WHO-EM/PME/005/E

Country Cooperation Strategy for WHO and Kuwait 2012–2016

World Health Organization

Regional Office for the Eastern Mediterranean

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Document WHO-EM/PME/005/E/02.14

CONTENTS

1. INTRODUCTION 1

2. HEALTH AND DEVELOPMENT CHALLENGES 2
2.1 Macroeconomic, political and social context 2
2.2 Other major determinants of health 3
2.3 Health status of the population 4
2.4 National response to overcoming health challenges 10
2.5 Health systems and services: six core components or building blocks 10
2.6 Summary 15

3. DEVELOPMENT COOPERATION AND PARTNERSHIPS 17
3.1 The aid environment in the country 17
3.2 Stakeholders analysis 17
3.3 Coordination and aid effectiveness in the country 18
3.4 Challenges 18

4. WHO COOPERATION OVER THE PAST CCS CYCLE 19

5. STRATEGIC AGENDA FOR WHO COOPERATION 20
5.1 Defining the strategic agenda 20
5.2 Strategic approaches 21

6. IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR WHO 26
6.1 The role of WHO according to the strategic agenda 26
6.2 WHO's presence 26

1. INTRODUCTION

The Country Cooperation Strategy (CCS) reflects a medium-term vision of WHO for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS process, in consideration of global and regional health priorities, has the objective of bringing the strength of WHO support at country, Regional Office and headquarters levels together in a coherent manner to address the country's health priorities and challenges. The CCS, in the spirit of Health for All (HFA) and primary health care, examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, the determinants of health and upstream national policies and strategies that have a major bearing on health.

The exercise aims to identify the health priorities in the country and place WHO support within a framework of 4–6 years in order to have stronger impact on health policy and health system development, strengthening the linkages between health and cross-cutting issues at the country level. This medium-term strategy does not preclude response to other specific technical and managerial areas in which the country may require WHO assistance.

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

The CCS for the Kuwait is the result of analysis of the health and development situation and of WHO's current programme of activities. During its preparation, key officials in the Ministry of Health were consulted. The critical challenges for health development were identified. Based on the health priorities of the country, a strategic agenda for WHO collaboration was developed.

2. HEALTH AND DEVELOPMENT CHALLENGES

2.1 Macroeconomic, political and social context

Kuwait, with a surface area of 17 188 square kilometres, is a constitutional emirate under the hereditary rule of the Al Sabah family since the middle of the 18th century. HRH Emir Sabah Al-Ahmed Al-Jaber Al-Sabah is the leader of the nation and holds ultimate executive power, appointing the prime minister and the government. The country has 6 governorates: Al ‘Asimah, Hawalli, Al Ahmadi, Al Jahra’, Mubarak Al-Kebir and Al Farwaniyah.

The total population of Kuwait is 2 736 732 (2010).[1] Nationals constitute about 32.1% of the total population, and 98.4% of the population lives in the large urban area in and around Kuwait City. The actual population density in built-up areas per square kilometre is many times higher than reported figure, which is calculated by dividing the total population by country’s surface area. The high population density and huge number of personal cars have resulted in congestion and pollution, consequently adversely affecting the health of the population. The crude birth rate in 2010 was 18.7 births per 1000 population and the crude death rate was 3.1 deaths per 1000 population (Table 1). The distribution of the population by sex and age is shown in Figure 1.

Table 1. Demographic indicators 2010[1]

Population, total	2 736 732
Average annual rate of population change, 2005–2010 (%)	3.8
Population, female (% of total estimate)	40.3
Birth rate, crude (per 1000 people)	18.7
Death rate, crude (per 1000 people)	3.1
Life expectancy at birth, total (years, 2005–2010)	74.2
Fertility rate, total (births per woman)	2.3
Adolescent fertility rate (estimated births per 1000 women ages 15–19, 2005–2010)	13.8
Urban population (% of total)	98.0

[1] World population prospects: the 2010 revision. New York: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat; 2011. (http://esa.un.org/unpd/wpp/index.htm, accessed 12 March 2013).

