WHO-EM/ARD/038/E

Country Cooperation Strategy for WHO and the Islamic Republic of Iran 2010–2014

Islamic Republic of Iran

World Health Organization

Regional Office for the Eastern Mediterranean

WHO-EM/ARD/038/E

Country Cooperation Strategy for WHO and the Islamic Republic of Iran 2010–2014

Islamic Republic of Iran

World Health Organization

Regional Office for the Eastern Mediterranean

World Health Organization 2010 ©

All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Publications of the World Health Organization can be obtained from Health Publications, Production and Dissemination, World Health Organization, Regional Office for the Eastern Mediterranean, P.O. Box 7608, Nasr City, Cairo 11371, Egypt. tel: +202 2670 2535, fax: +202 2765 2492; email: PAM@emro.who.int. Requests for permission to reproduce, in part or in whole, or to translate publications of WHO Regional Office for the Eastern Mediterranean – whether for sale or for noncommercial distribution – should be addressed to WHO Regional Office for the Eastern Mediterranean, at the above address: email: WAP@emro.who.int.

Document WHO-EM/ARD/038/E
Design and layout by Pulp Pictures
Printed by WHO Regional Office for the Eastern Mediterranean, Cairo

Contents

Abbreviations 5

Executive Summary 7

Section 1. Introduction 9

Section 2. Country Health and Development Challenges 13

2.1 General information 15
2.2 Economic and social development 17
2.3 Health 21
2.4 Key health and development challenges and opportunities 32

Section 3. Development Cooperation and Partnerships 37

3.1 Overview 39
3.2 UN agencies 39
3.3 United Nations Development Assistance Framework 42
3.4 Aid flow in emergency situations 42

Section 4. Current WHO Cooperation 45

4.1 Overview of past WHO cooperation 47
4.2 Partnership with UN and other development partners 49
4.3 Country office resources 50
4.4 Strengths and weaknesses of WHO cooperation: achievements and key opportunities 50
4.5 Challenges 51

Section 5. Strategic Agenda for WHO Cooperation 53

5.1 Guiding principles for WHO at country level 55
5.2 Strategic priorities for WHO support 55

Section 6. Implementing the Strategic Agenda: Implications for WHO 61

6.1 Implications for the country office 63
6.2 Implications for the Regional Office and headquarters 63

Abbreviations

BAFIA	Bureau for Aliens and Foreign Nationals Affairs
CCA	Common country assessment
CCS	Country cooperation strategy
CSDH	Commission on Social Determinants of Health
FAO	Food and Agriculture Organization of the United Nations
GDP	Gross domestic product
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GPW	General programme of work
GMP	Good manufacturing practice
HDI	Human development index
HEART	Health equity assessment and response tool
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HMIS	Health management information system
HPI	Human poverty index
IBRD	International Bank for Reconstruction and Development
IOM	International Organization for Migration
ISDR	International Strategy for Disaster Reduction
IT	Information technology
JPRM	Joint programme review and planning mission
MDGs	Millennium Development Goals
MIS	Management information system
MOHME	Ministry of Health and Medical Education
MSIO	Medical Service Insurance Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ODA	Official development assistance
OPEC	Organization of Petroleum Exporting Countries
PPP	Purchasing power parity
SSO	Social Security Organization
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNAMA	United Nations Assistance Mission in Afghanistan

UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNIC	United Nations Information Centre
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNODC	United Nations Office on Drugs and Crime
WFP	World Food Programme

Executive Summary

The second CCS was prepared by a team of WHO staff members led by the WHO Representative in the Islamic Republic of Iran. The team met and held detailed discussions with staff of various sections in the Ministry of Health and Medical Education regarding health development challenges still faced by the country and what they considered were priorities for WHO collaboration during the next five years (2010–2014), keeping in view the priorities for the health sector as outlined in the fifth 5-year national development plan (2010–2014). The team also met with senior staff of two medical universities in Tehran, the team of Tehran municipality implementing the Urban HEART initiative and a major nongovernmental organization dealing with prevention and treatment of special diseases and visited a research institute that also produces vaccines for use in the national programme for immunization. Discussions were also held with heads of United Nations agencies represented in the country, focusing on the work of each agency related to national health development, the current status of achievement of the Millennium Development Goals and the progress in formulation of the next United Nations Development Assistance Framework for the programme cycle 2010–2014.

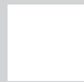
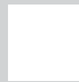
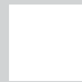
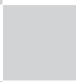
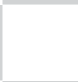
The discussions showed that the Islamic Republic of Iran still faces a number health development challenges. The government is cognizant of most of these challenges, especially as they relate to the financing of health care, e.g. reducing high rate of out-of-pocket expenditure, expanding access to primary health care and coverage of health insurance to 100% of the population (especially in the urban areas), and reducing the burden of road traffic injuries, and has included them as priorities in the fifth 5-year national development plan for which operational plans will be developed by the Ministry of Health and Medical Education. Other challenges faced by the country and identified in full consultation with the national authorities and partners are described in detail in the body of the report. Some of these include: regional disparities in certain critical health indicators such under-five mortality and maternal mortality rates; risk of re-emergence of certain communicable diseases due to importation from neighbouring countries; improving the leadership and governance function of the health sector; and the need to improve links and lines of communication with countries in the Region and in the rest of the world.

To address these challenges, the team recommended the following strategic directions for WHO's collaborative work during the next five years (2010–2014):

- Improving health equity and social determinants of health
- Strengthening primary health care
- Achieving universal coverage and improving equity in health care financing
- Improving leadership and governance
- Strengthening health security
- Managing the demographic and epidemiological transition
- Strengthening partnership for development.

These directions are in line with national priorities for national health development as spelled out in the fifth 5-year development plan and with WHO's own priorities as given in the WHO Medium-Term Strategic Plan 2008–2013.

Section 1

Introduction

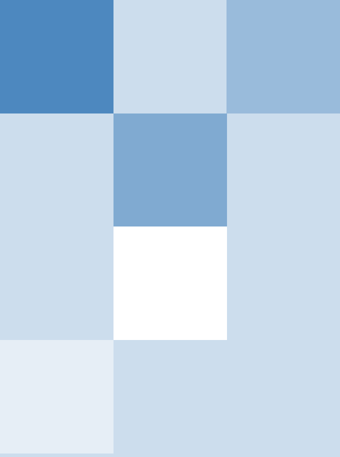
Section 1. Introduction

In order to strengthen the effectiveness of its cooperation with Member States, the World Health Organization (WHO) has institutionalized the Country Cooperation Strategy (CCS) as an integral component of its country focus policy. The CCS reflects a medium-term (4–5 years) vision of WHO for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS is a key instrument for WHO in aligning its own priorities and strategic plans with national health development plans and priorities and for harmonizing its work with other multilateral and bilateral agencies working in a given country. The CCS also aims to bring together in a coherent fashion the strength of WHO support at the country, regional office and headquarters level.

The CCS process examines the health situation in the country in a comprehensive manner taking into account the performance of the health sector, the health outcomes and the determinants of health. It also examines the national response to the health situation as stated in national development and sectoral plans and takes into account the work of other partners and stakeholders in health and health-related areas. In view of the recently completed work of the Commission on Social Determinants of Health, special attention is paid to the ongoing and planned role of other sectors in promoting equity and improving health outcomes and achieving the Millennium Development Goals (MDGs) by the end of the period covered by the new CCS.

The second CCS for the Islamic Republic of Iran is the result of the above mentioned analysis as well as of WHO's current programme of activities. During its preparation, a group of WHO officials led by the WHO Representative met with key officials in the Ministry of Health and Medical Education, other government authorities, and staff of United Nations (UN) agencies in the country. After identifying the key health development challenges faced by the country and taking into account the national health priorities and plans, a strategic agenda for WHO's collaboration was developed for the period 2010–2014.

The timing of the CCS process was opportune, as the government was finalizing the fifth 5-year national development plan, and the UN agencies in the Islamic Republic of Iran had just completed the United Nations Development Assistance Framework analysis of how the UN could contribute during 2011–2015 to support the government achieve its national development goals.



Section 2

Country Health and Development Challenges

2.1 General information

2.1.1 Geographic setting

The Islamic Republic of Iran is a lower-middle income country. With 73 650 000 inhabitants in mid 2008,[1] it has the third largest population in the WHO Eastern Mediterranean Region, after Pakistan and Egypt. It is also one of the largest, with an area of 1 648 000 km^2. Over half the country is mountainous, a quarter is desert and less than a quarter is arable land. Its climate is mostly arid or semiarid, and subtropical along the Caspian coast. The Islamic Republic of Iran enjoys rich natural resources including petroleum, natural gas, coal, chromium, copper, iron ore, lead, manganese, zinc and sulfur. The country is at high risk of natural hazards such as periodic droughts, floods, dust storms, sandstorms and earthquakes. It also has a strategic location along vital maritime pathways for crude oil transport.

2.1.2 Political structure and government

The Islamic Republic of Iran was established following the Islamic Revolution of 1979. Legislative power rests with the Islamic Consultative Assembly (Parliament). However, laws passed by the Assembly must be reviewed and ratified by the Council of Guardians before implementation. The Guardians' Council of the Constitution determines whether proposed legislation is both constitutional and faithful to Islamic law. In the case of differences of opinion between the Islamic Consultative Assembly and the Guardians' Council, an Expediency Council, appointed by the Supreme Leader, has the final verdict.

The Supreme Leader is appointed by the Assembly of Experts (members of this assembly are elected by popular vote). The President of the Republic is the head of government, elected by popular vote for a four-year term. He appoints a cabinet of ministers ratified by the Islamic Consultative Assembly.

2.1.3 Administrative structure

The Islamic Republic of Iran is administratively divided into 30 provinces each run by a Governor General appointed by the Ministry of Interior and ratified by the cabinet. Each province is divided into a number of districts administered by a Governor who is appointed by the Minister of Interior. Currently there are 336 districts, each with a number of urban centres (cities/towns) and villages. There are 889 cities (defined as more than 5000 inhabitants) and 69 000 villages in the Islamic Republic of Iran, based on the last household survey in 2007. There are also provincial, city and village councils in all parts of the country.

[1] *Demographic, social and health indicators for countries of the Eastern Mediterranean 2008.* Cairo, WHO Regional Office for the Eastern Mediterranean, 2008

2.1.4 Demographic information

The Islamic Republic of Iran is a diverse country. A number of ethnic groups live in the country: Persian 51%, Azeri 24%, Gilak and Mazandarani 8%, Kurd 7%, Arab 3%, Lur 2%, Balouch 2%, Turkmen 2% and others 1%. In terms of religion, 98% of the population is Muslim (Shia 89%, Sunni 9%); other religious groups include Zoroastrian, Jewish and Christian populations.

