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SECTION 1. INTRODUCTION

The Country Cooperation Strategy (CCS) reflects a medium-term vision of WHO for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS 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 (PHC), examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, the determinants of health and national policies and strategies that have a major bearing on health.

The 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 the Member States for achieving the Millennium Development Goals (MDGs).

The WHO country office in Saudi Arabia made necessary preparations for the CCS formulation exercise by updating information about the health sector and by arranging appointments to meet with key partners inside and outside the Ministry of Health. The joint exercise aimed at preparing the country cooperation strategy between Saudi Arabia and WHO offered an opportunity to interact with senior health officials and frame the priority areas for WHO support for the coming five years. In addition to representatives of the Ministry of Health, the CCS team also met with related ministries including education, agriculture and social affairs.

Visits were arranged to main WHO partners for health development from the United Nations system (UNICEF) and others, such as the Arab Gulf Program for Development (AGFUND) and Gulf Cooperation Council (GCC) health secretariat, in order to discuss ways and means of streamlining and of coordinating inputs in support of national health programmes and initiatives. A list of persons met is attached as Annex 1.

The CCS team also briefed senior Ministry officials about major strategic directions for WHO's cooperation with Saudi Arabia for the near future and discussed innovative approaches to reengineer technical cooperation taking into consideration country needs and WHO financial resources at country level.

SECTION 2. COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

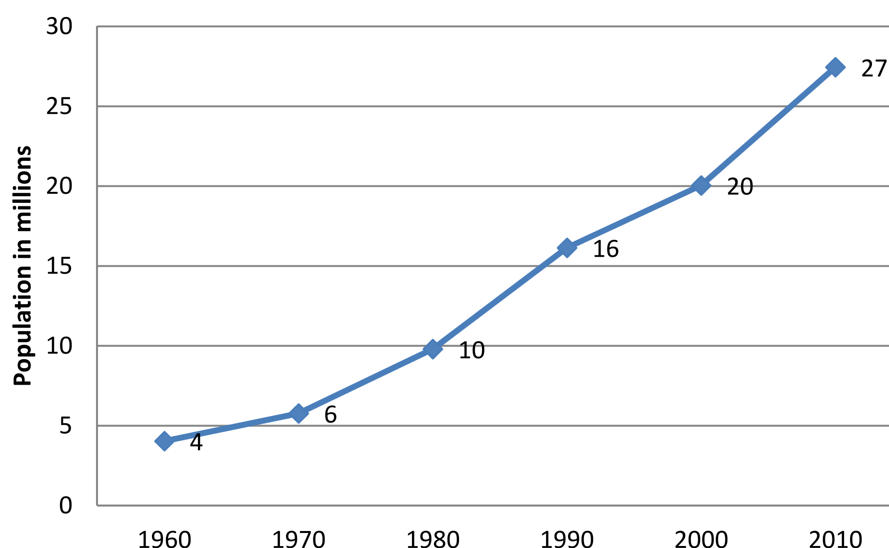
2.1 Social determinants of health

Saudi Arabia is a high-income country with a per capita GDP of US$ 22 713.4 in 2010 (Table 1) and an equally high human development index ranking, 56 in 2011.[1] The extensive health care system divided among three tiers of care and caters for a population of approximately 27 million (2010) (Figure 1), 30% of whom are under the age of 15 years (Table 2).

Table 1. Socioeconomic indicators 2010

Indicators	Data	Year
GDP growth (annual %)	4	2010
GDP per capita, PPP (current international $)	22 713	2010
Adult literacy rate, female 15+ years (%)*	85	2010
Adult literacy rate, male 15+ years (%)*	91	2010
Adult literacy rate, total 15+ years (%)*	88	2010
Population with sustainable access to improved water source (%)*	100	2010
Population with sustainable access to improved sanitation (%)*	99	2010

Source: World Development Indicators and Global Development Finance 2012 except where otherwise noted
*Source: WHO Regional Health Observatory 2012, http://rho.emro.who.int/rhodata/



Source: World Development Indicators and Global Development Finance 2012

Figure 1. Trend in total population, 1960–2010

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[1] Human Development Reports 2011 and 2010. United Nations Development Programme

Table 2. Demographic indicators 2010

Indicator	Data
Population, total	27 448 000
Population ages 0–14 (% of total)	30.0
Population ages 15–64 (% of total)	67.0
Population ages 65 and above (% of total)	3.0
Population growth (annual %)	2.0
Population, female (% of total)	45.0
Birth rate, crude (per 1000 people)	22.0
Death rate, crude (per 1000 people)	4.0
Life expectancy at birth, total (years)	74.0
Total fertility rate (births per woman)	3.0
Adolescent fertility rate (births per 1000 women aged 15–19 years)	18.0
Urban population (% of total)	84.0
Net migration	1 055 517
Percentage of population recognized as a national of Saudi Arabia*	68.9
Percentage of population recognized as a non-national of Saudi Arabia*	31.1

Source: World Development Indicators and Global Development Finance 2012 except where otherwise noted
*Source: Government of Saudi Arabia, http://www.moh.gov.sa/en/Ministry/Statistics/Indicator/Pages/Indicator-2012–01–10–0001.aspx

Oil revenues make up 80%–90% of fiscal earnings. Spending on health and social affairs has increased by 26% since 2010, in part due to the introduction of unemployment benefits.[2] In 2008, the youth unemployment rate was 28.2% (percentage of labour force aged 15–24 years), and 45.8% among women, and the total unemployment rate was 5.4% (15.9% among women).

