Country Cooperation Strategy (CCS) – Saudi Arabia

2018-2021

WHO

Table of Contents

Acronyms and abbreviations

AMR	Anti-Microbial Resistance
CCSF	Common Country Strategic Framework
CPD	Continuous Professional Development
CCS	Country Cooperation Strategy
FA	Focus Areas
HiAP	Health in All Policies
IHR (2005)	International Health Regulations (2005)
GPW	General Programme of Work
GDP	Gross Domestic Product
KSA	Kingdom of Saudi Arabia
ODA	Official Development Assistance
MMR	Maternal Mortality Ratio
MERS	Middle East Respiratory Syndrome
MERS-CoV	MERS Corona Virus
MoH	Ministry of Health
NTP 2020	National Transformation Programme 2020
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organizations
PHC	Primary Health Care
PB	Programme Budget
RTA	Road Traffic Accidents
RCJY	Royal Commission of Jubail and Yanbu
SFD	Saudi Fund for Development
SP	Strategic Priorities
SDG	Sustainable Development Goals
THE	Total Health Expenditure
UN	United Nations
UNCT	United Nations Country Team
USD	United States Dollar
UHC	Universal Health Coverage
WHO	World Health Organisation
VAT	Value Added Tax
VRO	Vision Realisation Office

Executive summary

The World Health Organisation (WHO) has provided technical support to the Kingdom of Saudi Arabia (KSA) since 1971. This is the 3rd Country Cooperation Strategy (CCS) developed for KSA. The CCS outlines the medium-term framework for WHO cooperation with the government of KSA.

The CCS has been created following an in-depth health and development situation analysis which was conducted by a joint working group from the WHO Regional Office, Ministry of Health (MoH) senior officials and the WHO representative for the country. Key stakeholders were consulted; these included senior officials in the MoH, Vision Realisation Office (VRO) and Saudi Health Council. In addition, consultations were conducted with UN partners.

The CCS was developed to support KSA's national health policies, strategies and plans as articulated in the Vision 2030, National Transformation Programme 2020 and the health priorities of KSA, in line with the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs), the WHO's 12th General Programme of Work (GPW) and the UN Common Country Strategic Framework (CCSF) 2017-2021.

The health sector in KSA faces a number of challenges. Among the most important is the financial sustainability. A number of factors contribute to a continuous increase in health spending. With around 71% of health spending coming from public sources, and in light of the current decline in petroleum revenue, the main source of government income, fiscal limitations leave no room for manoeuvring. As a result, the Government of KSA is embarking on a transformation programme with the aim of broadening the funding base and improving efficiency of the sector. A diverse set of technical expertise is needed to achieve the best attainable outcome.

Non-Communicable Diseases (NCDs) and their risk factors contribute the most to the burden of disease in KSA. With many of the health determinants that contribute to the NCDs burden lay outside the health sector, a multi-sectoral approach is needed. The Saudi Arabia NCDs Investment Case Study has shown that prevention, early detection and proper management of NCDs can be cost-effectively performed by the health sector. The Healthy Cities Programme addresses the social determinants that contribute to the high prevalence of NCDs. It brings together the efforts of the different sectors at a local level. Health in All Policies addresses the coordination of all sectors at a national level. Synergy between all actors and all levels can bring huge health and social returns.

The emergence of Middle East Respiratory Syndrome (MERS) in KSA is another area of concern. So far, 80% of identified MERS cases were reported in KSA. MERS is characterized by a high case fatality rate (35%), human to human transmission and lack of a definitive treatment. Putting the characteristics of the MERS infection together with the fact that KSA hosts the largest annual mass gathering during Hajj, makes the involvement of the WHO in areas related to MERS and International Health Regulations a priority.

Based on the challenges identified, three strategic priorities were identified for inclusion in the CCS:

1- Strengthen health system to achieve health system objectives particularly universal coverage;
2- Ensuring healthy lives and promoting well-being for all at all ages with health at the center of all;
3- Risk reduction and management of national health risks.

1. Introduction

WHO has provided technical support to KSA since 1971. This is the 3rd CCS developed for Saudi Arabia. The CCS outlines the medium-term framework for WHO cooperation with the government of KSA.

The CCS has been created following an in-depth health and development situational analysis which was conducted by a joint working group from WHO health programme specialists, Ministry of Health (MoH) senior officials and the WHO representative for the country. Key stakeholders responsible for defining health policy, programmes and practice were consulted. These included senior officials in the MoH, Vision Realisation Office (VRO) and Saudi Health Council. In addition, consultations were conducted with UN partners including the World Bank and UNDP. (A full list of everyone consulted may be found in Annex 3).

The CCS was developed to support KSA's national health policies, strategies and plans, in line with the 2030 Agenda for Sustainable Development, and the WHO's 12th General Programme of Work (GPW). It is based on the Vision 2030, NTP 2020 and the health priorities of KSA. The Vision 2030 is an ambitious vision that was announced in April 2016. It constitutes the vision and roadmap for the Kingdom's social and economic development until 2030. The NTP 2020 was launched in June of the same year, it sets out specific commitments of ministries and other entities for the period up to 2020.

The 2030 Agenda for Sustainable Development and the related Sustainable Development Goals (SDGs) were adopted in the United Nations (UN) General Assembly in September 2015. The WHO's 12th GPW provides a high level strategic vision for the work of WHO over a six year period that started in January 2014. Both the 2030 Agenda and the 12th GPW were developed through an extended consultative process with the UN and WHO member states.

An analysis of the mapping of the Saudi Vision 2030 against the SDGs demonstrated that, in general, all SDGs are relevant to the Saudi context with minor modification of targets and indicators[1] (1). The close similarity between the Saudi Vision 2030 and the 2030 Agenda demonstrates that sustainable development can be achieved in terms of both.

[1] The analysis was conducted as part of the United Nations Common Country Strategic Framework 2017-2021, Kingdom of Saudi Arabia (CCSF 2017-2021). The document details the strategic framework for the co-operation between the Government of KSA and the UN. The document was issued in February 2017.

2. Health and development situation

2.1. Socio-economic context

KSA is one of the largest 20 economies globally. Health, education and income indicators have been progressively improving over the past three decades. The Human Development Report 2016 ranked KSA 38th out of 188 countries on the Human Development Index (25). In 2016, 83.3% of the population lived in urban settings, while the literacy rate among adults 15 years and above was 94.8% in 2015.

