women's role in development. Today, more women graduate from the country's universities than men, and women are now well represented in the workforce, comprising 25%–30% of the total. According to the UNDP Human Development Report 2004, Bahrain ranked 66 on women's empowerment. The reform process initiated has served to further promote the position of women in society. Women have not only benefited from the reforms but have been active participants in the process. Women participated in drafting the National Action Charter and women turned out to vote in the referendum on the National Action Charter in almost the same numbers as men.

Central to the work of the Supreme Council for Women which was established in 2003 is to propose public policy to the government on issues relevant to women and to recommend amendments to existing legislation, as well as to encourage women's participation in public life. To give the Supreme Council for Women maximum government support, the council is chaired by H.H. Shaikha Sabeeka bint Ibrahim Bin Mohammed Al-Khalifa, wife of His Majesty the King of Bahrain and the Secretary-General of the Council holds ministerial status. Another major achievement for women was the appointment of the first female minister to the Ministry of Health in 2003. In 2004, female minister was also appointed also to the Ministry of Social Affairs. The Shura council includes among its members four women appointees.

2.1.3 Key challenges

Unemployment, especially among the young, and the continual depletion of oil resources are major long-term economic problems. Diversification of the economy, as well as the activities of the EDB, is directed toward meeting these challenges. A recent study initiated by the EDB suggested market labour reform as a strategy to alleviate the impact of the problem.

2.1.4 Evolution of the health system

The health services in Bahrain go back to the early 20th century when the American Mission Hospital was established in 1903 with a 21 bed capacity to treat Bahrainis as well patients from the region. Two years later, the Victoria Memorial Hospital was opened with a 12 bed capacity, staffed by a general practitioner appointed by the British
Government in India. Government services started in 1925 with a small clinic opened in a small shop and staffed by an Indian doctor appointed by the government to treat injured pearl divers. It was in the same year that a preventive care directorate, the Public Health Directorate was established.

A small hospital in 1936 was established for the Bahrain police force, and converted into isolation wards in 1937. The Police Hospital remained open until 1941. The discovery of oil in Bahrain in 1932 and the subsequent construction of a refinery led to the first planned medical provision when the Bahrain Petroleum Company (BAPCO) built a private hospital for its staff – Awali Hospital with 37 beds. Al Naim Hospital was the first formal government hospital. Work on Al Naim hospital started in 1938 and the hospital was inaugurated in intervals from 1940 to 1942.

As a result of dramatic increases in population and continual extension of Bahrain's economic sector, the development of a large modern hospital became necessary. Salmaniya Hospital was constructed in 1957, it was renovated in 1978 and further developed to function as a teaching hospital for Arabian Gulf University in 1984.

In 1997, the expanded Salmaniya Medical Complex was inaugurated. Currently, the Salmaniya Medical Complex is the main secondary and tertiary care facility in Bahrain. It provides a wide range of services including extensive outpatient services.

2.2 Health system inputs and functions

2.2.1 Financing

The total health expenditure in Bahrain is estimated to be BHD 106 million including the Bahrain Defence Force, private sector and Ministry of Health. The government is the major source of health service funding. The Ministry of Health budget for 2004 was BHD 88.4 million, which constituted 7.4% of total government expenditure. According to an intensive World Bank report in 2002, although health spending increased over recent decades, expenditure remains relatively low by comparison with other GCC countries and also relatively low by international comparison with countries of similar income level. Both per capita spending and expenditure as a percentage of GDP are below average relative to other countries worldwide with comparable income levels.

The Ministry of Health average expenditure per capita was BHD 120.9 in 2004 compared to BHD 85.8 in 2000. About 22.5% of the Ministry’s budget was devoted to primary and preventive health care and 58.2% to secondary care in 2004 with the remaining 19.3% for other expenses. For 2005, the cabinet approved around 20% increase in the budget of the Ministry of Health making it around BHD 96.9 million for recurrent budget.

To date, the government has funded the provision of comprehensive health services for all Bahrainis. Non-Bahrainis however, pay nominal fees for some services, which are also heavily subsidized by the Government.
Revenues depend mainly on general revenue with very limited cost sharing by expatriate patients at service entry. Currently, employers of 50 or more workers pay BHD 30 and BHD 18 per year for the coverage of non-Bahrainis and Bahrainis respectively. This is pooled in the government general fund. In addition, the General Organization for Social Insurance (GOSI) collects a payroll tax of 3% of employers and 1% of employee for employers of 10 or more in order to cover occupational health and injury-related insurance.

Non-Bahrainis also pay BHD 1 per visit to a health centre, and BHD 3 for a visit to the Accident and Emergency department at Salmaniya Medical Complex. Surgical procedures for non-emergency are charged at BHD 50–150 and deliveries cost BHD 100. Both Bahrainis and non-Bahrainis pay a fee of BHD 10 for the first visit to limited private practice outpatient services and a range of BHD 18–90 for a private room. Private sector services are paid through out-of-pocket payments and private employer-based insurance.

With the escalating cost of health services, attention is being paid to finding alternative ways of financing. The introduction of an insurance system for the provision of health care for non-Bahrainis is under consideration and this could be extended to Bahrainis in the future.

Several studies, consultative reports, study tours and committees have worked on insurance as an alternative way of financing since 1985. Due to the complexities of the issue, it has not yet materialized. The aim is to establish a system that alleviates the burden on public spending and at the same time does not jeopardize the level of population health achieved. The aspiration is that it will contribute to the enhancement of the efficiency and quality of services provided. The current proposal is to start with a scheme that targets the expatriate population, which constitutes 38% of the population.

Most of the studies, however, suggested phasing the implementation as the implications of a new insurance scheme on the health and welfare of the population need to be cautiously assessed. The choice of expanding the present financing scheme of the Ministry of Health as an option was repeated in the majority of these studies.

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<th>Table 2, Human resources (per 10 000 population)</th>
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<td>1.2</td>
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<td>25.8</td>
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<td>2.3</td>
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<td>28.9</td>
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Source: Health statistics, Ministry of Health, 2003
Late in 2004, a new multidisciplinary committee was formulated; it is headed by the Undersecretary of the Ministry of Health and includes representative from all stakeholders. Based on a review of previous studies and lessons learned from other countries, the committee suggested a framework for implementation on a gradual basis. Details of implementation will be specified upon completion of an actuarial study that is currently under consideration.

In May 2005, the Shura Council submitted a bill for implementation of a health insurance scheme which is expected to be issued by 2006.

2.2.2 Human resources for health

The Ministry of Health employs 7716 employees (2004), which represents 90% of the human resources working for health. Table 2 shows the distribution of human resources.

Human resources are disproportionately distributed. In an analysis of the strengths and weaknesses of various departments at the Salmaniya Medical Complex, almost every department emphasized a similar situation. This influences the efficiency and productivity of the system. According to a World Bank consultative report, there is an extreme shortage of management expertise, especially in Salmaniya Medical Complex.

Investment in human resources has been always considered important in the Ministry of Health. The training budget over the past 5 years have been in the range of US$ 378 000. The College of Health Sciences, which was established in 1976, graduates nurses and allied health professionals and is managed by the Ministry of Health. The Family Practice Residency Programme will complete 25 years of operation towards preparation of family physicians this year.

2.2.3 Equipment and drugs

The Medical Equipment Centre was established after approval by the Ministers of Health in the Arab countries of the Gulf region during the GCC Summit in 1978. Before that, in October 1972, a well-equipped medical equipment repair and maintenance workshop was established in Naim General Hospital. The status of the Medical Equipment Centre was elevated by an Amiri Decree to that of Medical Equipment Directorate in April of 1997.

