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Roadmap of WHO's work for the Eastern Mediterranean Region

2017–2021

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Foreword

I am pleased to introduce the roadmap for my first five-year term as WHO Regional Director for the Eastern Mediterranean. I would like to start by acknowledging the trust that Member States have placed in me to lead WHO's work in the Eastern Mediterranean Region for the next five years. I am fully aware of their expectations and will exert all efforts to fulfil the commitments I have made to them. I will ensure that WHO is on the frontline in providing health leadership, not only by working closely with Member States to provide all necessary technical support to address regional health challenges but in focusing on the priorities to which I have committed in my statements to the Regional Committee for the Eastern Mediterranean in October 2016 and at WHO's Executive Board in January 2017.

I have set out a vision and this roadmap underpins that vision for my five-year mandate as Regional Director. I aim to increase WHO's capacity to meet the needs of Member States by ensuring that WHO in the Region becomes ever increasingly effective, efficient, accountable and transparent.

WHO will work closely with Member States in order to achieve the targets of health-related Sustainable Development Goal (SDG) 3 "Ensure healthy lives and promote well-being for all at all ages"; an important prerequisite for achieving all other goals in the 2030 Agenda for Sustainable Development.

In ensuring alignment of this roadmap with the SDGs, focus is placed on five priorities – emergencies and health security, communicable diseases, noncommunicable diseases, maternal, neonatal, child and adolescent health, and health system strengthening – in order that tangible results are attained by the end of my term. Achievable and practical targets, indicators and milestones for programmes within each priority area have been identified and will be properly monitored.

Within the Organization, I will be working to enable a productive, creative and innovative environment as the foundation for WHO as a centre of excellence. I will focus on developing staff skills, promoting effective communication, establishing effective coordination mechanisms and facilitating teamwork. Enabling changes will include increasing delegation of authority to staff at different levels of the Organization to ensure objective accountability, greater transparency and the management of risks.

Progress in addressing these areas will only be possible through our sustained commitment, and that of Member States and partners. We will unite efforts, drawing on our own particular strengths and resources, to ensure holistic improvements to health.

Dr M. Fikri
Regional Director
WHO Eastern Mediterranean

1. Introduction

This roadmap of WHO's work in the Eastern Mediterranean Region (2017–2021) translates the vision of the WHO Regional Director into a set of strategic actions to guide WHO's work with Member States. It represents a five-year strategic plan for the WHO Regional Office under the leadership of Dr M. Fikri, the elected Regional Director.

This roadmap takes into consideration the global and regional environments in which WHO is working**,** including the global commitment to the 2030 Agenda for Sustainable Development and the WHO reform agenda. Hence, the roadmap considers the Sustainable Development Goals (SDGs) as the overall framework to guide WHO's work with Member States in the Region. WHO will support Member States to achieve the targets of all SDGs and will take the lead in supporting them to achieve SDG 3 in particular: "Ensure healthy lives and promote well-being for all at all ages" in the planning and implementation of their development policies, with a focus on progressing towards universal health coverage.

At the beginning of his term, an interdepartmental taskforce was established by the Regional Director to develop a clear roadmap for WHO's work for 2017–2021. The establishment of this taskforce aims to facilitate a Region-wide approach to addressing health priorities in a systematic and comprehensive way in order to ensure that the work of the Regional Office is aligned with the needs of Member States and World Health Assembly, Executive Board and Regional Committee resolutions and decisions.

The roadmap has been developed around four interrelated pillars – public health priorities, enabling factors, WHO's presence in countries; and WHO's working environment – that translate the vision into action to guide WHO's work. Focus is placed on five priority areas of public health outlined below. Challenges to addressing these priorities have been identified and strategic actions for change proposed accordingly. Achievable and practical targets, indicators and milestones for the period have been identified and progress will be properly monitored.

These priorities cannot be addressed individually, they are interlinked both in terms of challenges and the strategic approaches needed to address them. The priority areas identified for targeted action are:

- emergencies and health security to ensure a coherent public health approach to the emergency response in countries affected by emergencies and to enhance preparedness and health security for the Region, including the eradication of polio;
- prevention and control of communicable diseases to address the important gaps in vaccination coverage, control the rapid spread of antimicrobial resistance, and implement integrated disease surveillance to closely monitor these diseases and the impact of interventions aimed at reducing illness and death resulting from them;
- prevention and control of noncommunicable diseases, mental health and substance abuse to strengthen efforts to reduce the burden and mortality due to these diseases with a focus on reducing risk factors;
- maternal, neonatal, child and adolescent health to reduce neonatal, child and adolescent mortality and the remaining burden of high maternal mortality;
- health system strengthening to achieve universal health coverage.

Enabling factors include advocating for Health-in-All-Policies (HiAP),[1] building capacity of public health management and leadership, expanding partnerships with United Nations agencies and civil society, mainstreaming health in the SDGs, adopting multisectoral and risk management approaches, enhancing regional capacities in resource mobilization, strengthening monitoring and evaluation functions in the Organization, and addressing social and environmental determinants of health in WHO approaches.

The WHO Regional Office aims to strengthen and refine its work at country level to become increasingly responsive to the needs of Member States. Hence, the commitment made by the Regional Director to strengthen WHO's engagement and response and to enhance the image of the Organization at country level through greater transparency with Member States, joint planning, continuous two-way dialogue and greater engagement of countries in WHO's work, particularly in priority-setting, advisory forums, consultations and technical cooperation among countries. WHO's presence in countries also covers the Regional Director's intention to further strengthen WHO country offices to be more responsive to the needs of Member States and to facilitate expansion of partnerships with United Nations agencies, other partners and stakeholders, which has become more important than ever in the context of the 2030 Agenda for Sustainable Development.

The Regional Director will work to enable a productive, creative and innovative environment as the foundation for WHO as a centre of excellence. His aim is to delegate more authority to staff at different levels of the Organization to ensure objective accountability, greater transparency and the management of risks. This will require professional development, enhancement of staff skills, effective communication, coordination and teamwork and strengthening of the Organization's internal control framework.

As a results-based oriented organization, the WHO Regional Office has outlined clear strategic planning in the roadmap. This is supported by detailed operational plans for expected results with clear targets and indicators for monitoring and evaluation of the work for the timeframe of the roadmap. The Regional Director will provide a regular update to the WHO Regional Committee for the Eastern Mediterranean on the progress in implementing this roadmap through the Regional Director's annual report.

2. Current situation in the Eastern Mediterranean Region

WHO's Eastern Mediterranean Region spans from Pakistan in the east to Morocco in the west, hosting a population of nearly 645 million people[2] in 22 countries characterized by diverse socioeconomic status and health challenges.

The Region is witnessing an unprecedented magnitude and scale of crises. Since 2011, there has been an increase in the number of countries affected by conflict. Today, almost two thirds of countries in the Region are directly or indirectly affected by emergencies, including four countries (out of a total of six globally) graded by WHO and the United Nations as Grade 3 experiencing "major" emergencies – Iraq, Somalia, Syria and Yemen.[3] The Region also hosts countries witnessing protracted emergencies, including Afghanistan, Libya, Palestine, Pakistan and Sudan. Most of the remaining countries are affected by crises in neighbouring countries. Thus, many of our Member States face considerable hurdles in re-orienting national development plans to achieve the targets of the SDGs and increased efforts must be exerted to support those countries.