Total population was estimated at 32.3 million in 2016, around one third of them are expatriates. Total Fertility Rate has been declining over the years, reaching 2.5 in 2016. Annual population growth reached 2.25% in 2016 for the whole population (2), however, it was lower for the Saudi population (1.62% in 2014) (1). In addition to population growth, KSA is going through a demographic transition. The older age group is going to increase as a fraction of the population over the coming decades, increasing the significance of combating NCDs.

In 2016 The Gross Domestic Product (GDP) was Saudi Riyal (SAR) 2.42 trillion (US Dollar (USD) 646.4 billion). Per capita GDP in 2016 was SAR 75,107 (USD 20,029) equivalent to 54,431 international dollars (2). The economy relies mainly on petroleum and gas exports and to a lesser extent on services. The main activity in the services sector is the visiting of the holy sites in Mecca and Madina by Muslims from all over the world. Such visits can happen at any time of the year (Umra) or at a specific time of the year (Hajj – pilgrimage). Hajj results in the largest annual mass gathering in the world necessitating a high level of emergency preparedness.

KSA relies heavily on foreign workers, particularly the private sector. Due to the declining oil revenues and the staggering deficit, the government has adopted a more prudent fiscal policy[2], including cutting subsidies and imposing fees and taxes. The government also attempted to reduce wages of public employees but was unsuccessful. Policies to reduce dependence on foreign workers are being implemented.

Although total unemployment is relatively low at 5.6%, it is higher among the Saudi population at 11.5% in 2015 (1) and is skewed toward highly educated women and the youth. Unemployment has been increasing particularly among youth (15 – 24), who make up approximately 31.7% (2016) of the population (2).

2.2. Health status

KSA's population has a high total life expectancy at birth, estimated at 73 years for males and 76 years for females in 2015 (2). In 2015, Under-5 mortality per 1,000 live births was 14.5, while infant mortality was 12.5 and neonatal mortality was 7.9 per 1,000 live births (2).

[2] The Fiscal Balance Programme is one of the programmes announced in the Vision 2030, and aims at achieving budgetary balance by 2020.

2.2.1. Non-communicable diseases

NCDs are the most common cause of death in KSA, constituting 78% of total mortality (3). Cardiovascular diseases account for 46% of total deaths, diabetes 4%, cancer 10%, respiratory diseases 3%, and other NCDs 14% (3). Risk factors for NCDs among the population are also high: in addition to the 14.4% who are affected by diabetes, around two thirds (68.2%) are overweight, one third are obese (33.7%), and over half (58.5%) are physically inactive (4). Smoking is another important risk factor for men where 21.5% of males 15 years or older use tobacco, the prevalence for females is much lower at 0.9%. Although by far, NCDs and their risk factors are the single greatest challenge facing the health system, Road Traffic Accidents (RTA), and mental health and substance abuse are important contributors to the burden of disease.

2.2.2. Maternal and child health

KSA has made extensive gains in reducing maternal mortality, under five and neonatal mortality. The Maternal Mortality Ratio (MMR) was 13/100,000 live births in 2015, which falls just short of the Millennium Development Goal (MDG) target of 12/100,000 births. This is a significant improvement given that in 1990 the MMR was 46/100,000.

With successful reduction of infectious causes of morbidity and mortality among under-5 children, prematurity and congenital abnormalities emerge as the leading causes of deaths among under five children within the country (5).

2.2.3. Vaccine-preventable diseases

Notable successes have been achieved in controlling vaccine preventable conditions. The coverage rate of vaccination against major antigens reached 98% since 2008 and remained stable since then (2). The expanded programme on immunization is a successful example of Saudi Arabia's disease prevention programmes.

2.2.4. Infectious diseases

At present, communicable diseases play a minor role in the burden of disease, and as a cause of death. The incidence of TB was 12/100,000 in 2015 (2). KSA is considered low risk for malaria transmission, with pockets of disease confined to limited areas. 98% of cases are estimated to be imported, mostly from India and Yemen (6, 7). The country was close to malaria eradication, but pockets of this disease have been rising recently in areas close to the border with Yemen, due to the conflict there.

Middle East Respiratory Syndrome (MERS) is a viral respiratory disease caused by a novel coronavirus. It was first identified in KSA in 2012 (9). Globally, 2090 laboratory confirmed cases have been reported to WHO (8). So far, 80% of human cases have been reported in KSA. Approximately 35% of reported patients with MERS have died. No vaccine or specific treatment is currently available. Although the number of reported cases is not large, MERS assumes a particular importance due to the high case fatality rate, human to human transmission, lack of a definitive treatment, and its concentration in KSA where the largest mass gathering in the world takes place.

2.2.5. Emergency preparedness and response

With the largest mass gathering in the world during the annual Hajj event and the additional eight million annual Umrah visitors, emergency preparedness systems have been in place in KSA for a long time.

KSA is among 196 signatories to the International Health Regulations (2005) (IHR (2005))[3]. There is a longstanding successful WHO collaboration with KSA in its active participation and implementation of IHR.

2.3. Health system current situation, challenges and planned developments

2.3.1. Current situation

2.3.1.1. Financing

Total Health Expenditures (THE) in 2015 amounted to SAR 123.3 billion (USD 32.9 billion), out of which 70.9% were government spending (SAR 87.4 billion; USD 23.3 billion). Out of Pocket spending accounted for 17.2% of THE (SAR 21.2 billion; USD 5.6 billion). Other private sources of funding included voluntary health insurance which represented 6.8% of THE (SAR 8.4 billion; USD 2.2 billion) and employer based schemes which accounted for 5% of THE (SAR 6.1 billion; USD 1.6 billion).

Health expenditure has steadily increased in recent years and is among the highest per capita for the region. In 2015 it was around SAR 3,900 (USD 1,040) per capita and is expected to increase further. In 2015, government health spending accounted for 11.9% of total government spending.

Based on the current hospital expansion plans, health expenditure is expected to soar in the next ten years (11). Additional factors for such a huge increase include the effect of the high prevalence of NCDs and their risk factors, population growth, and increasing costs of medical technologies and interventions (21).