The Islamic Republic of Iran has experienced dramatic changes in fertility and population growth rates during the past 30 years. A change in population policy immediately after the revolution resulted in the suspension of the family planning programme and led to a huge rise in fertility and population growth rates. Following the revival of this programme in 1989, the fertility rate declined significantly and by late 2000 there were indications that the fertility rate had dropped to around replacement level (a total fertility rate of 2.1 per woman) in all urban areas as well as some rural districts.

The growth rate during 1975–2000 was high enough to lead to a doubling of the country's population during. The huge cohort of 31 million children born during 1979–1991 continues to present the country with problems. The proportion of the elderly (age group 65+) has risen to 5% and may soon pose major challenges for the social security system.

The past 30 years have also seen a significant rise in the urbanization rate of the population. In 2006, 71% of the population (just above 52 million) lived in urban areas (Table 1).

After Pakistan, the Islamic Republic Iran is the second largest host country for refugees in the world. As estimated in January 2007, there are 968 000 registered refugees (and approximately 2 million unregistered) in Iran, equivalent to 14 refugees for every 1000 inhabitants in the country.[2]

Table 1. Demographic indicators

Indicator	Value
Population (2008)	73 650 000
Birth rate (per 1000 population) (2008)	18.7
Crude death rate (per 1000 population) (2008)	5.9
Total fertility rate per woman (2006)	1.9
Population age <15 years (%) (2006)	25.1
Population age 65+ years (%) (2006)	5.2
Urban population (%) (2006)	71
Literacy rate, age 15+ years, female (%) (2006)	77
Literacy rate, age 15+ years, male (%) (2006)	87

Source:[1]

[2] UNHCR annual report 2006

2.2 Economic and social development

2.2.1 Economic development

The Iranian economy is the second largest in the Region after Saudi Arabia with a gross domestic product of over US$ 200 billion in 2006. The economy is mostly state-based and depends largely on oil revenue. Oil accounts for around 80% of export income and is the source of 40%–70% of government revenue.[3] Despite high oil prices, the rate of economic growth has slowed from 7.1% in 2003 to around 4.3% in 2007. At present, fiscal policy remains expansionary in keeping with the government's populist agenda. There has been a massive increase of public expenditure on health care, education, poverty alleviation and large cash handouts. These social measures have led to a significant increase in the inflation rate which reached an annual average of 25.5% in 2008, up from 17.1% in 2007. Iranian GDP is expected to grow to 2.9% in 2010–2011.

In 2007, the total expenditure on health per capita was US$ 259 at exchange rate and US$ 705 at international rate (PPP). The proportion of GDP spent on health was 6.8% in 2007.[1] Of this proportion, the private share was 46.5% while the public share was 53.5%.

2.2.2 Poverty

Druing the past two decades, material poverty has fallen significantly. This has in part been a result of a vast system of subsidies designed to reach out to the poor. An informative indicator is the share of the poorest quintile in national consumption, which equals 6%. Other indicators are the prevalence of underweight children, which decreased from 16% in 1991 to 5% in 2004, and the percentage of people living below the food poverty line, which was halved between 1999 and 2005.

Despite such progress, 7% of the population (approximately 5 million people) was estimated to live under the calorie-based poverty line threshold in 2005. An estimated 10–20 million Iranians live under a relative income poverty line. This means that up to a quarter or third of the population is likely to have less resilience and capability to respond effectively to vulnerability and proactively access support and care.

The proportion of the population living below US$ 1 and US$ 2 (PPP) per day has decreased from 1.2% and 9.1% in 1997, respectively, to 0.2% and 3.1% in 2005. Despite this reduction, the absolute number of people under various forms of welfare coverage has not declined similarly, indicating that income poverty indicators do not measure the purchasing power needed to maintain basic living standards. The downward trend in poverty has also been uneven: it accelerated from 1992 to 1998, then slowed down and even increased in 2000 due to a marked increase in consumer prices from 1997 to 2000. Thereafter, as inflation came down from 2000 to 2007 and support policies were increased, poverty resumed its downward trend. However, after 2007, inflation has increased once again.

[3] *The Economist.* 19 July 2007

The human poverty index (HPI) measures poverty from a broader human development perspective and is statistically correlated with per capita income index. In the Islamic Republic of Iran, HPI decreased steadily from 25% in 1991 to 12.4% in 2004. The component indicators of HPI, (population deprived of access to safe water, population deprived of access to health services and underweight children of age five and under) declined from 6%, 5% and 11% in 1998 to 5%, 4% and 5% in 2004, respectively.

In recent years the government has implemented a number of strategies to reduce poverty. These include implementation of various programmes within the scope of the social security system and expansion of the insurance system, as well as providing non-insurance benefits in various areas. The government has so far been successful in providing medical insurance for 94.6% of the population, including 21 million from rural populations and about 5 million vulnerable people.

Major challenges relating to poverty reduction can be summarized as follows.

- Conditions such as inflation, unemployment, migration, marginalization, lack of full social insurance coverage and other factors could lead to an increase in the number of people in need of support.
- The high potential for natural disasters increases the risk of hazards leading to increased poverty.
- Unbalanced population growth and distribution, increasing urbanization, changing population structure and increased proportion of youth all increase the risk of poverty.

2.2.3 Education

During the past two decades, education has been improving at all levels of the educational system in terms of access for both males and females in urban and rural areas. However there are growing problems with the quality of education in public services, and a rise in the number of private schools.

2.2.4 Gender equality and empowerment of women

Promotion of gender equality and empowerment of women is Millennium Development Goal 3, with the target of eliminating gender disparity at all levels of education by 2015. The gender parity index for education (ratio of girls to boys in primary, secondary and tertiary education) rose from 79% in 1990 to 95% in 2005. The 2006 census confirms that women account for the majority of undergraduate university entrants, though a large gender gap persists at postgraduate levels (Table 2). The gender parity index for literacy (ratio of 15–24 year old literate women to men) has also grown significantly, from 88% in 1990, to 99% in 2005.

While the unemployment rate among males decreased during 1997–2003, the rate increased for women during these years. One factor contributing to this situation may be the increased number of educated and unemployed women. In the past two years, the female unemployment rate also dropped, but to levels still nearly twice as high as the male unemployment rate. Unemployment rates, especially for women, vary considerably in different parts of the country, ranging from 2.3% in East Azerbaijan to 46.7% in Lorestan.

Table 2. **Students in higher education disaggregated by sex and educational level (2006)**

Students	Higher National Diploma	Bachelor's degree	Master's degree	PhD	Not mentioned	Total
Number	783 914	1 576 621	160 167	28 005	5017	2 553 726
Male (%)	56	44	58	78	65	49
Female (%)	44	56	42	22	35	51

The fourth 5-year development plan (2004–2009) included specific strategies and policies for decreasing gender inequity. However, despite the remarkable advances achieved by women in education, their share in employment and management and policy-making roles needs improvement, especially given that in the next ten years the country will face an increase in the number of single-person households headed by educated women. Major strategies for promoting gender equality in Islamic Republic of Iran are as follows.

- Increasing employment for women, especially educated women
- Promoting gender equality in the labour market
- Increasing support for women, in order to combine their roles in family and employment
- Improving vocational training programmes for women
- Reforming laws and regulations to improve gender equality
- Enhancing women's participation in management and policy-making positions
- Promoting nongovernmental organizations engaged in protection of women's rights

2.2.5 Youth

The Islamic Republic of Iran has a very young population. The "baby boom" of the 1980s has created demographic, social and economic opportunities and challenges. The current generation of Iranian youth, men and women is better educated than any time before.

As in other countries, the consequence of this educational success is reflected in changing aspirations of young people, particularly young women: higher education; delayed marriage and smaller family size; professional success and economic independence. Rising incomes, migration and urbanization have also led to changes in lifestyles – partly reflected in changing national consumption patterns towards leisure, fashion, music and alike. From the above, it is clear that young people today face issues and problems that are vastly different from previous generations. Moreover, the increasing globalization of culture combined with young people's evolving aspirations is determining changes in intergenerational relations.

At present, 35.5% of the population is between 15 to 29 years of age. Gaps exist between education and job opportunities.

Economic, social and cultural problems affect young people. Social marginality and exclusion are widespread. Major health risk factors are violence, tobacco and illicit drug consumption, risky sexual behaviours, psychological problems (e.g. anxiety, depression, stress), unhealthy diet and insufficient physical activity.

Despite the achievements in recent decades, the health and developmental needs of this important sector of the population could be better tackled by different related stakeholders. Promotion of health can include: knowledge and information in order to make informed choices; promotion of an environment to practice healthy behaviour; provision of youth-friendly health services (revising working hours, staffing, decoration, premises, etc.); and broadening access for youth problems. Successful health policies must be interdisciplinary and intersectoral, taking into account not only physical condition but also political, social, economic and mental development.

Research on the inclusion of youth and their successful transition to adulthood shows the urgency for: 1) acquiring skills for productive employment; 2) finding a job; and 3) setting up a family (young people often go unemployed for years rather than months, denying them the ability to marry and set up a home). While the reasons for this are multifaceted, many of them are rooted in a system of inefficient incentives and outdated institutions. Examples include an education system promoting the wrong type of skills and a rigid formal labour market ill-prepared for the creation of employment. The government is thus having increasing difficulty creating job opportunities for a younger and better-educated workforce. The result is a growing sense of frustration among youth, especially low-income and middle-income youth and educated women. Another concern is the growing drug demand among young people.

While both children and youth are of pivotal importance to national policy makers, the system of institutions and mechanisms for social protection needs to be adjusted to the changing needs and expectations of children, adolescents and youth. There is a need for youth-friendly policies in all social fields: health care, education, leisure, vocational training, community development and many more. The cumulative know-how of governmental and nongovernmental actors needs to be utilized in a participatory manner to find sustainable solutions. Further, the use of data and evidence-based planning must be improved, to enable tailored solutions to be developed for the many vulnerable groups among youth and children. United Nations agencies can assist the government in developing the capacity of national and subnational authorities to achieve this outcome.

2.2.6 Human development and MDGs

During the past 30 years, the Islamic Republic of Iran's human development index (HDI) has grown at an annual rate of 0.95%, rising from 0.562 in 1975 to 0.721 in 2002. Yet, the country ranked 106th among other nations in 2001, having dropped from 90th in 1999. This figure has been contested on the grounds that it is based on an estimated life expectancy of 69.8 years and a rather low adult literacy rate. Using a life expectancy of 70.6 years and an adult literacy rate of 80%

(75.5% for women and 84.3% for men) for 2001, the HDI would rise to 0.736 and to 94th place among other nations.[4]

According to the Iranian government, the unemployment rate was 12.5% in early 2009 and was significantly higher in women (18.4%) compared to men (11.3).[5] The high unemployment rates of medical doctors, nurses and technicians have become a matter of national issue and debate.