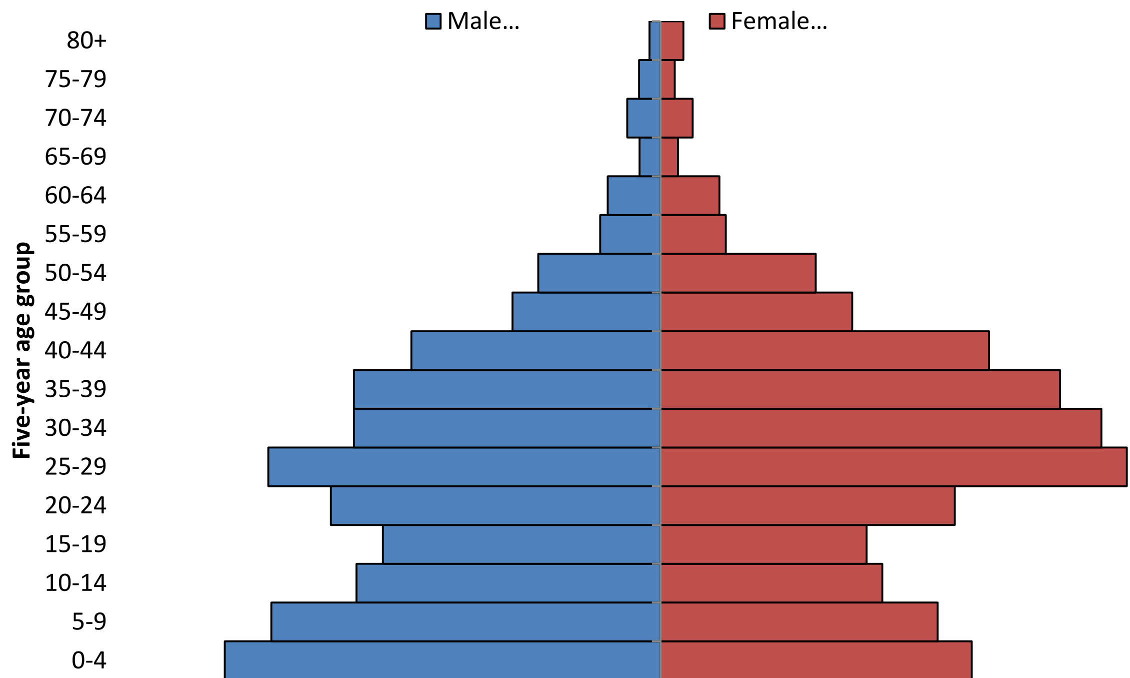

Figure 1. Population pyramid in Kuwait

Kuwait is a wealthy country with a total GDP, based on official exchange rates, of US$ 153 billion.[2] Its economic status has allowed the government to provide many social amenities and public services including good quality health care and education. The government also provides generous social welfare benefits to Kuwaiti citizens, such as retirement income, marriage bonuses, housing loans, virtually guaranteed employment, direct cash and debt write-offs. Kuwait has large oil and gas resources, with 104 billion barrels of oil reserves, or 8% of global oil reserves. Petroleum accounts for nearly half of the GDP, 95% of export revenues and 95% of government income.

2.2 Other major determinants of health

The adult literacy rate is high. In 2010, the adult literacy rate for females was 94%. The corresponding figure for males was 96% and the total adult literacy rate was 95%.[3] Primary and secondary level education is universal, with 100% enrollment for both males and females. A total of 779 government schools and 474 private schools in 2009–2010 ensured provision of education until secondary level. The high level of education in Kuwait, especially among

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[2] Development data. In: The World Bank DataBank [website]. Washington DC: The World Bank Group; 2013 (http://databank.worldbank.org/ddp/home.do?Step=12&id=4&CNO=2, accessed 12 March 2013).

[3] Regional health observatory [website]. Cairo: WHO Regional Office for the Eastern Mediterranean; 2013 (http://rho.emro.who.int/rhodata, accessed 12 March 2013).

women, has had a positive impact on health indicators in the country. Higher education has improved drastically over the past years. The largest university is Kuwait University, which is free for Kuwaitis and has over 1500 faculty members and 22 000 students. The Kuwaiti government offers scholarships to students accepted in universities in the United States of America, United Kingdom and other foreign institutes.

The high literacy rates in Kuwait have enabled women to participate fully in public and private socioeconomic activities (Table 2). In May 2005 women were given the right to vote. In 2009, four women entered parliament for the first time. Kuwait has a Gender Inequality Index (GII) value of 0.274, ranking it 37 out of 146 countries in 2012.[4] In Kuwait, 7.7% of parliamentary seats are held by women, and 52.2% of adult women have reached a secondary or higher level of education, compared to 43.9% of their male counterparts. In 2011, Kuwait was ranked at 63 among 187 countries on the Human Development Index, and in 2012 its ranking rose to 54 out of 186 countries.

