

Vision Four

Promoting Woman and Child health

Domain Twenty One

Woman Health

Vision: Promoting Woman and Child Health

Goal: Improving Health Care Provided to Women and Children

Domain: Woman Health

INTRODUCTION:

Since the Renaissance, Ministry of Health has committed to promote the health and development of the Omani citizens. Under this objective MoH has put the basis for basic and specialized health components in its place. Health services in Oman have developed dramatically in quantity and as well as quality. Now, 96% of population has accessibility to universal health care at primary health care level and specialized care at secondary and advanced care at tertiary level. This is as a result of well-organized and integrated health care system and further to decentralization of primary health care services and establishment of autonomous hospitals.

Women represent half the community and are important human resource. God has blessed women with special gift of giving birth to babies and ability to breast-feeding. In addition, they are the institution of care and builder of the new generation who subsequently will take the responsibility of building healthy and productive community.

As high as 26.5% of the total Omani population is females in the reproductive age (15-49). Women being an important section of the population, Ministry of Health (MoH) pays special attention to women's health. MoH has adopted a lot of policies and strategies to promote women's health such as, integrating all health component for mother, ensuring safe motherhood and providing several other health services.

Review of health indicators for the year 2005, pertaining to women's health have shown a great improvement in the health services provided to mothers, like Ante-natal coverage reaching to 99.4 % and birth attended by supervised medical attendants to 98 % (MoH data 2005). In addition, the Maternal Mortality Ratio has dropped to 15.4 per 100,000 live births (MoH data 2005), which is lower than many of the international and surrounding countries. This ratio reflects the progress, development and improved health quality of maternal services.

Rising rate of education and age of marriage amongst Omani females together with provision of birth spacing (BS) services by the Ministry of Health has encouraged the community to adopt it and thus has succeeded in achieving the balance between reproductive attitudes and healthy practices and has also contributed to built suitable environment to support Omani families. BS programme has succeeded in reducing Total Fertility Rate (TFR) from 6.9 births in year 1993 to 3.14 in year 2005 (MoH estimates) though it is still somewhat high in comparison to average TFR for women in the part of the world.

In spite of continued efforts of MoH to improve women's health, health indicators show that high risk patterns in the reproductive age and attitudes like pregnancies in younger and older age group still persist which need greater effort and encouragement at making them to use birth spacing methods. Furthermore, there is a slow decline in the anemia rate amongst pregnant women, since last 5 years (2000-2005) it has only decreased from 36.5% to 33.1 %, which indicates need to study its causes, further. Also, MoH Statistic shows an increase in the percentage of inpatient maternal morbidity from 9.4% in 1996 to 11.1 % in 2005.

A study on knowledge, attitudes and practices of adolescents on reproductive health issues carried in the 2001 showed that 80% of females supported female circumcision and, another regional study showed that the percentage of circumcised Omani female children (less than 3 years) was 100% in some willayats, which is a matter of concern.

The Population Pyramid in 2005 shows that about 6 % of population is of females beyond reproductive age. This percentage will increase, taking in account the current life expectancy, which is around 75 years for females. This age group usually faces a lot of medical problems most of which start by the end of the reproductive age. Post reproductive problems in women affect the quality of life and necessitate providing special services for them like, regular medical check up for prevention and early detection of diseases such as osteoporosis, breast and cervical cancer etc, that warrant conducting studies and providing data on the causes and morbidity amongst this age group.

For all above challenges and taking into the account the recommendation of international conferences on reproductive health and Oman's obligation to international convention and its principles to improve the woman health in all stages of her life, the objectives, goals and strategies of the 7th five-year plan (2006-2010) have been put in place.

OBJECTIVES :

- 1- Reduction of morbidity and mortality rates among women in the reproductive age.
- 2- Improving the healthy reproductive attitudes in the community.
- 3- Improving health care provided to women in the post reproductive age.

OBJECTIVES' INDICATORS:

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
First Objective's Indicators: Reduction of morbidity and mortality rates among women in the reproductive age			
1- Maternal Mortality Rate (Per 100,000 live births).	16.1	15.4	10
2- Still birth Rate (Per 1000 births).	10	9.1	6

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
3- Abortion Rate (Per 1000 women from 15-49 years).	11.9	9.2	8
4- Crude birth rate (per 1000 population).	32.58	24.75	22
5- Maternal Morbidity Rate (outpatient attendance per 10,000 women 15-49 year's age).	0.5	0.6	0.4
6- Percentage of anemia between pregnant women.	36.5%	33.1%	25%
Second Objective's Indicators: Improving the healthy reproductive attitudes in the community			
1- Percentage of women who have birth at interval more than 3 years.	32.7%	39.1%	45%
2 - Couple years of protection (CYP).	18762	25554	30000
3- Percentage of young pregnant women (less than 20 years).	7.5%	4.14%	3%
4 - Percentage of elderly pregnant women (more than 35 years).	17%	14.14%	13%
5 - Number of registered cases in infertility clinic in health institutions.	Not applicable	1116	1200
6 - Total fertility Rate.	4.7	3.14	2.9
Third Objective's Indicators: Improving health care provided to women in the post reproductive age			
1- Percentage of women in the menopause who are benefited from menopausal clinics.	Services are available but not organized (Data not available)	Programme is under development	60% of menopausal women

STRATEGIES:

Strategies to Achieve 1st objective: Reduction of morbidity and mortality rates among women in the reproductive age
<p>1-1- Providing Health Institutions with necessary items, training of medical staff and, encouraging women on early registration in the Antenatal clinic and on regular follow up according to New Ante-natal System.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Increase number of early detection of the cases with complication during pregnancy delivery and puerperium. ▪ Reduction in percentage of complication of pregnancy and delivery in high-risk cases. ▪ Increase in the percentage of women registered in first three months of gestation; and women who make visit in the last four weeks before delivery. ▪ Improve the quality of services provided to women during pregnancy and puerperium.

1-2- Supporting delivery services through providing staff and expertise in the hospitals and health centers; expanding the delivery services in the primary health care institutions; and implementing quality assurance standards.

Expected results:

- Increase in the number of birth attended by medical supervision.
- Decrease in the number of cases with risk factors during labour.
- Reduction in Still Birth Rate.
- Reduction in the number of emergency to elective caesarean sections.

1-3- To conduct campaigns on the mode of transmission and prevention of sexually transmitted diseases; Provision of counseling services and early treatment to reduce the sexually transmitted disease in mothers.

Expected results:

- Reduction in the percentage of mothers getting sexually transmitted infection.
- Increase in percentage of women that are aware about prevention of sexually transmitted diseases.

1-4- Monitoring and evaluating the causes of maternal deaths through strengthening notification systems and implementing the recommendations of maternal mortality committee.

Expected results:

- Reduction in the maternal mortality ratio.
- Improvement in the health services provided for mothers.
- Availability of data about causes of maternal death.

Strategies to Achieve 2nd objective: Improving community reproductive attitudes

2-1- Strengthen health education and media activities; encourage participation of other sectors and community members especially males; provide counseling clinics; expand and improve counseling on reproductive health and birth spacing methods especially so for long acting methods.

Expected results:

- Presence of high percentage of community members who have knowledge about reproductive health.
- Reduction in the percentage of high-risk pregnancies.
- Reduction in percentage of newborn babies with congenital anomalies.
- Reduction in maternal morbidity and mortality.

2-2- Strengthen birth spacing services by Developing / expanding Birth Spacing Clinics; provision of trained staff and uninterrupted provision of birth spacing methods.

Expected results:

- Reduction in the maternal morbidity.
- Increase in the number of clients benefited from the services.

2-3- Training primary health care staff and provision of services in the secondary care level to improve infertility services.

Expected results:

- Increase in the number of clients benefited from the infertility clinics.

2-4- Study the prevalence of female circumcision in the sultanate; design programmes for the community awareness on the subject and encourage participation of the community and other related sector's on the same.

Expected results:

- Availability of base line data on female circumcision.
- Put advocacy plan, in cooperation with other related sectors regarding awareness on female circumcision and its complication.

Strategies to Achieve 3rd objective: Improving health care provided to women in the post reproductive age

3-1- Conduct special clinics (some days in a week) to provide health services for women in post reproductive period, including provision of counseling services; provide trained staff, laboratory and radiological services.

Expected results:

- Increase early-detection of cases of cancers, osteoporosis, diabetes and hypertension.
- Increase in the percentage of clients satisfied with the services.
- Improvement in the quality of life of female of this age group.

3-2- Activate the participation of Women associations and willayat health committee's in supporting awareness programmes for female in the post reproductive age; and train health educators on this aspect.

Expected results:

- Adoption of Awareness programmes by willayat health committees.
- Awareness of community on post reproductive health problems.
- Improvement in quality of life in this age group.
- Reduction in the morbidity rate among female in the post-reproductive age.

3-3- Provision of data on post reproductive age women.

Expected results:

- Availability of data regarding female in the post-reproductive age.