All Saudi citizens and non-Saudi employees of the government have free access to government financed public facilities. Saudi nationals working for the ministries of defence, interior and national guard and their dependants have additional access to facilities run by their respective ministries (table 1). The same applies to ARAMCO which is a public company and the Royal Commission of Jubail and Yanbu (RCJY). Other foreign workers have access to services through mandatory employment based health insurance coverage. The Council for Cooperative Health Insurance was established in 1999 to regulate private health insurance.

KSA spends 4.7 % of its GDP on health which is lower than many western countries. Although lower spending is partly explainable by the younger population, public spending on health has a characteristic feature: it is heavily skewed towards infrastructure and curative care, with low spending

[3] IHR (2005) is a legal framework established by the WHO to achieve global health security in order to "prevent, protect against, control and provide a timely, appropriate, effective public health response to curb and prevent international spread of disease" (10).

on Primary Health Care (PHC). On the other hand, both PHC and curative services are inefficient, where the cost per unit of care is higher than most western countries in purchasing power parity (12).

2.3.1.2. Service delivery

The MoH is the major provider of health services in KSA. The private sector and other public entities play also an important role in the provision of health care (see table 1). The MoH runs 2,325 PHC centers and 274 hospitals, in addition to 350 other facilities and centers across the country (13). Specialized treatment facilities are mostly located in major urban centers.

Table 1: Number of hospitals and hospital beds by affiliation, and population served, 2016

no.	Health Service Operators	No. of Hospitals	No. of Beds	Primary Population Served
I.	**Government Sector**			
1-	***Ministry of Health***	274	41,835	All Saudi citizens and expatriate employees in government services
2-	***Other public entities***			
a.	Ministry of Defense and Aviation	22	4,772	Employees and their relatives
b.	National Guard	4	2,067	Employees and their relatives
c.	Ministry of Interior	1	867	Employees and their relatives
d.	King Faisal Specialist Hospital and Research Center	2	1,164	Referred Saudi citizens
e.	University hospitals	4	1,775	University employees and students + all Saudi citizens
f.	Royal Commission for Jubail and Yanbu (RCJY)	4	417	RCJY employees
g.	ARAMCO	2	366	ARAMCO employees
II.	**Private Sector** (including company operated hospitals)	152	17,428	Saudi citizens and expatriates
	TOTAL	**470**	**70,691**	

Source: reconstructed from tables published by the General Authority for Statistics, KSA (13).

2.3.1.3. Health workforce

With a total number of 288,000 health care workers, the government of the KSA is the single largest employer of health care workers (table 2). The health care workforce in Saudi Arabia is heavily dependent on expatriates who account for nearly three quarters of the total health care workforce (11). There is shortage of health care workers particularly nurses; family and internal medicine physicians; paediatricians; social workers; and pharmacy and laboratory technicians and specialists (11).

Table 2: Healthcare personnel in the public and private sectors, 2016

No.	Category	No. working for MoH and other Public Providers	No. working for Private Providers	Total no. of personnel	No. of health personnel per 10,000 population
1	Physicians*	59,575	29,701	89,276	27.7
2	Nurses	136,686	42,638	179,324	55.6
3	Pharmacists	5,723	19,309	25,032	7.8
4	Allied Health Personnel	85,768	19,978	105,746	32.8

* includes dentists

Source: reconstructed from table published by the General Authority for Statistics, KSA (14).

An in-depth review of public PHC services was undertaken in February 2016 by the WHO (15). The review report detailed the shortage among general physicians which is estimated at 20% of the total physician workforce. The proportion of Saudi nurses has increased from 32.3% to 37.5% of the total in the past few years. However, there is inequitable distribution of health care workers by facility and by region. Challenges identified included lack of incentives for staff to be deployed to rural and remote regions, in addition to lack of Continuous Professional Development (CPD) opportunities. A deficiency in structured orientation and integration programmes for Non-Saudi health workers was also noted (15). Population ageing and the alarming rise in NCD prevalence are the major factors contributing to increased demand for health workforce.

2.3.1.4. Leadership and governance

MoH is in charge of governance of the health sector in KSA. Several entities play specific roles in governance and regulation, such as licensing of medical facilities (Health Facilities Licensing General Department, MoH), accreditation of medical facilities (Central Board for Accreditation of Healthcare Institutions), pharmaceuticals (Saudi Food and Drug Authority), health insurance (Council for Cooperative Health Insurance) and health care workers (Saudi Commission for Health Specialties).

2.3.2. Health system challenges

Despite the achievements over the past decades, a number of challenges face the health system in KSA. Challenges include:

- Financing limitations: financing of healthcare services is heavily dependent on the general government revenue. With the current fiscal limitations, inefficiency of public providers and forecasted increased expenditures, the current financing model is unsustainable.
- Slow adaptation to the changing disease pattern; unbalanced health spending with overspending on infrastructure and curative services and suboptimal spending on PHC and prevention and control of NCDs.
- Heavy burden of NCDs and their risk factors, mental health, road traffic injuries, and the risk of emerging diseases.
- Concerns regarding equity and access to services particularly among rural populations and low income expatriates; underdeveloped private health insurance regulation contributes to reduced access even with mandatory coverage.
- Heavy reliance on expatriate health workforce, with high turnover and lack of continuity, coupled with limited capacity to train a larger number of nationals.
- Paper-based health information system at PHC level, and absence of electronic medical records.

2.3.3. Future health system developments

The National Health System Transformation Plan envisions the establishment of a new national health insurance scheme in order to improve quality and financial sustainability of the sector. The plan calls for separation of health functions among different organizations. The MoH will continue to be in charge of setting overall strategy, standards and governance of the system. It will be in charge of public health functions through the Center for Disease Prevention and Control. Providers will be corporatized into 15 – 20 clusters, where each cluster provides all levels of care in a specific geographic location. A

new “purchaser” organization will be created which will be in charge of pooling funds and strategically purchase services.

Financial sustainability will be achieved through two main sets of actions: First, diversify and broaden the funding base, which at present is limited by the government’s tight fiscal space; second, reduce inefficiency and waste in the sector. The funding will gradually shift from being mainly a government general revenue model to an employment based insurance. It will also be broadened by raising a projected 50 billion SAR, through alternative sources of revenue which include: 1. Sin taxes: taxation on tobacco, sugary drinks, junk food and surcharge on RTAs; 2. Pilgrimage related tax; 3. Value Added Tax (VAT) on consumer goods; 4. Regulatory revenues such as motorized vehicle tax. The proposed national health insurance scheme will be established, regulated and governed by the MoH. Reduced waste and inefficiency will be promoted through corporatization of the public providers (thus allowing more freedom in management and decision making), introducing purchaser-provider split; managing competition; strategic purchasing, including from the private sector; improvement in information systems; and transparency with respect to prices and outcomes.