The Medical Equipment Directorate is responsible for comprehensive management of medical equipment and health care devices worth more than BHD 25 million (approx. US$ 66 million) and maintains present value of spare parts in stock worth BHD 400 000 (US$ 1 million).

The Medical Equipment Directorate was established to meet the biomedical engineering technology requirements of repair and maintenance of medical and scientific equipment and associated service needs in the most logical, efficient and effective manner, with high level of quality and within available resources. This includes technical training for medical and paramedical personnel, both within the Ministry of Health and outside it, including through WHO fellowships. As a specialized centre, the Medical Equipment Directorate provides high level consultation via WHO to other countries in the Region and is considered a regional training centre for medical equipment repair and maintenance.
The Medical Equipment Directorate operates through five specialized departments: bio-electronics department, bio-mechanical department, laboratory department, imaging and radiation department, and an equipment and management group. The latter is responsible for medical equipment procurement, management, spare parts management, service contract management, payment and data.

As new sophisticated medical technologies are applied every day and new medical equipment that serve these technologies comes into the market, the Medical Equipment Directorate has maintained a high level of quality and management of health care devices in parallel with state-of-the-art technologies.

Bahrain imports all its medicines requirements. All medicines imports are governed by rules and regulations. The Drug Regulatory Authority controls the registration of pharmaceutical manufacturers and their products. GMP standards are adhered to. Government-imported drugs are analysed to ensure quality and safety and a random post-marketing analysis is conducted on products in the local market. Adverse drug reaction reporting is regulated by drug regulatory authorities. The total drug consumption of Bahrain is valued at BHD 34 million per annum. The private sector accounts for 60% of total drug imports, Ministry of Health 30% and the Bahrain Defence Force hospital 10%; 50%–60% of government imports are through GCC unified purchase. The per capita consumption is BHD 51 (US$ 134). Recently a draft national drug policy was developed with technical support from WHO.

### 2.2.4 Health information system

With the recognition of the importance of information technology in the health fields and the need to develop a national health information system, the Bahrain Health Information Centre was established within the Ministry of Health in the early 1980s. The main role of the centre at that time was to compile statistical information and publish it in the Ministry of Health annual report. In 1997, the centre was developed into the Health Information Directorate and its role has expanded dramatically to take full responsibility for developing the health information system for the Ministry. The mission of the Health Information Directorate is to provide the right information to the right people at the right time to facilitate improvements in Ministry of Health staff and services to produce the best health results at reasonable cost. The Health Information Directorate assumes its activities through four main sections: application development, decision support unit, technical support units and a projects office.

The main focus is the development of an automated system that will enable the management of various support functions and all sociomedical information related to patients. In addition to organizing information in a database for availability when and where required, the Health Information Directorate also has responsibility for statistical analysis and reporting of health data in the country. It has explored several possible approaches in the development of automated patient care and support services for the Ministry of Health.
Currently, the Health Information Directorate is responsible for the planning, development, implementation, management and support of the Ministry of Health information system. It serves as the primary expert for Information technology for approximately 7000 employees working in the Ministry of Health, as well as the management of Information, including data and statistics exchange and publications within the Ministry of Health.

The Health Information Directorate publishes a health statistics document on an annual basis. The document provides information related to health indicators, facilities, human resources and activities within the Ministry of Health as well as some private health organizations in Bahrain.

2.3 Service delivery

2.3.1 Overview and coverage

Comprehensive health services are provided to the whole population in Bahrain. According to Bahrain’s constitution, health services are provided free of charge to its citizens. The Ministry of Health offers most services. Primary health care is the cornerstone of the health system. Through 20 health centres and three clinics scattered throughout Bahrain, accessibility and coverage are almost 100%. The Ministry of Health operates the main hospital in the country, the Salmaniya Medical Complex with 875 beds, a psychiatric hospital of 201 beds, a geriatric hospital of 68 beds and four maternity hospitals of 241 beds.

Health care services are also provided by Bahrain Defence Force Hospital as well as several private hospitals and many private general and specialized clinics, polyclinics and specialized centres.

Primary health care

Primary health care has developed rapidly in Bahrain. All health centres provide family medicine, immunization programmes, health education and maternal and child health services. All health centres also offer dental services and laboratory investigations. Diagnostic radiology is provided in the vast majority of health centres. The service is available to all health centre visitors. Data for 2003 show that there were almost 2.4 million visits to general clinics in primary health care centres (excluding antenatal patients and patients attending nursing services at maternal and child health centres) with an average of 3.4 visits per capita per year. In 2000, the number of consultations per doctor averaged 9.8 per hour (around 5 minutes per visit).

Primary health care has a mission (2000): ‘to provide comprehensive family health care to all age groups, for people registered in all health centres in Bahrain. The care must be accessible and acceptable and continuous throughout the life span. The health care providers are committed to update their knowledge and skills using available resources for continuous education activities, and evaluate the impact of their working using the quality improvement principles.’ A new improvement and development plan for primary health care for the period 2005–2012 is being developed.

Although the mission is to provide comprehensive family care, the relationship between primary, secondary and tertiary care does not always support this mission. There are very few guidelines and agreed protocols for referral between primary, secondary and tertiary levels.
Several private clinics offer general primary care services along with several specialized services, including the Joslin Centre for Diabetes which was opened in 2003.

Secondary health care

The Salmaniya Medical Complex is the main secondary and tertiary care facility in Bahrain, with 875 acute care beds (including special care baby unit). It provides a wide range of services including extensive outpatient services with 188,774 patient visits in 2004. In all clinics, patient visits to the accident and emergency department numbered 283,818.

The 356-bed Bahrain Defence Force Hospital provides services to members of the Bahrain Defence Force and their families, as well as emergency care and cardiac care services to the whole population.

Another main government hospital, the King Hamad Hospital, is under development. With 312 beds, it will be a general teaching hospital that will replace an old maternity hospital in Muharraq.

A World Bank consultative report of 2002, however, warned of a problem with bed utilization in the country; the average length of stay was reported to be excessive. Increased efficiency in bed utilization is recommended.

Public health services are provided through several major divisions: communicable diseases, food hygiene, occupational health, public health laboratory services, vital statistics, and nutrition. Health education comes under the umbrella of primary health care.

Private sector

In general, privatization is encouraged in the country. In health care, however, the trend to encourage the private sector began in 1977 with the establishment of the limited private practice (LPP) scheme for government physicians. This arrangement was extended by the government in 1992 to establish part-time private practice (PPP) clinics and laboratory facilities outside the Ministry of Health. This allowed government staff to pursue part-time private practice while retaining full-time government employment and professional status. Referral to government hospitals from LPP and PPP combined is estimated at 9%–10% annually.

Private clinics and polyclinics are proliferating very rapidly. Some operate on a 24 hour basis. Hospitals include the International Hospital of Bahrain (57 beds), American Mission Hospital (40 beds), Awali Hospital (37 beds), Ibn Al-Nafees Hospital (15 beds), Bahrain Specialist Hospital (54 beds), and Gulf Dental Specialty Hospital (10 beds).

The Ministry of Health through its Office of Licensure grants licences for private health care providers and monitors the performance of those providers. The current capacity of the office is being reviewed with a view to strengthening it to enable it to assume its intended role.