STRATEGIES' INDICATORS :

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Indicators of Strategies of the 1st Objective			
1-1-a- Percentage of trained doctors on pregnancy, delivery and puerperium.	By the end of the plan	56.9%	80%
1-1-b- Number of trained Omani midwives on pregnancy, childbirth and puerperium.	By the end of the plan	167	200
1-1-c- Number of trained Health educators on the Mother's Health issues.	By the end of the plan	116	135
1-1-d- Number of trained community support group member on Mothers Health issues.	By the end of the plan	1707	100% of volunteers
1-1-e- Percentage of women making at least one ANC visit in last 4 weeks of pregnancy.	Annually	74.1%	80%
1-1-f- Percentage of anemia in pregnancy.	Annually	33.1%	25%
1-1-g- Percentage of pregnant women registered in 1st trimester of gestation.	Annually	65.5%	75%
1-1-h- Percentage of pregnant women visited the postnatal clinic at 6 weeks from delivery to registered pregnant women.	Annually	70 %*	85%
1-1-i- Percentage of pregnant women at delivery that are at low risk and have made 4-6 ANC visits.	Annually	New indicator	80%
1-1-j- Ratio of Post-Natal visits made to registered pregnant women.	Annually	1.29 per visit	1.4 per visit
1-2-a- Percentage of deliveries occurring under medical supervision.	Annually	98%	More than 98%
1-2-b- Percentage of type C health institutions.	By the end of the plan	9.6%	10%
1-2-c- Percentage of health institutions with ultra sound machine.	Annually	31.7%	35%
1-3-a- Percentage of pregnant women with syphilis	Annually	0.15%	0.1%
1-3-b- Number of Maternal death	Annually	12	< 10
Indicators of Strategies of the 2nd Objective			
2-1-a- Percentage of Primary Health Care (PHC) institutions with room with privacy for counseling.	Annually	44.9%	55%
2-1-b- Percentage of new users of Birth Spacing methods.	Annually	23.3%	30%
2-1-c- Percentage of PHC Institutions with a trained male staff on BS counseling.	By the end of the plan	New indicator	50%
2-1-d- Number of health projects on Birth Spacing Programme that are adopted by health committees.	Annually	New indicator	10

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
2-1-f- Percentage of users of modern methods birth spacing of during 1st year following delivery.	By the end of the plan	25% **	35%
2-2-a-Prevalence of B.S method use (new and traditional) between women in reproductive age.	By the end of the plan	32% ***	40%
2-2-b- Number of BS services users (women) in the reproductive age by age and method used.	Annually	New indicator	Will be calculated according to baseline data
2-2-c- Number of Doctors trained on BS programme (18 hours course).	Annually	42	50
2-2-d- Percentage of PHC Institutions, which provide IUCD.	Annually	49.2%	60%
2-2-f- Number of PHC Institutions, which have shortage of any B.S methods.	Annually	New indicator	0
2-3-a- Percentage of PHC Institutions that provide services for semen analysis.	Annually	66%	75%
2-3-b- Number of PHC Institutions that offer expanded infertility services	Annually	7	10
2-4-a- Availability of a baseline data on female circumcision in the sultanate.	By the end of the plan	N.A.	Availability of baseline data
2-4-b- Availability of Information Education and Communication (IEC) plan for the community on the complications of female circumcision.	By the end of the plan	N.A.	Implementation the plan
Indicators of Strategies of the 3rd Objective			
3-1-a- Number of menopausal clinics.	By the end of the plan	2	10
3-1-b- Availability of standard for the menopausal clinic.	By the end of the plan	Criteria for clinics	Standardization of clinics
3-2-a- Percentage of health educators trained on post reproductive women's health issues.	By the end of the plan	35%	100%
3-3-a- Percentage of clients benefited by the menopausal clinic.	By the end of the plan	10%	60%

* The actual Percentage is higher than what is shown in the table as some mothers attend hospital for the post-natal services at facilities other than the registering parent health care facility.

** Survey of child health register for birth spacing method use in 2004.

*** National health survey of the year 2000.

Domain Twenty Two

Child Health

Vision: Promoting Maternal and Child Health

Goal: Improving Health Care Provided to Women and Children

Domain: Child health

INTRODUCTION:

With nearly more than one third of the Omani population (around 37%) being children under 10 years of age (12% being under 5 years), there has been a recognizable development in child health programmes such as immunization programme, Integrative Management of Childhood Illness and Baby Friendly Hospital Initiative. However, there is a place for improvement in areas of specialized care and training of concerned staff.

The Ministry of Health is also committed to reduce factors related to child mortality and morbidity by upgrading its health services provided to children of all ages by paying special attention to newborns and children with disabilities and congenital anomalies.

Childhood mortality rate for under 5 years of age was 11.1/1000 live birth in the year 2004, the infant mortality was 10.3/1000 live birth. Although these numbers are showing reduction, they are still considered high in comparison to the developed world. Hereditary disorders and congenital anomalies constitute more than 95 % of the causes of infant mortality.

Researches and studies have shown that combating childhood mortality and morbidity can be achieved by providing quality health services and adopting healthy life style strategies. This current plan focuses its strategies to provide a safe environments to children indoors (homes & schools) and outdoors through health education Programme for parents and school staff. It also aims to train health care providers dealing with injuries and accidents on how to deal with these cases and provide the necessary equipments.

The Sultanate has also signed the international convention for children rights and so the plan aims to increase the awareness of health care staff on how to suspect and deal with child abuse cases and to make data bases at regional and national levels.

OBJECTIVES:

- 1- To reduce childhood mortality and morbidity rates with focus on neonates, infants and children less than 5 years of age.
- 2- To reduce childhood mortality and morbidity rates related to accidents.

OBJECTIVES' INDICATORS:

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
First Objective's Indicators: To reduce childhood mortality and morbidity rates with focus on neonates, infants and children less than 5 years of age			
1- Infant mortality rate/1000 LB.	16.7	10.3 (2004)	8
2- *Neonatal mortality rate/1000 LB.	1.63	1	0.8
3- *Perinatal mortality rate/1000 LB.	5	4.46	3
4- Under 5 mortality rate/1000 LB.	21.7	11.1 (2004)	9
5- Rate of children under 5 affected with diarrhea /1000 child.	300	200	90
6- Percentage of severe diarrhea to the number of cases.	0.3%	0.2%	0.18%
7- Number of deaths due to diarrhea.	3	zero	zero
8- Rate of acute respiratory tract infections /1000 children less than 5 years.	1600	1500	700
9- Percentage of severe infections to total acute respiratory infections.	0.6%	0.3%	0.2%
10- Number of admissions** for children under age 13 years to the total number of children affected with these chronic illnesses: a. Diabetes b. Asthma c. Cardiac disease d. Renal disease e. Neurological disease	Not available Not available Not available Not available Not available	Not available Not available Not available Not available Not available	20%
Second Objective's Indicators: To reduce childhood mortality and morbidity rates related to accidents			
1- Number of accidents & injuries to children under 15 /1000 child of same age group per year.	Not available	Not available	75
2- Mortality rate of children less than 15 years [#] due to accidents & injuries / total mortality of children less than 15 years.	Not available	36.7%	30%

* Data related to perinatal & neonatal mortality are only from cases admitted in MoH facilities.

** Number of admitted patients in MoH facilities.

Number of patients reported to MoH.

STRATEGIES:

Strategies to Achieve 1st objective: To reduce childhood mortality and morbidity rates with focus on neonates, infants and children less than 5 years of age

1-1- Training of staff working (doctors & nurses) at primary health care on how to deal with neonates according to MCH Module Part 4(Neonatal).

Expected results:

- Providing health care staff with good knowledge & skills to deal with sick neonates.

1-2- Training of doctors & midwives working at primary health care on Neonatal Resuscitation.

Expected results:

- Neonatal Resuscitation Programme certified doctors and nurses trained on how to deal with critical cases of newborns.
- Reducing complications associated with critically ill newborns.

1-3- Establishing a trained transport team (pediatricians & nurses) for the transport of critical cases to the referral hospitals and provision of the necessary equipment.

Expected results:

- Decreased transport related mortality & morbidity for critically ill neonates.

1-4- Upgrading and providing equipments for neonatal care at all health facilities where deliveries are being conducted.

Expected results:

- Improved care for newborns.

1-5- Implementing integrative management of childhood illnesses (IMCI) in all primary health care facilities in the Sultanate and train doctors & nurses.

Expected results:

- Early recognition of childhood illnesses and provision of necessary treatment.
- Capacity building of health care providers in knowledge and skills to deal with sick children.

1-6- Raising awareness of the community about childhood illnesses , causes and ways of prevention.

Expected results:

- A well oriented community on prevention of childhood illnesses and appropriate use of health services.

1-7- Training of Omani doctors in pediatrics through Omani Medical Specialty Board (OMSB), residency Programme.

Expected results:

- Availability of highly trained Omani pediatricians in all regions of the Sultanate.

1-8- Developing data base for children with chronic illnesses in collaboration with department of information and statistics.

Expected results:

- Availability of data base for all cases of children with chronic illnesses for every region.
- Provision of health services facilitated for chronically ill children.

1-9- Providing specialized medical staff (doctors & nurses) in pediatrics cardiology, pulmonology ,nephrology ,neurology and psychiatry in highly populated regions like Sohar, Sur, Salalah, Ibri and Nizwa.

Expected results:

- Specialized care delivered to children with chronic illnesses in the regions.
- Specialized services made available in the regions.

1-10- Expanding neonatal screening tests performed to include hereditary blood disorders (Sickle Cell Disease & Thalassemia) and some metabolic disorders in collaboration with the Genetic Center.