Electronic information systems will play a crucial role in the future health system. Standard coding and communication protocols will allow all transactions between the purchaser and provider to be conducted electronically. It will also allow easier monitoring by the regulator. This will not only expedite all transactions and improve quality, but will also control fraud, abuse and wastage.

The Health System Transformation Plan is trying to address health workforce challenges by establishing a national healthcare workforce planning unit within the MoH that would collaborate closely with the Ministry of Education and Ministry of Labour. The unit would be responsible for collecting, analysing, forecasting and updating stakeholder data that could be used to inform workforce strategic decision making. Furthermore, it would serve as a platform for discussing the supply and demand of health care workforce, allowing stakeholders to come to a consensus on workforce strategy (11).

2.4. Development partners environment

2.4.1. The Kingdom’s role in development cooperation

KSA ranks fourth in the league of donors, just after USA, UK and Germany. It’s assistance in 2014 totalled 14.5 billion USD, grossly 1.9% of the Kingdom’s Gross National Income (GNI), which far exceeds the proposed target set by the UN to spend 0.7% of the GNI for Official Development Assistance (ODA).

KSA has provided support not only to Muslim and Arab countries but also for least developed countries, contributing in several instances to international humanitarian relief. 78% of KSA’s ODA is provided as humanitarian and development assistance in the form of grants. In the case of humanitarian efforts, KSA was the 7th largest humanitarian donor in the world in 2014.

Saudi assistance is usually provided bilaterally, through the Ministry of Finance and institutions like the Saudi Fund for Development (SFD) and the newly created King Salman Humanitarian Aid and Relief Center, and multilaterally, through regional bodies. The SFD assisted over 80 countries in a variety of domains including social infrastructure, transportation and communications, power and agriculture. There is a preference for funding projects that are limited in scope and time, with priority given to

more visible projects and infrastructure, with a rather limited attention to a holistic and programmatic approach.

Public philanthropy and public-private partnerships, particularly in the provision of humanitarian assistance, is an important aspect of Saudi aid, where the principles of "Zakat" and "Sadaqa" which enjoin all Muslims to help others in need are evident. Non-Governmental Organizations (NGO), semi-governmental organizations and public relief campaigns are increasingly engaging in more countries outside of their traditional profile.

Since 1975 the SFD supported 47 health related projects globally with a total of USD 905.7 million which represents 6.6% of the total funds. Health projects included construction and equipping of public hospitals and medical facilities and faculties of medicine in a number of countries. In 2016 the SFD spent USD 15 million on two health related projects which represented 12.9% of the total funds spent in that year (17).

2.4.2. Collaboration with the United Nations system at country level

The WHO is the lead UN partner in all matters related to health where it provides technical expertise and evidence-based support. It is recognized as the repository of global standards, guidelines, strategies, best practices and policy advice. It is sought as the reference in all matters related to international health and the guide to the IHR.

The United Nations Country Team (UNCT) in KSA is represented by the following agencies: UNDP, UNICEF, UNHCR, FAO and WHO, as well as the World Bank/IFC. Non-resident Agencies include ESCWA, UNESCO, ILO, UNEP, UNIDO, UNFPA, OHCHR, OCHA, IAEA, UN Women, UN HABITAT and UNIC. The UNCT members, the Office of the UN Resident Coordinator and the Government, have prepared the UN Common Country Strategic Framework (CCSF) 2017-2021 as a basis of cooperation. The CCSF 2017-2021 focused on four priority areas (1):

1. Knowledge-based equitable and sustainable economic development, underpinned by technology, innovation and improved infrastructure;
2. Effective and equitable delivery of social services and education for improved quality of life;
3. Equitable, accountable, effective, and efficient public sector; and
4. Sustainable natural and cultural resources' management, use, and preservation.

WHO has actively participated in the CCSF 2017-2021 analysis and priority setting. It is committed to achieve the CCSF 2017-2021 outcomes, particularly the first three priority areas, and has aligned its work accordingly.

2.4.3. Country cooperation with the global health agenda

KSA has provided WHO with humanitarian funds to support its work in different countries (USD 48 Million in 2014 for Iraq, USD 15 million to Yemen in 2015, USD 10 million to Somalia and USD 2 million to Syria) and has expressed willingness to strengthen its cooperation and contributions. The provision of USD 2 million in support of WHO's work related to MERS Corona Virus (MERS-CoV) control activities has also been timely (18). It is worth noting that KSA reported to the Financial Tracking of OCHA 482 million USD in humanitarian aid in 2015, 68.6% as response to appeals, with the highest percentage (30%, USD 143 million) going to food (19), while health received 12.7% (18).

KSA is actively participating with the WHO to fulfil its international commitments. In addition to funding MERS-CoV control activities, WHO and the MoH have been working collaboratively to enhance capacity for surveillance, field investigation, detection and response to community and hospital acquired cases of the MERS-CoV. In addition, WHO and the MoH continue to conduct joint risk assessment and monitor the circulation, transmission and evolution of MERS-CoV.

There is a longstanding successful WHO collaboration with KSA in its active participation and implementation of IHR. In March 2017, a WHO led joint external evaluation of KSA's adherence, compliance and implementation of IHR (20) concluded that the country had succeeded in achieving core competencies in the majority of 19 technical areas. The report also identified areas where competency improvement is needed.

WHO continues to works with the MoH to assess and enhance public health preparedness for Hajj and Umrah and making sure that the health measures for Hajj and Umrah are in line with the requirements of IHR (2005). WHO has, recently, started its work to implement an early warning system for detection of potential health threats amongst the Hajj pilgrims in Mecca and Medina through establishing a syndromic surveillance system for potential health risks.

3. Setting the strategic agenda for WHO cooperation

3.1. A strategic agenda for cooperation

The strategic agenda for KSA-WHO cooperation will guide the WHO's work with the KSA over the 2017-2021 five year period. The strategic agenda was developed after careful consideration of the realities of the healthcare system in KSA, the challenges that it faces, and the areas where WHO can have an added value. It is based on the areas of congruency between the vision of KSA and the medium-term objectives that it wants to achieve as presented in the Vision 2030 and NTP 2020 on one hand, and on the WHO strengths and the priorities it identified as articulated in the 2030 Agenda for Sustainable Development, the 12th GPW, the Programme Budget (PB) 2016-2017 (24) and the CCSF 2017-2021 on the other hand.