[1] HiAP: "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts in order to improve populations health and health equity" World Health Organization. The Helsinki statement on health in all policies [Internet]. 8th Global Conference on Health Promotion; 2013 June 10-14; Helsinki (Finland). Geneva: World Health Organization; 2013.

[2] Eastern Mediterranean Region Framework for health information systems and core indicators for monitoring health situation and health system performance 2016. Cairo: World Health Organization; 2016. http://applications.emro.who.int/dsaf/EMROPUB_2016_EN_19169.pdf?ua=1.

[3] http://www.who.int/hac/crises/en/.

The Region continues to bear the largest burden of people in need of aid of different forms, including health care. By the end of 2016, out of a total of 140 million people in need of aid globally, more than 76 million people (59%) lived in countries in the Region directly or indirectly affected by emergencies.[4] Further exacerbating the situation, attacks against health care facilities and workers, reported in eight countries of the Region, accounted for 83% of attacks against health care globally in 2016.

In addition, the Region bears the greatest burden of displaced populations globally, with more than 30 million people displaced cross the Region. Over the past few years, the Region has seen massive internal displacement in Afghanistan, Iraq, Somalia, Syrian Arab Republic and Yemen. Neighbouring countries and host communities are disproportionately affected by the impact of displaced populations, and their capacities have been stretched to the limits in many cases. Increased demand on services like health, education, water and sanitation is overwhelming, exposing countries to serious public health risks and resulting in the loss of health gains that have been achieved with years of hard work. In this context, Member States agreed in the 2030 Agenda for Sustainable Development to "meet the special needs of people living in areas affected by complex humanitarian emergencies and in areas affected by terrorism."

Fragile health systems in a number of countries are being weakened by these emergencies and the health of populations across the Region is being negatively affected. As a result, a growing number of people are requiring life-saving trauma care, treatment for communicable and noncommunicable diseases and mental health disorders, maternal and child health care; in addition, the requirements of populations with special needs must be addressed.

This situation has taken its toll on health security in the Region – the high incidence of emerging and re-emerging infectious diseases poses a perennial threat to regional health security which also has a significant impact on health and economic development in the Region. At least 12 of the Region's 22 countries have experienced one or more emerging infectious disease outbreaks in the last decade with potential for global spread; these diseases have included Middle East respiratory syndrome coronavirus (MERS-CoV), avian influenza A(H5N1) infections, dengue fever, cholera, Crimean-Congo haemorrhagic fever, among others.

The principal risk factors contributing to the emergence and rapid spread of a high number of emerging diseases include ongoing humanitarian emergencies resulting in fragile health systems in many countries, increased population mobility (travel and displacement), fragile eco-systems (arid regions, desertification, water scarcity), rapid urbanization, climate change, knowledge gaps on the risk factors for transmission of emerging infections, weak and variable surveillance systems for early detection and response, inadequate country preparedness, limited laboratory diagnostic capacity, and increased human–animal interaction.

One infectious disease on the verge of eradication is poliomyelitis, and with the exception of Pakistan and Afghanistan all countries in the Region are polio-free. Afghanistan and Pakistan have made tremendous progress since 2014, with case numbers falling from a total of 334 cases in 2014 to 33 in 2016. In 2017, five polio cases have been reported in the first quarter so far (three from Afghanistan and two from Pakistan), compared with 12 cases in the same period in 2016.

Full achievement of the core public health capacities required under the International Health Regulations (IHR 2005) to effectively prevent, detect and rapidly respond to any public health threat before it becomes an international emergency remains compromised in countries of the Region. Independent assessment missions, conducted at the request of Member States during 2014–2015, in view of resolution EM/RC61/R.2 (2014), revealed a number of critical gaps in the surveillance and response capacity of countries to the threat of importation of Ebola virus disease in the Region, including in countries that announced they had met IHR requirements for surveillance and response by the first and second deadlines of 2012 and 2014. Furthermore, joint external evaluations (JEE) of IHR

[4] http://www.emro.who.int/eha/countries-in-crisis/index.html .

implementation in Member States, using the JEE tool, during 2016 and the first quarter of 2017, also identified additional gaps, including in capacities related to food safety, chemical and radionuclear events.

Antimicrobial resistance (AMR) has emerged as a significant public health threat with a grave impact on health in our Region. The driving forces for AMR include lack of infection prevention and control programmes to reduce the incidence of infections and transmission of resistant pathogens and irresponsible use of antimicrobials in humans, as well as food production and animal health. Thus, controlling the growing problem of AMR is an important regional priority.

Communicable diseases continue to account for significant morbidity and mortality in the Region. Despite earlier progress, multiple conflicts in the Region have resulted in weakened health systems and environmental services and other infrastructure in a number of countries, in addition to displacement of large populations, thus leading to re-emergence of communicable diseases long thought to be under control. Controlling these diseases is essential in order to meet the targets of the SDGs by 2030.

Despite the Region maintaining high routine immunization coverage, DTP3 vaccination coverage dropped to 80% in 2016, from 86% in 2011. In addition, controlling measles outbreaks remains a priority for the Region and reaching children who are not fully vaccinated. Of the 3.8 million children under one year of age who are not, more than 95% live in countries affected by emergencies.

Countries in the Region are endemic, or at risk, for a large number of vector-borne diseases, such as malaria, schistosomiasis, leishmaniasis, lymphatic filariasis, dengue, chikungunya and Crimean–Congo haemorrhagic fever. Two countries – Sudan and Pakistan – accounted for 80% of malaria cases in 2015. Tuberculosis remains a serious public health problem in the Region with only 64% of cases being notified to health authorities in 2015, and diagnosis and treatment of resistant cases covering only 21% of the estimated number of cases. Though prevalence of HIV in the Region is low (0.1%) compared to other WHO regions, the incidence is increasing and access to lifesaving antiretroviral therapy (ART) remains very low (14%), far from the global target. The prevalence of viral hepatitis C (HCV) is 2.3%, the highest of all WHO regions (about 15.1 million people are estimated to be chronically infected with HCV, with 80% of these individuals living in Egypt and Pakistan). The current availability of direct antiviral agents is a lifesaving opportunity to treat and control hepatitis C in the Region.

Noncommunicable diseases (NCDs) continue to be associated with a high health and development burden, remaining the leading cause of death and life-long chronicity in the Region, with 2.2 million related deaths every year, a figure that is projected to increase to more than 3.8 million by 2030.

In 2012, compared with other WHO regions, the Eastern Mediterranean Region had the second highest average smoking prevalence among men (almost 40%). According to current projections, prevalence of tobacco use will increase between 2010 and 2025 (up by over 4%), more than in the WHO African Region (up by around 2%), while in all other WHO regions, prevalence is projected to go down by 2025. Waterpipe use is an alarming and rising trend not only in the Region but globally. The prevalence of waterpipe use among 13–15-year-old school students in the Region ranges from 1.5% in some countries to almost 35% in others. Even more alarming is the fact that the Region is leading in waterpipe consumption among youth worldwide.

The Region also suffers from a double burden of malnutrition. In 2015, undernutrition was an underlying cause in 45% of deaths of children under-5 years of age, while maternal short stature and iron deficiency anaemia contributed to 20% of maternal deaths. Additionally, more than 45% of children under 5 are stunted in low-income countries in the Region, which affects their development and capacity to contribute to society.