Expected results:

- Screening of all newborns.
- Increasing number of disorders screened for.
- Improving health status of children through early detection of inherited diseases.

1-11- Allocating a pediatrician (specialist or junior specialist) in every region to be a coordinator on National child health programmes.

Expected results:

- Follow up, coordination and effective training on all national childhood programmes.

1-12- Continuing the school-aged children health check-up programme in collaboration with School Health Department.

Expected results:

- Early detection of health problems of children at school age.

Strategies to Achieve 2nd objective: To reduce childhood mortality and morbidity rates related to accidents

2-1- Strengthening the collaboration in child safety matters between different sectors through the Willayat Health Committees.

Expected results:

- An enhanced collaboration between different sectors to reduce childhood accidents.

<p>2-2- Educating parents about safety measures for children inside and outside the house.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Families enabled to follow safety measures for children.
<p>2-3- Enhancing role of school in child safety and first aid through training of school health supervisors at schools.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Reduction in numbers of accidents and injuries in schools. ▪ Enhancement of the role of the school health supervisor teacher.
<p>2-4- Training doctors working at primary health care on how to deal with accidents and injuries according to PALS (provide the regions with Master Trainers to train pediatricians at their regions).</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Improving skills & knowledge of health care providers on how to deal with accidents and injuries in children.
<p>2-5- Raising awareness of health care providers on child abuse cases.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Health care providers able to identify and deal with child abuse cases. ▪ Improved health service and psychological support to abused children.
<p>2-6- Establish a data base for child abuse cases.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Complete statistics on child abuse cases.

STRATEGIES' INDICATORS:

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Indicators of Strategies of the 1st Objective			
1-1-a- Number of annual training activities addressing neonatal care.	Annually	Not available	At least once annually per region
1-1-b- Percentage of doctors & nurses trained on MCH Module Part 4.	Annually	30%	100%

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
1-2-a- Percentage of doctors & midwives working at primary health care and are trained on Neonatal Resuscitation.	Annually	30%	100%
1-3-a- Number of available transport teams for critically ill children.	Annually	zero	2 teams at least by the end of the plan
1-3-b- Availability of equipment for safe transport of critically ill children according to centrally prepared standards.	Annually	Not available	Available equipment for at least 2 teams
1-4-a- Percentage of health facilities where deliveries are being conducted which are equipped for receiving newborns according to specified standards.	Annually	25%	100%
1-5-a- Percentage of Primary Health Care facilities where IMCI is being implemented.	Annually	30%	100%
1-5-b- Percentage of trained staff on IMCI	Annually	30%	100%
1-6-a- Number of annual community health educational activities in the field of child health.	Annually	Not available	At least once monthly for every region
1-7-a- Number of doctors who completed OMSB Programme in child health	Annually	20	60
1-8-a- Number of diseases included in the data base of chronic illnesses of childhood	Annually	4	10
1-9-a- Number of specialized pediatricians in the regions: <ul style="list-style-type: none"> ▪ Cardiology ▪ Chest diseases ▪ Nephrology ▪ neurology 	Annually	1 zero zero zero	At least one doctor in each specialty for every region.
1-9-b- Number of specialized paediatric nurses in: <ul style="list-style-type: none"> ▪ Cardiology ▪ Chest diseases ▪ Nephrology ▪ Neurology 	Annually	Zero Zero zero zero	At least one nurse in each specialty for every region.
1-10-a- Number of children benefiting from early detection of congenital hypothyroidism.	Annually	Not available	100%
1-10-b- Number of tests included in early screening Programme	Annually	2	At least 5 by the end of the plan.
1-11-a- Number of regions with a pediatrician supervising child health national programmes	Annually	zero	10
1-12-a- Percentage of school aged children included in full health check up programme	Annually	99%	100%

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Indicators of Strategies of the 2nd Objective			
2-1-a- Number of topics related to child safety discussed in Willayat Health Committees.	Annually	Not available	2 topics per year
2-1-b- Percentage of topics related to child safety that the Willayat Health Committees has decided about.	Annually	Not available	100%
2-2-a- Number of health education activities in relation to child safety inside and outside the house.	Annually	Not available	At least one per month.
2-2-b- Number of health education material /publishes directed to the families on children safety inside and outside the house.	Annually	Not available	5 publishes in the next 5 years.
2-3-a- Percentage of schools with health education activities related to children safety.	Annually	20%	100%
2-3-b- Percentage of health supervisor at schools trained on first aid.	Annually	Not available	100%
2-3-c- Percentage of schools with First-Aid kits according the list produced by MoH.	Annually	Not available	100%
2-4-a- Percentage of Primary Health Care doctors who are trained to deal with accidents in children according to Pediatric Advanced Life Support (PALS).	Annually	Not available	50%
2-5-a- Number of activities done to raise awareness of health care providers about child abuse.	Annually	Not available	At least one activity per year
2-6-a- Availability of a data base for child abuse cases.	Annually	Not available	To have a precise data base

Vision Five

Dissemination of Healthy Lifestyles

In the Community

Domain Twenty Three

Health Education and Communication

Vision: Dissemination of Healthy Lifestyles in the Community

Goal: Increasing Health Awareness, Correcting Attitudes and Establishing Healthy Behaviors and Practices in the Community

Domain: Health Education and Communication

INTRODUCTION:

Health education is the important of the health services and health programmes provided all over the country. Without health education health services can not reach its fully objectives. The recent advancements in the technology, and the improvement of social, and economical status of Oman affect people's live and has created both, a vegetative and positive changes in their daily behavior which in turn leads to emergence of lifestyle related diseases, such as diabetes, hypertension, cardiovascular & circulatory diseases, obesity, cancers, and genetic diseases due to inherited cultural and traditions; in addition to different communicable diseases. Exposure to other cultures from different parts of the world has lead to spreading of other communicable diseases and practicing the unhealthy behavior.

The continuation of theses unhealthy practices & behaviors with the resulting increase of morbidity rates and health problems, and the in-coordination between the Ministry of Health and the related Ministries; causes a great challenges to health education efforts, as it increases the financial burden on health institutions for providing special care and treatment to all these problems. However, lack of health education staff, continuous extension of health centers and increase the number of attendance comprise another challenge that facing the health education activities. Moreover, the spread of satellites and open media have a great effect on the population in all age groups and consequently causes different health problems.

For this situation, health promotion is needed to replace health education as the former is broader and cover all factors including social, environmental, economical and political aspects which have indirect effect on the health.

OBJECTIVES:

- 1- Provision of baseline data as regards knowledge, attitudes and practices of the community towards healthy lifestyle issues.
- 2- Development and improving skills and experiences of MoH staff working in the field of health education.
- 3- To increase health awareness, change unhealthy attitudes and practices and promote healthy lifestyles and behaviors in the community.
- 4- Adoption of "Health Promotion Project" by MoH and applying it in the community in order to unify the efforts for promotion of public health.

OBJECTIVES' INDICATORS:

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
First Objective's Indicators: Provision of baseline data as regards knowledge, attitudes and practices of the community towards healthy lifestyle issues			
1- Availability of baseline data about the healthy and unhealthy knowledge, attitudes and practices of the community.	Not available	Not available	Baseline data available
Second Objective's Indicators: Development and improving skills and experiences of MoH staff working in the field of health education			
1- Percentage of the primary health care workers (not health educators) who are trained on the communication skills and health education: § Doctors § Pharmacist and assistant pharmacist § Nurses § Medical orderlies	2% 0% 5% 11%	5% 0% 16% 29%	45% 57% 50% 65%
2- Percentage of health educators who completed advance training course in health education for one year. (Specialize Health Education Diploma).	0%	35%	80%
3. Percentage of health educators who are trained about the recent health issues to update their knowledge and to improve their performance.	0%	20%	70%
Third Objective's Indicators: To increase health awareness, change unhealthy attitudes and practices and promote healthy lifestyles and behaviors in the community			
1- Knowledge:			
a) Percentage of those having right information about hazards of smoking.	Not available	52% *	75%
b) Percentage of peoples who have right information about reproductive health.	Not available	46.5% **	75%
c) Percentage of mothers who know the benefits of breastfeeding.	93%	95%	99%
d) Percentage of those having right information about methods of prevention of AIDS.	Not available	48%	70%
e) Percentage of those having information about healthy nutritional habits.	Not available	66%	90%
2- Practices:			
a) Percentage of the smokers.	8% **	18% *	5%
b) Percentage of women who spaced between pregnancies more than three years.	32.7%	39.1%	45%

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
c) Percentage of mothers who are practicing breastfeeding for 5 months.	Not available	95%	98%
d) Percentage of those who are practicing physical activities.	Not available	29%**	40%
e) Percentage of those who are driving cars without license.	Not available	34%	10%

Fourth Objective's Indicators: Adoption of "Health Promotion Project" by MoH and applying it in the community in order to unify the efforts for promotion of public health

1-. Presence of situation analysis study regarding health promotion aspects in the sultanate of Oman.	Not present	Not present	The study is present
2- Presence of a national health promotion strategy and action plan.	Not present	Not present	Plan is present
3- Presence of a team of trained staff to implement the health promotion plan in the community.	Not present	Not present	The team is present

* Results of national health survey 2004.

** Results of the survey of knowledge, attitudes and practices of the secondary school students about the reproductive health and public health (2001).

