

## Introduction

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## Introduction

Health service is a complex, dynamic system which influenced by different historical, economic, political and other factors. Decision-makers need reliable information on the cost, effectiveness and efficiency of the policies, interventions and programs, targeting the health of the population, in a timely and useable fashion. In additions, information on choice of health intervention, system design, quality of care and ways to encourage desirable and discourage undesirable programs. This requires improving the government capacity, especially in the area of stewardship, and adjusting approaches to financing and resource generation as well as provision of health services.

One of the most difficult challenges for enhancing performance of health system is the design of the overall system. Better evidence is needed on the relationship between the performance and the organization of different health systems, and on the ways to manage the complex process of change.

Decision-makers at different levels need the tools, information and capacity to assess health needs, choice of health system strategies, design policy options appropriate to their own circumstances, monitor performance and manage changes.

Without reliable data, it is impossible to assess effectively the impact of policies, programs or any interventions in the health sector. Without the right indicators, important problems might not be detected. And without a system-wide scope, solutions with unintended consequences might be developed. Therefore, World Health Organization WHO is continuously developing stronger norms and standards for overall health information systems at national and sub-national levels, with a focus on quality of data, methods for data collection and estimations to enable managers and decision makers to:

- Assess health situation and trends;
- Assess needs for health services;
- Define and measure goals, objectives and targets of health programmes;
- Define the functions of health care services and units;
- Set priorities for the allocation of resources and, accordingly, plan the health services;
- Manage the health programmes, monitor and evaluate their performance, and assess efficiency of resources usage;
- Supervise and run training activities for the staff;
- Coordinate activities within the health sector, and with other sectors in the health related matters to avoid unnecessary duplication;
- Control communicable diseases.

### General Discussion

This introduction will tackle a discussion on health status and health services in 2003. It is intended to be meaningful to educate members of general public as well as to health care professionals. The main objective of the coverage that stimulate Ministry of Health discussion for further development of this and associated routine annual reports. The body of this report is structured as follows:

- A summary statistics of the population of the kingdom
- Health resources (physical, financial, and human resources)
- Health services and activities
- Health status

The report consists of sixteen chapters. Chapter one shows a summary statistics of all Health indicators for the Kingdom. The chapter covers all the above items such as the socioeconomic & demographic characteristics, health resources, utilization of Health Institutions, and health status. Chapter two presents selected tables that shows basic results out of the 2001 census. Chapter 3-9 focus on resources, facilities services, vital, morbidity and mortality statistics of Ministry of Health. Chapter ten present some of the activities in Bahrain Defense Force hospital and chapters 11-16 cover the services at Private Hospitals.

The report was compiled by the Health Information Directorate and is based on the statistics collected from most of MOH health care business areas, Patient Management Information automated system, Central Informatics Organization (CIO), Ministry of Finance and National Economy (MoFNE), and Private hospitals and clinics.

### Demographic and Socioeconomic Indicators

The estimated 2003 population was 689,418 and 538,085 in 1993. The proportion of the Bahraini Nationals to Non-Bahrainis were relatively equals over the last 10 years. In the year 2003, 62% of the population were Bahraini and 38% were Non-Bahraini. Compared to 63% Bahraini and 37% Non-Bahraini in 1993.

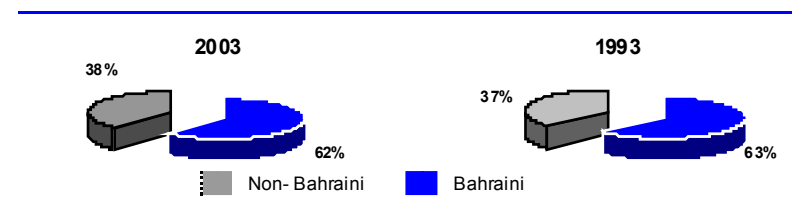
**Population Estimates** **Table 1**

Population	2003	1993	Annual % Change*
Total	689,418	538,085	2.5
Bahraini	427,955	338,744	2.4
Non-Bahraini	261,463	199,341	2.7

Ref: Central Informatics Organization, estimates based on 2001 & 1991 census  
 \* Annual % Change =  $[(Pop.2003/Pop.1993)^{1/A} - 1] * 100$