2.2.7 Vulnerability to natural disasters

The Islamic Republic of Iran is highly vulnerable to natural disasters, particularly earthquakes, flash floods and droughts. Earthquakes pose a particularly great threat The Islamic Republic of Iran is ranked first in the world in terms of number of earthquakes per year with a magnitude of at least 5.5 on the Richter scale. It also ranks first in terms of relative vulnerability and of the number of people killed per year as a result of earthquakes. Three quarters of the country's major cities are in potential major earthquake zones. While the probability of earthquakes is always high, the probability of floods has increased during the recent decade and floods have affected more people than those affected by earthquakes. Rangeland degradation and drought have also affected large parts of the country.

Between 1991 and 2001, disasters cost the Iranian economy US$ 1.1 billion per year on average. Adding the secondary damages and losses, the total costs amounted to 10% of GDP. Increased social problems and poverty, especially in rural areas, are common after major disasters due to loss of livelihood and infrastructure – with women and children often experiencing greater hardship, thus requiring tailored assistance and preparedness plans.

2.3 Health

2.3.1 Health system

General description

In 1985, medical education and allied health fields were integrated within the Ministry of Health, which was renamed the Ministry of Health and Medical Education. In 1993, the universities and the regional departments were merged in all provinces forming Universities of Medical Sciences and Health Services to assume both tasks of training human resources and providing health care services. The results of this integration were later assessed on several occasions.

In 1996 the MOHME assigned a group of experts to assess its structure with a view towards reforming certain aspects of the health sector. The need for reform had its roots in the limited perceived quality of the services rendered, lack of access of certain segments of society to the required services, irrational use of the limited existing resources and limited accountability. To this end, five overarching objectives were announced to be: efficiency, quality, equity, accountability and sustainability.

[4] *Fourth socioeconomic and cultural development plan of the Islamic Republic of Iran.* Tehran, Management and Planning Organization of the Islamic Republic of Iran, 2004

[5] Statistical Centre of Iran, 2009

Health sector reform began in early 2001. Its implementation has focused on capacity development, institutional strengthening and generation of evidence to support policies and strategies. The reform process has been inclusive, bringing together most stakeholders involved in the implementation.

The MOHME is currently responsible for planning and providing health care services and for monitoring and evaluating them at both national and provincial level through the universities of medical science and health services. The Chancellor of each university in any given province is an alternate to the Minister for Health within that jurisdiction. The universities with their board of trustees have authority for decision-making on issues such as budget approval, allocation of incomes, signing contracts, gathering aids, implementing employment regulations and reimbursement in return for research, teaching, authoring books, etc.

Two years ago, the MOHME set up a Health Policy Council as the national steering body. The health policy unit serves as the consultancy arm of the Council. The plan is for the policy unit, where policy-making on an issue is required through the decision of the Council, to provide adequate evidence through the secretariats of applied research or through assigning nongovernmental entities to conduct such studies in order to substantiate through data and scientific justification the MOHME policies. Should the nature of the policy require, the Council would ask for its adoption by the Supreme Council of Health and Food Security, which includes representatives of health-related sectors and is chaired by the President. The policy unit is also mandated to follow up on the implementation of policies and evaluation of the outcomes in practice.

Governance

The MOHME is the primary body responsible for oversight of the health system. It has the legal authority to oversee, license and regulate the activities of the health sector including private and non-state providers.

Most of the other supervisory and regulatory functions are conducted by MOHME itself or by the Universities of Medical Sciences on its behalf in the provinces. The Universities of Medical Sciences have a functional authority for supervising health care organizations and care standards, and they are ultimately responsible for the protection of patients and other citizens as consumers of health services and health-related products such as food and drugs.

The MOHME also has joint, and sometimes overlapping, supervisory and regulatory functions in such areas as occupational health (with the Ministry of Labour), water sanitation (with the Ministry of Energy), food safety (with the Ministry of Agriculture), environmental health (with the municipalities and the State Environmental Protection Organization), and school health (with the Ministry of Education).

Other governmental units also play significant roles. For instance, setting health services fees is the responsibility of the Ministry of Welfare and Social Security and the Supreme Insurance Council, which consists of representatives from the MOHME, insurance corporations, and other

economic and governmental bodies. This council develops suggestions for medical fees for Cabinet approval. Once approved, compliance by health care professionals is mandatory.

Other nongovernmental bodies also play a role in regulation. For example, the Iran Medical Council is a nongovernmental organization that regulates the relationship of most health care professionals with the government. It is involved in the licensing of medical professionals and acts as a union for the medical community.

Health services

The Iranian primary health care networks were devised in 1981 by creating health houses in rural areas, which emphasized community participation and intersectoral cooperation and focused on basic health care financed by governmental budget. Before the recent introduction of family medicine, the primary health care networks provided services including: immunization, prevention and control of communicable diseases, oral health, maternal and child health, family planning, nutrition, environmental health, occupational health and school and youth health. Each health house serves 1500 people in its village and surrounding settlements. There are 17 151 health houses around the country. As the first points of seeking services, health houses have a fundamental role in providing basic care in rural areas, where 33% of the population lives. The health house is staffed by locally sourced community health workers (*behvarz*) trained for two years at district level. The health houses refer patients to rural health centres. Health houses are supervised and supported by rural health centres, which cover about 6000 to 10 000 people. Each of the 2574 rural health centres has one or more general practitioners, several health technicians (mid-level workers responsible for a range of different activities including occupational health and environmental health, communicable diseases, etc), midwives and administrative personnel. The general practitioners in the health centres are also responsible for visiting the referring health houses in order to supervise the *behvarz* and see any patient who need a medical doctor. Some rural health centres also have delivery facilities.

The corresponding structures in urban areas are health posts which are similar to health houses but serve much larger numbers of people (about 12 000 people per health post). The health posts are also staffed by health technicians (usually three: family health technician, environmental health technician and midwife) who are trained at university level. The health post refers patients to an urban health centre which covers a population of around 50 000 people. There are 2182 urban health centres which are responsible for urban residents and occasionally villagers from close rural areas. However, primary health care in cities is fragile and loose compared to the comprehensive networks in rural areas. Usually, there are a number of volunteers in urban health centres who facilitate communication with the population, provide education for the public and follow up cases with special needs.

The health centres are under the management of a district health centre. The district health centre, an administrative

structure responsible for the management of the districts, is also linked to the provincial health centre. The latter centre is located in the capital city of the province and is chaired by the deputy chancellor for public health and is able to respond to educational and training issues, as well as obtain assistance and support from the University of Medical Sciences.

Hospitals are responsible for providing the secondary health care services. In 2007, there were 801 operating hospitals. Of these, 532 were affiliated with the MOHME (operated by the provincial medical science universities), 115 with private sector operators, and 154 with other sectors such as the Bank Melli Iran, the National Iranian Oil Company, national television and radio networks, charitable trusts and other ministries (e.g. Ministry of Education and Ministry of Social Welfare). Over the past 20 years the number of MOHME and other hospitals increased, with the number of private hospitals remaining fairly constant.

In 2007, of 87 175 active beds in the country, 62 391 were in MOHME affiliated units, 8375 in the private sector, 7126 in the Social Security Organization, 2207 in charities (including Imam Khomeini Foundation), and 5954 in the provider units managed by other operators.[6]

In addition to the Welfare Organization, other entities providing rehabilitation tertiary services include the Department of War Victims, the Department of Special Education, the Red Crescent Society and Imam Khomeini Relief Committee.

Health finance

Total health expenditure has increased very rapidly in the past decade. The per capita health expenditure increased from US$ 65 in 2000 to US$ 259 in 2007. In the same period the per capita government expenditure has increased from US$ 24 to US$ 121. However, the share of out-of-pocket expenditure is still over 50% and there are indications that it may actually have been even higher in 2009.

The health care financing system is organized through a number of public and non-public insurance schemes. Insurance schemes have developed in some parallel over time. Access to services and choice of provider is determined largely by the type of insurance coverage.

There are several insurers, each with a different benefits package co-payments and referral systems.

- The Social Security Organization (SSO) provides insurance for formal sector employees and self-employed labourers and their dependents (28 million people) through mandatory insurance schemes, and provides pensions for 1.2 million retired pensioners in 2008.
- The Armed Forces Medical Services Organization provides insurance for almost 2.5 million members of the military and their dependents.
- The Medical Service Insurance Organization (MSIO) provides insurance for government employees, rural households, self-employed and others such as students (38 million people in 2009). In 1996, 1.2 million self-employed people had this insurance. In 2005 and

[6] *Health financing reform in Iran: principles and possible next steps.* World Bank, 1999

following the implementation of family physician and rural insurance in rural areas and cities of less than 20 000 population, MSIO coverage expanded significantly. Within two years and by the end of 2007, 23 million people in rural areas and almost 2 million in small cities were given family physician insurance log-books by the MSIO.

- The Imam Khomeini Relief Foundation covers the poor and destitute. Almost 2.1 million people are under this scheme.
- There are also several smaller schemes covering employees and families of the banking system, national radio and television, municipalities, oil and gas industry and other public sector employees.
- In addition, there are private health insurance schemes. Most of the private health insurance schemes offer complementary health insurance to those covered by the main social health insurance schemes: SSO and MSIO.

In 1994, 40% of the population was benefiting from medical insurance coverage. The figure has now increased to 95%. However, due to lack of an integrated insurance database, and geographical coverage rather than another rationale for insurance which was expanded by the rural insurance scheme, it is estimated that 8%–12% of people more than one insurance scheme. Moreover, the distribution of health resources is not equitable and the present arrangements are unable to ensure provision of basic health care services to all citizens. If covered by health insurance, patients pay 25% of the fee for outpatient and 10% of the fee for inpatient treatment (consultation, laboratory investigations or medicines). Fees do not vary across age ranges. All emergencies are treated immediately without prior payment. Definition, organization and provision of a free and comprehensive universal basic minimum health care package are currently being discussed as a major issue for the ongoing health sector reform. The fifth development plan pays special attention to the issue.

Human resources

Just over 284 000 people worked in the MOHME in 2008, which is 12% more than the 252 000 employees in 1999.[7] According to the last update in late 2007, 29 937 doctors worked in the MOHME, reflecting a 12.7% rise as compared to the previous year.

Table 3 shows the percentage of various categories of human resources for health in the Islamic Republic of Iran in 2004.

Organizationally, decision-making in the health system is centralized. This leads to some delays in decision-making and undue emphasis on developing national 'standard' programmes which allow limited regional variation in services to reflect the heterogeneity of demand patterns. In spite of government attempts to decentralize the health system, functional decentralization has not progressed in line with geographic decentralization.