2.3.2 Performance of the health system

Bahrain enjoys an advanced level of health as manifested by its health status indicators (Table 3). “Health-for-all” objectives were achieved early in the 1990s.
Mortality rates

The infant mortality rate in Bahrain has improved drastically over recent decades, reaching 8.2 per 1000 live births in 2004. An active maternal and child health programme made a major contribution in this regard. The maternal mortality ratio is low, with most deliveries taking place in hospitals, whether government or private.

According to the health statistics report of 2004, the leading cause of death in Bahrain is cardiovascular disease (CVD), a trend that has not changed since the 1970s. Death as a result of CVD was recorded for 69.0 per 100 000 population. CVD accounts for 31.1% of total deaths in the Salmaniya Medical Complex, the main hospital in Bahrain. Cancer is the second leading cause of death and accounts for 11.9% of total deaths. Breast cancer is the most common malignancy among Bahraini women, while lung cancer is dominant in Bahraini males. A large proportion of cancers (61.5 per 100 000) are ill-defined cases. These represent nearly 19.6% of total deaths and constitute a challenge in terms of the accuracy of reported data.

Morbidity trends

In accordance with the global epidemiological trend, there is a visible shift from communicable disease to noncommunicable chronic disease. Such a shift represents an increasing economic burden for health care financing.

Communicable diseases

Communicable diseases are largely under control in Bahrain. No cases of diphtheria, whooping cough, neonatal tetanus or poliomyelitis have been reported since 1990. However, there was a rise in the number of pulmonary tuberculosis cases from 18.2 per 100 000 in 1990 to 23.3 per 100 000 in 2000. These are mainly imported cases within the expatriate working community. This was reduced however to 19.1 in 2003. Viral infections are also on the rise: from 28.9 per 100 000 population in 1999 to 70.8 in 2003 for gonococcal infection; from 15.8 in 1999 to 35.1 in 2003 for syphilis; and from 30.8 per 100 000 in 1999 to 76.7 in 2003 for hepatitis A.}

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<tr>
<th>Health Indicator</th>
<th>2000</th>
<th>2004</th>
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<tbody>
<tr>
<td>Crude birth rate (per 1000 population)</td>
<td>19.6</td>
<td>21.1</td>
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<tr>
<td>Still birth rate (per 1000 births)</td>
<td>10</td>
<td>8.2</td>
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<tr>
<td>Infant mortality rate (per 1000 live births)</td>
<td>8.6</td>
<td>9.5</td>
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<tr>
<td>Maternal mortality ratio (per 100 000 live births)</td>
<td>15</td>
<td>22</td>
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<tr>
<td>Under 5 mortality rate (per 1000 live births)</td>
<td>11.4</td>
<td>11.2</td>
</tr>
<tr>
<td>Total fertility rate per woman (15–49)</td>
<td>2.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Crude death rate (per 1000 population)</td>
<td>3.0</td>
<td>3.1</td>
</tr>
<tr>
<td>Life expectancy at birth of both sexes (years)</td>
<td>72.9</td>
<td>73.8</td>
</tr>
</tbody>
</table>

Source: Health statistics, Ministry of Health, 2004
in 1999 to 42.5 in 2003 for viral hepatitis. Available data indicate a low prevalence of HIV, but accurate data are not available.

**Noncommunicable diseases**

Noncommunicable diseases such as CVD, diabetes, cancer and injuries, are rising dramatically in Bahrain, and represent the leading causes of death in the country. Accurate data on prevalence are needed. According to the noncommunicable disease control section in the Ministry of Health, most of the studies available need to be considered with caution because of limitations in study design and thus inability to generalize the results. The National Family Health Survey conducted in 1995 revealed that 25.8% of males and 8.8% of females aged 15 years and above smoked. A national nutrition survey conducted in 1997 indicated obesity as an emerging major problem, with prevalences of obesity as measured by Body Mass Index of 21.2% in men and 48.6% in women.

**Immunization**

Bahrain has a very efficient immunization programme. Infectious diseases of childhood have been almost eradicated in Bahrain. Through the expanded Programme on Immunization (EPI), Immunization coverage has reached more that 98%. In 2004, immunization coverage against measles, mumps and rubella was almost 99% for dose 1 and 100% for dose 2, and was 97.7% against poliomyelitis.

**2.3.3 Organization and management**

Health services in Bahrain are organized and managed by the Ministry of Health. The Ministry of Health is responsible for the provision of comprehensive health care services to individuals and the community. It is also responsible for regulating health services in the country, including planning, implementation and evaluation of health programmes. In addition to formulation, updating and evaluation of public policies for their impact on health status, this dual role of service provision and regulation has had its influence on the balance between these two important functions. Regulation is an area that needs greater consideration especially in light of the Ministry’s long-term orientation of restricting its role to regulation. Currently, the Ministry of Health is managed centrally through the Minister of Health who is appointed by the King. The Minister is a member of the Cabinet of Ministers headed by the Prime Minister. The Minister is supported by the undersecretary and four assistant undersecretaries for each of the main areas of primary care and public health, secondary care, finance and human resources, as well as planning and training. Given the vision of the Ministry of Health of increasing coordination and integration of services, the organizational structure has long been identified as a hindering factor in that regard. Some efforts are currently being made for modification and improvements.

**2.4 Governance**

**2.4.1 Health policy**

Currently there are 13 laws related to the health care sector. These include Death and Birth Registration, Drug Control, Public Health Law, Prevention of Communicable Diseases, Monitoring of Imported Food Stuff, Private Hospitals Law, Licensing of Pharmacy and Allied Health Professions, Licensing of Medical Professions and
Dentistry, Smoking Prevention, Monitoring of the Use, Marketing, and Promotion of Breast Milk Substitutes, Organization of Pharmacy Profession and Pharmacies, Organ Transplantations, and (in 2004) Premarital Medical Examination. Some of these have been revised recently, some others are under revision, and some new laws are in the process of being added. Generally, these laws provide guidelines for minimum standards and accountability mechanisms.

2.4.2 Health strategy

The health sector in Bahrain has witnessed three phases of development in relation to strategy formulation. The first national plan focused on the need for facilities, and the second phase was one of consolidation and building on achievements, during which the goal of health for all by the year 2000 was attained. In 2002, the Ministry of Health officially launched the Bahrain Health Strategy, which represents a framework for action for the period 2002–2010. The Bahrain Health Strategy was developed with the purpose of developing the health system through an organizational development process. Involvement of staff from the Ministry of Health as well as other stakeholders including private sector and relevant educational institutions was a critical element in the development process. A shared vision was stated as follows: ‘The Ministry of Health works in partnership with stakeholders to improve the health of the population of Bahrain and ensure that everyone has access to a high quality, responsive health service throughout their life time.’

The strategy identifies a set of 12 strategic goals in the following areas:

- Health gain
- Community Involvement
- Quality, performance excellence and performance improvement
- Organization and management
- Primary care development
- Human resources
- Service development
- Education, research and development
- New investment
- Financial management
- Partnership working
- Information and communication technology

A project management approach is adopted for implementation, monitoring and follow-up. The basic principle is to have a multidisciplinary project team with representation of all possible stakeholders.

2.4.3 Health system goals: achievements and future challenges

The World Health Report 2000 ranked Bahrain 42nd in terms of health system performance (Table 4). Given Bahrain’s status on the human development index, and the history of its achievements, in addition to the resources available to health, the country had expected to achieve a better rank on non-health indicators of health system performance assessment.