The Strategic Agenda comprises a set of Strategic Priorities (SPs) and Focus Areas (FAs) within those SPs for WHO's cooperation with the KSA (table 3). The Agenda was finalised after reviewing a large number of documents and following an analytical process (figure 1), and in consultation with the government of KSA at the highest level and with other partners, especially UN agencies. The CCS was jointly agreed on with national authorities.

The SPs constitute the medium-term priorities for WHO's cooperation with the KSA on which WHO will concentrate the majority (at least 80%) of its resources over the CCS cycle. The achievement of SPs is the joint responsibility of the government of KSA and WHO. It is a partnership that requires active engagement and collaboration from KSA authorities, as well as productive involvement of the WHO which partly depends on the availability of human and financial resources.

Three SPs were selected for inclusion in the WHO CCS 2017-2021:

4- Strengthen health system to achieve health system objectives particularly UHC;
5- Ensuring healthy lives and promoting well-being for all at all ages with health at the center of all;
6- Risk reduction and management of national health risks.

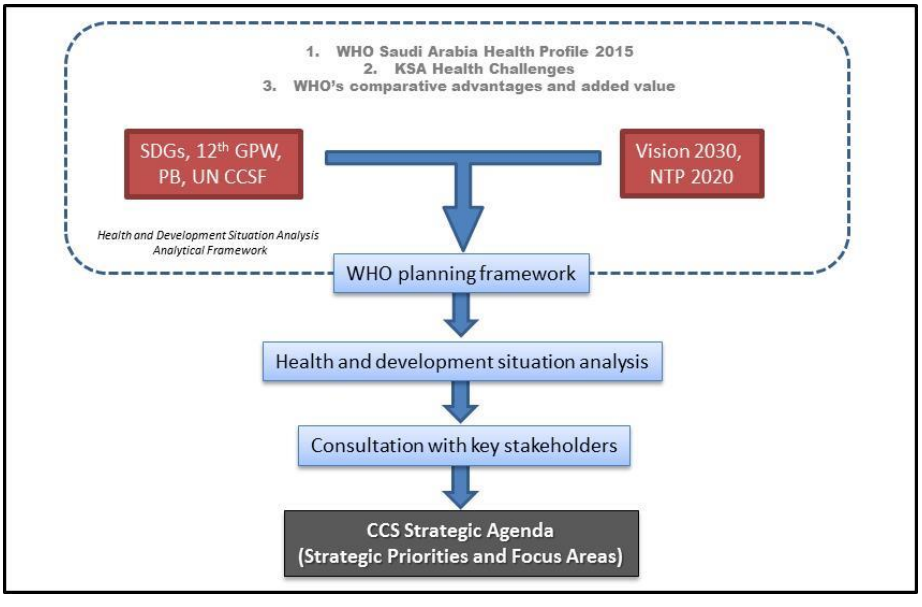

Figure 1: Process followed to select the CCS strategic priorities

3.2. Saudi strategic and medium-term objectives

The Vision 2030 envisions a stronger economy, with diversification in economic activity, fiscal discipline, a larger role for the non-profit and private sectors and foreign investments, and replacing foreign workers with nationals (Saudization). To achieve the ambitious targets, the kingdom recognizes that it will depend on its real asset and true wealth: it's people; the engine and the ultimate objective of development. The vision thus stresses the importance of human development, targeting better education and a healthier population. To achieve the vision, a number of executive programmes including the NTP 2020 were launched to achieve interim targets. The NTP 2020 involved 24 governmental bodies operating in the economic and development sectors, one of them was the MoH. The MoH has developed the medium term Health Sector Transformational Plan which is composed of six thematic strategic areas (11):

1- Consumer-centric model of care, that focuses on prevention and emphasizes primary care as the guardian of patients;
2- Health care financing that aims at setting up a national health insurance system with revenue generation, and purchaser provider split;
3- Governance, creating slimmer health structures that separate policy and provision of services;
4- Private sector engagement and participation, with increase in health care delivery through the private sector;
5- Human capital, enhancement of quantity and quality of the human resources for health and;
6- Digitalizing the service provision and achieving full information and communication technology capacity throughout the country.

3.3. KSA-WHO current collaboration on strategic priorities

The MoH and the WHO are already collaborating on a number of activities that are aligned with the SPs and contribute to their achievement. These activities will be further expanded and others added to them over the coming years to achieve the objectives of this CCS. Current activities include:

3.3.1. Prevention and control of NCDs

The government is highly committed to addressing NCDs and their risk factors. KSA in collaboration with the WHO has developed ten progress-monitoring indices to tackle NCDs. The government has implemented a number of actions including reducing the affordability of tobacco and sugary drinks by imposing a special tax, enacting a law that bans tobacco smoking in the workplace, public areas and public transport; introducing national policies to reduce sodium intake; and adopting WHO recommendations on food and non-alcoholic beverage marketing to children. The government is also implementing the "STEPS" health survey every 5 years. KSA has also implemented evidence-based policies for managing NCDs through PHC as well as providing drug therapy and counselling for those at high risk of cardio or cerebrovascular disease (3). Although there is progress, plenty of work lies ahead.

In February 2017, at the request of the MoH, the Saudi Arabia NCD Investment Case workshop and study were conducted in collaboration with the WHO, UNDP and World Bank (22). The workshop served to enable KSA to quantify costs of the NCD burden to its health sector and to the wider economy, and the benefits of scaled up action in addressing this issue. It is generally acknowledged

that although significantly large public investments are needed to achieve the NCD-related SDG targets, such investments are expected to have huge returns. In addition to highlighting the role of "Best Buys" in the prevention and control of NCDs, the main outcome of the workshop was to provide the technical skills and knowledge necessary for the MoH to develop a country tailored, evidence informed advocacy case for NCD intervention and programme financing. Furthermore, technical experts from the WHO and UNDP in areas of non-communicable diseases, health economy and epidemiology evaluated current legislation that could be used in support of NCD prevention efforts (22).