On the other hand, the burden of overweight, obesity and diet-related chronic diseases continues to increase due to nutrition transition in many countries, especially in high-income and middle-income countries. The age standardized prevalence rate of overweight among adults was estimated at 46.8% in the Region, with a higher prevalence among women (50.1%) compared to men (43.8%). Additionally, the average estimate for prevalence of obesity in the Region is 19.0%, with a higher prevalence among

women (23.6%) compared to men (14.6%). Accordingly, more than 60% of the adult population of the Region is either overweight or obese.

Approximately 40% of countries in the Region have recognized government-approved evidence-based national guidelines/protocols/standards for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases. Nearly sixty percent (59.1%) of countries have incorporated risk factor detection and disease management into national primary health care systems. Less than half of the countries (45.4%) in the Region have included the key essential NCD medicines and technologies in their national essential medicines lists and which are generally available in the public health sector, as per WHO recommendations.

The disease burden for mental, neurological and substance use disorders is highest in countries of North Africa and the Middle East primarily due to high rates of major depression and anxiety accounted for by the ongoing humanitarian emergencies in the Region. Meta-analysis of the most robust epidemiological surveys in conflict-affected populations showed average prevalence of 15.4% for post-traumatic stress disorder (PTSD) and of 17.3% for depression. These rates are substantially higher than the average 7.6% (any anxiety disorder, including PTSD) and 5.3% (any mood disorder, including major depressive disorder).

Environmental risks, including air pollution, contribute to about 854 000 premature deaths annually in the Region, of which, three quarters are due to noncommunicable diseases and injury.

Road traffic injury continues to pose a grave concern in the Region despite a decrease in the regional road traffic fatality rate from 21.3 to 19.9 per 100 000 population between 2010 and 2013. This fatality rate remains higher than the global rate, and puts the Region second, in terms of highest fatality rates, among all WHO regions. Nearly two thirds of road traffic deaths occur among both the younger and economically active age groups (15–59 years), with males accounting for the majority of these deaths. Road traffic injury is a problem for all countries in the Region regardless of income level.

In spite of some progress during the period of the Millennium Development Goals (MDGs), the Eastern Mediterranean Region has the second highest rates of maternal, neonatal and child mortality among all WHO regions. The maternal mortality ratio decreased from 362 to 166 per 100 000 live births between 1990 and 2015 – a reduction of 54%. Only three countries[5] achieved MDG 5. In all countries of the Region, the main causes of maternal death are preventable; they include haemorrhage (32.9%), sepsis (9.1%), and hypertension of pregnancy (8.4%).[6]

Between 1990 and 2015, the under-5 mortality rate (MDG 4) decreased by 48% in the Region (from 100 deaths per 1000 live births to 52 deaths per 1000 live births)[7]. The neonatal mortality rate decreased by only 37% in the Region between 1990 and 2015. In 2015, neonatal mortality accounted for around 51% of under-5 child mortality in the Region leading to the deaths of 454 000 newborns. Eight Member States have under-5 mortality higher than the global SDG target for 2030 (to reduce under-5 mortality to at least as low as 25 per 1000 live births in each country) and nine Member States have neonatal mortality higher than the global SDG target for 2030 (to reduce neonatal mortality to at least as low as 12 per 1000 live births in each country). About 210 000 children under 5 die annually due to environmental risk factors.

There is eminent variation in the reproductive, maternal, neonatal, child and adolescent health figures and achievements between and within Member States of the Region with more than 90% of maternal and under-5 deaths taking place in just nine countries.[8]

Adolescents make up around a fifth of the population of the Region (125 million), with the adolescent mortality rate in low- and middle-income countries around 115 deaths per 100 000. Globally, it is the second highest after WHO's African Region. The top five causes of mortality among

[5] Islamic Republic of Iran, Libya and Lebanon.
[6] Say L et al. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health 2014;2:e323-e333.
[7] Levels and trends in child mortality 2015, http://www.childmortality.org/files_v20/download/IGME%20Report%202015_9_3%20LR%20Web.pdf.
[8] Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Somalia, Sudan, Yemen.

adolescents are collective violence and legal interventions, road traffic injury, drowning, lower respiratory infections and interpersonal violence. The top five leading causes of adolescent Disability Adjusted Life Years (DALYs)[9] are collective violence and legal interventions, iron-deficiency anaemia, road traffic injuries, depressive disorders and childhood behavioural disorders.[10] One in every five deaths among adolescent males in low- and middle-income countries in the Region is due to war or conflict. Maternal mortality remains a critical cause of female adolescent deaths.

The foundation for properly addressing the challenges is a well-functioning health system. However, health systems in countries of the Region clearly reflect the regional diversity which generally corresponds to the income level of Member States. Low- and middle-income countries are characterized by: inequity in health; low public funding for health; high out-of-pocket payment, elevated catastrophic and impoverishing expenditures; weak governance and stewardship by ministries of health; challenges in quantity and quality of the health workforce; weak and fragmented health information systems; a growing, mostly unregulated, private health sector; and weak regulation of health products, services and educational institutions. In middle- and high-income countries the challenge is to extend financial protection to cover the whole population including expatriate populations and displaced populations and refugees. Other challenges include inefficient use of scarce health resources, quality of services, inadequate preventive care, and the need to strengthen health system governance.

A particular challenge vis-à-vis health systems is the complexity of maintaining functional health systems in emergency situations. With more than half the countries in the Region experiencing some form of emergency, health systems need to adapt to respond to increasing health and humanitarian needs.

Although most countries in the Region subscribe to the vision of universal health coverage, there is huge diversity in service delivery among countries. Access to health care services is still a major challenge. Health equity is intimately linked to socioeconomic equality and environmental parity. Family practice is still a new concept to ministries of health in many countries and there is insufficient political support to strengthen the necessary interventions. Well-functioning integrated district health systems are not yet established in many countries. Service delivery in countries affected by emergencies is fragmented and mostly relies on mono skilled outreach teams and community health workers. In many countries, the predominance of hospital -, single disease -, and self-contained “silo”-based care models further compounds the problem of fragmentation. Patient safety, quality and accreditation of health services are serious challenges in all countries. The prevalence of adverse events among inpatients is up to 18% in some countries.

There remain major health workforce gaps in the Region. Overall production and availability of health workers is suboptimal and imbalanced. Inequitable geographic distribution is another critical challenge that needs to be addressed in most countries. There are also concerns in relation to quality, relevance and performance of health workers. Lack of reliable and updated information about the health workforce impedes the process of health workforce strategic planning and implementation. Countries facing protracted crisis are concerned with the impact of further shortages, and increasingly with the safety and security of health workers. Eighty-six percent (86%) of 2520 health workers injured or killed, reported globally in 2014–2015, were in the Region.

The Region is also a low investor in health. Total health spending in 2014 was US$ 153 billion for a population of more than 620 million; i.e. barely 2% of global health spending for almost 9% of the world’s population – with huge disparities between and within countries. Around 16.5 million individuals face financial hardship and around 7.5 million are pushed into poverty every year in the Region because of excessive out-of-pocket payment.

[9] DALYs. The sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability (http://www.who.int/mental_health/management/depression/daly/en/).

[10] WHO. Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000–2015 Geneva; 2016 (http://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html).