There is also a need to follow up on the set of recommendations made by the WHO team who has tried to assess the integration of health service provision and medical education.

[7] *Three decades of endeavor on the health front: status report on health care and medical education.* Tehran, MOHME, 2009

Table 3. **Human resources for health, by sector, 2004**

Category	Total number	Public sector		Private sector	
		Number	%	Number	%
Physicians					
Generalists	41 796	10 732	26	31 063	74
Specialists	18 995	9 921	52	9 074	48
Nurses (including auxiliary nurses)	83 175	53 661	65	29 514	35
Midwives (including auxiliary midwives)	13 087	8 443	65	4 644	35
Dentists (including oral health technicians)	13 135	3 875	30	9 260	70
Pharmacists (including technicians)	14 140	4 019	28	10 121	72
Laboratory (including technicians)	13 134	6 905	53	6 229	47
Radiographers	6 915	4 461	65	2 454	35
Community health workers	25 242	25 242	100	0	0
Environmental and public health workers	10 004	6 354	64	3 550	36

Source:[8]

Medical products and technologies

The Department of Food and Drug in the MOHME is officially in charge of policy-making and sustainability of supply for essential and particular medicines. It created a Medicinal Drug Planning Council in 1995, which is responsible for main policy-making on medicinal drugs. The committee approved a 13-point national drug policy in 2003, revised in 2008, which has been at the core of action in the medicinal drug system. Since 2006, the council is headed by the Minister of Health and Medical Education and his deputies. The council has drawn up a list of Iranian medicinal drugs which has been handed out to the members of the medical community. Under article 93 of the 4th development plan, physicians are urged not to prescribe items which are not in the list.

After the revolution, almost all major drug companies were taken over by the government. As they were mostly connected with the international pharmaceutical industry, the takeover led to imposition of restrictions on the import of many products. To deal with this limitation, as well as foreign exchange shortages, the government developed a list of basic drugs to be produced locally. Between 1988 and 1993, the industry was handed over to the private and semi-private sector and almost all of the drug companies are now privately

[8] MOHME. Human resource profile 2004

owned and managed. The pharmaceutical industry recently started joint projects with international companies for production of new drugs.

The government has however maintained overall control in the area of pricing and quality assurance. The distribution system, which has traditionally consisted of individually owned facilities, has remained intact over the years. Currently, there are 28 distributing companies nationwide, a six-fold increase over the previous decade.

At present, there are 70 pharmaceutical companies running across the country, 10 of which were established after 2000. In addition, there were 44 feedstock producers and 45 producers of natural and herbal medicines in the country in 2008.[7] There were 4000 pharmacies across the country in 1993 and 8000 in 2008. For the past 15 years, local companies have been producing 95% of all local needs for medicinal drugs, thanks to increasing local production of basic pharmaceutical elements as well as erasing monopoly after the revolution in 1979. New and infrequently prescribed medicines are separately imported or manufactured and offered through special stores affiliated with the Red Crescent Society, private sector and/or voluntary associations formed to support people suffering from specific disorders. To date, local companies produce 1200 items and the MOHME has issued 3800 production licenses to manufacturers.[7]

However, the pharmaceutical industry is restricted by the price control strategy imposed by the MOHME to keep the cost of pharmaceuticals low and affordable. The substantially low prices of locally produced generic medicines encourage irrational use and smuggling of medicines to neighbouring countries. The MOHME over the past few years has gradually withdrawn the access of the pharmaceutical industry to subsidized hard currencies and this has increased the price of pharmaceuticals.

In parallel with the development of the industry, measures have been taken to ensure medicine quality, including implementing a performance management system and good manufacturing practices, drawing up a new pharmacopoeia, enforcing a branded generic naming system and establishing a centre for registration and review of adverse drug reactions. Other measures include implementation of a quality assurance system, registration of products by companies and conducting bioequivalence tests. However due to the ongoing sanctions, some of these efforts do not align with international standards and many companies abide only by national rules and regulations. Conformity with international standards and regulations would ensure high quality of the products as well as create more chances for Iranian products in the international market. In 2001, WHO set up a service, the prequalification project, to facilitate access to medicines that meet unified standards of quality, safety and efficacy for HIV/AIDS, malaria and tuberculosis commodities.

Vaccine needs in the Islamic Republic of Iran are primarily met through local production by the Pasteur Institute of Iran and the Razi Vaccine and Serum Research Institute, each established over 70 years ago. The Pasteur Institute supplies the entire national demand for BCG, while Razi supplies the other vaccines

for the Expanded Programme on Immunization (OPV, DTP, DT, Td, measles). The Act for Food, Beverages, Pharmaceuticals and Medical Devices, issued in 1955 (Act 1334) and later amended in 1967 and 1988, defines the scope and responsibilities of the MOHME as official national regulatory authority supervising the production of vaccines, as well as the function and responsibilities of an advisory and decision-making committee. As part of the WHO vaccine prequalification process, WHO has conducted four formal assessments to document recommendations to strengthen the Iranian vaccine regulatory system (1997, 2002, 2004 and 2006), and seven follow-up visits during the same period. This is the first step towards the prequalification of vaccines by WHO.

Medical and laboratory equipment was mostly imported until a few years ago. After the war with Iraq, the country gave more attention to internal production of such equipment. In 1990, there were 61 manufacturers for such equipment in the country. This figure had risen to 415 by 2008, producing 520 pieces of necessary equipment at international quality standards. This equipment accounts for 85% of disposable products, laboratory kits and dentistry equipments which are consumed locally.

For policy-making and quality control of this equipment, the Department of Medical Equipment was created in the MOHME in 1993. Currently, the responsibility falls on the Centre for Management and Coordination of Commercial Affairs. The MOHME has recently introduced a function of health technology assessment, which will help the MOHME to better select, manage and assess the added value of health and biomedical technology.

Health information system

According to the MOHME Statistical Office, health statistics are fairly good and allow the production of reliable epidemiological reports However, while there is a well-established and functioning health information system at rural primary health care level, data collection in the urban areas is more challenging as many people use private health providers both for common ailments and for complex interventions. In the urban areas family records at health posts and urban health centres are a vital source of routine data. These are augmented by data from the health volunteers. However, there are no mechanisms to routinely capture and pool data from private sector providers as well.

With a few exceptions, Iranian hospitals have little or no computerization. What computerization does exist is mostly focused on financial processing, including that which is aimed at dividing the revenues between the institution and its attending physicians.

Health insurance agencies have some computerization, but it is doubtful that they are capable of performing the complex reimbursement schemes which the reform process will likely introduce (capitation, global capitation, more complex fee-for-service arrangement, more contracting with the private sector, bonus and incentive schemes for good management etc.). Expansion and improvement of the HMIS faces key challenges such as insufficient managerial authority, low political commitment and lack of national health data dictionary, etc.

The health system has enormous opportunities to benefit from the development of an integrated HMIS, which would underpin all the essential administrative and clinical operations in modern health financing and health care delivery systems.

The government will need to play a key role in regulating the development of common IT and management information system standards to ensure inter-operability among different users and beneficiaries. In particular, in the areas of disease surveillance and public health monitoring, a national HMIS would be required to monitor health indicators across the country on a timely basis. The participation of the private health sector is critical in the development of common HMIS standards and procedures.

The development of a national HMIS will require certain conditions: the availability of inexpensive, ubiquitous and reliable telecommunications; a sufficient "pipeline" of new student talent; strong enforcement of intellectual property rights in order to encourage investment in HMIS software development; robust and comprehensive health information standards; an overall coordinating centre for HMIS coordination and development; and cooperation and involvement from the private health sector.

There is a fragmentation of service delivery (especially in urban areas), poor intrasectoral and intersectoral coordination, and weak linkages between and within health care institutions. While the rural areas are well covered by public sector primary health care providers, in large cities, private providers are in a dominant position in service provision. However, the systems for regulating the capacity and behaviour of private providers are underdeveloped.

There is a need to update the national burden of disease analysis in order to better assess health system performance and improve priority setting and resource allocation.

2.3.2 Health status measures and outcomes

Main health indicators

Health outcomes in the Islamic Republic of Iran have improved greatly over the past 30 years and now generally exceed regional averages. Key to this success has been the government's strong commitment to and effective delivery of primary health care. Moreover, as a result of the prioritization and effective delivery of quality primary health care, health outcomes in rural areas are almost equal to those in urban areas.

In 2006, life expectancy at birth in the Islamic Republic of Iran was 70 years for men, 74 years for women, and 72 years for both sexes.[9] The same year, healthy life expectancy at birth was 60, 62, and 61 years for men, women and both, respectively. In 2004, the infant mortality rate was 29 per 1000 live births, almost half of the 1990 rate of 54 per 1000 live births. At present, the maternal mortality ratio stands at 24.6 per 100 000 live births, compared to 91 per 100 000 live births in 1990.[7] The MOHME reports the infant and under-five mortality rates for 2007 at 18.9 and 22 per 1000 live births, respectively.[7]

[9] World Health Statistics (http://www.who.int/whosis/whostat)

There are challenges in addressing a number of regional disparities in health that are particularly evident in estimates of life expectancy and child deaths. UN data show that life expectancy in Tehran was more than 70 years in 1996, compared with 61 years in Sistan-Baluchestan. The average Iranian infant mortality rate was 31.7 per 1000 live births, while for Tehran it was 26.9 per 1000 live births, and Sistan-Baluchistan, 65.9 per 1000 live births, indicating a significant differential. The probability of a child dying before age 5 was about 32 per 1000 live births in Tehran, but almost three times that figure in Sistan-Baluchestan.

While the family planning programme provides free services throughout the country, some areas show lower levels of contraceptive use. Family planning use is lowest in Sistan-Baluchestan (42% of married women), followed by women in the southern province of Hormozgan (55%). In Tehran, 82% of married women use family planning methods.

Between 2000 and 2007, 7% of babies were low birth-weight, while 11% of children under five were suffering from underweight, 2% of them at severe scale. Malnutrition and low-weight births are higher than average in many parts of the country.

Health transition and the changing patterns of morbidity and mortality

Communicable diseases are no longer major cause of mortality. Together, they account for less than 5% of deaths, while ischaemic heart disease and traffic-related accidents account for one-third of deaths in the Islamic Republic of Iran. The MOHME reports that heart conditions account for 38% of deaths and reduce life spans by 23.4%. Injuries cause 18% of deaths, claiming 50 000 lives each year.

In 2008, the prevalence of cancer was 100 cases per 100 000 population,[7] accounting for 11.86% of healthy life years lost. A 2005 review of risk factors for noncommunicable disease showed that lack of physical activity (69%) is the leading major contributor to cardiovascular diseases. That is followed by cholesterol levels of more than 200 mg (44%) and overweight (28%). Male smokers number significantly more than female smokers, and smoking is more prevalent in the age group of 35–54 years.