2.4.4 Key health development challenges and opportunities

As part of the process of development of the Bahrain Health Strategy in 2002, an intensive analysis of strengths, weakness
and challenges was conducted utilizing the strategic planning tool of SWOT analysis. Review of the results of SWOT analysis suggested that these findings are still valid. These are as shown in Table 5.

The key challenges can be summarized as follows.

- With the proliferation of the private sector in its different forms (hospitals, general and specialized clinics, polyclinics and alternative medicine) regulation is essential. Regulation and accreditation is important in order to maintain the advanced health status of the population and to regulate the public–private health care relationship.
- With the continually increasing demand for health services and escalation in costs, efficiency and alternative ways of financing are required to maintain and sustain health system development.
- With the political transformation in Bahrain, policy formulation, analysis and implementation will be in greater demand. Policies that foster the implementation of various laws and ensure compliance with regulation and accreditation standards are critical.
- Human resources planning has been a chronic issue. There is a pressing need to plan to match the required specialities with appropriate numbers and quality of human resources.
- Improvement of the Information system is needed to capture the information required for evidence-based planning and management.
- With the change in the lifestyle of the population and demographic trends, noncommunicable diseases present a major health challenge for the country. Plans and actions to alleviate the burden of noncommunicable diseases on population health and on health resources are critical.
- With the continuous development of health services, major developments have occurred in human resources, equipment and facilities. However, this has not been accompanied by similar developments in management, coordination and organization.

<table>
<thead>
<tr>
<th>Table 4. Bahrain status on health system performance assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
</tr>
<tr>
<td>Overall goal attainment</td>
</tr>
<tr>
<td>Overall system performance assessment</td>
</tr>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>Health</td>
</tr>
<tr>
<td>Responsiveness</td>
</tr>
<tr>
<td>Fairness in financial contribution</td>
</tr>
<tr>
<td>Sources: World Health Report 2000</td>
</tr>
</tbody>
</table>

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Although information is gathered on a regular basis from all business areas and published annually, this remains raw data that needs to be interpreted, analysed, used and complemented by health system research to be able to generate intelligence and evidence to support decision-making.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly qualified staff</td>
<td>Dual role as regulator and provider are often confused</td>
</tr>
<tr>
<td>Comprehensive range of services</td>
<td>Lack of integration, communication and coordination</td>
</tr>
<tr>
<td>Support from top leaders</td>
<td>Workforce planning</td>
</tr>
<tr>
<td>Good infrastructure – advanced technology, good facilities</td>
<td>Financial system</td>
</tr>
<tr>
<td>Strong alliances = local, regional and international</td>
<td>Organizational structure</td>
</tr>
<tr>
<td></td>
<td>Performance management</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Opportunities</strong></td>
<td><strong>Threats/challenges</strong></td>
</tr>
<tr>
<td>Open political environment</td>
<td>Government control of finance</td>
</tr>
<tr>
<td>Strategic alliances with other organizations</td>
<td>Demographic changes</td>
</tr>
<tr>
<td>Community participation</td>
<td>Unplanned service development</td>
</tr>
<tr>
<td>Investment in Information technology</td>
<td>Negative media and unrealistic public expectations</td>
</tr>
<tr>
<td>Acknowledged role of service planning</td>
<td>Attraction of staff by the private sector</td>
</tr>
</tbody>
</table>

Table 5. SWOT analysis for Bahrain health system
Section 3

Development Assistance and Partnerships: Aid Flow, Instruments and Coordination
Development assistance has been granted from neighbouring GCC countries, mainly Kuwait, Saudi Arabia and United Arab Emirates. According to the Ministry of Finance, development assistance funds received were US$ 50 million and US$ 58 million in 2003 and 2004, respectively. This amount is integrated with the government revenue and used in the general financing of various development projects.

Partnership and multisectoral collaboration have always been valued. Activities of this sort include collaboration with other ministries, such as the Ministry of Interior to reduce road traffic accidents and collaboration with the Ministry of Education for the school health programme including eye screening and oral health. In addition, collaboration exists with several civil society organizations and professional associations.

UNDP’s programmes in health-related areas are limited to support, with the public health directorate, for surveys on noncommunicable diseases and in projects such as HIV/AIDS prevention.

Regional partnership continues to be strengthened through the Health Ministers’ Council for the Cooperation Council States, established 30 years ago.

Health Ministers’ Council for the Cooperation Council States

Most WHO activities are coordinated with Bahrain through the technical office of the Health Ministers’ Council for the Cooperation Council States, which is a regional specialized organization under the umbrella of the GCC. The Council was established in 1976 with the purpose of integrating and complementing services and activities between the countries of the GCC. Membership is limited to the Minister of Health in each country (Bahrain, Kuwait, Oman, Saudi Arabia, United Arab Emirates and Qatar). Recently, Yemen joined the Council. Many WHO policies are implemented collectively; coordination with the GCC countries is through the Council. Collaboration is exercised through regional joint technical committees in the following areas: scientific research, control and prevention of noncommunicable diseases, control and prevention of diabetes, cancer registration, patient safety, ethics of health professions, smoking prevention, blood transfusion services, organ transplantation, mental health, health system performance, nursing services, prevention of blindness (Vision 2020), expatriate labour force, health education and health media, unified purchasing of drugs and equipments, drug control and registration, and school health.
Section 4

WHO Current Cooperation
4.1 WHO and Bahrain

Bahrain joined the WHO in May 1967. The Ministry of Health considers itself in partnership with WHO in all activities that promote the health status of the population. Areas of close collaboration have been primary health care and public health, as well as elements of health system performance in general. Over the years, WHO standards and regulations have been the benchmark that the Ministry of Health uses to measure its achievements and development. The Bahrain Health Strategy, officially launched in 2002, reflects all the components of the Joint Programme Review and Planning Mission (JPRM) and share the same future orientation.

The biennial assistance for Bahrain declined from US$ 625,000 in 2000 to US$ 292,000 in 2004. Over the years, WHO assistance has supported short-term consultancies, fellowships, national training activities, regional meetings and all forms of capacity-building activities. Currently Bahraini health professionals are acting as WHO consultants in several areas. The Nursing Division at the College of Health Sciences was designated as the first WHO Collaborating Centre for Nursing Development in the Region in 1990. Bahrain is used often for placement of WHO Fellows from the Region in various programmes; the fellowship programme is usually organized by the Directorate of Training and the College of Health Sciences.

Activities with WHO are defined by the JPRM (see Figure 1), through a standing JPRM committee at the Ministry of Health. The committee involves representation from planning, training, primary and secondary care, and public health.

There is no WHO Representative in the country; however, more than 95% of the work load of the office of international relations at the Ministry of Health is directed towards administration and coordination of WHO activities. Close collaboration is maintained through continuous exchange of information and follow-up on progress of activities.

4.2 Key areas of work

The WHO 2004–2005 regular budget supported 14 areas of work covering the following areas.

- **Health policy and planning.** Conducting in-depth review of the system, assistance in conduct and analysis of national health accounts, burden of disease studies, preparation of the social health insurance plan, and strengthening of the national health research system.

- **Health statistics and biomedical information.** Creation of a virtual health sciences library.

- **Control of endemic diseases.** Progress toward the 2005 targets and expanding DOTS to 100% coverage.

- **Emergency preparedness and humanitarian action.** Building the capacity of national teams and establishment of a toxicology centre.
Healthy lifestyle. Development of a database on priority health-related risk factors and development and operationalization of behaviour patterns, in addition to establishment of a surveillance system and integration of community-based initiatives to promote healthy lifestyle.

