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Director-General

Address to the Regional Committee for the
Eastern Mediterranean, Sixty-third Session
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Mr Chairman, honourable ministers, distinguished delegates, Dr Alwan, ladies and gentlemen,

The humanitarian situation in the Eastern Mediterranean Region has deteriorated significantly over the past year. The numbers are staggering.

At the end of 2015, more than 62 million people affected by emergencies in the region needed access to health services.

More than 60% of all refugees and internally displaced persons worldwide originate from this region.

The war in Syria has entered its sixth year. Each month, at least 25,000 people suffer conflict-related injuries, creating a tremendous need for trauma care.

In Iraq, millions of displaced civilians can find no safe place to stay. WHO is using mobile clinics to extend health care to these fluid populations.

The health system in Yemen has collapsed. That country has recorded the world's highest number of deaths and injuries caused by explosive weapons.

As the security situation forces more aid agencies to leave, the burden on WHO and remaining partners escalates.

In the three level 3 emergencies, staff in hospitals that are still able to function are overwhelmed, with caseloads increasing in some areas by more than 200%.

We must admire these staff for their courage and tenacity.

The situation is getting worse, not better.

Since the beginning of this year, WHO has recorded hundreds of attacks, including deliberate air strikes, on hospital and health facilities.

Nothing sets hard-won health gains backwards so dramatically as humanitarian crises on this scale. The consequences are felt throughout the region.

Attention focused on the refugee crisis in Europe often fails to note that the vast majority of people forced to flee their homes are generously being accommodated in your countries.

Staff in the regional and country offices, together with their humanitarian partners, have worked heroically to get essential life-saving medical assistance to many millions of people.

The logistical challenges are immense. Unmet needs are vast.

In Iraq, the immunization status of children in Mosul, besieged for two years, is simply unknown.

In Syria, 75% of health facilities have no medicines to manage diabetes, let alone heart attacks, strokes, and cancer.

The issues are highly politicized. I thank Dr Alwan and all EMRO staff for remaining steadfast in your support and neutral in your position.

Humanitarian assistance must always be motivated by compassion, not politics.

We will not be deterred. Just three days after the UN convoy in Syria was attacked, our country office had a convoy of medical supplies ready to go to a besieged suburb of Damascus.

Ladies and gentlemen,

Viewed against the demands of these severe humanitarian crises, also in Libya and Somalia, the region's achievements are all the more remarkable.

Political commitment to universal health coverage is strong, and you can now move forward with a high-priority, high-impact package of essential interventions and services.

Strategies for addressing specific problems consistently work to build capacities and strengthen health systems.

One of the smartest moves has been to focus on the development of information systems, especially for civil registration and vital statistics.

This emphasis has made it possible to provide each country with a succinct annual profile showing where it stands in addressing national and region-wide priorities.

The nine countries with a high burden of maternal and child mortality have been targeted for accelerated action, in line with the ambitions set out in the Sustainable Development Goals.

A paper published last month in the Lancet brought good news from Bamyan, Afghanistan.

In that province, the proportion of births delivered by skilled birth attendants increased from 7% in 2003 to 47% in 2015. This is an enormous achievement.

The fact that so many childhood immunization programmes have been maintained in emergency situations is a credit to

the determination of ministries of health and the support they receive from the regional and country offices.

However, serious problems need more attention, including through the use of legislative and fiscal measures.

Noncommunicable diseases are the region's biggest cause of premature deaths. Tobacco use is still increasing, and the rates of obesity and overweight in children and adults are alarmingly high.

In his annual report, Dr Alwan refers to a "great deal of optimism" that the region has reached a turning point in its effort to eradicate polio.

Afghanistan and Pakistan continue to record ongoing transmission of wild poliovirus, but the levels are now very low, thanks to strong political commitment and innovations in the design, implementation, and oversight of polio programmes and immunization campaigns.

I am likewise optimistic. But moving from low-level transmission to the interruption of transmission faces obstacles that must be overcome.

In Afghanistan, finding and vaccinating chronically missed children is a top priority.

In Pakistan, immunity gaps in the remaining reservoir areas remain a serious concern. Pockets of under-immunized children give the virus its best chance to survive and revive.

I call on all countries in the region to support Afghanistan and Pakistan in implementing their national emergency action plans. I also ask you to maintain a high level of routine immunization coverage as a barrier to re-infection.

Ladies and gentlemen,

As this is the last time I will address this committee, I will conclude with what I regard as a tremendous success story for public health.

Egypt and Pakistan have the highest burdens of hepatitis C in the world.

In late 2013, sofosbuvir, a direct-acting antiviral treatment for the disease, came onto the market in the US.

The drug, with its shortened duration of therapy and high cure rates, was a potential game-changer for the 130 to 160 million people worldwide chronically infected with hepatitis C and at risk of fatal liver disease.

What stifled that game-changing potential was the launch price of $1000 a pill, or $84,000 for a 12-week treatment course.

Egypt, which made the prevention and treatment of hepatitis C a priority more than a decade ago, was the first country in the world to enter negotiations with the originator company, and got the price down to $900 for a treatment course, the lowest price available anywhere.

But Egypt did not stop there. The national treatment programme diversified procurement to include generic products from local companies.

Generic competition lowered the price to an astonishing $172 per treatment course, while the country’s network of treatment centres helped ensure broad access. Keep in mind: this is a nearly 500-fold price reduction.

The government is now moving forward with a very ambitious goal for expanded treatment, aimed at driving prevalence down dramatically.

Both the government and WHO are aware of the need to continue the country's strong preventive measures, even as scaled up treatment is being launched.

The President of Egypt announced last week that Egypt today has no waiting list for patients requesting treatment and the focus is now on prevention and case detection.

Pakistan followed a similar approach, using competition among generic manufacturers to get the price down dramatically.

Successful expansion of treatment depends on full confidence that generic products are equivalent to the originator product.

WHO is expediting its pre-qualification assessment to ensure that generic drugs for hepatitis C meet international standards of quality and efficacy.

In the midst of so many headline stories about shocking drug price hikes, it is vastly encouraging to see that the opposite can also be made to happen.

As I conclude, I wish the Eastern Mediterranean Region many more success stories that can keep the momentum for better health moving forward during this ambitious new era of sustainable development.

Thank you.