Table 2. Socioeconomic indicators[2]

Indicator	Data	Year
GDP growth (annual %)	5	2011
GDP per capita, PPP (current international $)	54 283	2011
GNI per capita, PPP (current international $)	53 720	2011
Labour force, female (% of total labour force)	24	2011
Unemployment, female (% of female labour force)	2	2005
Unemployment, male (% of male labour force)	2	2005
Unemployment, total (% of total labour force)	2	2005
Adult literacy rate, female 15+ years (%)*	94	2010
Adult literacy rate, male 15+ years (%)*	96	2010
Adult literacy rate, total 15+ years (%)*	95	2010
Population with sustainable access to improved water source (%)	100	2011
Population with sustainable access to improved sanitation (%)	100	2011

2.3 Health status of the population

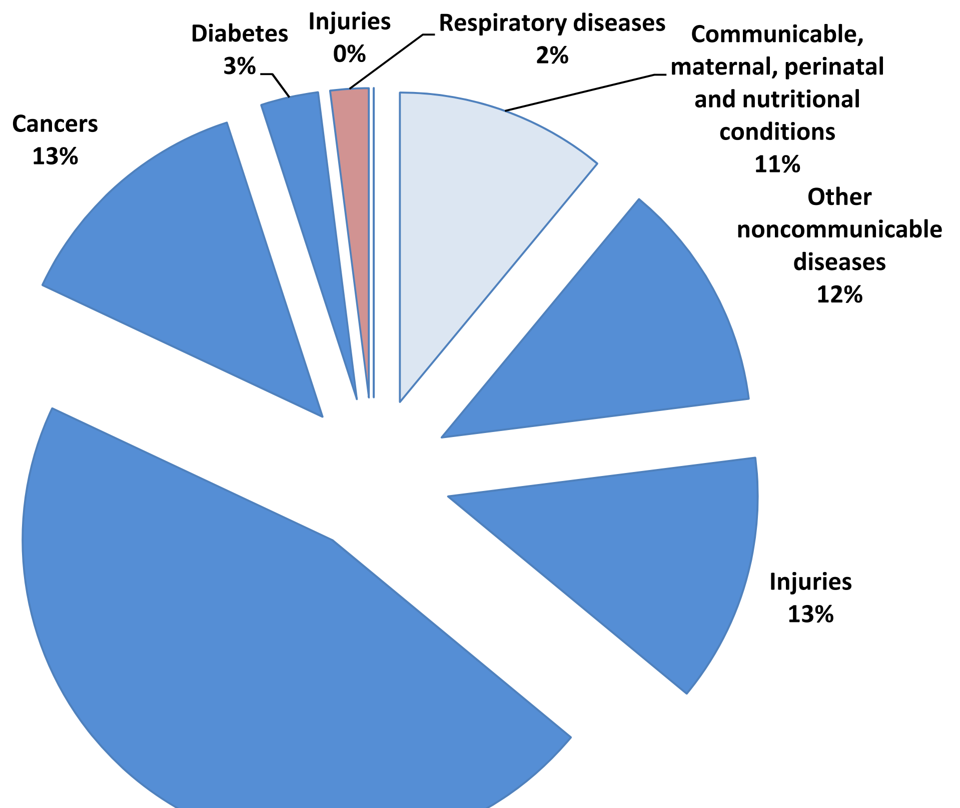
People in Kuwait enjoy a high standard of health. Adequate hospitals, health centres and clinics staffed by skilled health workers provide safe and effective health care to people. The health indicators and the burden of disease are similar to those of highly developed countries (Tables 1 and 3).

[4] Human development report 2013.New York: United Nations Development Programme; 2013.

Table 3. Health status indicators, 2011[3]

Neonatal mortality rate per 1000 live births	6.4
Infant mortality rate per 1000 live births	10.7
Under five mortality rate per 1000 live births	12.6
Maternal mortality ratio per 100 000 live births	9.9
Births attended by skilled health personnel	100.0
Estimated prevalence of anaemia in non-pregnant women of reproductive age (%)	28.7

More than 76% of causes of death are due to noncommunicable diseases, see Figure 2. The entire population has access to local health services, safe drinking water and adequate excreta disposal facilities (Table 2).



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