An assessment of burden of disease, risk factors and healthy life expectancy was carried out in 2006 at the national level and for six provinces of the country. Briefly, the results show that the highest proportion (33%) of total disability adjusted life years belonged to the 15–29 year age group, followed by 30–34 years (20%). The age groups 0–4 years and 45–59 years contributed 15% each. Noncommunicable diseases account for most of the disease burden (45% among males and 33% among females), followed by accidents and injuries.

In terms of risk factors, obesity, arterial hypertension, inadequate physical activity, hypercholesterolemia and addiction are the five risk factors causing the highest proportion of risk factor burden (68%).

As noted earlier, the Islamic Republic of Iran is among the most disaster-vulnerable countries in the world, with floods, drought and earthquakes being the most frequent natural disasters. 97% of the country is located on major seismic fault lines and

more than 120 000 of people have lost their lives due to earthquakes in the past two decades.[7]

2.3.3 Social determinants of health

The Islamic Republic of Iran has made an important contribution to the understanding of social determinants of health and health equity. Following the Islamic revolution in 1979, the new constitution prioritized poverty alleviation and social and health equity, and carried forward in subsequent development plans. These prompted activities that resulted in a significant improvement in health status at the national level and in disadvantaged areas, though inequities still persist. In view of the Iranian experience in promoting health equity, in late 2005 the country became a partner in activities promoted by the WHO Global Commission on the Social Determinants of Health. The Deputy Minister for Health was appointed as a focal point to promote and advocate social determinants of health and to be ultimately responsible for developing a national strategic plan and plan of action with intersectoral collaboration. The underlying philosophy and objectives of the WHO Global Commission on the Social Determinants of Health are recognized by the Islamic Republic of Iran

Policy responses to issues around social determinants of health and health equity have included: the establishment of health councils which discuss health policy issues with other line ministries; the establishment of the MOHME to bring medical training in line with the main objectives of the health system; and the establishment of social determinants of health focal point and secretariat within the Ministry.

At the programmatic level, the government has encouraged intersectoral collaboration to tackle major health and social problems. Specifically, the MOHME has worked with other line ministries to tackle the social determinants of health and associated health priorities in a number of areas: traffic accidents, obesity, HIV/AIDS, mental health, water and sanitation, urban settings and the needs of deprived areas, and community-based initiatives.

In 2007, a situation analysis of the important social determinants of health and health equity in the Islamic Republic of Iran was prepared with technical assistance from WHO. This was updated in May 2008. It includes recent relevant data and has drawn on the most recent work of the very active cadre of Iranian researchers and on current statistical data provided by the MOHME and other ministries and agencies in the government.

The review presented an analysis of the current priorities in the area of social determinants of health and health equity and initiatives in pursuit of the social determinants of health agenda in the country and is seen as critical for the preparation and updating of a strategic plan for social determinants of health and health equity which will be finalized at the end of 2009.

Prioritizing social determinants that need to be tackled through policy and programmatic action is a complex task. Priority areas recognized by different interest groups are not necessarily similar. For example, while researchers may respond by listing their particular areas of expertise, community members may classify their

Box 1. Priority social determinants of health in the Islamic Republic of Iran (2008)

- Geographical inequities among provinces and urban and rural areas
- Socioeconomic status
- Gender, specifically inequities in education and literacy among mothers
- Lifestyle-related determinants, especially those associated with high rates of obesity, traffic accidents, mental health problems and addiction
- Employment setting
- Youth unemployment
- Early childhood development: especially the overlapping issues of residence and low socioeconomic status
- Health services as a barrier to health care

concerns in a much broader framework focusing on the difficulties they encounter in their daily life. The list of priority areas in social determinants of health for inclusion in the strategic plan and in the action plan to be implemented is provided in Box 1.

These priorities are related to those specifically addressed in the Fourth Development Plan, 2005–2009 and identified in the 2003 burden of disease study: malnutrition and healthy eating; traffic accidents; addiction; HIV/AIDS; and mental problems.

There are some differences in human development among the provinces of the Islamic Republic of Iran, specifically between the more developed centre of the country and the less developed border areas, especially in the south-east. Serious inequities in health outcomes at the provincial level, and hence in underlying social determinants, recorded in the areas of child mortality, trained attendance in childbirth, adult literacy and access to safe drinking-water.

Globalization is an important structural social determinant that adversely affects the ability of the government and people to act on social determinants of health and realize greater health equity. Global factors that have affected the Islamic Republic of Iran include years of war, sanctions, international isolation and long boundaries with countries in conflict.

Challenges for the next future are as follows: developing plans of actions for the identified priority areas and integrating these plans in to the primary health care system; designing a national databank for social determinants of health; and developing a national system and tools to measure and monitor health inequities. In this regard, the urban health equity assessment and response tool (Urban HEART) is an example to consider for a national initiative.

2.4 Key health and development challenges and opportunities

2.4.1 Overview

Notwithstanding the substantial progress in providing access to primary health care to nearly all the population in the country, and controlling and preventing the majority of communicable diseases, the Islamic Republic of Iran still faces several health development challenges. The government recognizes most of these challenges, especially as they relate to the health care

financing, expanding access to primary health care and health insurance coverage to 100% of population (especially in the urban and peri-urban areas), and reducing the burden of traffic accidents, and has included them as priorities in the fifth 5-year national development plan (2010–2014), for which operational plans will be developed by the MOHME.

2.4.2 Challenges

Global

- The recent financial crisis and the fluctuations in the price of oil have limited the fiscal space for the government to reform the social sector.
- Climate change may adversely affect national efforts for vector control and may lead to resurgence of some vector-borne diseases. Consequences of climate change such as floods and droughts could also affect agricultural production and increase the potential for humanitarian crises.

Regional

- Having long borders with countries in conflict or with poor socioeconomic conditions, the Islamic Republic of is constantly under pressure to accept refugees.
- Some of the communicable diseases that have been controlled, e.g. polio and malaria, are still prevalent in neighbouring countries and thus there is constant threat of importation of cases.

Political

- The relative isolation of the country during the past three decades and sanctions have limited the transfer of knowledge/technology and contacts of health personnel with their counterparts abroad.
- After the Islamic revolution, a structured welfare state system was created with specific attention to delivering health, education and social assistance. The focus on social rights, equity, and social justice has been a characteristic of the past 30 years. However, general policies influencing the country's socioeconomic status have sometimes risked compromising the effectiveness of the welfare system. The private sector is rapidly emerging in areas normally managed by the public services, and this will have an impact on the welfare of the people and the poor in particular.
- The role of women in political decision-making is still limited.
- Violence (in the streets, at home) has emerged as a serious threat to health and security at various levels.

Demographic transition and urbanization

- Slightly over one third of the population is between the ages of 15–29 years that are affected by several economic, social and cultural problems and are at risk of suffering from major health problems such as violence, tobacco consumption, drug addiction, traffic accidents, sexually transmitted infections and psychological problems.
- The emergence of noncommunicable diseases as a major cause of morbidity and mortality puts added pressure on the social welfare system, delivery of services in terms of long-term

care for those suffering from chronic noncommunicable diseases.

- The population is graying and the need for the care of elderly at domestic and community level is rapidly emerging. During the coming years the focus of the health assistance should move from hospital based to home care, which requires a flexible, social-oriented approach. Nonprofit organizations should play a complementary role to public institutions.
- The rapid increase in populations in urban areas of the country has outpaced the supply of adequate public health facilities.

Social determinants of health

- The Islamic Republic of Iran has taken a lead in the Region in investigating its social determinants of health and several key determinants have been identified. Notable amongst them are regional disparities in health indicators. Developing and implementing appropriate responses, both at policy and programme levels, is a substantial challenge and need to be taken as a priority.
- Social determinants of health-related initiatives need to be integrated into the primary health care system.

Health system

- The primary health care system that was established over 30 years ago, requires upgrading to meet the expectations and needs of the communities in view of the evolving social and economic situation.
- With widespread literacy in rural areas and changes in health priorities, the role of and expectations from community health workers (behvarz) have changed and need to be retooled.
- Access to quality health care remains limited in less developed provinces where health indices are below the national level.
- The quality of services in different health facilities need to improve and patient safety ensured.
- The country has had nearly 25 years experience with integration of medical and allied health education within the health system. It is timely to build on the success of this integration to upgrade the educational and health services to make them fit for the 21st century.
- The family practice model needs to be expanded to give high priority to suburbs and more deprived urban areas.
- The health care financing system like the delivery system is pluralistic and its organization through a number of public and non-public insurance schemes has led to a multiple benefit packages that has created a complex system of co-payments and referral systems.
- Between 5% and 10% of the population has no health insurance coverage, partly due to their inability to pay for the basic insurance coverage after paying for basic necessities. This has led to an increase in out-of-pocket expenditure, from 48% in 1980 to 2001 to 58%. Catastrophic health expenditure affects more than 2% of the population.
- Rigorous evidence-based policy/ programming approaches are generally lacking throughout the government structure. The MOHME with WHO

support has recently initiated the establishment of a health policy unit. This unit should be appropriately staffed and commissioned to provide policy analysis and options for action on pressing health issues.

- A variety of individuals/groups in the MOHME establishments produce health- related information; however, this information is dispersed and often not easily accessible. All this information needs to be brought together in a unified health information system which would then be available for planning, monitoring and evaluation purposes at all levels of the health system. Similarly, a large amount of health research is carried out but no systematic attempt has been made to either disseminate or utilize the findings.
- Due to frequent staff turnover at all levels of health system, the leadership and governance functions have suffered especially in the areas dealing with policy guidance, formulation of sector strategies and specific technical policies, setting priorities, and defining the role of public and private sector and of civil society.
- Decision-making is still highly centralized. 'Decision space' at provincial and lower levels is negligible or nonexistent.

Other challenges

- The approaches to health promotion, prevention and care are still very medically oriented. There is a need to identify all concerned stakeholders and involve them closely in the planning and delivery of health-related services.
- Establishing partnerships among national institutions and with those in countries abroad increases the opportunities to improve technical knowledge, enlarges professional and cultural horizons and paves the way for further improving the health and well-being of the Iranian people.
- Partnership with neighbouring countries is also important for setting up effective strategies against common health problems.
- The considerable potential of Iranian institutions and scientists to contribute to the health development of neighbouring countries remains relatively untapped.

2.4.3 Major opportunities

- The formulation of the fifth five-year national development plan is partially coinciding with the planning for the next UNDAF. There is alignment/ convergence between the possible areas for UNDAF programming and the development plan directives. This can be of benefit for the role of UN agencies including WHO in facilitating the achievement of the national development goals.
- The Islamic Republic of Iran was the only country from the Region to be included in the Global Commission on Social Determinants of Health and a comprehensive national report was prepared in April 2007 and updated in May 2008 with WHO's technical assistance. The enthusiasm generated by this report should be maintained in order to build up a solid evidence base for social determinants of health

and health equity that would lead to formulation of policies and programmes to tackle the priority social determinants of health.