**Population Percentage By Nationality**

**Figure 1**



### Population Sex Ratio

The sex ratios for the entire population were nearly stable in both years irrespective to the nationality (135 in 2003 and 137 in 1993). The sex ratio (male per 100 female) among Bahraini was constant in both years 102. In contrast to the Non-Bahraini population which was relatively high in both years (236 in 1993 and 223 in 2003). This was due to the male-dominant immigration, especially the middle age group (i.e. the working age group). (see table 2)

**Population Sex Ratio**

**Table 2**

Nationality	2003	1993
Total	135	137
Bah	102	102
Non- Bah	223	236

Population Sex Ratio (male per 100 female) = (No. Male/No. Female)\*100

### Population by Age, Sex and Nationality

As mentioned previously, although there has been an increase in the estimated population in 2003 from 1993 (as illustrated in table 3), but the percentage of people under 15 years of age has decreased since 1993 from 30.1% to 27.6. In fact, this decrease was also true for both nationalities. Nevertheless, the Bahraini population of this age group took the bulk of these percentages which was 40.9% in 1993 and 36.2% in 2003, comparing to 13.8 in 1993 and 13.5 in 2003 for Non-Bahraini.

**Population Distribution by Age Group & Nationality** **Table 3**

Population (%)	2003			1993		
	Male	Female	Total	Male	Female	Total
<b>Total (both Nat.)</b>						
Pop<15	24.5	31.7	<b>27.6</b>	27.8	36.5	<b>30.1</b>
15-64	73.3	65.4	<b>69.9</b>	70.1	61.0	<b>67.7</b>
65+	2.2	2.9	<b>2.5</b>	2.1	2.5	<b>2.2</b>
<b>Bahraini</b>						
Pop<15	36.6	35.7	<b>36.2</b>	41.4	40.3	<b>40.9</b>
15-64	59.8	60.5	<b>60.1</b>	55.2	56.6	<b>55.9</b>
65+	3.6	3.8	<b>3.7</b>	3.4	3.1	<b>3.2</b>
<b>Non-Bahraini</b>						
Pop<15	10.1	21.2	<b>13.5</b>	11.4	25.8	<b>13.8</b>
15-64	89.4	78.2	<b>85.9</b>	88.2	73.6	<b>85.8</b>
65+	0.5	0.6	<b>0.6</b>	0.4	0.6	<b>0.4</b>

The proportion of middle age group or working group aged (15-64) years out of the overall population was two third of the total population 69.9% in 2003 and 67.7% in 1993. The population proportion by Nationality was 60.1% for Bahrainis and 85.9% were non-Bahraini in 2003. However, in 1993 it was 55.9% were Bahrainis and 85.8% were non-Bahrainis. There was a noticeable increase in the percentage among Non-Bahraini than Bahraini population of the age group 15-64 years in both estimates.

However, the percentage of persons aged 65 years and over has been maintained at a low proportion: 2.5% during 2003 and 2.2% in 1993. While the distribution of that age group by nationality showed that, 3.7% among Bahrainis and 0.6% for non-Bahraini in 2003, and 3.2% for Bahrainis and 0.4% for non-Bahraini population in 1993.

As shown in the table above that sex differential is in favour of female in the youngest (age < 15 years) and oldest 65+, but not in the middle age especially among Non-Bahraini.

### Age Dependency Ratio

The total dependency ratio in Bahrain (defined as the number of persons in a population who are not economically active for every 100 economically active persons in that population). It is usual to use as a rough guide the Childhood dependency ratio (age groups 0-14) and aging dependency ratio (aged 65+), to the population in the age group 15-64 years, since the retirement age in Bahrain is 65 years.

There is a significant drop in the dependency ratio for the past ten years. In year 2003 the dependency ratio was 39.4%, 3.6% and 43% for the childhood, aged and the total dependency ratio populations respectively. Comparing to 1993, the dependency ratios were 47.1%, 3.4% and 50.5%.

However, the number of individuals receiving welfare payments from the kingdom has increased for the past five years as reported by Ministry of Labour. The value of the payment rose from 3.9 million in 2000 to 4.2 million in 2003. Out of this amount 43% goes for the elderly.