STRATEGIES:

Strategies to Achieve 1st objective: Provision of baseline data as regards knowledge, attitudes and practices of the community towards healthy lifestyle issues

1-1- Conduct regular studies about health knowledge, attitudes and practices of the community towards health (every 5 years) and recommend the suitable actions.

Expected results:

- Identifying the knowledge, attitudes and practices of the community towards health at beginning and end of the plan.

1-2- Development and standardize a unified health education records at the level of health institutions.

Expected results:

- Registration of all of the implemented health education activities.
- Easily accessible information and indicators needed for health education.

1-3- Develop a mechanism for follow up and evaluation of the health education activities through the registers and supervisory visits.

Expected results:

- Presence of specific standards for follow up and evaluation.
- Improve the activities according to the results of the follow up and evaluation.

1-4- Designing a website for health education.

Expected results:

- Increased the awareness of health problems.

Strategies to Achieve 2nd objective: Development and improving skills and experiences of MoH staff working in the field of health education

2-1- Training of selected health staff (doctors and pharmacist) on communication skill and methods of health education.

Expected results:

- Increase the efficiency and effectiveness of health education efforts.

2-2- Training of selected nurses and medical orderlies on communication skill to support health education activities specially in the primary health care institutions which had no staff for health education.

Expected results:

- Health education messages reaching most of the community sectors.
- Implementation of health education programmes.

2-3- Continuous training for health educators about the recent different health issues.

Expected results:

- Increase efficiency and effectiveness of health educators.

2-4- Improve the training courses for health educators (Specialized health diploma on health education) for development of their skills in the field of health education and communication.

Expected results:

- Increase efficiency and effectiveness of health educators.

Strategies to Achieve 3rd objective: To increase health awareness, change unhealthy attitudes and practices and promote healthy lifestyles and behaviors in the community

3-1- Using social marketing methods to disseminate health awareness through mass media.

Expected results:

- Methods and ways of health education are different and convenient to the targeted population.

3-2- Concentration of educational activities to cover the all health topics in the health institutions and the community.

Expected results:

- Change of unhealthy knowledge, attitudes and practices.

3-3- Production of different and advanced high quality educational materials and tools.

Expected results:

- Provision of sufficient educational materials and tools with high quality to support the efforts to change unhealthy behaviors.

Strategies to Achieve 4th objective: Adoption of “Health Promotion Project” by the MoH and applying it in the community in order to unify the efforts for promotion of public health

4-1- Advocate for the importance of health promotion among stakeholders in the ministry of health and other related ministries.

Expected results:

- Understanding support of stakeholders of the ministry of health and other ministries for the importance of health promotion.

4-2- Conducting situation analysis for the aspects of the health promotion in the sultanate of Oman.

Expected results:

- Provision of data and information about some aspects of health promotion.

4-3- Develop a national strategy and action plan for health promotion in the community.

Expected results:

- Coordinated efforts were collected by all governmental and non governmental organizations to promote the community health.

4-4- Training of human resources (team work) to apply the plane of health promotion in the community.

Expected results:

- A well trained team to implement health promotion plan is available.

4-5- Activating the national health education committee by coordinating with other government agencies related to health promotion.

Expected results:

- Cover health topics touching the community need.

STRATEGIES' INDICATORS:

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Indicators of Strategies of the 1st Objective			
1.1-a- Number of the conducted studies about health knowledge, attitudes and practices of the community.	One Study at 2006 and another study at 2010	no national KAP studies	national studies
1-2-a- Percentage of health institutions using register to record health education activities.	Annually	0%	100%
1-3-a- Number of supervisory visits performed by the department of health education for follow up and evaluation of the health education activities in the region.	Annually	3	20 visits / year
1-4-a- Availability of website for health education.	2007	No website	Website available by 2007
1-4-b- Number of visitors to the website.	Annually	Not available	4000 visitors to the website yearly
Indicators of Strategies of the 2nd Objective			
2-1-a- Percentage of the doctors and pharmacist that have been trained on communication skills.	Annually	5% doctor 0% pharmacists	45% doctors 57% pharmacists
2-2-a- Percentage of the trained nurses and medical orderlies on communication skills.	Annually	16% nurses 29% orderlies	50% nurses 65% orderlies
2-3-a- Percentage of the health educators that have been trained on latest health information.	Annually	20%	100%
2-4-a- Percentage of the health educators that have advance health education training courses (Specialize Health Education Diploma).	Annually	35%	100%
Indicators of Strategies of the 3rd Objective			
3-1-a- Rate of coverage of health series in the TV.	Annually	31	52 series/year
3-1-b- Rate of coverage of health series in the radio.	Annually	37	52 series/year
3-1-c- Rate of coverage of health topics in the newspapers.	Annually	8	52 topic/year
3-2-a- Number of health education activities implemented in the health institutions and community.	Annually	200 thousand activities	250 thousand activities/year

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
3-2-b- Percentage of the beneficiary from health education activities in the health insinuations.	Annually	10%	50%
3-2-c- Percentage of the beneficiary from health education activities in the community.	Annually	15%	50%
3-3-a- Number of health education materials that are produced on health topics.	Annually	24 material	30 material/year
Indicators of Strategies of the 4th Objective			
4-1-a- Presence of cooperation between the members inside and outside the ministry of health to implement health promotion.	Annually	--	Cooperation is present
4-2-a- Provision of data and information about aspects of health promotion.	Annually	Not available	data available
4-3-a- Availability of strategic plan for the health promotion.	Annually	Suggestion for the plan is present	MoH adopt the plan and implement it
4-4-a- Presence of trained staff on methods of implementation of health promotion action plan.	Annually	Training not started	Trained team is present
4-5-a- Number of meetings of national health education committee.	Annually	One meeting	Twice a year
4-2-b- Number of topics dealt by the national health education committee.	Annually	One topic	5 topic/yearly

Domain Twenty Four

Adolescent and Youth Health

Vision: The dissemination of Practice of Healthy lifestyles in Community Life

Goal: Increasing Health Awareness, Correcting Attitudes and Establishing Healthy Behaviors and Practices in the Community

Domain: Adolescent and Youth Health

INTRODUCTION:

Adolescents and youth in the age group 10 to 24 years constitute a significant sector of Omani society. They represent approximately 34% of the population as per census of 2003. They are also considered the main investment in the future national development.

Adolescence is considered a transition stage in human being life's as he gets physical, biological, psychological and social changes which substantially shape his personality and attitudes. However during this delicate phase of a lifetime, many sources can influence the attitudes and behaviours of adolescent and youth such as peer pressure, media and communication technology...etc. Adolescents and youth may be exposed to risky behaviors such as sexual behaviors, tobacco and drugs addiction, exposure to psychological diseases which may negatively affect their attitudes and practices.

Many studies conducted by Ministry of Health had shown that adolescents and youth are vulnerable to many risk behaviors. The Global Youth Tobacco Survey (GYTS) 2003 showed that prevalence of students who are smokers at the time of the survey is 9.1% (16.6% boys and 1.8% girls), Percentage of students who use Hubble-bubble is 9.9% (16.6% boys and 2.6% girls). 9.1% (15.3% boys and 2.7% girls) are using the smokeless tobacco. The results of adolescent health survey 2001 showed that students in age group 15-19 years who had used alcohol is 4.3% (6.6% boys and 2% girls). Results also showed that 57.5% of students in the same age group are driving without license, which could expose them to the problems of injury and different disabilities. This sector of the society is liable to many psychological problems as shown by the results of the same survey. It showed that 45% of students in 15-19 years suffer from psychological problems.

In order to take care of this category, school health services to age group 10-19 years are currently available within the health system. It aims to promote health through raise awareness, improve lifestyles and improve nutrition. It also has preventive aspects as immunization and early detection of health problems among students. However, it currently covers students of government schools only. In the current health system, there are no services or programmes targeting adolescents outside the educational system and youth (20-24 years) except some symposiums and educational lectures in AIDS and Tobacco use.

The Omani family is considered the most important supporter in providing the favorable conditions to promote health of adolescents and youth. This could be achieved through their important role in their development and providing them with knowledge, and skills. However, the weak dialogue between generations and lack of parents' knowledge towards adolescents and youth's health issues requires introduction of targeted programmes to promote health of adolescents and youth.

OBJECTIVES:

- 1- To promote healthy lifestyles among adolescents and youth in all regions of the Sultanate.
- 2- To expand the efficient, high quality, and comprehensive health services to all adolescents and youth in all regions of the Sultanate.