Section 3

Development Cooperation and Partnerships

3.1 Overview

For most of the past 30 years the Islamic Republic of Iran has benefited little from foreign aid, particularly official development assistance (ODA). It received US$ 169 million in net aid in 1996, which fell to US$ 130 in 2000, US$ 115 million in 2001 and US$ 102 million in 2007. These figures represent less than 0.1% of overall gross national income. In 2005, external resources for health as a percentage of total expenditure on health amounted to 0.1%.

International aid, traditionally low for a middle income country with important resources, has declined further during recent years due to the political isolation of the country. Most of the development assistance received has been from or through various UN organizations. Recently the Global Fund to Fight AIDS, Tuberculosis and Malaria started different programmes with MOHME, UNDP and WHO.

3.2 UN agencies

3.2.1 Overview

UNFPA, UNICEF, UNODC, UNHCR, UNDP, UNAIDS and WHO are the main international UN agencies that have provided support in the health or related fields. Other UN agencies present in the country are FAO, WFP, UNESCO, UNOCHA, UNIDO, UNIC, UNAMA, ISDR and IOM. Their collective contribution has been less than 0.5% of the government's spending on health care.

3.2.2 UNICEF

UNICEF has been present in the country since 1963. Its main counterparts are the MOHME and the Ministry of Education. Currently, UNICEF works in the country under a basic cooperation agreement, within the framework of an agreed 5-year programme of cooperation (2005–2009). This programme currently focuses on four main areas: girl's education and women's empowerment; child protection; HIV/AIDS and adolescent-friendly service; and monitoring the Convention on the Rights of the Child.

In 2007, the country budget was just over US$ 3.5 million for programme activities. Recently, UNICEF collaborated with some private Iranian companies for fundraising among corporate donors.

3.2.3 UNFPA

UNFPA collaboration with the Islamic Republic of Iran began in 1970 on a project basis. UNFPA is collaborating with a number of partners in the country, including the MOHME, Statistical Centre of Iran, and a network of some 70 nongovernmental organizations. The current country programme (2005–2009) is the fourth cycle of cooperation, and includes a number of projects to:

- increase availability of high-quality reproductive health services and commodities;
- improve youth-friendly reproductive health information and services;

- improve information and services for sexually transmitted infections and HIV/AIDS;
- increase awareness and capacity in reproductive health, reproductive rights and gender issues;
- strengthen national capacity in disaster preparedness to address reproductive health concerns in emergency and post-conflict situations.

The country programme has envisaged total resources of US$ 10.5 million, of which US$ 9.5 million comes from UNFPA regular sources and US$ 1 million from other sources. UNFPA is also supporting a project for Afghan refugees through its allocations for Afghanistan.

3.2.4 UNODC

UNODC established an office in the Islamic Republic of Iran in 1999 with the purpose of minimizing drug-related crimes. UNODC has close collaboration with the Drugs Control Headquarters, the Ministry of Interior, Judiciary, MOHME and nongovernmental organizations. The Strategic Programme Framework for Iran (2006–2008) is designed to assist the Iranian government in reducing the trafficking of narcotics into, within and outside the country. Also a co-sponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNODC has been particularly active in supporting the comprehensive drug control programme through a variety of activities. Its strategic programme budget (2005–2007) is US$ 23 million aiming at promoting cooperation among all national stakeholders and international donors in line with guaranteeing participation and financial support to drug control and crime prevention projects. In particular, UNODC projects within the country focus on drug supply reduction, drug demand reduction and rule of law.

3.2.5 UNDP

UNDP has had a representative office in the country since 1966 and has worked closely with its major development partners, the government, local councils, civil society, academic institutions and the private sector, to promote sustainable human development in rural and urban communities. UNDP helps the government to meet its commitments to international environmental conventions on combating desertification, protecting biodiversity, reducing greenhouse gases, reducing persistent organic pollutants and eliminating ozone depleting substances. It is also working closely with the government on reducing the impact of natural disasters on economic and social development. The UNDP country programme (2005–2009) focuses primarily on strengthening capacities and capabilities for achieving the MDGs; enhancing good governance; and improving economic performance and employment generation, disaster management and energy efficiency.

For the years 2005–2007, the UNDP country programme received US$ 2.6 million from regular resources, plus US$ 18 million for other resources including GFATM, the private sector, and international agencies. It also received US$ 6.3 million as contributions from various donors at the same period.

The UNDP Resident Representative also serves as the Resident Coordinator of the UN Country Team (UNCT). The Resident Coordinator assumes overall responsibility

for, and coordination of, UN operational activities at the country level, and also follows up with the Common Country Assessment (CCA) and the United Nations Development Assistance Framework (UNDAF).

3.2.6 UNHCR

UNHCR has been present in the country since 1984, with the mandate to lead and coordinate international action of the worldwide protection of refugees and the resolution of the refugee problem. UNHCR has close collaboration with the Bureau for Aliens and Foreign Nationals Affairs (BAFIA), the Ministry of Interior and the MOHME.

UNHCR expanded its presence and scope of activities with the massive influx of Iraqi refugees following the Gulf War in 1991 and the start of mass return movement to Afghanistan in 1992.

In 2004, BAFIA assumed responsibility for management of Afghan and Iraqi refugee camps, and UNHCR's assistance programme was largely phased out. UNHCR's current main objectives in the country are as following:

- Enhancing the international community's awareness and recognition of the Iranian authorities' three-decades-old hosting of refugees;
- Working with the government to strengthen the protection of Afghan and Iraqi refugees and the asylum environment;
- Supporting the voluntary repatriation of registered Afghan and Iraqi refugees as appropriate;
- Providing targeted assistance to Afghan and Iraqi refugees with specific needs to enhance their self-reliance, allowing them to rebuild their lives upon return home;
- Encouraging the Iranian authorities to use bilateral channels with the Government of Afghanistan to discuss the management of migration issues.

In order to provide the target population with above mentioned support, US$ 13.6 million in 2008 and US$ 14 million in 2009 were allocated to programmes in UNHCR.

3.2.7 UNAIDS

The UNAIDS Secretariat is currently focused on facilitating inclusive, country-driven processes for scaling up HIV prevention, treatment, care and support with the aim of coming as close as possible to the goal of universal access to treatment. In this regard, priority objectives were recently identified as follows.

- Strengthening national capacity on strategic information and analysis including country capacity in resource tracking/allocation
- Sensitizing policy-makers about HIV/AIDS prevention and control and contributed to removing punitive laws, policies and practices, stigma and discrimination that block effective responses to AIDS
- Increasing coverage of care among people living with HIV through enhancing social protection for people affected by HIV
- Strengthening national infrastructure for a timely, harmonized and targeted response to HIV/AIDS in a broader context of partnership

- Controlling sexual transmission of HIV
- Providing required treatment and effective follow-up for people living with HIV especially women and children

3.2.8 World Bank

The International Bank for Reconstruction and Development (IBRD) has long been interested in supporting the health sector. IBRD has been the primary lender to the Islamic Republic of Iran. The last loan agreement between the IBRD and the government was signed in June 2005 for the amount of US$ 120 million. The purposes of the loan were water sustainability and quality and improving agricultural productivity.

3.3 United Nations Development Assistance Framework

The UNDAF is the planning framework for the development operations of the UN at country level. It provides a collective, coherent and integrated UN system response to key national priorities and needs, as set out in the CCA, and within the framework of the MDGs and the Millennium Declaration. The Framework consists of common objectives and strategies of cooperation, a programme resources framework and proposals for follow-up, monitoring and evaluation. The updated UNDAF for 2011 will address areas of emphasis in the fifth 5-year national plan (2010–2014)

Preparations for developing the UNDAF for the period 2011–2015 commenced in 2008 with commissioning of a country analysis study and the convening of several consultations. This resulted in the identification of challenges that were grouped according to common root challenges, yielding three potential focus areas of UN support in the coming four years.

- Supporting governance and national institutions.
- Supporting development of socioeconomic equity
- Supporting knowledge and innovation for sustainable development

For each of the above three main areas, several challenges were identified for UNDAF programming. Some of the challenges related to health (directly and indirectly) include the following.

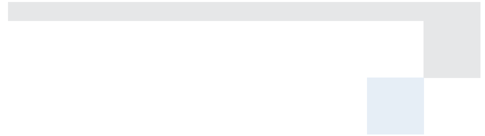
- The quality of disease prevention and control
- Access to quality health services
- Prioritization of policy and implementation plan for disaster risk management
- Coordination for disaster management
- Targeted policies and action plans for vulnerable groups in disaster management
- Social and economic problems of youth
- Gender equity
- The social security and social welfare system
- Environmental education and awareness
- Integrated and evidence based policy and programming

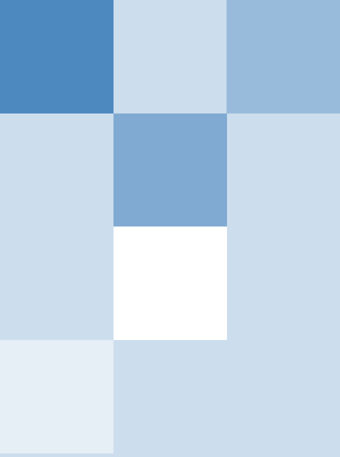
3.4 Aid flow in emergency situations

Unlike the foreign aid for development, the aid received on a humanitarian basis is comparatively significant given the high level of risk and vulnerability to disaster. In the past few years, emergencies have included

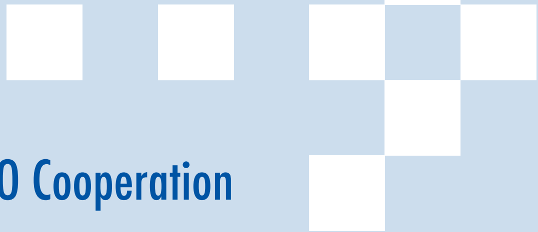
earthquakes in Ghazvin, Avaj and Bam, two instances of flooding in the northern part of the country and chronic disaster conditions such as drought and conflict in two neighbouring countries. These events generated considerable support, including financial support. Consequent to the earthquake in Bam city and surrounding villages on 26 December 2003, the assistance of the international community, both at bilateral and multilateral levels, was speedy and significant. In response to the UN Consolidated Interagency Appeal, US$ 16.9 million was made available, In addition, US$ 95 million was committed by different bilateral and multilateral agencies.