Overall, the rate of disability among Bahraini population represented only less than 1% of the total population.

## Health Facilities and Health Resources (1999-2003)

### Physical Resources

The Health system delivery is shared between both government and private sectors. The Health facilities have improved rapidly during the past five years which illustrated in table 4. This can be witnessed clearly through the remarkable evolution in regard to the size and quality of the services at Salmaniya Medical Complex (main hospital in Bahrain). The building has been expanded to enable the introduction of new services such as Oncology and Kidney Transplant. The installation of new sophisticated medical equipment contributed in the diagnosis, treatment and rehabilitation of the patients. In addition to that a great attention was given to improve the quality of the services provided at the Psychiatric Hospital, Geriatric and the five Maternity Hospitals.

Continuation of improvements in health care services never stopped with government only, but it includes the private sector. The opening of the Bahrain Specialist Hospital in 19<sup>th</sup> October 2003 was a clear eye witness for that. In addition to that, and several private clinics, Polytechnics and Medical Centers in various medical specialties were opened. Seven of these clinics are operating round the clock.

The expansion of the services was not limited to the Secondary Health Care, but it included also the Primary Health Care. To maximize the capacities and accessibility to the services in Primary Health Care, many steps were taken during the past five years such as:

- Formulation of the primary health care quality improvement committee to improve the overall performance at the health centers.
- Empowering the staff through decentralizing the process of decision making, the scheme was implemented at A'Ali and Bliad Al Kadeem health Centers as pilot.
- Reducing the cost of some provided services by enhancing the way they are performed.

- Setting up standard procedures and policies for the health centers.
- The operating of MCH expansion at Budaiya Health Center on 20<sup>th</sup> Aug 2003.
- The opening of Mohammed Jassim Kanoo night shift on 1<sup>st</sup> April 2003.
- Upgrading of Dair Health Center and Zallaq Clinic.
- Providing the Physiotherapy at Mohammed Jassim Kanoo Health Center commencing 12 April 2003.
- Provision of dental services at night session at A'ali Health Center starting 19<sup>th</sup> Dec. 2003.
- As part of Health Centers Automation project, A'ali on 2<sup>nd</sup> March 2003, National Bank of Bahrain on 26<sup>th</sup> April 2003 and Sh. Salman Health Centers on 3<sup>rd</sup> Feb 2003 were fully automated.
- Increase number of specialized clinics for diabetic patients at Bilad Al Kadeem in Oct, Mohammed Jasim Kanoo and East Riffa in Nov. 2003.

**Health Facilities** **Table 4**

Description		2003	2002	2001	2000	1999
Hospitals	Govern*	9	9	9	9	9
	Private	6	6	5	3	3
Beds	Govern	1,691	1,680	1,696	1,678	1,689
	Private	213	244	150	134	134
Primary Health Care	Govern	23	23	23	22	22
Inpatients	Govern	77,710	76,624	71,756	72,478	62,231
	Private	8,387	6,838	4,435	4,616	4,863
Outpatients	Govern	3,862,871	3,768,188	3,619,036	3,594,914	3,293,632
	Private	420,463	341,478	309,003	294,332	290,368

\* Govern = Government- Including Directorate of Health & Social Welfare previously Public Security Health Center. Private Primary Health Care is provided through the private companies clinics.

From the above table it showed a remarkable increase in the health care facilities especially in private sectors, which nearly doubled from the past five years.

### Financial Resources

With growing population, health care budgets are coming under mounting strain as the country strives to maintain and improve its services. Financial allocation for medical care have risen substantially in recent years. But still they are not sufficient for the demands placed upon them.

Nowadays, the major challenge that the Ministry faced is to maintain current health services and strive for health for all. With the continuous increase in the provision of health care services commencing 1973 and continued until today (see table 5), the Ministry requires a mechanism that brings additional financial resources in order to sustain the best quality of health services.