3.3.2. Public health law

WHO is working at the request of and in conjunction with the MoH and the National Centre for Disease Prevention and Control in reviewing KSA's health system functions and legislations to provide Universal Health Coverage (UHC) in line with the national vision 2030 and its strategic directions (23). The overarching objective is to support local capacities to develop supportive health legislation and cost-effectively utilize existing resources. This project will take place in three phases: phase 1: capacity building and mapping the existing health context in terms of current legislation, national context and priorities. In addition, key health system stakeholders, their roles, responsibilities and interlinking functions will be identified. Phase 2 will build on phase 1 and include interactive health policy discussions with the objective of recommending actions to strengthen current health system response in meeting national health priorities. In phase 3, based on the knowledge gathered from phases 1 and 2, WHO will provide expertise and assistance in how to draft public health law and its accompanying discussion paper. In addition it will provide a comprehensive review of the current health system and recommended options for strengthening it. The workshop took place on 9th-13th May 2017 (23).

3.3.3. Health in all policies

With major determinants of health lying outside the health sector, public policy has to address the social, economic, and environmental drivers of health related risk factors, not only public health laws. Health in All Policies (HiAP) addresses these determinants by working across all sectors of government to improve population health. The WHO supported the VRO in delivering a HiAP strategy formulation workshop (10th-11th May, 2017) for the MoH and Ministry of Economic Planning (WHO, 2017c). An initial preliminary analysis of risk factors and determinants suggests that the ministries of Interior, Transport, Education, Culture and Information, Planning and Economy, and Labour and Social Development, among others, will be key partners in addressing improving the health of the population. A designated HiAP unit has been established within the VRO and staff are being hired. With the technical assistance and expertise of the WHO, a formal strategy for HiAP is being developed (WHO, 2017c).

3.3.4. Healthy Cities Programme

The Healthy Cities Programme, a WHO pilot that has become institutionalized, has been built around the concept of addressing the social determinants of health. The programme has managed, over 18 years, to gain strong political support from city governors in mobilizing the community and major governmental sectors to improve the population's health. However, the lack of clarity on the roles of different sectors and the lack of a defined plan have resulted in unsustainable and fragmented efforts and a lack of documented success. Support for the local efforts conducted through the Healthy Cities Programme is expected with the development of HiAP at the central level. The synergy will be

reflected in the successful achievement of the SDGs. These efforts are expected to improve with Vision 2030, which, while it does not mention the social determinants of health directly, has put improving the population's health on everyone's agenda, including families and the population at large. In addition, two of the main Vision 2030 themes are a "vibrant society with fulfilling lives" and "an ambitious nation responsibly enabled". The Vision describes health and well-being as a multifaceted goal to be achieved through improving the economy, environmental health, accountability and society.

3.4. Strategic priorities and focus areas

3.4.1. Strategic priority 1

KSA has a well-established healthcare system, however, with the fiscal limitations, demographic changes, the high expectations of the population, and the forecasted increase in the cost of sustaining the current system, transformation was inevitable. The transformation is in need for the technical advice that the WHO can offer. The impartial evidence-based policy advice, sharpened over years of globe-wide experiences is the main reason that national stakeholders seek WHO's services.

The transformation will change the funding model into an insurance based one; however, it will continue to be firmly based on PHC as the gatekeeper of the health system (Focus Area 1.5). SP 1 will focus on the transformation which will require new skills related to the purchaser-provider split and managed competition (FA 1.2); will require new governance and legal structures (FA 1.1); and will require effective information systems (FA 1.4). Support for a national health workforce plan (FA 1.3) is needed to cater for the health system transformation (SP 1) as well as for combating NCDs (SP 2).

3.4.2. Strategic priority 2

The high prevalence of NCDs and their risk factors represent the main burden of disease in KSA. It puts a heavy burden on the healthcare system as well as socially. The Saudi Arabia NCD Investment Case study confirmed the huge health and social returns for investing in the prevention and control of NCDs (FAs 2.1 and 2.2). With many of the health determinants that contribute to the NCDs burden lying outside the health sector, a multi-sectoral approach at the national and sub-national levels is needed. This is where the HiAP at a national level, and Healthy Cities at a subnational level fit in (FA 2.4). Success in such a huge undertaking needs the collaboration of everyone, including the private sector, and the non-profit sector (FA 2.3).

3.4.3. Strategic priority 3

The emergence of MERS in KSA is another area where WHO expertise is urgently needed. So far, 80% of identified MERS cases were reported in KSA. MERS is characterized by a high case fatality rate (35%) and human to human transmission of the MERS CoV. There are still gaps in knowledge in relation to MERS CoV. Putting the characteristics of the MERS infection together with the fact that KSA hosts the largest annual mass gathering of human beings from all corners of the globe, makes the involvement of the WHO in areas related to MERS and IHR an utmost priority (FAs 3.1 to 3.4).

The three SPs identified for the CCS 2017-2021 strategic agenda, and FAs selected for each SP are presented in table 3. Table 4 presents a matrix which links the SPs and FAs with the SDG targets, the Vision 2030 goals, and the PB categories.

Table 3: CCS 2017-2021 Strategic Priorities (SP) and Focus Areas (FA)