Almost two thirds of Member States have adopted national medicine and health technology policies yet implementation is weak. It is further estimated that 30–50% of medical products are wasted through irrational use despite the presence of essential and priority lists. Over 90% of medical products are imported in the Region. Medicines procured as branded have on average a 2.9 times higher price than their generic equivalent. Despite the presence of national regulatory authorities in more than 90% of countries, their performance needs improvement. National regulatory authorities mainly focus on the regulation of medicines and do not properly regulate biological products (vaccines, labile blood components, plasma-derived medicinal products, immunoglobulins), medical devices and clinical technologies, including laboratories.

In the area of health information systems, a rapid assessment of the capacity of Member States (19 participated) to report on the core indicators for monitoring the health situation and health system performance[11] revealed that although there is some improvement in reporting on the core indicators since their endorsement in 2014, no countries in the Region are currently reporting on all 68 indicators in a timely manner. Reporting on the core indicators in 2016 ranged from 38 to a maximum of 58 indicators. While this was a notable improvement compared to when the initiative started, the gaps are still considerable. Even in countries with adequate infrastructure, information systems are fragmented and national approaches for consolidation and validation of the data are weak or non-existent. As a result, most countries do not have adequate access to reliable and timely data to address all public health challenges, despite increasing investment in this area.

This is further augmented by existing limitations in national civil registration and vital statistics systems. Rapid assessments and comprehensive assessments conducted in the Region from 2013 to 2016 revealed that only six countries have satisfactory systems that produce sufficient quality data and eight countries have either weak or dysfunctional civil registration and vital statistics systems. Even within those countries with adequate systems, inherent problems in health information systems mean that often causes of death are inadequately or inaccurately recorded or analysed. Among countries that report causes of death, 20–48% of the causes of death are coded erroneously. Such limitations will be augmented in the era of the SDGs, in which effective follow up of several targets (13 indicators) will be reliant on accurate assessment of these causes.

In relation to WHO's presence in countries, there are currently 18 WHO country offices with a physical presence in countries of the Region and with dedicated staff. These vary according to a number of factors, including size and context of the country and availability of resources. The remaining four countries do not have a WHO physical presence through a country office, but rather have desk officers dedicated to supporting them. At country level, the country cooperation strategy (CCS) is a key aspect of WHO's work. Currently, only six countries have a valid, newly finished or almost complete CCS. Four countries have initiated a CCS development process, and countries affected by emergencies still need guidance on a "shorter" medium-term strategy that covers humanitarian needs.

3. Regional challenges

There are a number of persistent overarching challenges impeding progress in the areas identified as public health priorities for WHO's work in the Region which may continue in the next five years. Cross-cutting challenges are internal, external and area specific.

Internal challenges for WHO include:

- paucity and unpredictable provision and mobilization of financial resources, which may hinder activities at regional and country level;
- difficulties in recruitment and retention of talented and experienced staff in a number of technical areas, both at Regional Office and country office levels;
- poor coordination and collaboration with partners, stakeholders and sectors beyond health;

[11] Covering key domains of: existing data sources, frequency of data collection, data analysis, existing resources and use of appropriate standards for data collection, processing, and analysis.

- insufficient coordination between programmes at regional and country level.

External challenges include:

- insufficient political commitment to some areas, or when political commitment is present it is not always translated into action in terms of resource (human and financial) allocations;
- inadequate public health capacities and resources to sustain programmes at national level;
- political instability, protracted crises and humanitarian emergencies which weaken national health systems and hinder progress of ongoing programmes;
- limited availability of reliable and timely data on some public health issues;
- limited coordination within and between sectors beyond health;
- weak management processes at all levels of health care services in most countries, which is a root cause for many shortcomings in national health systems;
- uncontrolled population growth causing a consistent gap in meeting health needs and straining overall development;
- widening gap of access to, and coverage by, health care services;
- increasing numbers of refugees/migrants and displaced populations which places an additional strain on WHO's already limited resources.

In addition to the above-mentioned general challenges, there are some priority area-specific challenges which are summarized below.

In the area of emergencies and health security, lack of funding and inadequate technical capacity at country level have substantially impeded capacity-building for emergency risk management and response. Furthermore, the diversion of available funding towards the humanitarian response often threatens the implementation of preparedness actions on the ground. Attacks on health care facilities and the health workforce in the Region, lack of optimum and systematic preparedness of health systems, ongoing insecurity and limited access for humanitarian workers to people in need continues to challenge WHO's capacity to respond to life-saving needs.

Epidemic disease control and elimination efforts covering both emerging and re-emerging diseases are offset by the presence of weakened or fragmented disease surveillance systems and threat detection capacities of countries. This necessitates a shift in approach to enhance political commitment and engagement of all shareholders to address threats to health security in an integrated, cohesive and coordinated manner with time-bound goals and targets, through development of national plans of action based on the outcomes of the IHR joint external evaluations.

The main challenges for polio eradication are: sustaining the quality of activities and political and community commitment; improving access to large numbers of children in two endemic and six 'at-risk' countries; meeting resource requirements; and sustaining organizational focus.

In the area of communicable diseases, challenges include weak infrastructure for surveillance and laboratory which represents a barrier to disease prevention and control efforts; dependence on unpredictable external resources to fund national communicable disease programmes; and inadequate political commitment at national level.

In the area of noncommunicable diseases, challenges include insufficient political commitment and capacity at country level to develop multisectoral NCD plans and prioritize key strategic interventions. Risk factors, including tobacco control, still need to be addressed and there should be full implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC). There is a lack of robust integrated NCD surveillance systems that generate national data for policy and planning and the focus at national level is on curative services as opposed to preventive services and early detection. Environmental monitoring is not linked with health surveillance systems. Challenges to bridging the mental health and substance abuse treatment gap are mainly the scarcity of human and financial resources and inequities in their distribution and inefficiencies in their use, in addition to stigma associated with mental disorders which may prevent people from accessing services.

In the area of maternal, neonatal, child and adolescent health there is low coverage of reproductive, maternal, neonatal, child and adolescent health services, insufficient targeting of the main causes of maternal, neonatal, and child mortality and morbidity, and insufficient coordination and alignment among concerned stakeholders. There are also challenges embedded in communities that relate to women's status, traditional practices and people's capacity to access and utilize quality services. These can be addressed by improving the social determinants of health, something for which Member States can advocate, with the support of WHO.

In the area of health system strengthening, access to health care services is a major challenge which is further exacerbated by: high out-of-pocket expenditure on health; imbalance in the overall production, distribution and availability of health workers; inadequate performance of national regulatory authorities and reliance on imported medical products; fragmentation of health information systems with major gaps in reporting on the core indicators (especially cause-specific mortality) impeding the use of health information in policy and planning. Emergencies, conflict and displacement are further contributing to fragile and weakened health systems in countries. Health systems need to be aligned to address the most immediate health needs in those countries affected by emergencies.

4. Strategic directions 2017–2021

In order to address regional challenges the following strategic directions will be adopted to guide WHO's work in each priority area for the next five years. The Regional Office and country offices will mobilize and direct efforts to address priorities in a collective manner. Each individual programme, department and office will work in close coordination to demonstrate collective responsibility, follow the same strategic directions and guidance, and work for the same goals.