In May 2007, three and half years after the Bam earthquake, a regional centre to reduce the damage from such seismic threats was launched by the government and the United Nations unit focused on disaster mitigation. The Asian Centre on Seismic Risk Reduction aims to build awareness and provide training in order to improve construction urban planning standards, develop appropriate early warning systems and enhance disaster management and encourage a culture of safety. Through these efforts, it will encourage regional and interregional networking and partnerships to reduce seismic damage. Earthquakes are responsible for 73% of the deaths and 51% of the economic damage caused by all natural disasters in the Region.





Section 4



Current WHO Cooperation

Section 4. Current WHO Cooperation

4.1 Overview of past WHO cooperation

The partnership between WHO and Islamic Republic of Iran started in 1955. The present WHO Representative's Office was established in 1984 in the old building of the MOHME. In September 2004 it moved to its current location in the main building of MOHME.

The broad objective of the partnership is to promote the health and well-being of the population. WHO provides extensive technical and information support to the national health programmes and to emerging health issues. The budget (regular and other sources) allocated to the country is planned and programmed through a biennial joint programme review and planning mission (JPRM) comprising WHO and national team members.

The priority areas of the WHO–MOHME collaborative programmes during 2006–2007 and 2008–2009 focused on health policy and health services improvement; combating HIV/AIDS, malaria, tuberculosis and other communicable diseases; sustainable development for health including community-based initiatives; social determinants of health and health equity; emergency preparedness and humanitarian action; prevention and control of noncommunicable diseases and injury prevention; health technology and quality of medicine.

Six directions of the first CCS 2005–2009 guided WHO in addressing the health and development challenges (Table 4). During the 2006–2007 biennium, these strategic directions were the basis for identifying country priorities and supporting 39 workplans within the framework of regional programme areas. In the JPRM 2008–2009, 42 workplans were elaborated within the strategic directions of the CCS.

Capacity-building, both in the country and outside, accounted for 60% of the total budget. Iranian expertise is increasingly mobilized and strengthened to help in managing collaborative programmes. External consultants are used only if national expertise is not available, and this has helped in upgrading national know-how and in building capacity.

The country office was involved extensively in coordinating the Intergovernmental Negotiating Body at regional level to draft the WHO Framework Convention on Tobacco Control and in evaluation and validation of community-based initiatives. WHO was also engaged in the development of a proposal for submission to the Global Fund to fight AIDS, Tuberculosis and Malaria. WHO jointly with MOHME developed and submitted a proposal for tuberculosis and malaria in 2007 (Round 7) which was approved. WHO has been acting as a sub-recipient of this grant. The implementation of this project was put into effect from October 2008.

WHO as a collaborating partner with the World Bank agreed to assist in the implementation of the health sector reform

Table 4. Working budget for each strategic direction in the CCS for 2006–2007 and 2008–2009

Strategic directions in CCS	2006–2007 working budget (US$)	Revised strategic directions in CCS after review	2008–2009 working budget (US$)
Promoting health as central to sustainable human and economic development	403 250	Promoting health and welfare as central to sustainable human and economic development	260 771
Enhancing leadership capabilities for reforming the health system	1 397 579	Enhancing leadership and managerial capacities for reforming the health system	1 031 925
Applying risk management approaches for effectively dealing with behavior related disorders and conditions	465 293	Applying risk and disease management approaches for effectively dealing with the disorders and conditions related to behaviour, occupation and environment	530 000
Addressing the unfinished and emerging agenda for communicable diseases	346 551	Addressing the unfinished, neglected and emerging agenda for communicable diseases	1 721 729
Promoting a culture of research and technological development	630 663	Promoting technological development and a culture of research	98 000
Strengthening institutional mechanisms for emergency and humanitarian action for health	763 336	Strengthening institutional mechanisms for effective management of trauma, emergencies and humanitarian action	203 124

subcomponent of the World Bank-assisted second primary health care and nutrition project (2004–2006).

During 2007–2008, the country office in consultation with the Regional Office and headquarters carried out a comprehensive country cooperation review. The main purposes of the review was to improve the quality of cooperation between WHO and Islamic Republic of Iran and the contribution of WHO to national health agenda based on the priorities identified during the first CCS in 2005. The salient findings of the review are given section 4.4.

WHO is also playing a major role in introducing good manufacturing practices in local vaccine production through capacity building in the national regulatory authority and national control laboratory.

Also as part of its collaboration, WHO is supporting the government in monitoring environmental health, communicable disease surveillance and revival of the city and district health infrastructure as part of health system development and one component of community-based initiatives, i.e. the healthy city programme.

WHO collaboration with the government has multidimensional aspects, therefore health improvement requires multisectoral collaboration. The main collaborating partner of the WHO country office continues to be the MOHME. Since the health equity and tackling social determinants are considered priorities of both WHO and the government, it is anticipated that as an outcome of the CCS, new meaningful and productive partnerships will be developed between WHO, ministries and nongovernmental organizations of other sectors whose responsibilities and work contribute to health development. WHO has designated 11 research and training centres as collaborating centres.

4.2 Partnership with UN and other development partners

The country office has remained a key and influential partner among UN agencies and other development partners in driving the national health and development agenda forward. The country has benefited from its support in partnership and coordination of resources.

Since December 2005, WHO has been the Chair of the UN Theme Group on MDGs, leading and coordinating the implementation of the health-related MDGs and monitoring their progress. In addition WHO has has been a member of other UN theme groups such as those on gender, HIV/AIDS, good governance and human rights, disaster management, sustainable development, food security and security management over the CCS period.

As part of UN system, WHO played a key role in the formulation of the CCA and in the development and implementation of the UNDAF 2005–2009. During the earthquake in Bam 2003, WHO successfully coordinated health cluster operations during the rescue, relief, recovery and rehabilitation phases. WHO collaborated with UNDP and FAO to effectively manage the epidemic of avian influenza in some parts of the country and provided continuously updated information at the national, regional and global levels.

Since its inception, the WHO country office has largely limited its collaboration to the MOHME. At present, communication with other sectors, ministries and nongovernmental organizations is required to be channeled through the International Relations Department of MOHME, which makes the process long and excessively bureaucratic. Although the MOHME should continue to be the main counterpart, establishing direct partnerships and joint activities with other stakeholders should also be considered in order to address health needs and response in a comprehensive way.

4.3 Country office resources

Human resources at the level of both professional and support staff in the WHO country office are insufficient to meet the requirements and expectation of the national authorities.

The WHO country office has been accommodated in new premises within the recently constructed MOHME building, which is more spacious to accommodate staff and visitors. The office is equipped with telecommunication equipment including desktop and laptop computers, servers, routers, radio base stations, mobiles and local and wide area network equipment. Continuous upgrading will be necessary for both hardware and software in order to meet the office requirements in near future. Other IT equipment may also be needed for the office to retain functionality with WHO systems. In-depth needs assessment will be conducted to identify the exact IT requirements for the next few years.

4.4 Strengths and weaknesses of WHO cooperation: achievements and key opportunities

The WHO country cooperation review carried out during 2007–2008 found that WHO was seen as a technically credible partner and good and honest broker for the government in health policy and health systems development. WHO enjoys the wide confidence of all stakeholders and is in a position to facilitate the government's coordination of development partners. WHO's health leadership role during crisis situations, as manifested during the earthquake in Bam, has been well recognized by the government and partners.

As part of the review, achievements resulting from WHO collaboration in the six priority areas identified during the first CCS were identified and are described in detail in the report of the review. Some of WHO's significant contributions to national health development include the following.

- WHO has played an important role in promoting health for sustainable human and economic development in underprivileged areas. With WHO's support, the country has expanded community-based initiatives in 19 provinces and incorporated the recommendations of the Commission on Macroeconomics for Health into the national development plan.
- WHO has remained an honest broker and close partner of the government in health policy and health system development. It supported the establishment of an effective Health Policy Unit in the MOHME and was influential in channeling World Bank support towards health sector reform.
- With the support and guidance of WHO, the introduction of a surveillance system for risk management enabled the government to formulate evidence-based health policies and plans to respond to the changing demographic epidemiological and environmental context in the country.
- With WHO's steady technical and financial support, the Islamic Republic of Iran has remained polio free since 2003 and has sustained routine immunization coverage of more than 95%, which is appreciably higher that

coverage in some countries with similar socioeconomic conditions.

- WHO's leadership role in health action in crises has been well recognized by the government and partners alike.

Some of the perceived weaknesses were as follows.

- Lack of proper attention and effective programmes on health policy and system development, particularly after the end of World Bank reform project.
- Lack of full utilization of health research studies and WHO collaborating centres.
- Need for spreading the limited resources of the Organization among many programme areas.
- Frequently weak quality of international and local consultancies, with limited impact on programme development.
- Bureaucratic nature and lack of flexibility of the Organization with regard to administrative and financial issues, negatively affecting its effectiveness and efficiency.
- Scarce opportunities for country office staff to improve their technical and functional capabilities in their field of work.

4.5 Challenges

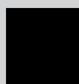
Collaborative workplans, expected results, activities and sub-activities need to be reduced in number and improved in quality. A smaller number of WHO interventions should be selected, strictly linked with the CCS strategic lines. Proper planning, monitoring and evaluation of the activities should be implemented in order to ensure their quality.

Headquarters, the Regional Office and the country office need to organize updated rosters for international and Iranian consultants. In this regard, a critical review of the selection process should be undertaken, identifying criteria which can assure the quality of consultancies. The contribution of the WHO local and international consultants should be properly evaluated. The reports of the WHO consultants should be utilized introducing changes and improvements into the work practice. Mechanisms to facilitate this process should be implemented.

Management and administrative procedures need to be more flexible and more opportunities for training are needed for country office staff.

Section 5

Strategic Agenda for WHO Cooperation



5.1 Guiding principles for WHO at country level

The guiding principles and overall policy framework for work of WHO are set out in the 11th General Programme of Work (GPW) for the period 2006–2015, in WHO Medium-term Strategic Plan (2008–2013) and in the statement of regional priorities

Analysis of the 11th GPW shows several areas of unrealized potential for improving health, particularly the health of the poor. The gaps are identified in areas of social justice, responsibility, implementation and knowledge. WHO's response is translated into priorities in the following areas according to its results-based management framework.

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

The Medium Term Strategic Plan translates the 11th GPW's long-term vision for health in to 13 strategic objectives, reflecting country priorities (particularly those expressed in country cooperative strategies) and provides the basis for detailed operational planning. The Strategic Objectives provide clear and measurable expected results of the Organization.

The structure of WHO secretariat assures involvement with countries, with headquarters focusing on issues of global concern and technical back stopping. Regional offices focus on technical support and building national capacities. WHO's presence in the countries allows it to have a close relationship with the ministries of health and with its partners inside and outside the government. The Organization also collaborates closely with other bodies of the UN system and provides channels for emergency support.