### Financial Resources Table 5

Financial data	2003	2002	2001	2000	1999
% of allocated budget to MOH from total Government expenditure	7.4	7.1	7.8	7.8	8.5
MoH Budget* (BD. in Million)	80.6	71.0	64.4	61.0	61.7
MoH average recurrent health expenditure/ capita	113.8	103.1	96.6	85.8	86.1
<b>Cost per MOH Visits (BD.)</b>					
Primary outpatients	3.4	3.0	2.9	2.6	2.7
Secondary outpatients	30.7	27.8	26.6	27.3	25.1
Secondary Inpatients (per day)	122.7	112.2	106.6	109.3	100.5
Deliveries (maternity Hosp.)	315.5	278	287	267	269.5
<b>% MOH recurrent expenditure on:</b>					
Primary & Preventive H.C.	22.7	22.2	21.9	21.0	21.0
Secondary H.C.	58.8	59.1	60.0	59.5	58.8
Total Other	18.5	18.7	18.1	19.5	20.2

1US\$ = 0.377 BD

\* Source: Ministry of Finance & National Economy - MOH budget include projects received

The Ministry of Health is the major provider of health services and is considered as a major source of health financing. The budget of the Ministry of Health was 80.6 million in 2003, which was 7.4% of the total government expenditure. In that year, the Ministry's recurrent budget was BD. 78.4 million with annual growth rate of 13.3%, whereas in 1999 the Ministry's budget was BD. 61.7 million which represented 8.5% as percentage of the total government expenditure. The Ministry's recurrent budget was BD. 57.4 million.

The Ministry of Health average expenditure per capita has increased from BD. 84 (equivalent to U.S \$223 per person) in 1993 to BD. 113.8 (equivalent to U.S. \$ 302) in 2003. More than half of the Ministry budget was devoted to Secondary Health Care (58.8% in 2003 which is equivalent to 1999). However, only 22.7% of the Ministry's budget was devoted to Primary and Preventive Health Care in 2003 and 21% in 1999.

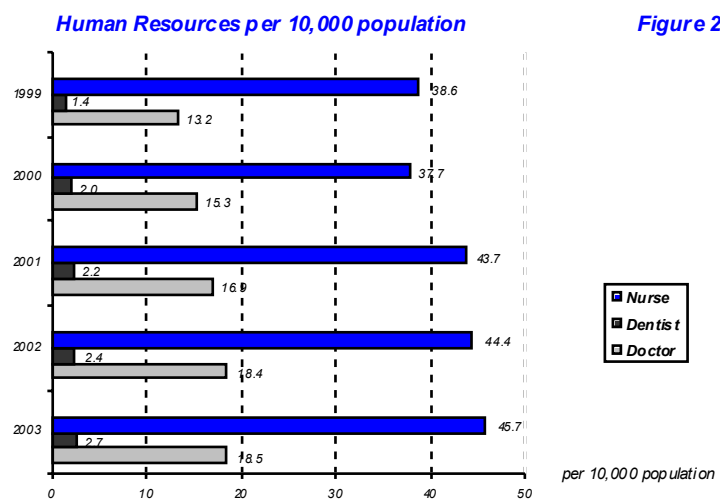
The average cost per visits for primary Health care clinics was BD. 3.4 in 2003 relatively at the same range in 1999 (BD. 2.7). On the other hand, the cost of the services per person in the secondary health outpatient clinics has been increased since 1999 from BD. 25.1 to BD.30.7 in 2003. Moreover, the cost of the inpatient per day has also increased from BD. 110.5 in 1999 to BD. 122.7 in 2003 (see table 5).

### Human Resources

Table 6 below shows the development of the medical resources over the past five years at the national level respectively. During the 1999, per 10,000 population, there were 13.2 doctors, 1.4 dentists and 38.6 nurses, while they were 18.5, 2.7, 45.7 respectively in 2003. The nurse-doctor ratio was 2.4 in 2003.

**Human Resources** **Table 6**

Indicators (per 10,000 Population)	2003	2002	2001	2000	1999
Doctors	18.5	18.4	16.9	15.3	13.2
Dentists	2.7	2.4	2.2	2.0	1.4
Nurses	45.7	44.4	43.7	37.7	38.6
Nurse per doctors	2.4	2.4	2.6	2.5	2.9
Bed	28.1	28.6	28.2	26.2	27.4



### Health Status of the Community

The following are selected standard health indicators that reflect Bahrain's improving health status.