OBJECTIVES' INDICATORS:

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
First Objective's Indicators: To promote healthy lifestyles among adolescents and youth in all regions of the Sultanate			
1- Prevalence rate of tobacco use among adolescents (13 – 15 years).	N.A	19.5% (2003)	15%
2- Prevalence rate of substance use among adolescents (15 – 19 years).	N.A	4.3% (2001)	4%
3- Percentage of adolescents (15 – 19 years) who have a good knowledge about reproductive health.	N.A	50% (2001)	90%
4- Percentage of students (13 – 15 years old) who use seat belts in the car driven by another.	N.A	33.3%	50%
5- Percentage of students (13-15 years old) who get their breakfast most of the days.	N.A	50.3%	70%
6- Percentage of tenth grade students (15-16 years old) who are overweight.	N.A	4.1%	2%
7- Percentage of students (13-15years old) who did not practice physical activity outside the school during the year preceding the survey.	N.A	39%	30%
8- Percentage of youth (20 – 24 years) who have knowledge and positive attitudes and practices on reproductive health and lifestyles.	N.A	N.A	50% increase from the current status
9- Percentage of families who have knowledge and positive attitudes and practices on adolescent and youth health.	N.A	N.A	50% increase from the current status

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Second Objective's Indicators: To expand the efficient, high quality, and comprehensive health services to all adolescents and youth in all regions of the Sultanate			
1- Percentage of Wilayats which have at least one PHC health institution provides counseling service to adolescents and youth.	N.A	N.A	50%
2- Percentage of public schools with comprehensive school health services.	100%	86%	100%
3- Percentage of private schools with school health services.	5%	30%	100%
4- Percentage of centers for special needs which have school health services.	N.A	40%	100%
5- Percentage of higher educational institutions where health education activities are implemented.	1%	1%	60%

STRATEGIES :

Strategies to Achieve 1st objective: To promote healthy lifestyles among adolescents and youth in all regions of the Sultanate
<p>1-1- Preparation of educational package addressed adolescents, youth and their families aimed at changing the knowledge, attitudes and behaviours among them with regard to the use of tobacco, substances abuse, reproductive health, risky behaviors, the problems associated with nutrition, physical activity and mental health.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Changing knowledge of adolescents, youth and their families towards health issues.
<p>1-2- Implementation of peer education strategy through training of school health staff to train members of adolescents and youth to educate their peers with regard to risky behaviors.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Increase awareness of adolescents and youth.
<p>1-3- Implementation of the National Strategy of Information, Education and Communication on adolescents' health.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Good coordination between sectors dealing with issues of adolescents and youth.
<p>1-4- Periodic conduction of studies to monitor factors that affect the healthy behaviours of adolescents and youth.</p>

Expected results:

- Updating of the database on the practices of adolescent health and youth.

1-5- Use of website of Ministry of health on the internet to meet the information needs of adolescents and youth.

Expected results:

- Availability of reliable source of information concerning the adolescents and youth health.

Strategies to Achieve 2nd objective: To expand the efficient, high quality, and comprehensive health services to all adolescents and youth in all regions of the Sultanate

2-1- Encouragement and support the provision of comprehensive school health services in private schools , centers for people with special needs and health education services at higher educational institutions.

Expected results:

- Complete coverage of adolescents and youth health services provided in educational institutions.

2-2- Strengthening the cadre of trained school health nurses as per the ratio of one nurse to 2500 students in urban areas and one to 750 students in mountainous area.

Expected results:

- Availability of adequate trained nurses to provide comprehensive effective school health activities.

2-3- Implementation of the national school health strategy which meets the eight components of comprehensive coordinated school health Programme and define the role of each sector.

Expected results:

- Coordination between different sectors.

2-4- Implementation of Health Promoting School Initiative in 59 schools (one in each Wilayat) and creation of the national health promoting schools network.

Expected results:

- Promotion of adolescents' health in schools.

2-5- Conduction of an evaluation study to identify the health services available to adolescents by the end of 2006.

Expected results:

- Identification of health services to adolescents.

2-6- Introduction of counseling services for adolescents and youth in some primary health care institutions to meet their needs. This would be through training of the health workers in PHC and school health on communication skills.

Expected results:

- Provision of counseling services in PHC institutions which would help to solve the problems of adolescents and youth in particular the lifestyles.
- Building bridges of communication and trust between service providers, adolescents and youth.

2-7- Training of health supervisors teachers on health programmes for adolescents.

Expected results:

- Provision of counseling on issues related to adolescents in the educational institutions by qualified persons.

STRATEGIES' INDICATORS:

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Indicators of Strategies of the 1st Objective			
1-1-a- Educational package for adolescents (10-19 years) is available.	By the end of the plan	N.A	Available
1-1-b- Educational package for youth (20-24 years) is available.	By the end of the plan	N.A	Available
1-1-c- Educational package for families of adolescents and youth is available.	By the end of the plan	N.A	Available
1-2-a- Percentage of school health workers trained in peer education.	Annually	Less than 1%	60%
1-2-b- Percentage of adolescents and youth who are trained in peer education.	Annually	3%	20%
1-2-c- Percentage of peers who are educated.	Annually	5%	70%
1-3-a- Percentage of sectors that have implemented the national strategy of information, education and communication in adolescents' health.	Annually	10%	100%
1-4-a- Number of studies conducted to monitor the determinants of health behaviors among adolescents and youth.	At the beginning and by the end of the plan	N.A	Study for youth and families in the beginning of the plan and a study for adolescents, youth and families at the end

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
1-5-a- Availability of a page on the ministry website to meet the information needs of adolescents and youth.	Annually	N.A	Available
1-5-b- Percentage of adolescents who use the website to get information on adolescents and youth.	Annually	N.A.	30%
Indicators of Strategies of the 2nd Objective			
2-1-a- Percentage of students in private schools who get school health services.	Annually	New service	80%
2-1-b- Percentage of students in centers of special needs who get school health services.	Annually	New service	80%
2-1-c- Percentage of students in higher educational institutions who get health education services.	Annually	New service	25%
2-2-a- Nurse to students ratio in urban areas (nurse to 2500 students).	Annually	0.6	1
2-2-b- Nurse to students ratio in mountainous areas (nurse to 750 students).	Annually	0.7	1
2-2-c- Percentage of school health nurses who are trained in the school health training Programme.	Annually	33.3%	100%
2-3-a- Percentage of schools that implement the national strategy of school health.	Annually	N.A.	50%
2-4-a- Percentage of school that declared health promoting schools.	2007 2010	19 schools are implementing but not declared	100%
2-5-a- Number of studies that evaluate the health services to adolescents.	At the beginning of the plan	N.A.	One study
2-6-a- Percentage of adolescents and youth beneficiaries from counseling services in primary health care.	Annually	N.A.	50%
2-6-b- Percentage of health workers trained in counseling.	Annually	N.A.	50%
2-7-a- Number of training workshops to health supervisors teachers in adolescents health.	Annually	N.A.	5 workshops annually /region
2-7-b- Percentage of schools which have health supervisor teachers trained in adolescents health.	Annually	N.A	50%

Vision Six

Better Nutrition for All

Domain Twenty Five

Nutrition

Vision: Better Nutrition for All

Goal: Improvement of the Nutritional Status of Omani Society

Domain: Nutrition

INTRODUCTION:

Studies indicate the spread of nutritional problems among various sectors of the population in the Sultanate of Oman, which is a source of concern among health authorities because of the adverse effects of malnutrition on immunity, thus contributing to increased risk and duration of illness among children and women in the childbearing age as well as pregnant women in addition to its effect on the individual and national productivity.

Almost 18% of the children under the age of five years suffer underweight (1999), and 40% of them are anemic (2004), whereas 48.9% of school males were found to be anemic compared to 52.7% of school female students in 1996. The National Health Survey found in 2000 that 42.8% of pregnant women were anemic, whereas in 2004 39.6% of non-pregnant women at the child bearing age and 12% of men were anemic.

In 2004, the micronutrients survey showed that almost 34% of the Omani households do not consume iodized salt, which indicates that Universal Salt Iodization is not achieved in Oman. This points a concern of IDD; in addition vitamin A fortification has been looked at and found to be a needed intervention which will assist in gradual withdrawal of the vitamin A supplementation for women and children. On the other hand, the studies have shown that fats and meat are consumed above the recommended amounts by 25%, meanwhile the consumption of cereals, vegetables, fruits and dairy products is at only 50% of the recommended quantities. Around 28% of adult men and women were obese in 2000. The prevalence of obesity among men in Oman was twice the prevalence of obesity among men in Bahrain and Emirates, and more than five times the prevalence in Iran.

There is no data on the prevalence estimates of food-borne illnesses, but the communicable diseases surveillance indicates the incidence in 2003 was 50 per 10,000 populations which constitute 1.4% of the outpatients' attendants. Diarrhea and Gastroenteritis incidences varied between 110,000 to 130,000 cases in 1997 and 2002 respectively.

Reduction of nutrition related morbidity has very important financial and human implications. It has been documented that a 5% reduction underweight may contribute to lowering of childhood mortality by 30%. Direct and in-direct financial implications of malnutrition are varied and studies showed that every dollar invested in an intervention related to PEM or micronutrients deficiency returns between 5-20 dollars.

OBJECTIVES:

- 1- Control of Protein Energy Malnutrition among preschool children.
- 2- Promotion of adequate nutritional practices and optimum nutritional status among the whole population.
- 3- Control of micronutrients malnutrition among the whole population.
- 4- Prevention of nutritionally related chronic illnesses.
- 5- Support of food safety systems in coordination with other sectors.
- 6- Provision of high quality nutrition and dietetics services in all health institutions.