WHO is operating in an increasingly complex and rapidly changing landscape. The boundaries of public health action have become less clear and now extend into other sectors that influence health opportunities and outcomes. Supported by the work of WHO Commission on Determinants of Health, the importance of economic, social and environmental determinants of health has grown enormously.

5.2 Strategic priorities for WHO support

The strategic priorities for WHO support were derived from a careful situation analysis, summarized in section 2, taking into account the key health and development challenges being faced by the country as analysed by the WHO CCS team in full consultation

with senior officials in the MOHME, other stakeholders and partners at the country level. The proposed strategic priorities are considered to be fully in alignment with the national priorities for health as given in the fifth five-year national development plan and are in accordance with the Medium Term Strategic Plan as well as with regional priorities.

The CCS team also felt that during the coming years, WHO should concentrate its efforts and resources to intervene on a few principal areas, disregarding numerous minor interventions dispersed in a wide range of health fields where the WHO comparative advantage is not clearly demonstrated.

The strategic priorities are as follows.

- Improving health equity and social determinants of health
- Strengthening primary health care
- Achieving universal coverage and improving equity in health care financing
- Improving leadership and governance
- Strengthening health security
- Managing the demographic and epidemiological transition
- Strengthening partnership for development.

5.2.1 Improving health equity and social determinants of health

It is important that social protection systems are designed such that they are universal in scope for population's health in general and the health of the lower socioeconomic groups in particular. Universality means that all citizens have equal rights to social protection. In other words, social protection is provided as a social right rather than as charity. In this respect WHO support will focus on the following areas.

- Promote actions on the social determinants of health and health equity in line with the recommendations of the WHO Commission on Social Determinants of Health.
- Collaborate with the government to further consolidate the welfare system, in line with social values of the country, in order to achieve equity. Social protection should be further improved including food, clothing, housing, health and medical care and necessary services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livlihood in circumstances beyond individual control.
- Support government reforms aimed at developing safety nets for poor and vulnerable groups. Particular interest should be paid to developing alternative solutions to government subsidies such as cash transfer. Interim arrangements should be made until alternative solutions are fully operational. Safety nets for the poor and vulnerable groups should be developed in a sustainable and equitable way.
- Support government efforts to enhance investment in health development mainly through increasing public spending in order to reduce the burden on individuals and households. MOHME capacity would be strengthened to formulate strategies for addressing the underlying social and economic determinants of health through policies and programmes that enhance health and equity and integrate pro-poor, gender-responsive and human rights-based approaches. More specifically

WHO should support the Iranian institutions and particularly the MOHME in strengthening the public sector leadership based on the principle of social justice, participation and intersectoral collaboration.

- Facilitate the development of a national surveillance system to monitor health inequities and social determinants of health and to evaluate the health equity impact of policy and actions. The efforts through the Urban HEART project and other community-based initiatives should be further supported and extended to national level in order to generate additional information and to implement evidence-based interventions to reduce inequities and address determinants of health.
- Support efforts aimed at expanding literacy, particularly among women.

5.2.2 Strengthening primary health care

The government needs to be supported in its efforts to upgrade the primary health care system to meet the expectations and needs of the communities in view of evolving social and economics situation. In this respect WHO support will be directed to the following areas.

- Assist the MOHME in developing family practice in urban areas and instrengthening family practice in rural areas through retooling of community health workers (*behvarz*).
- Improve the quality of health services and patient safety.
- Integrate the social determinants of health approach at community level.

5.2.3 Achieving universal coverage and improving equity in health care financing

The focus of WHO support will be on the following areas.

- Provide technical support to the MOHME and other involved institutions in order to achieve universal health coverage and promote reform of the health care financing system through harmonization of the various benefit packages, rationalization of co-payments, elimination of balanced billing and introduction of incentives for providers to contain costs.
- Facilitate the extension of coverage to the population currently uninsured.
- Support the development of the family practice model at primary health care level for the insured population.

5.2.4 Enhancing capacities for health leadership and governance

The capacity of MOHME in various functions of the health system including policy analysis, health planning and management, formulation of evidence-based policies and strategies, health financing and the health information system will be strengthened. WHO collaboration will focus on the following areas.

- Strengthen the health policy unit within the MOHME and its links to the other relevant bodies involved in strategic health policy and planning (universities, research institutions, health commission of parliament, etc.).
- Support the establishment of a national health policy forum involving all the main stakeholders in the health sector.

- Promote the increased use of analytical tools, e.g. national health accounts, burden of disease assessments and cost-effectiveness analysis of various public health interventions, for strategic planning.
- Strengthen the regulatory capacity of the MOHME in areas such as standard-setting, accreditation, public–private partnership and better management of dual practice.
- Improve the performance of health facilities at the primary level, by strengthening family practice in rural areas and extending it in the urban areas, and at secondary and tertiary care level, through use of economic and managerial tools and principles in health management of hospitals.
- Assist the MOHME in developing expertise in health technology assessment.

5.2.5 Strengthening health security

According to the global and regional threats which are affecting the health of the Iranian people, WHO collaboration will be focused on the following activities.

- Improve cross-border coordination, particularly for communicable disease control (e.g. polio, malaria, tuberculosis, HIV/AIDS).
- Coordinate and strengthen the surveillance system (emerging and re-emerging diseases) including the use of forecasting and predictive techniques.
- Strengthen implementation of the International Health Regulations.
- Continue supporting the vaccine development programme, strengthening the national regulatory authority, implementing the prequalification process and supporting vaccine producers in meeting GMP requirements.
- Assist the MOHME in developing its capacities for preparedness and response to natural and man-made disasters.

5.2.6 Managing the demographic and epidemiological transitions

In view of the current high proportion of youth and emerging ageing population and the epidemiological transition resulting in a higher burden of noncommunicable and chronic diseases, WHO will focus its support in the following areas.

- Support the MOHME in assessing health needs and challenges faced by the adolescents and young people to achieve their full potentials in the society. Promote proper strategies and the adoption of healthy lifestyles and avoidance of policies and risky behaviours leading to road traffic injuries, drug addiction, sexually transmitted diseases, violence and other public health threats for young people.
- Promote the health and well-being of the elderly population and their social integration in communities, facilitating the development of community-based health care programmes.
- Facilitate the wide implementation of strategies for the prevention and care of noncommunicable diseases particularly those found to be most prevalent in the country (e.g. mental health, cardiovascular diseases, diabetes).
- Strengthen MOHME programmes for

improving the health and well-being of women throughout their life cycle, including programmes aimed at further reducing the existing subnational disparities in maternal and neonatal mortality rates.

5.2.7 Strengthening partnership for health development

Collaboration within the country among different health stakeholders (public, non-profit and private sectors) and partnership with other countries increases the opportunity to improve technical knowledge and enlarge professional horizons. The link with abroad is particularly relevant to the Islamic Republic of Iran, as its academic and research institutions and their staff have been relatively isolated during the past couple of decades. Partnership with neighbouring countries is also important for setting effective strategies against common health problems and preventing the importation of diseases already under control.

WHO will support the MOHME using the following strategic approaches.

- At the national level, extend technical support to the MOHME in organizing and convening national health forums whose participants would include the stakeholders in the health sector, notably academia, professional associations, nongovernmental organizations, civil society organizations, private sector and representatives of the clergy.[10]
- At the regional level, facilitate the development of cross-border activities to limit the spread of communicable diseases, and promote the utilization of Iranian institutions and experts for providing technical assistance to countries in the Region in the spirit of South–South cooperation.
- At the international level, assist Iranian scientists and institutions in linking up with international networks of affiliated institutions and scientists throughout the world through promoting technical partnerships and twinning initiatives. health needs and challenges faced by the adolesc

[10] In the 1980s, synergy between the clergy and the health sector was extremely successful in promoting family planning, resulting in a considerable decline in fertility and population growth rates. That experience could be a model for further future involvement of the clergy.

Section

6

Implementing the Strategic Agenda:
Implications for WHO

Section 6. Implementing the Strategic Agenda: Implications for WHO

The Islamic Republic of Iran, in regional terms, enjoys a significantly developed health sector and is endowed with sufficient high quality medical and public health skills and specialists. The country has a well known primary health care system with a successful track record and a wealth of experience. However, the country continues to face formidable health challenges, especially in view of demographic changes resulting in higher health care expectations and demands. In this respect, WHO has a unique catalytic role in facilitating the initiatives, innovations and programmes that are needed to update and maintain the reputation of the health sector. In addition, WHO in the past has played an effective role in connecting health professionals and national health programmes to regional and global health networks and academia. As well, WHO has provided specialized technical support in high priority public health areas. These three types of support should continue to characterize WHO collaborative efforts in the next coming years.

6.1 Implications for the country office

The CCS has given very high priority to health systems development. This will entail provision of special support by WHO for health system development. Th capacity of the WHO country office to provide such specialized technical assistance should be upgraded. This may include assigning high-level national or expatriate specialists on a long-term or short-term basis. In view of the paucity of professionals experienced in health care financing in middle-income countries, the Regional Office and headquarters should provide the necessary technical support through periodic visits.

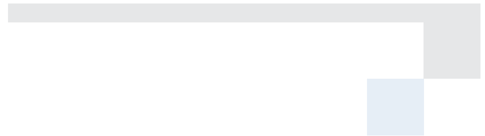
The other priority area requiring sufficient resources and capability is support for national projects, studies and initiatives that relate to social determinants of health. In view of existing and emerging urban health and social concerns, such as health equity, air pollution impact on health, health security in cities, expertise in social sciences such as sociology, urban demography, rural urban migration and behavioural sciences will be needed to respond to these issues. Similarly these types of input may be required for WHO to assist in matters relate to healthy lifestyles and environment. The current urban primary health care and Urban HEART initiative that has been started may also be supported through these skills. National expertise in such areas is available and could be utilized to help the programme in terms of timeliness and efficiency. The office is well staffed and equipped with necessary IT equipment and complies with WHO criteria for safety and functionality.

6.2 Implications for the Regional Office and headquarters

The attention of the CCS mission was drawn on several occasions to delays in recruiting consultants and marginal contributions to improving the performance of the health system. Due to prevailing geopolitical conditions, the Regional

Office should have a medium-term rollover roadmap for technical backstopping for priority areas such as health system development, social determinants of health, etc. These strategic roadmaps should be clearly synchronized with the country office and national authorities. In view of difficulties in recruiting high-level consultants, key technical staff from the Regional Office and headquarters need to continue to visit to provide the necessary technical input.

The Regional Office and headquarters are expected to support the networking between Iranian health academia and experts with regional and global counterparts. For many years this interconnectivity has been viewed as a priority by the Islamic Republic of Iran. Furthermore the Regional Office and headquarters are expected to help in knowledge management and health documentation and communication.



www.emro.who.int