Emergencies and health security

1. WHO will support capacity-building of health sectors in Member States affected by graded and protracted health emergencies to respond to health emergencies of all hazards through scaling up response and early recovery measures through a multisectoral approach, by:
    - supporting Member States to establish and institutionalize incident management systems and ensure linkages with the emergency operations centre (EOC) network, supporting establishment of EOCs where needed;
    - scaling up evidence-based public health interventions and essential packages of health services and the implementation of the country business model in Grade 3 and high-risk countries with protracted emergencies;
    - ensuring that affected Member States receive essential supplies and logistics within 72 hours through the continuous development and expansion of WHO health logistics and supply chain capacities and their enabling procedures; and upgrading and strengthening the Dubai logistic platform to be responsive to regional needs in emergencies; and
    - enhancing leadership and partnerships for coordinated, predictable collective action by ensuring that health cluster coordination has been established and/or is being supported in all graded emergency countries.
2. WHO will enhance prevention and control of emerging, re-emerging and epidemic-prone diseases with a view to scaling up prevention, containment and control efforts targeting diseases that are easy to eliminate, prevent and control by:
    - providing Member States with evidence-based guidance, expert knowledge and best practices for eliminating and controlling the risk of epidemic diseases;
    - enhancing the capacity of Member States to forecast, early detect and assess the risk of any potential health event;
    - supporting Member States to mount an early and rapid response should an outbreak occur; and
    - continuing to support "high-risk" Member States to develop comprehensive and integrated preparedness and response plans for epidemic diseases based on a comprehensive risk assessment and mapping of hotspot areas; and to develop an appropriate framework for a real-

time surveillance system for early detection of emerging and epidemic-prone diseases using an innovative approach.

3. WHO will support countries to meet their IHR obligations to build and maintain their IHR capacities for preparedness, surveillance and response to public health events by:
   - supporting Member States, including countries affected by emergencies to continuously evaluate their capacities using the four components of the IHR monitoring and evaluation framework and developing national plans of action for health security with the involvement of all relevant stakeholders and in harmony with all existing relevant plans;
   - continuing to support Member States to enhance the capacity of the national IHR focal points with the necessary knowledge and training;
   - supporting Member States to mobilize resources to implement their plans of action through guiding the identification of local partners; mapping and fostering coordination and dialogue with global and regional partners; and establishing a mechanism to facilitate country-to-country support.
4. WHO will support Member States in completely interrupting the circulation of poliovirus in the Region and in certifying eradication of poliomyelitis by:
   - supporting Pakistan and Afghanistan to fully implement their National Emergency Action Plans for Polio Eradication;
   - protecting at-risk countries and areas through implementation of high quality immunization activities and support for sustaining high sensitivity of the AFP surveillance system backed up by polio laboratories;
   - ensuring that all countries maintain updated polio outbreak response plans and field-test them by conducting simulation exercises;
   - closely monitoring implementation of the Global Action Plan for Poliovirus Containment (GAPIII) and providing timely technical support to Member States;
   - supporting priority countries in developing their transition plan according to the stipulated time;
   - improving the quality of certification documentation and validation of the reported data through field assessments;
   - contributing to development and implementation of the global post-certification strategy.

Communicable diseases

1. WHO will work with Member States to strengthen their capacity to better prevent, diagnose, and treat communicable diseases by supporting their efforts in:
   - improving immunization coverage of DPT3 and eliminating measles as per implementation of the regional vaccine action plan and supporting the implementation of emergency vaccination campaigns in high-risk areas affected by emergencies;
   - controlling the spread of antimicrobial resistance by ensuring better infection prevention and control in health care settings and cautious antibiotic use in human and animal health sectors;
   - accelerating efforts towards malaria elimination in countries with low transmission and reducing malaria morbidity in other countries;
   - reducing the burden and threat of vector-borne diseases through integrated vector management;
   - accelerating efforts to eradicate dracunculiasis, eliminate schistosomiasis and eliminate lymphatic filariasis and trachoma as a public health problem in most affected countries;
   - improving tuberculosis (TB) detection rates and successfully treating all detected TB cases to decrease the mortality rate;
   - accelerating access to continuum of HIV care, including prevention, diagnosis, treatment and care;
   - ensuring access to services and covering the entire continuum of hepatitis services, including prevention, diagnosis, treatment and care;
   - improving integrated disease surveillance, monitoring and evaluation systems for all communicable diseases.

Noncommunicable diseases

1. WHO will support Member States to implement the commitments of the United Nations Political Declaration on the Prevention and Control of Noncommunicable Diseases, especially cardiovascular diseases, diabetes, cancer, and respiratory diseases. WHO will also ensure sustained technical support to Member States to articulate and scale up comprehensive national NCD responses recommended in the four areas of governance, prevention, surveillance and health care of the regional framework for action, focusing on addressing the risk factors for NCDs and environmental interventions by:
   - developing guidelines for the management of NCDs during emergencies and especially among refugees and displaced populations;
   - working with Member States and partners to ensure universal access to effective nutrition actions and to healthy and sustainable diets, through a life-course approach; and to achieve the global nutrition targets and implement the second International Conference on Nutrition framework of action;
   - supporting Member States in strengthening implementation of the WHO FCTC and its related commitments as per target 3.A of the SDGs, in addition to encouraging the ratification of the WHO FCTC protocol.
2. WHO will provide support to Member States to improve road safety in the Region through the development and implementation of evidence-based national policies, strategies and action plans for road traffic injury prevention and control. WHO will support Member States in enhancing country capacity for the transfer, adaptation and implementation of evidence-based cost-effective interventions and strengthen the role of the health sector in road traffic injury prevention and control from data to care, within the broader multisectoral circle.
3. WHO will provide support to countries to bridge the treatment gap and achieve the overall goal of promoting mental well-being, preventing mental health disorders and reducing mortality, morbidity and disability for persons with mental health disorders. The need is to focus on key strategic interventions to scale up holistic mental health care, outlined in the regional framework, supported by a set of indicators to monitor the implementation and backed up with a set of resources and WHO tools to support countries in planning and implementing their national mental health action plans.

Maternal, neonatal, child and adolescent health

1. WHO will work with Member States by supporting their efforts to ensure women's, newborn's, children's and adolescents' well-being by responding to their health needs and enabling them to survive, thrive and transform, by:
   - increasing coverage and ensuring equitable access to reproductive, maternal, neonatal, child and adolescent health cost-effective and life-saving interventions, along the continuum of care, in line with the *Global Strategy for Women's, Children's and Adolescent's Health (2016–2030)*, every newborn action plan and accelerated action for the health of adolescents through national multisectoral plans;
   - improving quality of care services and adoption of the WHO guidelines, standards and protocols for better health care services; meanwhile building capacity of programme managers and service providers;
   - counting every woman's, newborn's, child, and adolescent death by adopting evidence-based surveillance systems (e.g. perinatal and maternal death surveillance and response, neonatal and child mortality surveillance system);
   - adopting an integrated multisectoral coordination and partnership approach with involvement of communities and civil societies to ensure optimal outcome of reproductive, maternal, neonatal, child and adolescent health programmes;
   - prioritizing and targeting countries affected by emergencies by implementing rapid reproductive, maternal, neonatal, child and adolescent health context-specific response plans focusing on vulnerable population groups;
   - supporting the incorporation of early childhood development interventions within national plans and scaling up child development interventions and services within the health sector;

- strengthening school health platforms and scaling up health-promoting schools to promote child and adolescent health and development.