OBJECTIVES' INDICATORS:

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
First Objective's Indicators: Control of Protein Energy Malnutrition among preschool children			
1- Prevalence of wasting among preschool children.	7%	6%	5%
2- Prevalence of underweight among preschool children.	17.9%	14% (projected)	10%
3- Prevalence of stunting among preschool children.	10,6%	10,6%	10,0%
Second Objective's Indicators: Promotion of adequate nutritional practices and optimum nutritional status among the whole population			
1- Rate of adequate nutritional practices among preschool children aged 2-5.	unavailable	From the dietary intake survey	60%
2- Rate of adequate nutritional practices among women in the childbearing age 18-49.	unavailable	From the dietary intake survey	30%
3- Rate of adequate nutritional practices among other age groups.	unavailable	From the dietary intake survey	30%
Third Objective's Indicators: Control of micronutrients malnutrition among the whole population			
1- Prevalence of anemia among pregnant women.	42.6%	38%	33%
2- Prevalence of anemia among adolescents 12-18 years old.	40.9%	Not available	38%
3- Prevalence of anemia among infants 6-24 months old.	Not Available	42%	35%
4- Prevalence of low Urinary Iodine among women in the childbearing age.	Not available	4.9%	4.9%
5- Prevalence of low serum retinol among women in the child bearing age.	Not available	5%	5%

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Fourth Objective's Indicators: Prevention of nutritionally related chronic illnesses			
1- Prevalence of overweight and obesity among adults.	46.2%	Not Available	46%
2- Prevalence of hypercholesterolemia among adults.	40%	44%	44%
3- Prevalence of high triglycerides among adults.	Not available	Not available	Constant
4- Prevalence of fasting IGT among adults.	6.1%.	Not available	Constant
5- Prevalence of hypertension.	15.2%	17%	17%
6- Proportion of the population with high waist circumference.	Not available	Not available	Constant
Fifth Objective's Indicators: Support of food safety systems in coordination with other sectors			
1- Number of microbiological food poisoning cases.	Not available	Not available	Reduction by 10%
2- Rate of chemical food contamination.	Not available	Not available	Reduction by 10%
Sixth Objective's Indicators: Provision of high quality nutrition and dietetics services in all health institutions			
1- Percentage of primary Health care institutions that provide the targeted quality of nutrition and dietetics services.	Not available	Not available	80%
2- Percentage of primary Health care institutions that provide the targeted quality of nutrition and dietetics services.	Not available	Not available	60%

STRATEGIES:

Strategies to Achieve 1st objective: Control of Protein Energy Malnutrition among preschool children	
1-1- Weighing and follow up of all children under the age of five years in the health institutions.	
Expected results:	
<ul style="list-style-type: none"> ▪ Early detection of underweight. 	
1-2- Enforcement of the Baby Friendly Hospitals Initiative in all MoH and private hospitals.	
Expected results:	
<ul style="list-style-type: none"> ▪ Exclusive breastfeeding for all newborn infants in the hospitals. ▪ Breastfeeding counseling for all postnatal mothers. ▪ Activate and implementation of the Code of Marketing of Breast milk Substitutes. 	

1-3- Activate the implementation of the PEM manual in all health institutions.

Expected results:

- Improve the health workers practices in the management of PEM.
- Treatment of all PEM cases according to the MoH PEM manual.

1-4- Empower the breastfeeding and complementary feeding counseling programmes.

Expected results:

- Training of health workers on Breastfeeding and complementary feeding counseling.
- Increase the rates of exclusive breastfeeding at the age of 6 months.
- Practice safe preparation of complementary foods.
- Introduce timely complementary foods for children in the adequate quality, quantity and consistency.

1-5- Activate the role of the community support groups in the prevention of PEM through training them on nutrition.

Expected results:

- Delivery of adequate messages to the mothers through community support groups.

1-6- Activate the severe PEM management policy in all levels of health care.

Expected results:

- Adequate management of severe PEM cases.

1-7- Implement and activate the national Strategy for Infant and Young child feeding in all MoH institutions.

Expected results:

- Improve nutritional Status of all infant and young children.
- Implement better parenting especially in relation to infant and young child feeding.
- Create a system for monitoring of the National Strategy.

Strategies to Achieve 2nd objective: Promotion of adequate nutritional practices and optimum nutritional status among the whole population

2-1- Develop and establish the national food based dietary guidelines.

Expected results:

- Available nutrition information to all members of the community.

2-2- Develop and implement a social marketing plan to disseminate adequate practices to all sectors of the population.

Expected results:

- Increase awareness of adequate nutritional practices among all sectors of the community.
- Advocate for appropriate dietary habits among decision makers and workers in the area of nutrition.

2-3- Cooperate with all related sectors to implement the plan including the private sector, agriculture, commerce and marketing.

Expected results:

- Educate the concerned sectors with their role in promotion of adequate nutrition practices.
- Actively involve other sectors in the nutrition promotion programmes.

2-4- Develop programmes to create an environment conducive of the implementation of the food based dietary guidelines.

Expected results:

- Implement community based initiatives that promote the implementation of the guidelines.

2-5- Surveillance and monitoring of the factors related to nutrition.

Expected results:

- Implementation of a monitoring and surveillance system for food and nutrition data.

Strategies to Achieve 3rd objective: Control of micronutrients malnutrition among the whole population

3-1- Implementation of anemia control programme for infants at the age of 6-24 months.

Expected results:

- Detection of anemia among all infants at the age of 9 and 18 months.
- Management of anemia cases.
- Make available iron supplements for low birth weight infants.

3-2- Conduct a study to assess the compliance and effectiveness of the anaemia control programme for pregnant women, and implement necessary modifications to the program.

Expected results:

- Re-enforce the pregnancy anemia control programme.

3-3- Evaluate and enforce the flour fortification programme using the results of the micronutrients survey.

Expected results:

- Increase the levels of iron to the recommended levels in flour.

3-4- Evaluate the need for control programmes for other micronutrients with focus on calcium, vitamin D and B12 through the MoH reporting system.

Expected results:

- Availability of data on various micronutrients deficiencies in the Omani population.

3-5- Continue to provide vitamin A supplements to postpartum women and children.

Expected results:

- Improve the vitamin A status among the Omani population.

3-6- Initiate vitamin A fortification programmes.

Expected results:

- Provision of an additional source of vitamin A in diet.

3-7- Issue appropriate legislations for salt iodization monitoring in Oman, and adopt an import certification system for iodized salt.

Expected results:

- Increase the coverage of salt iodization in Oman

3-8- Implement social marketing programmes for food fortification.

Expected results:

- Increase the awareness of fortified foods.
- Improve consumption practices of fortified products.

Strategies to Achieve 4th objective: Prevention of nutritionally related chronic illnesses

4-1- Establish food composition tables for Oman.

Expected results:

- Make available a database and a document outlining the food composition of Omani dishes and foods consumed in Oman.

4-2- Provide adequate and balanced information to the community through:

- Issue of clear messages targeted to the community.
- Preparation and make available dietary guidelines information.
- Education, communication and awareness.
- Encourage the development of education and adult literacy programmes.
- Marketing, advertisement and promotion control.
- Food labeling.

Expected results:

- Increase the community awareness of adequate nutritional practices.
- Collaboration with all sectors to avail the health promoting information and infrastructure.

4-3- Guide national policies for health protection and promotion.

Expected results:

- Promote foods of high nutritional value.
- Evaluate the tax policies that influence food production and consumption.
- Evaluate the agriculture production and distribution policies that influence the food system.

4-4- Develop and implement effective school based strategies for nutrition promotion, including school canteens.

Expected results:

- Increase nutrition awareness among students and teachers.
- Reduction of malnutrition and obesity among students.

4-5- Organize events with non-governmental, consumer, and women organizations to promote adequate nutrition.

Expected results:

- Increase awareness among decision makers in non-government, consumer and women organizations and discuss the roles and responsibilities for each in supporting nutrition and physical activity.
- Spread the information on balanced nutrition and physical activity.
- Organize media campaigns for promotion of balanced nutrition and physical activity.
- Network for the promotion of balanced nutrition and physical activity in all regions and wilayats.

4-6- Educate and engage the private sector in the programmes related to health promotion and nutrition.

Expected results:

- Promote healthy diet and physical activity according to the Omani food based dietary guidelines.
- Limit the levels of saturated fats, free sugars and salt in the food products.
- Develop and make available healthy and cheap alternatives to the consumer.
- Research to produce innovative food products with improved nutritional value.
- Practice responsible marketing.
- Issue scientifically based health guidelines to empower the consumer to make informative decisions.
- Make available healthy food choices in the workplace.

Strategies to Achieve 5th objective: Support of food safety systems in coordination with other sectors

5-1- Review the national food law and facilitate it's issue by concerned authorities.

Expected results:

- Issue of the national food law by concerned authorities.

5-2- Conduct the Total diet study.

Expected results:

- Database of chemical food contaminants.

5-3- Collaborate with other sectors for food control.

Expected results:

- Implement the Hazard Analysis Critical Control Points system in the hospitals.
- Develop a system to control pesticide residues.
- Implement the import certification system.

Strategies to Achieve 6th objective: Provision of high quality nutrition and dietetics services in all health institutions

6-1- Increase the number of qualified staff in nutrition according to the manpower assessment report.

Expected results:

- Provide high quality nutrition care in MoH institutions.

6-2- Make available fully equipped nutrition clinics in all MoH institutions.

Expected results:

- Provide high quality nutrition care in MoH institutions.

6-3- Continued training for all target health workers.

Expected results:

- Improve the dietary and nutrition services to the patients and the community.

6-4- Develop Standard operating procedures for dietetics according the patients needs and train health workers.

Expected results:

- Make available Standard operating procedures for the nutritional management of various diseases.
- Trained health workers on the SOP's.

6-5- Implement quality assurance programmes for all nutrition services in health institutions.