Environmental health. Development of national policy and adoption of environmental health international standards.

Family health (reproductive health and research). Formulation of national policies and strategies on integrated reproductive health care.

Human resources development. Support in the adaptation of evidence-based nursing and allied health education, establishment of the undergraduate pharmacy programme.

Human resources policy formulation, planning and management. Revision and implementation of national policy for human resources with special emphasis on continuing education for health personnel to strengthen partnership between human resources development and service provision.

Noncommunicable diseases. Development of guidelines on palliative care and formulation of a national genetics plan.

Nursing and paramedical resources. Improvement of community psychiatric nursing and promotion of evidence-based nursing practice, development of a national health strategy for nursing practice in primary health care, building capacity of nursing and midwifery.
**Nutrition and food safety.** Capacity-building in the detection of radiation contamination of food by using portable equipment, and establishing a food quality management system.

**Occupational health.** Development of a national strategy for occupational health and safety. Creation of a national database, epidemiological profile and indicators of occupational health, in addition to widening the coverage of occupational health services for workers in various sectors.

**Primary health care.** Review of the role of secondary and primary health care in delivering health care, review of quality, clinical excellence, licensure and re-licensure, and performance management.

4.3 Challenges for the WHO country programme

Over the years, WHO has contributed to the health development of Bahrain and enhancement of the country’s understanding of global issues in health; and to improvement in, and learning about health system development. Accessibility to WHO through the Eastern Mediterranean Regional Office has been a major strength. However there have been some challenges including:

- Lack of a system of evaluation and follow-up of activities. This is an internal constraint within the Ministry of Health due to the limited number of staff assigned to follow up on WHO activities with the Ministry. In some countries, this limitation is rectified by the presence of a WHO Representative in the country.

- The majority of the work of the International relations office at the Ministry of Health is directed toward WHO activities. However, there has been a limitation in the number of staff available for follow-up and monitoring of the implementation of consultant reports. This is currently under revision and a new structure is under consideration.

- With the overall development in Bahrain in general, and in the health professions in particular, the level of human potential in the country has increased. This represents a greater challenge to the process of selection of consultants assigned to the country.

- There has been some discontinuity of efforts and fragmentation of activities for given projects. Due to the lack of a proper monitoring, evaluation and follow-up system, the country repeats some already accomplished activities. This situation occurs when the individuals responsible change position or the report of the activity does not meet the expected outcome.
Section 5. WHO Policy Framework: Global and Regional Directions

5.1 Operating framework

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

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

- WHO collaboration will be more strategic and focused on fewer priority areas, which will be an amalgam of global, regional and national priorities;
- Increased emphasis will be given to WHO’s role as a policy adviser and broker;
- Opportunities will be sought for increasing and strengthening partnerships with other International and national agencies, including nongovernmental organizations working in the field of health;
- Innovative approaches will be sought to increase the effectiveness of WHO support;
- Attempts will be made to ensure the utilization of the knowledge and skills present in the country for WHO’s normative work.

5.2 Country level functions

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

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

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

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

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

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

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

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

5.4 WHO global priorities

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

1. Malaria, tuberculosis and HIV/AIDS: these three major communicable diseases pose a serious threat to health and economic development and have a disproportionate impact on the lives of the poor.

2. Cancer, cardiovascular diseases and diabetes: there is a growing epidemic of these diseases in the poor and in transitional economies.

3. Tobacco: is a major killer in all societies and rapidly growing problem in developing countries.

4. Maternal health: the most marked difference in health outcomes between developed and developing countries show up in maternal mortality data and it is difficult to reduce maternal mortality without a well-functioning health system.

5. Food safety: poses a growing public health concern with potentially serious economic consequences.

6. Mental health: five of the ten leading causes of disability are mental health problems; major depression is the fifth contributor to the global burden of disease and may be second by 2020.

7. Safe blood: is both a potential source of infection and a major component of treatment, and crucial in the fight against hepatitis and HIV/AIDS.

8. Health systems: development of effective and sustainable health systems underpins all the other priorities; demand is substantial from Member States for support and advice on health sector reform.

9. Investing in change in WHO: is a prerequisite for WHO to become a more efficient and productive organization
and one capable of response within an increasingly complex environment. The development of new skills, systems and process is central to the effective management of WHO’s core functions.

5.5 WHO regional priorities

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

An epidemiological shift is being witnessed in the Region. Currently, due to changes in lifestyles, noncommunicable diseases constitute 40% of the disease burden. It is projected that by 2020 the share of the burden for noncommunicable diseases will increase to 60%. This is creating a double burden of both communicable and noncommunicable diseases. Maternal mortality is still unacceptably high in some countries. The average maternal mortality ratio for the Region in 2001 was as high as 330 per 100,000 live births, while over 60% of infant deaths occur in the neonatal period in most countries. Foodborne diseases are also on the rise and represent a major public health challenge. The rapid change in lifestyles in many countries is having a clear impact in terms of stress and mental health-related conditions.

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

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

- Promotion and development of healthy lifestyles through programmes such as the Tobacco Free Initiative, healthy communities, villages and cities, action-oriented school health activities, health of special groups and health education.

- Strengthening of national and regional initiatives to improve nutritional status through raising awareness of individuals and the community and control of micronutrient deficiencies.

- Integration of health promotion aspects with clinical approaches at all levels of the health care system, such as in the example of the regional initiatives to integrate at the primary health care level maternal, child and adolescent health, prevention and control of noncommunicable diseases and mental health activities.

- Promotion and strengthening of environmental health initiatives, particularly those relating to water safety and security, environmental health impact assessment, food safety and healthy environments for children and development of intersectoral activities in this respect.

Community development

- Addressing the underlying determinants of health and poverty as essential to ensuring sustainable development and sustained health improvements in the long term. Community-based initiatives such as basic development needs (BDN), healthy cities, healthy villages and women in health and development are among the priorities adopted by countries. In all these initiatives special emphasis is given to strengthening and enhancing the role of women as major stakeholders in achieving and sustaining the desired health and development goals.

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

Disease control

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

- An integrated approach in communicable disease control programmes through ensuring political commitment, integrating cross-cutting control activities, scaling-up disease-specific control activities, and developing synergy of managerial processes.

- Essential packages of services for prevention and control of priority diseases and indicators to monitor and evaluate these programmes will be developed.

- Integration of cross-cutting control activities will cover at least communicable disease surveillance, epidemic preparedness and response including developing early warning and surveillance systems, infection control and containment of antimicrobial resistance, integrated human resource development, health education and advocacy, and operational research.

- Scaling-up of disease-specific activities includes immunization programmes, tuberculosis control, malaria control, HIV/AIDS/STD prevention and control, elimination and eradication of specific diseases.

- Immunization programmes maintained and strengthened, with particular focus on countries that have lower immunization coverage and problems in certification of poliomyelitis eradication.

**Country Cooperation Strategy for WHO and Bahrain**

- 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 analyses.

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.
Strategic Agenda: Priorities Jointly Agreed for WHO Cooperation in and with Bahrain for 2005–2010
6.1 Process

The CCS team held extensive discussions with key officials within the Ministry of Health as well as representatives of other government and private health care stakeholders, academia (Arabian Gulf University, College of Health Sciences), professional organizations (medical and nursing), civil society, and officials from the Shura Council, the parliament, municipal councils and UNDP. A rapid review of the health sector situation was undertaken, identifying the major challenges facing health development in Bahrain. Then, based on these, the priority directions for WHO’s technical collaboration with the Government of Bahrain were identified.