A nationalization policy is in place with the aim of reducing dependency on foreign workers and increasing opportunities for nationals to gain employment.[3] By recent royal decree, women are encouraged to seek jobs in fields previously reserved for men, such as law and business.

Education in Saudi Arabia has in recent years focused on closing the gender gap in literacy and education in general. The literacy rate among adult females (15 years and older) went from 79.7% in 2004 to 85.0% in 2010, with a total adult literacy rate of 88% in 2010 (Table 1). Among the overall population with at least a secondary education (percentage ages 25 and older) in 2010, females comprised 50.3% and males 57.9%.[1] Obtaining a university degree is increasingly seen as a goal for many Saudi women, who currently make up 59% of

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[2] Economist Intelligence Unit: Industry Report, Healthcare Saudi Arabia, February 2012.

[3] *Draft country programme document Saudi Arabia 2012–2016*. Executive Board of the United Nations Development Programme and of the United Nations Population Fund, 2011 Annual Session.

Table 3. Health status indicators (2010)

Indicator	Rate
Neonatal mortality rate (deaths per 1000 live births)	10.7
Infant mortality rate (deaths per 1000 live births)	17.3
Under five mortality rate (deaths per 1000 live births)	20.0
Maternal mortality ratio (deaths per 100 000 live births)	14.0
Births attended by skilled health personnel (%)	97.0
Pregnant women with iron deficiency anaemia (%)	30.3

Source: WHO regional health observatory 2012, http://rho.emro.who.int/rhodata//

the national student body.[4] However, legislation legally mandates gender segregation in all university campuses and not all classes or disciplines are available on women's campuses, specifically in areas of science such as engineering and veterinary medicine. In 2008 Saudi Arabia allocated 19.3% of government expenditure towards education and 5.6% of GDP.[5]

Millennium Development Goals

Saudi Arabia is on track to achieve the MDG targets. Over its past two development plans (2000–2004 and 2005–2009), extensive progress has been made in economic development. As a result of the strong economy, the country has rapidly expanded health, education and social services infrastructure. Health status indicators are shown in Table 3.

2.2 Health system

Health planning

The Ministry of Health is the main provider of health care services. Health has featured in the national 5-year development plans since 1970, and is seen as a key part of overall development in the country. The eighth national development plan 2005–2009 addressed a number of public health issues. The number of primary health care centres was increased by 8.9% from 2004.[6] The number of hospitals, physicians and nursing staff also increased. Improvements were gained in health care indicators in the areas of immunization, maternal and child health (reduction in mortality rates) and a decrease in vaccine-preventable diseases as well as eradication of poliomyelitis at national level.

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[4] Mills A. Saudi universities reach toward equality for women. *Chronicle of higher education.* August 3, 2009.

[5] World Bank online database. Available at: http://data.worldbank.org/country/saudi-arabia/

[6] *The ninth development plan 2010–2014*. Saudi Arabia, Ministry of Economy and Planning, 2010. Available at: http://www.mep.gov.sa/themes/GoldenCarpet/index.jsp;jsessionid=DE18367AF91D1864700943FF804E9022.alfa

As part of the ninth national development plan, 2010–2014, the following policies are being implemented with regard to health.[7]

- Introducing multiple sources of funding for health activities, through the Cooperative Health Insurance Scheme, as well as through enhancing the role of civil charities and the *waqf*, while rationalizing government spending and ensuring optimal use of resources, with the state budget remaining the major source of funding for basic government health services.
- Supporting information systems in the health sector through advanced information technology to make data available at both sectoral and national levels.
- Implementing mechanisms for increasing national employment in health to achieve self-sufficiency.
- Developing appropriate management and operation systems in health facilities and achieving efficient management and service standards, through adopting decentralized management, allocating separate budgets for health areas, specialist and referral hospitals, and other health agencies, and applying appropriate methods and procedures to achieve rationalization and raising efficiency.
- Implementing decentralization in management by the Ministry of Health and ensuring application of quality standards and provision of integrated comprehensive health care for the entire population in a fair, affordable manner; coordinating with other health agencies through the Council of Health Services, with other governmental health agencies being committed to performing their role within the objectives and policies of the health care strategy;
- Strengthening the role of the private health sector in complementing public efforts to achieve the goals and policies of the health care strategy. Supporting and developing the primary health care services provided by the Ministry of Health and other sectors as the cornerstone of the health system, in such a way as to raise efficiency and apply an integrated, comprehensive health care approach for the entire population.
- Raising efficiency of the emergency medical services to meet the needs in normal situations and in disasters;
- Supporting and developing curative care within an integrated, comprehensive health care framework that consists of four curative levels: primary, secondary, specialist and referral services;
- Achieving balanced distribution of health services, including specialist services, both

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