Expected results:

- Improve the quality of dietary and nutrition service in health institutions.

STRATEGIES' INDICATORS :

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Indicators of Strategies of the 1st Objective			
1-1-a- Detection rate of PEM.	5 years	32.4%	75%
1-2-a- Percentage of exclusively breastfed newborns at discharge.	Annually	96%	100%
1-3-a- Percentage of trained personnel on PEM management.	Annually	20%	100%
1-4-a- Percentage of exclusively breastfed infants at the end of the fifth month.	Annually	33%	50%
1-4-B- Percentage of mothers practicing adequate complementary feeding practices.	Every five years	Not available	10% annual improvement
1-5-a- Percentage of CSG trained on nutrition.	Annually	Not available	80%
1-6-a- Rate of improvement of PEM cases to normal.	Annually	18,5%	70%
1-7-a- Rate of adequate infant and young child feeding.	Annually	Not available	50%
Indicators of Strategies of the 2nd Objective			
2-1-a- Availability of dietary guidelines for the community.	Every five years	Not available	Available
2-1-B- Rate of compliance to the national dietary guidelines.	Every five years	Not available	20%
2-2-a- Percentage increase in the awareness of mothers and caretakers.	Annually	Not available	30%
2-3-a- Number of sectors that are active.	Annually	Not available	100%
2-4-a- Rate of the participation of the community organization in the promotion of the dietary guidelines.	Annually	Not available	100%
2-5-a- Availability of food and nutrition surveillance data.	Annually	Not available	Data available
Indicators of Strategies of the 3rd Objective			
3-1-a- Percentage of target children screened at 9 months.	Monthly	3,3%	100%
3-2-a- Modification of the pregnancy anemia control Programme..	Every five year	Available not up to date	Updated strategy
3-3-a- Flour fortification coverage.	Annually	81.2%	100%
3-4-a- Availability of fortification surveillance data.	2006	Not available	Available

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
3-5-a- Coverage of vitamin A supplementation..	Monthly	82,2%	100%
3-6-a- Vitamin A fortification coverage.	Annually	66,5%	95%
3-7-a- Salt iodization coverage.	Annually	67.3%	95%
3-8-a- Awareness rate on fortification.	Every five years	Flour 6.1% Salt 35.5%	60%
Indicators of Strategies of the 4th Objective			
4-1-a- Availability of electronic food composition data.	2007	10%	100%
4-2-a- Availability of the accurate information at the community level.	Every five years	Not available	30%
4-3-a- Availability of healthy diet in the local markets.	Every five years	Not available	50%
4-4-a- Prevalence of overweight among school children.	Annually	Not available	20%
4-4-b- Prevalence of malnutrition among school children.	Annually	Not available	10%
4-5-a- Awareness of target organizations about nutrition.	Every five years	Not available	100%
Indicators of Strategies of the 5th Objective			
5-1-a- Availability of a national food law.	Every five years	Not available	Available
5-2-a- Availability of food contaminants database.	Annually	Not available	20%
5-3-a- Rate of HACCP implementation in hospitals.	Annually	0	100%
Indicators of Strategies of the 6th Objective			
6-1-a- Percentage of qualified staff in nutrition in the health institutions.	Annually	50%	80%
6-2-a- Percentage of fully equipped nutrition clinics in primary health care institutions.	Annually	9%	100%
6-3-a- Percentage of trained staff working in nutrition care.	Annually	50%	100%
6-4-a- Rate of availability of dietetics SOP's.	One time during the plan	Not available	40%
6-5-a- Percentage of health institutions that improved according to the quality assurance guidelines.	Annually	Not available	60%

Vision Seven

Joint Action for Better Community Health

Domain Twenty Six

Community Participation

Vision: Joint Action for Better Community Health

Goal: Mobilization of the Community and Health Related Sectors for Health Promotion

Domain: Community Participation

INTRODUCTION:

Community participation provides the opportunity for the community members to be self-reliant in improving their own health. Local communities are capable of dealing with root causes of most health problems through their participation in many projects such as; environmental sanitation, provision of safe water, vector control and primary prevention of NCDs through promotion of healthy life style programmes. The community participation can also assist in transforming the traditional health education sessions from a passive learning process to an active one through creation of community groups that advocates for healthy active living and sharing information for their own better health rather than passive recipient of services.

It is also the responsibility of the health related sectors to participate in the provision of needed health information and encouraging the healthy life styles and the other health promoting behavior. But the biggest share of this responsibility is falling on the community members.

In 1947 the World Health Organization (WHO) adopted a broad definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

This definition takes a holistic view of health; it deals with all the factors that affect the health of an individual for optimal physical, psychological and social development. It equates health with a productive and creative existence, and focuses on the living state rather than on categories of disease causing an illness or death. Therefore and in order to promote this definition and broader concept of health there is a need to mobilize community members to take action and responsibility for their own health. Among the factors identified to help in this regard, is the emphasis on the role of health related sectors on health promotion, in addition to participation of local communities in community based initiatives for health and also the utilization of international experience gained overtime in these fields.

The community participation in Oman at present is represented by the Wilayat Healthy Committees, the Community Support Groups and the existence of few models of CBI projects. This existing community participation structures and initiatives need further strengthening and consolidation to achieve the desired goals of better health for the community.

The MoH wishes during the seventh planning cycle for health development to foster the concept of community participation, improve intersectoral action and consolidate and expand the implementation of the CBI projects.

Community participation in Oman is becoming inseparable component of the health system, this association started with the establishment of CSG experience in 1992, then followed by the formation of the "Wilayat Health Committees" in 1998. this two major establishments have lead to increased awareness of communities towards the health issues and their responsibilities to their own health.

The "Wilayat Health Committees" have been regularly organizing community based health activities to be planned and carried out by Community Support Groups members, directed to solve specific priority health problems. Also Among the important current achievements of MoH in the field of community participation is the implementation of Nizwa Healthy Life Style project in 2000, Sur Healthy city project in 2003, Qalhat Healthy Village project in 2003, Muscat Healthy Neighborhood and Villages in 2004, and recently preparatory steps were taken to initiate the Healthy City project in Sohar and Basic Development Needs project in Wadi Bani Khalid Wilayat.

OBJECTIVES:

- 1- To foster the concept of community participation among population.
- 2- To ensure adequate involvement of communities in planning and implementation of CBI and other health activities.
- 3- To strengthen inter-sectoral coordination and cooperation.
- 4- To encourage the implementation of CBI projects intended for health development and promotion.

OBJECTIVES' INDICATORS:

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
First Objective's Indicators: To foster the concept of community participation among population			
1- Number of CBI promotional material developed in yearly basis.	5	13	44
2- Number of CSGs members.	3488	4291	5210
Second Objective's Indicators: To ensure adequate involvement of communities in planning and implementation of CBI and other health activities			
1- Number of CBI projects in which the community have participated in its planning and implementation.	23	47	126

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
2- Number of Wilayat Healthy Committee members that have participated in the planning process of CBI projects.	227	369	565
3- Number of CSGs members that have participated in the planning process of CBI projects.	166	466	1170
Third Objective's Indicators: To strengthen inter-sectoral coordination and cooperation			
1- Number of CBI projects implemented in cooperation with other sectors.	27	83	200
2- Number of private sectors that have participated in the finance of CBI projects.	20	64	145
Fourth Objective's Indicators: To encourage the implementation of CBI projects intended for health development and promotion			
1- Number of implemented CBI projects.	1	7	20
2- Number of Volunteers participating in the implementation of CBI projects.	15	227	766

STRATEGIES:

Strategies to Achieve 1st objective: To foster the concept of community participation among population
<p>1-1- Conduct training courses and workshops on community involvement in health and their expected role in health promotion and development.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Raising awareness of community members on the importance of community participation in Health. ▪ Increased percentage of Community Volunteers participating in the implementation of CBI projects.
<p>1-2- Utilize the mass media in fostering the concept and mechanisms of Community participation in CBI projects.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Provision of CBI promotional material directed towards encouraging the community towards participating in solving its own health problems.

Strategies to Achieve 2nd objective: To ensure adequate involvement of communities in planning and implementation of CBI and other health activities

2-1- Involve the members of Wilayat Healthy Committee and Community Support Groups in planning for CBI projects.

Expected results:

- Increased number of CBI projects.
- Increase in community resources available for CBI projects.
- Adoption of priority health problems by community members.

2-2- Encourage the members of Omani Women Association and the members of other Civil Society Organizations (CSO) to participate in the planning and implementation of CBI projects.

Expected results:

- Increased participation of women in CBI projects.
- Increased percentage of CSGs participating in CBI projects.
- Increased support to on going Health Activities.

Strategies to Achieve 3rd objective: To strengthen inter-sectoral coordination and cooperation

3-1- Train of health workers on communication skills.

Expected results:

- Available health workers capable of communicating with communities as well as other sectors.
- Increased percentage of community members participating in CBI projects.

3-2- Train CSGs in CBI.

Expected results:

- Available CSG members trained on CBI projects.

3-3- Mobilize community members and members of other sectors through involving "Wilayat health committees" in planning processes at various levels.

Expected results:

- Community needs assessment and identification of priority problems.
- Commitment to hold the recommended number of meetings of "Wilayat Health Committees" during the year.
- Commitment to implementation of meeting recommendation.