Health system strengthening

1. WHO will provide support to Member States to ensure that all people (including refugee and displaced populations, and other vulnerable groups) in the Region have equitable access to needed quality health care without discrimination and with dignity, and without undergoing financial hardship. WHO will support countries to explore and implement health systems reforms and modalities to advance towards universal health coverage as part of the 2030 Sustainable Development Agenda and in line with the *Framework for action on advancing universal health coverage in the Eastern Mediterranean Region* through investing in health system strengthening by:
   - strengthening health governance and leadership, supporting ministries of health in their changing roles and assisting them in improved policy formulation and implementation;
   - supporting countries to extend financial protection to the whole population through pre-payment arrangements, public-private-partnerships, and extending social health insurance;
   - organizing people-centred integrated health services that are safe for patients and of assured quality, based on the family practice approach, at primary health care level with robust referral systems between primary health care and hospital care;
   - developing context-specific basic service packages for all graded emergencies with effective engagement of the private health sector;
   - investing in production and availability of an appropriately skilled health workforce;
   - building reliable and usable health information systems;
   - improving access to quality assured and affordable essential medicines, vaccines, blood and blood products, diagnostics, medical devices and other health technologies;
   - strengthening the resilience of the health sector to respond to climate change.
2. WHO will develop a strategic framework for building resilient health systems in order to invest in the capacity of institutions, the health workforce and people to prepare for and effectively respond to crises, maintain core functions during a crisis and ensure the resilience of health systems once a crisis is over.

5. Enabling factors

In order for the Regional Office to deliver on the strategic directions outlined in Section 4 and to meet the expectations of Member States for timely, quality and relevant support to national policies, strategies and action plans for the wider SDG agenda, there are a number of approaches that will be further enhanced.

1. Advocating Health-In-All-Policies (HiAP), with a focus on both the social and environmental determinants of health, which are often better addressed through policies, interventions and actions outside the health sector. Supporting Member States to develop and implement evidence-based national policies, strategies and action plans for addressing the social and environmental determinants of health and embedding HiAP is key to contributing to the achievement of the SDGs and reducing health inequities in the Region.

   WHO will support ministries of health in Member States to ensure that they maintain a stewardship role in HiAP, have the capacity to advocate for health impact assessments, develop capacities and share regional and global experiences, best practices and lessons learned. WHO will support Member States to document and disseminate their own experiences.
2. Strengthening public health leadership capacity, which is critical for addressing joint public health priorities. Many health issues are not confined to national boundaries and call for action to address global determinants. Public health leaders are crucial health diplomats in the 2030 Sustainable Development Agenda in which focus has shifted from health governance to governance for health.

In the SDG era, these leaders need to be equipped with the skills in order to be able to work within the changing landscape of health and foreign policy.[12] Thus, Member States need to invest in building public health leaders who can actively identify public health priorities and engage in multisectoral global health discussions that are of national and regional importance. WHO will support Member States in this area through the development of Region-specific training courses and opportunities to enhance leadership skills. Additionally, effective public health leadership requires availability of timely intelligence to improve evidence-informed decision-making. WHO will support Member States in increasing the institutional capacities of ministries of health in priority-setting and in obtaining and using research evidence in policy development.

3. Expanding partnerships, within the United Nations system and beyond, to ensure a streamlined approach to supporting countries and to avoid overwhelming Member States with the burden of duplication and fragmentation that may result from the rapidly multiplying number of partnerships and initiatives in the health sector. Strong partnerships among United Nations agencies will also maximize the benefits to Member States and will support the scaling up of successful programmes. WHO aims to utilize and strengthen existing partnerships and build new ones when opportunities arise, at both regional and national levels.

4. Engaging with civil society organizations and academic institutions to make further progress in addressing priority areas of public health identified for the Region. Addressing these health issues is no longer confined to the health sector alone; and engagement of civil society organizations is a commitment that Member States have signed up to in a number of international fora (2030 Sustainable Development Agenda, United Nations Political Declaration on Prevention and Control of Noncommunicable Diseases, etc.). Academic institutions have the expertise needed in a number of research and capacity-building areas – tapping into this resource may avail huge returns in terms of implementation of public health programmes. WHO, in pursuing this aim, will ensure alignment with the Framework of Engagement with Non-state Actors, endorsed by the Sixty-ninth World Health Assembly, and appropriate mechanisms are put in place to safeguard WHO's mandate from vested interests.

5. Enhancing resource mobilization, especially at country level. One of the key components of WHO reform is improved Organization-wide resource mobilization to ensure predictability and sustainability of WHO's financing, especially at country level where much of the resources lie. WHO, to this effect, will strengthen relationships with regional and global donors and partners, increase support to WHO country offices in the mobilization of resources, and ensure an enabling policy environment for resource mobilization.

6. Strengthening a culture of evaluation and ensuring that monitoring and evaluation systems are established and strengthened for improved performance and quality to enable proper planning and for measuring progress towards the targets of the SDGs and the United Nations Political Declaration on Prevention and Control of Noncommunicable Diseases and other global and regional commitments.

7. Improving communications and advocacy to support WHO priorities and fulfil the Organization's obligation to raise awareness of problems and communicate solutions. Communications and advocacy to make the case for change are integral to WHO fulfilling its strategic goals. WHO will ensure that: 1) it adopts a proactive approach to demonstrate leadership in relevant health and development topics; 2) it focuses on digital communications and increases online engagement with the aim of engaging audiences in an interactive dialogue; 3) it conducts communication capacity-building to guide and support communications efforts in the Regional Office and country offices via face-to-face and online training.

8. Ensuring commitment to continue the implementation of WHO reform efforts with a focus on: implementing further improvements in risk management, transparency and accountability;

[12] Kickbusch et al. Global health diplomacy: training across disciplines. Geneva: *Bulletin of the World Health Organization*; December 2007, 85(12).

increasing monitoring, efficient operations and evaluation for performance and quality; strengthening enabling processes within a healthy working environment; and promoting a culture of excellence for empowerment and to ensure “best value for money”.

9. Implementing “Whole of WHO” ways of working. Regional planning that promotes theory of change and ensures more holistic integrated delivery approaches and coordinated support to country offices will be initiated through the introduction of inter- and cross-programme planning processes with time in the corporate calendar set aside for more extensive cooperative missions and work. A calendar of technical meetings will be planned and approved as part of operational planning to maximize the impact of the Regional Office’s convening power, avoid duplication and ensure the optimum involvement of participants from Member States. To support continuous technical coordination through the implementation phase, regular cross-division technical coordination and learning forums will be convened that, inter alia, share best practices, discuss future strategic activities, new programme initiatives, emerging priorities and evaluation findings and lessons learnt. To provide back-up support to countries intercountry (multidisciplinary) support teams will be established for groups of countries to provide technical and capacity-building support. Capitalizing on WHO reform and the introduction of the technical category and programme area networks, Directors will take an active and prominent role in technical monitoring, leading peer reviews for quality assurance and robust performance. The terms of reference for Regional Advisers will be revised to reflect and reinforce both their Region-wide responsibilities for technical relevance and quality of programmes and their representational responsibilities. A culture of evaluation will be promoted with the express leadership of the Directors through the Standing Group on Evaluation commissioning one to two country or thematic evaluations each biennium.

6. WHO’S working environment

WHO in the Region reflects the diversity of WHO’s staff and inclusion of different backgrounds and skills. As of 31 December 2016, the Regional Office had 1066 staff members, including 264 in the professional and higher categories, with approximately 50% originally from within Member States of the Region.