The strategic directions for WHO’s Cooperation Strategy for the next 6 years take into account the health status level achieved in Bahrain, the demographic transition, the epidemiology of prevailing and projected disease pattern, the National Health Strategy, and the goal of the Government of Bahrain to provide high quality health coverage to all people at an affordable cost, as well as the overall socioeconomic and political developments, the transition period and the focus on diversification of the economy.

Four strategic directions were identified to build on the achievements and successes of the health sector in Bahrain and address the current challenges and the future possible scenarios. In addition to supporting the Ministry of Health, the directions were selected to be sensitive to the new realities and to support other major health partners in government, the private sector, civil society, nongovernmental organizations, professional organizations, educational institutions and UN agencies. Lastly, the strategic directions were formulated in accordance with WHO’s mandate, means and technical domain.

6.2 Strategic directions

6.2.1 Sustain and build on the achievements of Bahrain’s health system through strengthening the role of the public sector and better public–private partnership

The health system should improve its organization and management leading to increased efficiency, quality, patient safety and responsiveness. Efforts should be coordinated with other partners in health development including the private sector, other public sector providers, nongovernmental organizations, civil society and professional organizations in order to seek better integration.

Accountability and transparency

Benefiting from the present culture of accountability in the country, a culture of accountability should be developed at all levels of the health system, relying on a set of transparent well developed norms and standards. A start could be development of an accreditation system of the health facilities and services, information sharing and exchange, and partnership development. Such a culture contributes
to developing credible health care delivery trusted by users;

- balancing personal and public health ensuring continuous caring relations;
- increasing accountability by establishing “payment by result”;
- developing lines of accountability and communication between the different levels of care;
- optimizing clinical outcomes (safety, quality), total cost, coordinate care referral and continuity of care.

Criteria for accountability and partnership should be well designed and more decentralization in human resources and financial management should be sought.

Leadership and governance

Development of strategic thinking in policy analysis and formulation should be done through the establishment of a think tank responsible for drawing up a policy and strategic directions for health development. This forum should address the long-term scenarios for human resource development, mapping of the future health facilities needs for the whole country and selection of medical technology.

It is suggested that planning at the Ministry of Health structurally and functionally be further strengthened to cover monitoring and evaluation, health planning and policy implementation, and evidence and information for policy.

Strategic planning tools including scenarios, predictive techniques and utilization of certificate of need could be promoted.

A national observatory for the health system needs to be considered in order to assess and monitor the performance of the health system, to identify needs for reforms and to forecast the potential changes and challenges facing health development.

Strengthening of leadership and governance should also include better coordination and streamlined intersectoral collaboration in order to seek better public–private partnership. Position papers on health care financing (collection, pooling and purchasing), human resources development, health promotion and health care utilization should be developed by the Ministry of Health. Such position papers should include critical analysis, proposed norms and standards, scenarios, tools, roles and functions of Ministry of Health and other stakeholders, requirements and steps for implementation.

The role of the Ministry in regulating the whole health system should be further strengthened, maintained and supported by legislation and appropriate instruments for enforcement including adequate inspectors in various areas (medical practice, pharmacy, financial auditing, etc.) guidelines and advocacy. Options for outsourcing should be studied according to economic and technical implications, and should be supported by evidence.

Licensing, re-licensing and accreditation of health care providers and institutions should be further developed and should be supported by appropriate legislation.

National standard-setting for all the functions of the health system including: health care financing, human resources development, and provision of promotive,
preventive and curative services should be improved. This could be achieved through the development of national norms and criteria, operating procedures and treatment protocols. This will facilitate the monitoring and evaluation function of the Ministry of Health and other partners.

**Resource development**

Bahrainization policies will be supported and efforts should be made to secure a better skill mix which will be determined by the epidemiological profile. Coordination within the Ministry of Health in the area of human resources development (planning, production and management) needs to be enhanced to facilitate the Ministry leadership in developing strategic alliances for human resources development between the Ministry and educational institutions. Coordination between Ministry of Health and training institutions should be better strengthened.

The Ministry of Health will collaborate with the concerned agencies and stakeholders to develop a system for accreditation of health personnel education institutions with the contribution of all concerned partners and stakeholders including the professional associations and educational institutions.

Planning for human resources development and in particular formulation of a national plan for human resources for health is critical. This plan should define the number and categories of health personnel needed to meet the present and future health service needs. All key partners in human resources development, including the Ministry of Education, universities, the Civil Service Bureau and the private sector, should participate in this exercise.

Special attention should be paid to the management of human resources to ensure proper utilization of this important resource and improve performance and increase productivity.

**Establishment of a national committee for the selection and assessment of biomedical technology should be considered. This committee should include representatives of all concerned parties.**

**Health service delivery**

The health system will be further equipped to better respond to the demographic and epidemiological transition and will aim to improve organizational management, increase internal efficiencies and improve quality of services.

Indicators to measure the performance of various actors will be developed to allow checks and balances in health service delivery.

In line with the Ministry of Health's commitment towards primary health care, the focus will be on strengthening primary health care, on improving community empowerment and participation for health development, and on strengthening decentralization and integration.

Outreach programmes, including home health care, will be promoted with the help of community health support groups. The community health nursing education and community health nursing services delivery systems need to be reformed and expanded to meet the existing and future needs.

Health providers should be made aware of the cost of services, and should be involved in efforts to improve the overall efficiency of the health system.
Improvement of hospital performance in the public sector should remain a priority. Hospital managers should be well trained on new tools and techniques including costing, cost analysis, and management information systems.

A system of quality assurance and improvement should be developed and patient safety should be monitored at various levels of the health system.

All aspects of care-seeking behaviours should be studied at all levels of care, public or private, including the sick leave phenomenon, patterns of utilization of care, and types and categories of services sought and users.

**Financing**

Development of necessary information on health care financing through national health accounts, costing and cost analysis, should facilitate economic analysis of the health system performance and should help in designing appropriate and equitable options for health care financing.

The focus in the coming years will be on development of pre-payment schemes for the expatriate population and development of cost sharing for publicly provided services.

Efforts should be made to assess the fairness of financial contribution through household expenditure and utilization surveys.

Necessary preparations should be made to better implement health insurance reform through sound actuarial studies, legal documents and institutional development. The suggested social health insurance authority should be under the trusteeship of the Ministry of Health in view of the important technical dimensions involved in the development of health insurance including benefit packages, provider payment mechanisms, control, etc.

Mechanism to address strengthening of the health system functions

In order to strengthen the health system functions (governance) the tools developed by WHO and others in management, planning, policy analysis, etc. will be promoted. These include problem-based learning by district teams, management effectiveness, etc. Specific interest will be paid to the development of analytical tools used to measure health system performance and to improve the implementation of the various health system functions. These analytical tools include burden of disease analysis, national health accounts, cost effectiveness analysis, policy analysis, stakeholder analysis, etc.

Institutional (rather than individual) development could include the establishment of a formal think tank evolving as a health policy forum. This forum should be supported by qualified experts in the use of the above-mentioned analytical tools. This high policy forum should include representatives of the main partners including academia, the private sector, professional associations and civil society.

A culture of health system research should be promoted in order to help develop evidence-based policies and strategies. Training of health professionals in the methodology of health system research will be continued. In the initial stage, attention may be concentrated on the small scale health system research activities which will help to
improve the organization and management of service delivery in the public network leading to improved efficiency. Special attention should be paid to the utilization of research findings in improving services.