#### Vital Statistics

Table 7 below shows that most of the vital statistical indicators were relatively constant for the past five years. For example, crude birth rate per 1000 population was 21.1 in 2003 and 19.8 in 1999. Infant mortality rate per 1000 live births recorded a significant variation in 2003 which was 7.3, this was undoubtedly due to the high level of preventive and curative for the mother and child health programs.

**Vital Statistics as reported by Public Health Directorate** **Table 7**

Health Indicators	2003	2002	2001	2000	1999
Crude birth/1000 population	21.1	20.1	20.5	19.6	19.8
Still birth rates/1000 births	7.2	9.8	8.7	10.0	8.6
Infant mortality rate/1000 live births	7.3	7.0	8.7	8.6	7.7*
Maternal mortality rate/1000 live births	0.21	0.22	0.22	0.15	0.23
Under 5 yrs mortality/1000 live births	9.5	8.5	12.1	11.4	11.7
Under 5 yrs mortality/1000 child <5 yrs old	2.2	1.9	2.7	1.9	2.0
Total Fertility Rate per woman (Female 15-44)	2.5	2.5	2.5	2.5	2.5
Crude death rate/1000 population	3.1	3.0	3.0	3.0	2.9
Life expectancy rate at birth both sex	73.8	73.8	73.8	72.9	72.9

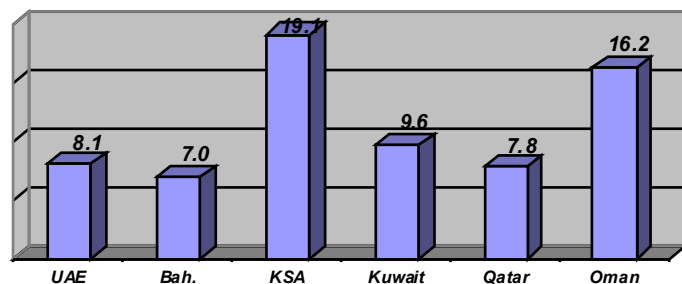
\*Excluding 27 deaths under 25 weeks of gestation who died shortly after birth

Total fertility rates (per woman of age 15-44) are consistent for the past five years at 2.5 in (3.4 for Bahrainis and 1.6 for Non Bahrainis).

Life expectancy rate at birth for both males and females was 73.8 years in 2003, 72.1 for male and 76.3 for female. Comparing to 1999, it was 72.9 for both sex, 70.4 for male and 75.3 for female respectively. This is a substantial achievement as the Global indicator No.10 stated that the averaged life expectancy rate at birth should be 62 years.

Looking to figure 3, The Kingdom of Bahrain is one of the healthiest country in the region and head of the rest of the other GCC countries.

**Infant Mortality Rate/1000 live Birth for year 2002 – GCC Countries Figure 3**



"Vital Health Indicators - 2003", Executive Office of the Health Ministers Council for GCC, 8<sup>th</sup> Edition.

**Nutritional Status of Children**

Birth weight is an indicator of the health and nutritional status of mothers, as well as a prediction of infant health and development. In Bahrain, the percentage of newborns weighing at least 2.5 kg. has remained relatively constant for the past five years at 90.0%, 90.4%, 90.3%, 90.1%, and 90.4% for the years 2003, 2002, 2001, 2000, 1999 respectively. In addition to that, the percentage of children below five years with weight-for-age values corresponding to acceptable standard reference values has significantly increased since the early Nineties from 77% to remain relatively stable around (92±.5%) for the past five years. It is well known that the better educated mothers the greater impact will be on the health of the whole family, as well as newborns.

**Mortality**

In 2003, 2,114 deaths were reported to Public Health Directorate as compared to 1,997 in 1999, mostly from hospitals (51% deaths occurred at Salmaniya Medical Complex). The crude death rate continues to be very low and nearly constant (3 per 1000 population) since 1999. Most deaths recorded in Bahrain from the disease are amongst male 59% rather than female.

Diseases of the circulatory system/ Cardiovascular diseases constitute the highest single cause of mortality in Bahrain representing 86.6 per 100,000 population, accounting for more than 28.2% of total deaths at Salmaniya Medical Complex.