Over the coming five years, the focus will be on ensuring an enabling environment by strengthening the Regional Office to enable the work of WHO country offices through efficient and effective support of programme implementation. All efforts will be made to make the Regional Office a supportive environment for future public health leaders to facilitate the development and attraction of talent, as well as retaining staff through investing in their development and learning through a clear career development pathway, aligned with the Region’s emerging and evolving needs. Staff rotation and mobility will ensure that more attention is given to the needs of staff members and their families, while ensuring that WHO has the right skill set in the right position.

Internally, a number of changes will be introduced in the working environment in WHO to ensure and facilitate:

- wide delegation of authority, associated with comprehensive risk management, technical and administrative compliance monitoring and clear accountability and transparency in line with the principles of WHO reform;
- effective communication and coordination mechanisms within and between technical departments and across the three levels of the Organization, and existing mechanisms, such as taskforces, will be strengthened and additional ones introduced, such as the Technical Coordination and Learning Forum to enable the Regional Office to strengthen its efforts to ensure comprehensive and coordinated approaches across technical programmes;
- staff excellence in delivering on WHO’s core commitments to Member States, through regular appraisal of staff performance, recognizing good performance and identifying substandard performance;

- creativity and innovation in implementation to overcome challenges and hurdles;
- productivity at the highest level and standard, through skill development opportunities for staff enabling the best use of available skills and expertise;
- a teamwork spirit to deliver as "One WHO" capable of supporting Member States in their quest for health and development of their populations;
- promotion of the effective management of risks and risk-informed planning and execution;
- increased country-based capacities associated with clear performance targets and reduced risk and control exposures identified through coordinated oversight mechanisms and focus enabling processes to support efficient and effective programme delivery, and ensuring effective use of donor funding;
- improved efficiency and accountability in the areas of finance, procurement and general management.

7. WHO'S presence in countries

In line with the WHO Constitution, the overall objective of WHO's work in the Region "shall be the attainment by all peoples of the highest possible level of health". In this context, WHO's presence in countries is the platform for effective cooperation with Member States for advancing the global health agenda, contributing to the development of national policies and plans, and aligning country priorities and realities with global policies and priorities. It refers to the work of the Secretariat as a whole, carried out through the physical presence of WHO offices in countries; WHO's normative work, involving norms and standards setting; coordinated support from other levels of the Secretariat, through technical backstopping from the regional and headquarter's level (including technical support, capacity-building, programme management and coordination for country support). Preliminary results from the country presence survey administered to all WHO representatives, reflects that in the Region, the majority have rated the capacities of their professional staff as requiring further development in order to be able to meet the needs of Member States. This is further understood by noting that many countries have one technical staff member covering most technical domains, or 1–2 providing support in several programmes. They are usually overburdened and may not be able to provide optimal support to Member States. It is at country level where the building blocks to WHO's work are initiated and consequently, the stronger the base, the stronger the structure. This is an area that will receive undivided attention over the next five years.

To achieve all of this, the Regional Office in its work with Member States will advocate strongly to ensure:

- ownership of joint work by Member States to ensure continuity of health programmes and sustainability of joint achievements;
- a holistic approach to addressing health issues in Member States through coordination with ministries of health to facilitate engagement of non-health sectors in WHO's work, where appropriate;
- transparency, to ensure that Member States are kept fully abreast of developments and progress in implementation of joint activities;
- joint planning to ensure that programmes address the needs of Member States and ensure best utilization of available resources (human and financial) for both the Secretariat and Member States. The bottom-up planning approach adopted to date will be analysed and lessons learned will be carefully drawn to guide future planning;
- two-way dialogue facilitating the sharing of experiences and concerns between the Secretariat and Member States;
- investment in the development of staff skills in country offices, and assurance that WHO country offices are capacitated to allow adequate technical support to Member States.

Over the coming five years, the Regional Office envisages the stronger engagement of Member States in setting priorities for WHO's work to ensure that limited resources are allocated where they are most needed, while ensuring that WHO's work in the Region is aligned with global agendas. Mechanisms to achieve this include expansion of advisory forums and consultations with Member States, as well as supporting and facilitating technical cooperation among countries. While there is great diversity among countries of the Region, it must always be remembered that there are huge similarities. Building on the experiences and achievements of other countries in the Region is key to achieving progress in others.

It is clear that WHO's presence is uneven across countries of the Region, due to a number of factors, including size and context of the country and availability of resources. A focus will be to increase WHO's presence in countries physically and virtually to empower country offices to better meet the needs of Member States.

WHO alone cannot support countries in attaining their desired health goals, as the involvement of other sectors is intrinsic to achieving better health outcomes. Expanding partnerships with United Nations agencies, partners and stakeholders from both within and beyond the health sector will be a core component of the roadmap for the next five years.

Similarly, WHO and partners will not be able to progress in any of the areas without the commitment and investment of Member States in respective areas of work; an important prerequisite to attaining and achieving the strategic directions outlined in this document. The roadmap serves as guidance on the main areas in which WHO will focus its support over the coming five years, as its implementation will vary according to the country context, challenges and needs.

Annex 1. Indicators for success

Priority area	Strategic direction	Indicator	Baseline	Target	
			2017	2019	2021
Emergencies and health security	Humanitarian emergencies	Percentage of countries affected by graded and protracted health emergencies with an established incident management system to coordinate response actions	0%	50%	100%
		Number of countries with functioning emergency operations centres within the ministry of health connected to the regional emergency operations centre	5	12	22
		Percentage of countries affected by graded and protracted health emergencies receiving fully staffed and coordinated health operations, including an essential package of life-saving health services	20%	50%	100%
		Percentage of countries affected by graded and protracted health emergencies with fully established health cluster coordination support	30%	50%	100%
		Percentage of countries affected by graded and protracted health emergencies receiving essential supplies and logistics within 72 hours	50%	80%	100%
		Number of countries supported by the Regional Office for prevention and control of diseases targeted for elimination in the strategic framework for prevention and control of emerging diseases	0	8	22
	Emerging and re-emerging diseases	Number of countries with integrated preparedness and response plans for priority epidemics	5	10	22
		Number of countries with a One-Health framework for harnessing effective intersectoral collaboration and cooperation between the animal and human health sector	0	10	22
		Number of countries with real-time early warning surveillance system using both syndromic and event-based surveillance	0	11	22
	Preparedness and International Health Regulations (IHR 2005)	Number of countries that have conducted joint external evaluation of IHR capacities	14	22	22
		Number of countries with after action review and simulation exercise to further evaluate	3	12	22
		Number of countries that have developed a national action plan for	3	22	22