The development of these capabilities will be through capacity-building, institutional strengthening, provision of technical expertise and the promotion of health system and services research.

The excellent health information system that already exists in Bahrain will be built on and strengthened into an integrated health information system that includes other health care providers and the private sector. The system will allow evidence-based decision-making, policy development, and monitoring and evaluation of the functions of the health system.

Special attention should be paid to strengthening communication and information technology, adequately equipping the system to obtain the minimum data requirements, and integration and validation of the data. In addition, a knowledge management system should be established to enhance and enforce evidence-based decision-making, management and planning.

6.2.2 Address new evolving scenarios including the changing role of the Ministry of Health, dealing with the impact of globalization and managing partnership for health development

The Ministry of Health will have a stronger role in regulating and steering the whole health system. Channels of communication with the main partners including users representatives, civil society and professional associations will be strengthened.

The Ministry of Health will continue to invest in primary health care, to be fully operational as its default system, and other forms of care will be subject to scrutiny on the extent of support they provide to primary health care. The unit cost of primary health care activities will be studied.

The Ministry of Health will design patient segmentation across the spectrum of health risk in order to ensure risk minimization and demand management of care, it will: address unmet needs for real care (competence, more meaningful consultation time, empathy); improve adherence with evidence-based standards of care; improve internal performance assessment capabilities (for example through problem-solving techniques); introduce behaviour-change tools; and develop emergency medical services to rationalize use of accident/emergency services.

The plan for national disaster, emergency and response, will be updated and activated, identifying roles of different partners, improving coordination mechanisms, with the contribution of ministries and concerned nongovernmental organizations.

The opportunities and potential negative impact of WTO agreements on the health system and public health should be well studied including possibilities for medical tourism.
6.2.3 Address new epidemiological realities and promote behaviour conducive to better health

**Healthy lifestyle promotion**

Bahrain is among the countries of the Region where the epidemiological transition and the so-called “paradigm shift” are fully taking place. Strengthening of the campaigns aiming to promote healthy lifestyles is needed through:

- integrated governance with the involvement of public and community stakeholders;
- strengthening the existing organization responsible for health promotion in the Ministry of Health;
- clear-cut multisectoral interventions through the community, schools, media, religious institutions, sports and entertainment institutions, and the like;
- setting targets for behavioural and lifestyle interventions covering financial, organizational and human resource development;
- legislating and enforcing regulations for food, smoking and the like;
- making lifestyle interventions institutional and sustainable by continuous monitoring and evaluation;
- strengthening interventions to address road traffic injuries, other injuries and violence;
- strengthening plans for the care of the elderly at all levels of care, and especially within the community.

**Noncommunicable diseases**

Noncommunicable diseases are the greatest health challenge in Bahrain. The five leading causes of death in Bahrain are all noncommunicable diseases, which are mainly behaviour and lifestyle-related. The main strategic directions in dealing with these conditions are:

- formation of a National Steering Committee and another Supervisory and Evaluation Committee for strategy building, planning, provision of information in the area of noncommunicable diseases and healthy lifestyle promotion;
- promotion of healthy lifestyle and healthy behaviour;
- further integration of interventions for noncommunicable diseases at all levels of the primary health care system;
- strengthening early detection, surveillance and early treatment interventions for cancer, cardiovascular diseases, diabetes and the like.

Hereditary diseases and haemoglobinopathies are common public health problems in Bahrain. Through measures such as health education and premarital counselling, the prevalence of sickle cell disease was reduced by half among newborns (from 2.1% to 0.9%, 2002). Recently legislation has been passed in the area of premarital counselling. Further development and nationwide availability of premarital counselling, screening, early diagnosis and provision of available treatment modalities and psychosocial support to families will continue. Further strengthening
of the genetic diseases control programme will also continue, as will community participation mechanisms involving the nongovernmental organizations, charity organizations and volunteer groups.

Risky behaviour, HIV/AIDS and substance abuse

Substance abuse is on the increase in the Region and is becoming a more important health hazard than it has been in the past. Bahrain is not immune to this trend. Also, in many countries, the prevalence of HIV/AIDS is on the rise and, in addition to sexual transmission, an important part of this increasing prevalence is related to injecting drug use and the sharing of needles and syringes. Therefore programmes to address both of these conditions should be formulated in such a way as to enable the issues to be addressed in an integrated manner for example, the formation of a multisectoral policy-making committee for drug abuse is recommended; and ensure that the programmes to address drug abuse and other behaviour associated with risk taking are diverse and innovative in order to address the complex aspects associated with prevention, treatment, health hazards and harms.

In addition, official ratification of the Framework Convention on Tobacco Control should be given priority, to help the anti-tobacco campaigns and decrease the prevalence of tobacco-related illnesses. It will also have a positive effect on the campaign to combat drug abuse.

Mental health

The prevalence of mental health-related issues and illnesses, and the burden of disease caused by this condition, in Bahrain is not less than the global average. To respond to this burden, a national mental health programme was designed about 15 years ago, in which emphasis is laid on integration of mental health into primary care. As a result of this programme, a very good community-based approach to the provision of mental health services was introduced in some parts of the country, but it remains the fact that the main venue for delivering services is still the psychiatric hospital. This means continuation of stigma, long average duration of stays and lack of emphasis on prevention of illnesses and promotion of positive mental health. It also causes the concentration of the focus on major mental illnesses and tends to neglect the more prevalent, minor or stress-related conditions which are expected to rise in a society going through rapid social change.

The main strategic directions to address these issues can be summarized as follows.

- Efforts to further integrate mental health within primary health care should continue and should be strengthened. Attention should be paid to developing a clear definition of the responsibilities of each level of care. Furthermore, training packages and referral systems should be designed in accordance with the responsibilities expected from each level. Involvement of the private sector is desirable.

- A full-scale programme for stress-related mental health conditions, depression and suicide prevention should be developed with elements for primary prevention, early diagnosis, treatment and rehabilitation.
The Mental Health Act should be finalized.

Environmental health, food safety, and health of special groups

The following strategic guidelines are suggested in these areas.

- Efforts to draft and approve legislation in the areas of environmental health and food safety, and coordination for enforcing existing legislation, are essential.

- Formation, strengthening and support of multisectoral committees composed of governmental, nongovernmental and private sector stakeholders for environmental health, food and chemical safety is essential.

- It is essential to strengthen efforts to train more food inspectors and harmonize their activities with other stakeholders, such as municipalities.

- A national plan on occupational health will be developed with involvement of the Ministry of Health, Ministry of Labour, other ministries and relevant stakeholders.

- The school health programme recently launched by the Ministry of Health and Ministry of Education will be further strengthened.

6.2.4 Sustain the national programmes of communicable diseases control with specific focus on the surveillance system for emerging and reemerging diseases

Reporting of communicable diseases and surveillance systems should be further strengthened to sustain the national surveillance system, with specific focus on continuation of a strong surveillance system for existing emerging diseases. Ability for an alert and timely response should be developed and maintained through increasing human resources, and high quality and reliable laboratory services. Forecasting techniques should be made use of to better manage potential public health hazards. Information sharing with neighbouring countries and regional networks should be further developed.
Section 7

Implementing the Strategic Agenda: Implications for WHO Secretariat, Follow-up and Next Steps at Each Level
Bahrain has witnessed tremendous achievements in health development in recent years. The present concerns are similar to those of developed countries, namely control of noncommunicable diseases and lifestyle-related diseases. The shift of health priorities poses major challenges for the country and for WHO's technical cooperation.