The known risk factors for CVD such as smoking, and raised blood cholesterol, and the risk makers such as lack of physical activity, obesity, and alcohol consumption are expected to have increased in Bahrain over the last two decades. In addition to that, the continuing rise in the incidence of the Cardiovascular in association with the rise in the size of the population over sixty five years of age.

Neoplasms or Cancer is the second most common cause of death in Bahrain accounting for about 12.8% of total deaths. This accords with the world pattern. The great majority of deaths (68.7%) from Cancer were in age group over 60 years.

Deaths from the Infectious and Parasitic rose significantly in 2003, 17.5% from previous year. Other major causes of death were injuries & poisoning, endocrine, nutritional & metabolic disorders, congenital anomalies, Genitourinary diseases and diseases of the digestive system (see table 8).

One of the recommendations of the World Health 2003 Report "Reducing Risks report" was that "countries should give top priority to developing effective, committed policies for the prevention of globally increasing high risks to health." The main risk factors as defined by WHO are high blood pressure and high blood cholesterol are closely related to excessive consumption of fatty, sugary and salty foods. They become even more lethal when combined with the deadly forces of tobacco and excessive alcohol consumption and unsafe sex in connection with HIV/AIDS.

**Top Leading Causes of Death**

**Table 8**

Causes of Death (rates per 100,000 Population)	2003	2002	2001	2000	1999
Diseases of circulatory system	86.6	86.5	86.3	77.6	85.0
Symptoms, signs and abnormal clinical & Lab. Findings not elsewhere Classified	39.3	45.2	49.6	45.0	42.5
Neoplasms	39.3	41.4	36.9	35.8	35.0
Injuries & poisoning	26.5	26.5	28.1	44.9	23.9
Endocrine, nutritional & metabolic disor.	24.2	28.1	24.9	20.3	22.2
Respiratory system	20.7	18.0	16.2	12.2	18.8
Digestive system	13.8	10.4	9.6	10.6	11.4
Certain Infectious & Parasitic diseases	11.9	10.1	7.5	12.3	8.0
Genitourinary System	11.0	7.6	8.2	7.8	8.4
Congenital Anomalies deformations & chromosomal abnormalities	7.8	6.7	10.1	12.3	10.1

**Morbidity**

The health problems of Bahrain are those generally found in countries passing through the stage of transition from developing to developed nations. Communicable diseases are declining as the major causes of mortality and morbidity. They are being replaced by non-communicable ones such as cardiovascular diseases, cancer, metabolic diseases, congenital anomalies and accidents. The main causes of hospital admissions, based on the statistics of Salmaniya Medical Complex are illustrated in table 9.

Spontaneous abortion/miscarriages were the most common complication in pregnancies throughout the world. The SMC data showed that most of the listed morbidity have risen for over the past five years. This may highlight that more attention should be given to the environmental risks, community lifestyle and health education.

**Top Ten Morbidity Based on Discharges from Salmaniya Medical Complex<sup>1</sup> Table 9**

Morbidity (rates per 100,000 Population)	2003	2002	2001	2000	1999
Complication pregnancy, childbirth & puerperium ( 15-44) <sup>2</sup>	6,231.7	6,226.4	6,132.1	6,248.5	6,301.2
Spontaneous abortion	895.0	1,017.4	1,012.1	1,012.1	1,053.4
Hereditary anaemias	363.8	277.5	227.2	233.4	229.4
Neoplasms	220.3	237.9	241.5	221.9	146.3
Ischemic heart disease	165.4	159.5	148.6	128.4	152.2
Diabetes	107.2	85.4	88.6	94.8	75.5
Asthma	56.6	66.1	61.1	69.9	72.4
Acute respiratory infection	30.9	43.7	41.7	43.4	59.4

<sup>1</sup> Rates per 100,000 population

<sup>2</sup> Rates per 100,000 females age 15-44 yrs

### Immunization

Due to an efficient Expanded Program on Immunization (EPI) and high immunization coverage more than 98% , childhood diseases have been almost eradicated in Bahrain. According to the World Health Organization (WHO) Immunization Schedule, Measles vaccine as single antigen dose1 and MMR as dose2 were replaced by MMR1 given to children at one year of age MMR2 at 4-6 years of age since 1999. (See table 10)

The EPI team coordinate with the Ministry of Education to carry out the Immunization activities on the schools children at all levels for both government & private under the umbrella of the school health program.