Priority area	Strategic direction	Indicator	Baseline	Target	
			2017	2019	2021
		health security in harmony with existing relevant plans			
		Number of countries with national public health plans for all-hazards preparedness and response	4	12	22
		High-quality immunization activities through targeted campaigns in high-risk areas/populations with inactivated polio vaccine (IPV)	70% of lot quality assurance sampling (LQAS) passed	80% of LQAS passed at 90% coverage	No mass campaigns
		Enhanced sensitivity of the surveillance system and expanded environmental surveillance and primary immune deficiency surveillance in selected countries	Non-polio acute flaccid paralysis (AFP) rate ≥ 2/100 000 < 15 years Stool adequacy ≥ 80%	Sustain	Sustain
	Polio eradication	Number of countries with developed or updated polio outbreak response plans, which have been field-tested	All the countries of the Region have developed response plans	Updated plans available	Updated plans available
		Number of countries implementing oral poliovirus vaccine (OPV) withdrawal as per the global policy	22	22	22
		Completion of Global Action Plan (GAP) Phase I and II and Phase III implemented	22	22	22
		Number of transition plans developed and implemented for priority countries	0	5	5
		Certification documentation is updated to declare the Region as polio-free	22	22	22
Communicable diseases	**Prevent, diagnose and treat communicable diseases**	Percentage of tuberculosis cases notified/number of estimated cases	61%	70%	80%
		Percentage of multi-drug resistant (MDR) cases detected/number of MDR cases estimated	21%	40%	60%
		Mortality rate/100 000 of treated cases	12	10	8

Priority area	Strategic direction	Indicator	Baseline	Target	
			2017	2019	2021
		Incidence of malaria cases per 1000 persons per year	2015: estimated 13 per 1000	10 per 1000	7 per 1000
		Number of countries that have eliminated malaria since 2015	0	0	2
		Number of countries that have established a functional integrated vector control unit/department	6	14	18
		Number of countries with functional entomological surveillance	7	14	18
		Number of countries with national laboratory policies and mechanism for implementation in place	5	10	20
		Number of countries with national biosafety/biosecurity policies/guidelines for health laboratory services in place	9	15	20
		Number of regional reference laboratories leading tiered referral networks for surveillance and detection of epidemic- and pandemic-prone diseases	0	2	4
		Number of countries that have achieved 100% voluntary non-remunerated donation of blood	2	8	17
		Number of countries that have developed and implemented national guidelines on appropriate clinical use of blood	13	16	20
		Number of countries with national antimicrobial resistance (AMR) action plans and have started implementation	7	12	22
		Number of countries that have initiated early implementation of the Global Antimicrobial Resistance Surveillance System	5	13	22
		Number of countries with national infection prevention and control programmes	6	12	18
		Number of countries with DTP3 coverage reaching above 90%	14	16	22
		Number of countries with zero cases of measles	4	8	22
		Number of countries decreasing HBsAg prevalence to < 1% in < 5 years	8	12	22
		Number of countries with a HIV plan of action developed and control targets defined	7	≥ 7	22

Priority area	Strategic direction	Indicator	Baseline	Target	
			2017	2019	2021
Maternal, neonatal, child and adolescent health		Number of countries where 50% of people living with HIV know their HIV status	0	≥ 2	≥ 5
		Number of countries where 90% of those living with HIV are receiving treatment	0	≥ 2	≥5
		Number of countries where 90% of those treated are virally suppressed	0	≥ 2	≥ 5
		Number of countries with **hepatitis plans of action** developed and control targets defined	2	≥ 5	22
		Number of countries where at least 50% of injections in health care settings are safe			22
		Number of countries where at least 30% of people with hepatitis C are treated	0	≥ 2	≥ 6
	Women's, newborn, children's and adolescents' well-being	Number of countries that have ensured skilled birth attendance over 90%	10	15	20
		Number of countries that have developed surveillance systems for maternal and/or perinatal death	5	10	15
		Number of countries that have implemented evidence-based interventions for adolescent health aiming at reducing mortality and morbidity of adolescents	0	6	15
		Number of countries that have included early childhood development as part of national development plans	0	8	18
		Number of countries that promote healthy physical activity through mass media campaigns and ensure adequate legislation supporting delivery of daily physical activity for students in schools and universities	4	10	15
		Number of countries that ensure comprehensive delivery of regular, quality physical education to all children as a key component of education in schools	7	12	17
		Number of countries that have developed and implemented an urban planning policy to ensure that urban environments encourage physical activity	2	8	15
	Social determinants of health	Number of countries that have a national strategic plan on social determinants of health/health-in-all policies	1	3	7

Priority area	Strategic direction	Indicator	Baseline	Target	
			2017	2019	2021
Noncommunicable diseases and mental health	Non-communicable diseases (NCDs)	Number of countries which have set time-bound national NCD targets and indicators	6	11	15
		Number of countries implementing on a regular basis tobacco-related surveys, to monitor the tobacco epidemic (from the Global Tobacco Surveillance System (GTSS)-related tools)	7	9	12
		Number of countries that have reviewed/developed national strategies and action plans in nutrition and diet-related risk factors	8	15	22
		Percentage of countries that have implemented a national level NCD surveillance (STEPS) or health examination survey		50%	80%
		Number of countries that have incorporated early detection, referral and management for NCDs into primary health care	13	15	17
	Road traffic injury prevention and control	Number of countries that have a national road safety strategic plan with time-bound targets	9	11	15
		Number of countries that have done a standardized national post-crash emergency care services assessment to identify gaps and set priority actions for system development	4	8	12
		Number of countries that have a national strategy on post-crash rehabilitation	0	4	7
	Mental health and substance abuse	Percentage of countries that have developed or updated an operational multisectoral national mental health policy/plan		60%	80%
		Percentage of countries that have integrated evidence-based interventions for mental conditions in primary health care		20% of general hospitals in 50% of the countries	Service coverage for severe mental disorders will have increased by 20%
Health system strengthening	Health system as platform for universal health coverage	Number of countries which have incorporated universal health coverage vision in national health policies	5	10	18
		Number of countries which have developed their health financing strategies	2	9	12
		Number of countries which have conducted a policy dialogue with	1	4	9

Priority area	Strategic direction	Indicator	Baseline	Target	
			2017	2019	2021
		budget and finance officials on fiscal sustainability			
		Number of countries which use/institutionalize *A System of Health Accounts 2011* to track financial resources within the health sector	5	10	15
		Number of countries with critical shortage that have health workforce strategic plans	3	5	7
		Number of countries in the Region to have reformed their medical education	1	2	3
		Number of countries that have developed a model of an integrated district health system based on the family practice approach	2	6	15
		Number of countries implementing WHO primary health care quality/patient safety indicators	5	8	14
		Number of countries that have health technology assessment programmes instituted within national health systems	1	3	7
		Number of countries with Good Governance of Medicines (GGM) plans	0	4	9
		Number of countries where local manufacturers are able to produce quality essential medicines at affordable prices	1	2	4
		Number of national regulatory authorities that have development plans to strengthen their capacities		5	10
		Number of countries that have conducted a comprehensive assessment of the health information system	1	10	22
		Number of countries that have developed national strategies for health information system strengthening	None	10	15
		Number of countries with improved reporting of the Sustainable Development Goal 3 (SDG3) indicators	0	5	22
		Number of countries with a maximum of 20% erroneous coding of causes of death	1	5	10
		Number of countries with established national bioethics committees	Unknown	15	22
		Number of countries with established national research for health committees	Unknown	15	22

This roadmap of WHO's work in the Eastern Mediterranean Region (2017–2021) translates the vision of the WHO Regional Director into a set of strategic actions to guide WHO's work with Member States in the Region. It takes into consideration the global and regional environments in which WHO is working, including the global commitment to the 2030 Agenda for Sustainable Development and the WHO reform agenda. In ensuring alignment of this roadmap with the SDGs, focus is placed on five priorities – emergencies and health security, communicable diseases, noncommunicable diseases, maternal, neonatal, child and adolescent health, and health system strengthening.