Strategic Priorities (SP) and Focus Areas (FA)	
SP 1	**Strengthen health system to achieve health system objectives particularly UHC**
FA 1.1	Support the development of regulatory and legal frameworks including public health law and regulation of private health insurance.
FA 1.2	Support healthcare finance functions to reduce waste and inefficiency, and improve access.
FA 1.3	Support the development and implementation of a national health workforce plan, including training and deployment, to address shortages and suboptimal distribution of healthcare workers.
FA 1.4	Support the establishment of comprehensive and effective health information systems that contribute to improved quality of care, disease surveillance, service monitoring, and public health planning. Develop the ethical standards that govern use of data in research.
FA 1.5	Strengthening PHC, adopting family medicine and an integrated district approach. Emphasising adherence to standards, guidelines and protocols; outreach activities; prevention, detection and management of NCDs; and strengthen referral.
SP 2	**Ensuring healthy lives and promoting well-being for all at all ages with health at the center of all policies**
FA 2.1	Finalize the Investment Case on NCDs and the development and implementation of a multi-sectoral action plan to address NCDs and their risk factors.
FA 2.2	Support activities to combat tobacco use including implementing tobacco control legislation, develop and strengthen the tobacco surveillance system and construct a database for tobacco control economics.
FA 2.3	Support the MoH to develop a multi-sectoral coordination mechanism involving the non-profit and private sectors to promote healthy lifestyle and advocate for road safety.
FA 2.4	Support the revival of the healthy cities programme, and alignment with the HiAPs strategy as a feasible platform for the design and implementation of multi-sectoral health interventions.
FA 2.5	Implementation of the national efforts towards every mother every child, every adolescent global initiative including developing transformative accountability for adolescents.
SP 3	**Risk reduction and management of national health risks**
FA 3.1	Support measures to prevent local and international spread of infections and emerging infections during the mass gatherings of Hajj and Umra, including establishment of a national programme, a surveillance system (possibly syndromic based), a risk communication plan, updating health requirements for pilgrims and Umra visitors, and a regular information exchange or coordinating mechanism with other countries.
FA 3.2	Support establishment of an event-based surveillance system, with multi-sectoral collaboration (i.e. animal health sector and food sector) and strengthening infection prevention and control, control of Anti-Microbial Resistance AMR, laboratory biosafety and strengthening laboratory diagnostic capacity (one laboratory in the country with BSL-3 capacity) and establishment of the National Laboratory Working Group by MoH.
FA 3.3	Support research to address critical knowledge gaps related to MERS CoV and AMR. In addition, support the early development and implementation of a multi-sectorial national coordination mechanism and action plan to oversee the AMR response.
FA 3.4	Adopt a national plan for emergency response to public health threats per international standards.

Table 4: Matrix showing the link between the strategic priorities and focus areas and the SDG targets, the Vision 2030 goals and PB categories.

Strategic Priorities	Focus Areas	SDGs	Vision 2030 Goals	PB Categories
SP1	FA 1.1	2.2, 3.4, 3.5, 3.6, 3.7, 3.8, 3.9, 10.2, 11.1, 12.4, 12.5, 16.6	• To increase the average life expectancy from 74 years to 80 years • To raise our ranking in the Government Effectiveness Index, from 80 to 20 • To raise our ranking on the E-Government Survey Index from our current position of 36 to be among the top five nations • To rise from our current position of 25 to the top 10 countries on the Global Competitiveness Index • To have 3 Saudi cities be recognized in the top-ranked 100 cities in the world	Category 4
	FA 1.2	3.4, 3.6, 3.7, 3.8, 3.c, 10.2, 11.1		
	FA 1.3	3.2, 3.4, 3.5, 3.6, 3.7, 3.c, 4.3, 4.4, 4.7		
	FA 1.4	2.2, 3.4		
	FA 1.5	2.2, 3.2, 3.4, 3.7, 3.8		
SP2	FA 2.1	2.2, 3.4, 3.5, 3.a	• To increase the average life expectancy from 74 years to 80 years • To increase the ratio of individuals exercising at least once a week from 13% of population to 40% • To have 3 Saudi cities be recognized in the top-ranked 100 cities in the world • To raise our ranking in the Government Effectiveness Index, from 80 to 20 • To rise from our current position of 25 to the top 10 countries on the Global Competitiveness Index	Category 2 Category 3
	FA 2.2	3.4, 3.5, 3.a, 4.7		
	FA 2.3	2.2, 3.4, 3.5, 3.6, 3.a, 4.7, 12.8		
	FA 2.4	2.2, 3.4, 3.6, 3.9, 6.b, 10.2, 11.6, 11.7, 11.b, 12.5		
	FA 2.5	2.2, 3.2, 3.7, 3.8, 5.6, 11.1		
SP2	FA 3.1	3.d, 11.5, 11.b	• To increase the average life expectancy from 74 years to 80 years • To raise our ranking in the Government Effectiveness Index, from 80 to 20 • To increase our capacity to welcome Umrah visitors from 8 million to 30 million every year	Category 5
	FA 3.2	3.2, 3.d, 11.5, 11.b		
	FA 3.3	3.2, 3.d		
	FA 3.4	3.d, 11.5, 11.b		

4. Implications of implementing the Strategic Agenda

4.1. Country level

The strategic agenda for WHO collaboration in KSA calls for further expansion of the country presence. At present, the Country Office is staffed with one international staff (WHO representative) and three national staff (administrative officer, technical assistant and a driver). An increase in both national and international staff is required in order to fulfil WHO's commitment to the country.

4.2. Regional level

The Regional Office should support the capacity of the Country Office by providing technical backstopping in all areas, specifically those not covered by the Country Office staff. Regional Office staff should support efforts to monitor and evaluate the CCS. Senior national officials should be involved in normative work carried out at regional level in order to benefit from their experience and to establish working arrangements with counterparts in other countries of the region.

4.3. Global level

National experts should be involved in global activities of WHO and efforts should be made to ensure better coordination between the three levels of WHO when providing technical support to various health development programmes and activities.

5. Monitoring and evaluation of the CCS

5.1. Participation in CCS monitoring and evaluation

The Country Office, under the leadership of the WHO Representative, with the support of the Regional Office, and with the full participation of and in coordination with the MoH and national stakeholders and UN agencies that participated in the CCS formulation, will monitor and evaluate the CCS.

5.2. Timing

The CCS will be monitored and evaluated regularly during implementation. Semi-annual monitoring of activities will be conducted for all planned activities during the six-months period (see tables 5 and 6). Semi-annual monitoring reports will be compiled into an annual monitoring report. An annual monitoring and evaluation report will be compiled in collaboration with national stakeholders. A comprehensive report will be developed for each biennium, reporting on the two consecutive years: 2018-19 and 2020-21. The monitoring and evaluation report at the end of each biennium will roughly correspond with the middle and the end of the CCS cycle. These two reports will be shared with national stakeholders.

5.3. Evaluation methodology

5.3.1. Regular monitoring

Regular activity monitoring will be conducted Semi-annually to support effective management and ensure alignment of the CCS with the WHO biennial work-plan, the UNCCSF 2017-2021, and national priorities as articulated in the NTP 2020, Vision 2030 and National SDGs plan. In addition, this will ensure that Country Office staff have the appropriate core competencies for delivering results in the focus areas. Semi-annual monitoring of activities will be an ongoing process conducted by the Country Office staff.