The CCS provides the basis to articulate strategic directions in major planning at all levels of the Organization.

7.1 Implications at country level

The health sector in Bahrain is readjusting to the new challenges introduced by the market reform in the country, and the demographic and epidemiological transition. The shift from mainly communicable diseases control to facing the growing burden of noncommunicable diseases and accidents, and the consequences of an ageing population, calls for adjustment in WHO's presence and technical support.

National health authorities have highlighted WHO's instrumental role in Bahrain's health development over the past decades. Nevertheless, in the recent years, WHO managerial, technical and financial resources have been spread too thinly over a wide range of activities. Better focus on strategic objectives should significantly improve the impact of the Secretariat's work in Bahrain.

The CCS process in Bahrain should lead to provision of timelier, more efficient technical advice by the WHO Secretariat to better respond to the evolving country needs.

Bahrain is a good example of the countries that have achieved a considerable development in health. The efficiency of the health sector in Bahrain, based on its track record over the past four decades, provides a good opportunity for effective strategies for health development, especially human resources development, which could be adopted and replicated in other countries.

As part of CCS plans, WHO technical cooperation in improving the health system's performance and in health promotion will substantially increase, necessitating the provision of technical advice in improvement of the health system, and in health promotion, advocacy and social marketing.

7.2 Implications for WHO Regional Office and headquarters

The provision of technical backstopping by WHO calls for strengthening the capabilities of the Regional Office and headquarters in the areas of advanced health technologies and information. Such a strengthening will have resource implications. Innovative approaches for fund-raising need to be considered to provide the necessary resources. For example, the Regional Office could support the following proposals:
technical cooperation and experience exchange between Bahrain and other GCC countries on health financing, health technologies, human resources development, healthy environment, healthy cities, healthy villages, lifestyle and noncommunicable diseases, and care of the disabled people;

broker a fund-in-trust to enhance joint collaboration with countries; however, to encourage countries’ greater interest in such a fund, WHO should re-examine the programme support cost procedures;

development by the Regional Office and headquarters in close collaboration of an up-to-data roster of consultants and databank for regulation, governance, financing of health care, human resources development, healthy lifestyle promotion, noncommunicable diseases, mental health, occupational health and safety, environmental health, food safety, and assessment and transfer of modern medical technologies;

strengthening the country desk office to facilitate more efficient and effective liaising between the Regional Office and the country; different mechanisms need to be examined and established to respond to these requirements.
Annex 1

Persons met during the CCS mission

Ministry of Health

Her Excellency Dr Nada Abbas Hafadh, Minister of Health

Dr Abdul Aziz Hamza, Undersecretary for Health

Dr Abdulwahab Mohammed, Assistant Undersecretary for Primary Health Care and Public Health

Dr Fawzi Ameen, Assistant Undersecretary for Training and Planning

Dr Abdul Hai Al-Awadhi, Assistant Undersecretary for Secondary Care

Mr Ebrahim Shehab, Assistant Undersecretary for Human and Financial Resources

Dr Lameea Al-Tahoo, Chief of Strategic Planning Unit

Mr Yahya Ayyob, Legal Adviser

Dr Sameer Khalfan, Director of Public Health

Dr Khayrja Mosa, Head Nutrition, Public Health

Dr Hussain Al-Mukharraq, Chief of Medical Staff, Secondary Care

Dr Awatif Sharaf, Chief Medical Staff, Primary Care

Dr Bahia Al-Assomi, Deputy, Chief of Medical Staff, Primary Care

Dr Jamal Al-Sayyad, Chief, Office of Medical Review

Dr Shawqi Abdulla Amin, Dean, College of Health Sciences

Dr Anisa Al-Sindi, Associate Dean, College of Health Sciences

Dr Hala Al-Mehza, Ag. Chief, International Relations

Mr Adel Abdullah, Ag. Director, Public and International Relations

Hakeema Ghuloom, Head of Nursing Continuing Education,

Mr Shahab Al-Fardan, Head of Administration and Evaluation, Training

Mrs Fatima Abdul Wahid, Nursing Development Consultant

Mr Adel Khalaf, Director of Materials

Mr Ahmed Al-Hujairi, Director, Health Information Directorate

Mr Ebrahim Yaccob, Director, Medical Equipment

Mr Hassan Jaber, Director of Finance

Mrs Layla Abdul Rahman, Director of Drug Control

Mr Mohammed Al-Qahtani, Director of Engineering and Maintenance

Mr Sayed Najeeb Sharaf, Director of Personnel

Dr Tawfeeq Naseeb, Chief of Licensure and Registration
Mrs Beema Sultan, Chief Nursing Staff, Secondary Care

Dr Abdul Hussain Al-Ajmi, Chairman, Hidhafs Health Centre Council

Dr Khalil Mohammed, Chairman, Sitra Health Centre Council

Dr Abdulla Mansor, Chairman, Al-Razi Health Centre Council

Dr Najah Khalil, Chairman, National Bank of Bahrain Health Centre Council

Mrs Seham Al-Rashid, Chief, Nursing Staff, Primary Care

Ms Iftikhar Naseemi, Regional Nursing Officer

M. Sawsan Abdul Karim, Health Economist, Planning Unit

Dr Amal Al-Jowder, Head, Health Education, Public Health

Dr Abdulla Ahmed, Head, Food Control, Public Health

Mr Ali Al-Anjawi, Head Environmental Health and Public Health

Dr Adel Al-Oufi, Consultant Psychiatrist

Dr Mariam Al-Mulla, Head, School Health

Members of health insurance projects from outside Ministry of Health

Mr Tawfeeq Shehab

Dr Zakarla Sultan

Mr Ashraf Bseisu, Representative, Insurance Society

Arabian Gulf University

Dr Faisal Al-Nasser

Dr Khaldoon Al-Roomi

Municipality Councils

Mr Murtadah Bader, Representative, Manama Area Municipality

Mr Abbas Mahfooze, Representative, Middle Area Municipality

Mr Khalil Al-Bualnain, Representative, Southern Area Municipality

Shura Council

Dr Faisal Radhi Al-Musawi, Chairman, National Assembly

Mr Ismail Akbari, Director of Public Relations, Media and Protocol

People's Assembly

Mr Khalifa Al-Dahrani, Chairman Council of Representatives

Members of Service Committee:

Dr Essa Al-Mutawa

Dr Saadi Mohammed

Dr Ali Ahmed

Mr Mohammed Khalid

Mr Mohammed Al-Khayyat

United Nations Development Programme (UNDP)

Dr Khalid Allosh

Mr Ali Radhi

Nongovernmental organizations

Ms Rula AlSaffar, Bahrain Nursing Society

Dr Ali Al-Aradi, Bahrain Medical Society

Private sector

Dr Qassim Aradati, Bahrain Specialist Hospital

Ms Seham Al-Shaikh, Joslin Centre
Annex 2
Participants in the CCS mission to Bahrain

Dr Belgacem Sabri, Director, Division of Health Systems and Services Development, WHO Regional Office for the Eastern Mediterranean

Dr Ahmed Mohit, Director, Division of Health Protection and Promotion, WHO Regional Office for the Eastern Mediterranean

Dr Ahmed Abdellatif, Regional Adviser for Health Care Delivery, WHO Regional Office for the Eastern Mediterranean

Dr Fariba Al-Darazi, Regional Adviser for Nursing and Allied Health Personnel and Bahrain Desk Officer, WHO Regional Office for the Eastern Mediterranean