Strategies to Achieve 4th objective: To encourage the implementation of CBI projects intended for health development and promotion
<p>4-1- Mass media promotion for CBI.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Increased orientation on CBI. ▪ Increased number of implemented CBI projects.
<p>4-2- Train CSGs on Management of CBI projects.</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Available trainers for community on CBI management. ▪ Increased sense of ownership and self reliance by the community towards CBI.
<p>4-3- Mobilize the private sector to support CBI</p> <p>Expected results:</p> <ul style="list-style-type: none"> ▪ Private sector supportive to CBI. ▪ CBI projects that have Positive impact on the community.

STRATEGIES' INDICATORS:

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Indicators of Strategies of the 1st Objective			
1-1-a- Number of training courses and workshop on community participation in CBI.	December Yearly	12	18
1-1-b- Percentage of participating members in each round of training.	December Yearly	422	95 – 100% of invitees
1-1-c- Percentage of beneficiaries of training courses in CBI.	December Yearly	25%	75% of beneficiaries
1-2-a- Percentage of advocacy media activities for CBI (print and audiovisual).	December Yearly	N/A	5 for each medium
Indicators of Strategies of the 2nd Objective			
2-1-a- Percentage of CSGs members that are involved in the planning of CBI projects.	December Yearly	10%	15%
2-1-b- Average number of meetings of the “Wilayat Health Committee” per year.	December Yearly	2,5	4

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
2-1-c- Percentage of implemented recommendations out of total recommendations made by the Healthy Committee.	December Yearly	10%	30%
2-2-a- Number of new CSO that are registered yearly.	December Yearly	N/A	3
2-2-b- Average number of Health Activities in the year carried out by each CSO.	December Yearly	N/A	5
Indicators of Strategies of the 3rd Objective			
3-1-a- Percentage of active Health workers "through performance assessment sheet" yearly.	December Yearly	15%	40% of All members
3-2-a- Percentage of trained CSG members out of all members.	December Yearly	30%	60% of all members
3-3-a- Number of Health related Sectors that are involved in planning for CBI every Year.		4	5
Indicators of Strategies of the 4th Objective			
4-1-a- Number of CBI projects implemented every year.	December Yearly	7	20
4-2-a- Number of community representatives that are trained on Management of CBI projects.	December Yearly	N/A	100 (20X5) yearly
4-3-a- Number of private institutions that are participating in financing CBI projects.	December Yearly	N/A	25

Vision Eight

Achieving Excellence in Managerial Processes

Domain Twenty Seven

Health Management

Vision: Achieving Excellence in The Managerial Processes

Goal: Development of Health Management Practices at All Levels

Domain: Health Management

INTRODUCTION:

The development of health services in the Sultanate of Oman is one of the hallmarks of the process of economic and social development. It includes radical changes in the dimension of standards and quality of health services, placing Oman in the rank of developed countries where solid strides have produced tremendous achievements in all the areas covered, including health management.

The health system in Oman is based on a solid infrastructure. One of the most important cornerstones adopted by the Ministry of Health is to develop health management; management is the foundation of every health institution and aids the organization to proceed in the correct manner. The past years have witnessed a growing interest for the health sector to adopt the concept of management from an organizational prospective. The organization is aware of the achievement of organizational objectives through its workers and several other resources. It can also recognize the achievement of goals through five basic administrative functions: planning, organization, employment, guidance and inspection. The administration contains human and material resources, and has the authority to rearrange them accordingly, in order to make them as productive as possible.

The health department deemed necessary distinct activities of different administrative decision-making, problem solving, learning, and strategic planning. Moreover, strengthening of decentralization through the preparation of appropriate models of health services and referral systems is a good way for coordination between the various levels of the health system, and aid the formation and completion of the organizational structures in all Wilayats health services. Furthermore, access to excellence in management practices through support systems of health management through training of human resources, and the provision of technical expertise and resources to health.

OBJECTIVES:

- 1- To activate and improve methods of communication within the health system.
- 2- To activate the system of decentralization.
- 3- To ensure balanced distribution of various resources.
- 4- To strengthen and upgrade the private health sector.
- 5- To expand the application of Quality Assurance / Improvement System at all administrative structures.

OBJECTIVES' INDICATORS:

INDICATORS	PAST SITUATION 2000	CURRENT SITUATION 2005	TARGETED SITUATION 2010
First Objective's Indicators: To activate and improve methods of communication within health system			
1- Percentage of health institutions that apply computer system.	12.5%	57.5%	80%
2- Percentage of health institutions and health administrative departments connected to the integrated communications network.	0 %	0 %	50%
3- Activation of an integrated electronic system for human resource and administrative departments.	Unavailable	Unavailable	Presence of system at the departmental level and its components at all institutions level
Second Objective's Indicators: To activate the system of decentralization			
1- Percentage of wilayats that have a decentralized Health management.	0 %	95%	100%
2- Percentage of wilayats that has updated its health management's organizational structures and resources.	0 %	7%	60%
Third Objective's Indicators: To ensure balanced distribution of various resources			
1- Percentage of health institutions that are covered by human cadres in accordance with the criteria laid down standard.	19%	33%	85%
2- Percentage of health institutions covered by equipment in accordance with the criteria laid down standard.	22%	46%	90%
Fourth Objective's Indicators: Strengthening and upgrading the private health sector			
1- Percentage of private health institutions that are committed to the requirements according to the standards set.	25%	53%	95%
2- Percentage of private health institutions that apply computer system.	0 %	0 %	25%
Fifth Objective's Indicators: To expand the application of Quality Assurance/Improvement System at all administrative structures			
1- Number of administrative departments that apply a quality assurance system	Unavailable	Unavailable	Apply to all departments

STRATEGIES:

Strategies to Achieve 1st objective: To activate and improve methods of communication within health system

1-1- Continuing the introduction of the technical electronic system in all health institutions with more frequent visits and linking it with an integrated communications network (within regions and between regions and central level).

Expected results:

- Activation of referral and feedback system.
- Time saved in the transfer of information and response to correspondences.

1-2- Support communications between the health systems at all levels.

Expected results:

- Exchange of experience of information management, health and medical services to provide better services in all regions.
- Streamlining procedures.
- Save time and effort in various transactions.

1-3- Introduction of information technology system in human resources.

Expected results:

- Completion of transactions on time and with accuracy.
- Cost reduction.
- To avoid mistakes and prevent duplication in decision-making.
- Provide accurate information at all levels.

1-4- Leadership training management at administrative and technical decisions making based on evidence and proofs.

Expected results:

- Upgrading service.

Strategies to Achieve 2nd objective: To activate the system of decentralization

2-1- Updating organizational structures in all regions (and all autonomous hospitals) and the identification of the job descriptions for all administrative and technical cadres.

Expected results:

- Approval of the Organizational structures.

Strategies to Achieve 3rd objective: To ensure balanced distribution of various resources

3-1- Developing national standards for the distribution of health resources.

Expected results:

- Ensure fair distribution of resources among the institutions in accordance with national criteria.

Strategies to Achieve 4th objective: To strengthen and upgrade the private health sector

4-1- Review and development of standards for Private Health Institutions.**Expected results:**

- Ensure patient safety in private sector.
- Presence of a standard manual in all private health institutions.
- Ensure the quality of care provided by private health institutions.

Strategies to Achieve 5th objective: To expand the application of Quality Assurance / Improvement System at all administrative structures

5-1- Application control system performance and quality control at all levels of management.**Expected results:**

- Dissemination of quality culture between administrative staff.
- Adoption of evidence of the quality of work in all areas.
- The presence of trained administrators exercising quality control and quality improvement (i.e. trained and certified administrative auditors).

STRATEGIES' INDICATORS:

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Indicators of Strategies of the 1st Objective			
1-1-a- Percentage of feedback reports to number of referrals.	Annually	30%	70%
1-1-b- Percentage of health institutions covered by the Internet.	Annually	25%	70%
1-2-a- Percentage of electronic correspondence to all correspondence (on the level of the institutions and all regional level).	Annually	8%	50%
1-3-a- Percentage of trained electronic system to all workers.	Annually	50%	80%
1-4-a- Administrative manuals issued.	Biennially	Unavailable	Available

INDICATORS	FOLLOW UP TIMING	CURRENT SITUATION 2005	TARGETED SITUATION 2010
Indicators of Strategies of the 2nd Objective			
2-1-a- Number of hospitals with approved organizational structure.	Annually	Unavailable	All hospitals Reference
2-1-b- Number of regions with approved organizational structure.	Annually	Unavailable	All Areas
2-1-c- Percentage of Directorates (Departments) that completed job cadres in all regions.	Annually	40%	80%
Indicators of Strategies of the 3rd Objective			
3-1-a- Presence of national standards for the distribution of resources between health institutions.	Annually	Unavailable	available
Indicators of Strategies of the 4th Objective			
4-1-a- Percentage of eligible Private clinics to the total number of private clinics.	Annually	85%	100%
4-1-b- Number of new private institutions.	Annually	10	40
Indicators of Strategies of the 5th Objective			
5-1-a- Percentage of the institutions that apply quality system in management structures.	Annually	0%	100%
5-1-b- Percentage of administrative workers trained in quality system.	Annually	0.5%	87%
5-1-c- Percentage of administrative workers trained to assess quality (i.e. trained auditors).	Annually	Unavailable	80%