5.3.2. Mid-term and final evaluations

The comprehensive reports developed at the end of 2019 and 2021 will correspond with the mid-term and final evaluations of the CCS. The two evaluation reports should measure the extent to which the CCS strategic priorities supported the NTP 2020 and National SDGs plan, as well as contributing to the UN CCSF 2017-2021. The evaluation will determine the extent to which the CCS strategic priorities were adopted by the national policies/strategies to achieve the SDGs. The evaluation should also identify the critical success factors and impediments; and lessons to be applied in the next CCS cycle. Based on the local staff capacities and the availability of financial resources, a consultant may be hired to participate in compiling the final evaluation report.

Table 5: Matrix used for semi-annual planning of activities

WHO, Saudi Arabia Country Office

Activity Planning

Year: 2018 / 2019 / 2020 / 2021

Quarter: Q1/Q2 - Q3/Q4

Strategic Priority (SP) / Focus Area (FA)	**Planned Activity**		**Activity Objectives / Targets**	**Deliverable (GSM)**	**Link to SDGs**		**Expected Implementation Date**	**Required WHO Resources**	**Collaborating National Entity**
	Programme Area (Category)	Task Number (GSM)			SDG Target	SDG Indicator			
SP1									
FA1.1									
FA1.2									
…									
SP2									
FA2.1 FA2.2 …									
SP3									
FA3.1 FA3.2 …									

Table 6: Matrix used for semi-annual monitoring of activities

WHO, Saudi Arabia Country Office
Monitoring Report

Year: 2018 / 2019 / 2020 / 2021
Quarter: Q1/Q2 - Q3/Q4

Strategic Priority (SP) / Focus Area (FA)	**Activity**		**Activity Objectives / Targets**	**Deliverable (GSM)**	**Link to SDGs**		**Implementation Date**	**Activity Outcome**	**Obstacles**	**Lessons Learned**	**Recommendations / Follow up**
	Programme Area (Category)	Task Number (GSM)			SDG Target	SDG Indicator					
SP1											
FA1.1											
FA1.2											
…											
SP2											
FA2.1 FA2.2 …											
SP3											
FA3.1 FA3.2 …											

References

1) United Nations Common Country Strategic Framework 2017-2021 Kingdom of Saudi Arabia, February 2017. (http://planipolis.iiep.unesco.org/sites/planipolis/files/ressources/saudi_arabia_ksa-unccsf_final_signed_in_february_2017.pdf)

2) World development indicators. Washington DC: World Bank Group; 2017 (http://databank.worldbank.org/data/views/variableSelection/selectvariables.aspx?source=world-development-indicators, accessed 22 October 2017).

3) WHO, 2016. National response for prevention and control of NCDs. , pp.10–11.

4) WHO, 2016. Health profile Saudi Arabia 2015. Available at: http://apps.who.int/iris/bitstream/10665/253771/1/EMROPUB_2016_EN_19272.pdf

5) WHO:Department of Health Protection and Promotion, H., 2017. Health through the life course Summary points for Saudi Arabia CCS-10 Jan 2017, Meeting with MoH.

6) Progress toward malaria elimination in Jazan Province, Kingdom of Saudi Arabia: 2000–2014. Ibrahim M. El Hassan et al., Malaria Journal 2015 14:444. 9 November 2015. https://doi.org/10.1186/s12936-015-0858-1

7) WHO, East Mediterranean region, regional malaria country profiles 2016, Saudi Arabia. http://www.who.int/malaria/publications/country-profiles/profile_sau_en.pdf?ua=1&ua=1

8) Middle East respiratory syndrome coronavirus (MERS-CoV) – Saudi Arabia, Disease outbreak news, 9 October 2017. http://www.who.int/csr/don/09-october-2017-mers-saudi-arabia/en/

9) Middle East respiratory syndrome coronavirus (MERS-CoV), Fact sheet. Updated May 2017. http://www.who.int/mediacentre/factsheets/mers-cov/en/

10) WHO, Strengthening health security by implementing the International Health Regulations (2005), About IHR. Available at: http://www.who.int/ihr/about/en/ [Accessed July 10, 2017].

11) Ministry of Health, D.C. presentation, 2015. KSA Health System Transformation.

12) MoH, Power Point Presentation, Program for Insurance and Purchasing of Healthcare Services, (Purchasing Program) Key slide collection, August 2017.

13) General Authority for Statistics, Kingdom of Saudi Arabia table 4-2, accessed on 17/10/2017 on: https://www.stats.gov.sa/en/868

14) General Authority for Statistics, Kingdom of Saudi Arabia table 4-18, accessed on 18/10/2017 on: https://www.stats.gov.sa/en/868

15) WHO, EMRO, In-Depth Review of Primary Health Care for the Kingdom of Saudi Arabia. 13-18 February, 2016. Unpublished report.

16) Official Development Assistance of the Kingdom of Saudi Arabia, UNDP, 2016. (get link)

17) SFD Annual Report for 2016 (https://www.sfd.gov.sa/cs/groups/public/documents/document/mdaw/nzy4/~edisp/121-document-768705.pdf)

18) Country Cooperation Strategy at a glance Saudi Arabia, WHO. Updated May 2017. (http://apps.who.int/iris/bitstream/10665/136842/1/ccsbrief_sau_en.pdf)

19) Generous Contribution from Kingdom Of Saudi Arabia Allows WFP To Feed Millions In Yemen, World Food program, published on 11 September 2015. (https://www.wfp.org/news/news-release/generous-contribution-kingdom-saudi-arabia-allows-wfp-feed-millions-yemen)

20) WHO, 2017. Joint external evaluation of Kingdom of Saudi Arabia Executive summary.

21) Alkhamis, A., 2012. Health care system in Saudi Arabia: An overview. Eastern Mediterranean Health Journal, 18(10), pp.1078–1079.

22) WHO, 2017. Kingdom of Saudi Arabia NCD Investment case: Terms of Reference.

23) WHO, 2017. Concept note: Improve Health Systems Performance, Responsiveness, and Accountability to achieve the Vision 2030 and Universal Health Coverage in the Kingdom of Saudi Arabia.

24) Proposed Programme Budget 2016–2017, WHO. (http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_7-en.pdf)

25) Human development report 2016. New York: United Nations Development Programme; 2016 (http://hdr.undp.org/sites/default/files/2016_human_development_report.pdf).

Annex 1

Vision 2030

Annex 2

National transformation Plan“Health 2020” strategy

Annex 3

List of stakeholders consulted

Annex 4

Saudi funding for WHO