**Immunization Coverage Percentage Table 10**

Immunization Against	2003	2002	2001	2000	1999
DPT	97.3	98	99	97	97
Mumps, Measles, Rubella (MMR1)	100	99.9	97	98	93
Mumps, Measles, Rubella (MMR2)	99.5	97	99	92	98
Poliomyelitis	97.3	98	99	97	97

### Communicable Diseases

No cases were reported of the Diphtheria, Whooping Cough, Neonatal Tetanus or Poliomyelitis since 1990. Nevertheless, table 11 below shows that there were some variations in the rates trend of communicable diseases for the past five years. Although there was a marked rise in Gonococcal Infection (28.9/100,000 in 1999 to 70.8/100,000 in 2003), Syphilis incidence showed that there was a continuous rise to reach 242 cases (35.1/100,000) in 2003 from 105 cases (15.8/100,000) in 1999.

Furthermore, there was also a substantial decrease in the number of Malaria (*P. vivax*) cases from 55 cases (8.0/100,000) in 2003 as compared to 65 cases (9.8/100,000) in 1999. There was an increase of the Viral Hepatitis totals to reach 42.5/100,000 in 2003 from 1999 which was 30.8/100,000. Most of the sexual transmission diseases cases were increased lately due to unsafe relations.

**Communicable Diseases Rates (Reported New Cases) Table 11**

Disease (rates per 100,000 Population)	2003	2002	2001	2000	1999
Pulmonary TB	19.1	18.7	17.0	23.2	14.7
Gonococcal Infection	70.8	62.0	36.4	34.0	28.9
Syphilis	35.1	36.9	22.8	31.8	15.8
Viral Hepatitis (Total)	42.5	36.3	35.1	23.3	30.8
Malaria ( <i>P. vivax</i> )	8.0	7.0	7.0	7.7	9.8

## New Millenium Development Goals (MDGs)<sup>7</sup>

At the United Nation Millennium Summit in 2000, world leaders from around the world (189 countries) endorsed a set of goals and targets for the year 2015. The eight goals, known as the Millennium Development Goals (MDGs) cover a range of development issues, such as reducing poverty, fighting various infectious diseases, and promoting gender equity.

The eight Millennium Development Goals comprise 18 targets and 48 indicators. The targets set quantitative targets for poverty reduction and improvements in health, education, gender equality, the environmental and other aspects of human welfare. These goals are:

- Goal 1: Eradicate extreme poverty and hunger
- Goal 2: Achieve universal primary education
- Goal 3: Promote gender equality and empower women
- Goal 4: Reduce child mortality
- Goal 5: Improve maternal health
- Goal 6: Combat HIV/AIDS, malaria, and other diseases
- Goal 7: Ensure environmental sustainability
- Goal 8: Develop a global partnership for development.

Three goals, Eleven targets and seventeen indicators were directly related to health which WHO is responsible in terms of reporting at global level.

The MDGs are being used to focus and reorient the work of individuals and programs, and as a benchmark against which to assess overall county and organizational performance.

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- 6) "Evidence-Based Healthcare *How to Make Health Policy & anagement Decisions*", by J.A. Muir Gray. Churchill Livingstone. 1997
- 7) <http://www.developmentgoals.org/Goals.htm>

## Appendix 1: Selected W.H.O. Global Health Indicators

[G.I.7]	The percentage of the population covered by eight elements of primary health care
[G.I.7(c)]	The percentage of infants immunized against diphtheria, tetanus and whooping cough
[G.I.7(e)]	The percentage of infants immunized against polio
[G.I.8(a)]	The percentage of newborns weighing at least 2.5 kg. at birth
[G.I.8(b)]	The percentage of children whose weight-for-age and or weight-for height are acceptable
[G.I.9(a)]	The Infant mortality rate/1000 live births
[G.I.9(b)]	Maternal mortality rate/1000 live births
[G.I.10(a)]	Life expectancy rate (male & Female) at birth in years
[G.I.10(b)]	Male life expectancy rate at birth in years
[G.I.10(c)]	Female life expectancy rate at birth in years
[G.I.12]	Per capita gross national product in US dollars \$