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Shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO 2012–2016

Introduction and highlights of the report

1. This report provides an update of the situation in the Region and progress made since I assumed the post of Regional Director in February 2012 in five strategic areas: health systems strengthening towards universal coverage, maternal and child health; health security and communicable diseases; noncommunicable diseases; and emergency preparedness and response. These were endorsed as priorities by the WHO Regional Committee for the Eastern Mediterranean at its 59th session in October 2012.

2. At that time, the situation in various countries of the Region was already impacting population health but we could not imagine the magnitude of human crisis that would soon engulf the lives of millions of people. Today, more than half of the world's refugees come from three countries of our region (Afghanistan, Somalia and Syrian Arabic Republic) and are hosted in just four countries (Islamic Republic of Iran, Jordan, Lebanon and Pakistan). The Region hosts the largest number of internally displaced persons as a result of conflict. The harm caused to human health is catastrophic. At this moment, there seems to be no end in sight and the crises will continue and their enormously negative impact on health in affected and neighbouring countries may even worsen.

3. Nevertheless, WHO and Member States, working collaboratively with each other and with partners, have made major gains in the Region by focusing efforts on the five key areas where we are making a positive contribution towards change and laying the foundation for continued development in health.

4. In health systems strengthening, we conducted an extensive review of the health system building blocks in countries of the Region and agreed on seven key priorities that we should collectively address during the five year period. Based on this review and in close consultation with Member States, a country profile was developed for each Member State covering the key health system indicators, achievements, strengths, weaknesses and priorities for action. An important achievement was made in moving towards universal health coverage with the development of a framework for action on advancing universal health coverage which many countries are now using as a guide to accelerate progress. This is a roadmap for achieving access to health care for the whole population, including the vulnerable and marginalized, in every country. WHO is now supporting countries in achieving this objective.

5. Leadership and governance for public health has also been advanced through a range of programmes. Responding to the gaps in public health capacity in many countries and working with leading international and regional experts, tools for assessing public health functions in ministries of health have been developed and successfully piloted in two countries. The assessment report for each identifies areas for strengthening and provides recommended actions. More countries will be assessed in 2016. In collaboration with the Harvard School of Public Health, a leadership for health programme has been offered which has graduated more than 50 future health leaders in the past two years.

6. Another major achievement is the development of the framework for health information systems, following intensive consultation with the different sectors in Member States and international experts. The framework has three key components: monitoring of key risks and determinants, assessing health status including cause-specific mortality and measuring health system response. For each component, a set of core indicators has been agreed. We are currently assessing the capacity of each country in generating reliable data for the 68 core indicators of the framework. We have also conducted an in-depth assessment of the civil registration and vital statistics system in all countries. The information generated through this programme is the most extensive and comprehensive across all WHO regions. Based on this

assessment a regional strategy was developed. All countries now have a clear identification of gaps and areas that require strengthening and they have been offered technical support as they move forward in addressing the gaps.

7. To support development of the health workforce in the Region, a framework for action on medical education was developed, based on extensive situation analysis and a regional survey of medical schools. A similar framework provides strategic directions to strengthen education and practice in nursing and midwifery. WHO has also been building country capacity to engage with and regulate the private health sector, in order to support moving towards universal health coverage. A robust assessment of health technologies, including medicines, has been launched, including a pharmaceutical profile for each country, which can support cost-effective purchase decisions.

8. Among the main concerns in the Region in 2012 was maternal and child health, in particular the persistent high levels of maternal and child mortality in some countries. Most of the causes were identified as health systems issues and so a major initiative was launched on "Saving the lives of mothers and children". Support was provided to the nine countries with a high burden of maternal and child mortality to develop strategies to improve survival and health. A situation analysis was conducted in each country to identify gaps and a country profile was developed highlighting the situation, challenges and actions needed, together with a cost analysis. This was followed by the development of multisectoral acceleration plans with detailed cost-effective interventions for each country. Most of the countries with a high burden of maternal and child mortality and morbidity have launched their plans and are currently implementing them.

9. For noncommunicable diseases, the Region developed a framework for action to implement the United Nations Political Declaration on Prevention and Control of Noncommunicable Diseases, which includes 17 strategic interventions in the four components of the framework (governance, prevention, health care and surveillance), and 10 indicators against which countries can measure their progress. Extensive work was done, based on review of evidence and international experience, to develop practical technical guidance on how to implement the interventions, such as tobacco control measures, salt, sugar and saturated fat reduction and elimination of industrially produced *trans*fat, and on legislation to reduce risk factors. These guidelines are now available and are being used by many Member States. Two other major areas of focus are considered vitally important – guidance on integration of health care into primary care and continuity of treatment during emergencies and the surveillance framework that should be used by countries to monitor progress.

10. Brief profiles are being produced annually on each country's response based on the progress indicators in the framework. A recent review of progress shows that a lot of work still needs to be done to meet the time-bound actions required by the political declaration and WHO will continue to support countries in their efforts to meet these targets.

11. Health security has been a major focus of our work in communicable diseases. Preventing and responding to outbreaks of emerging and re-emerging diseases has been a priority in the past four years with the deterioration in the public health situation in a number of countries. Massive campaigns were conducted to control significant outbreaks of polio and measles, as a result of which these were successfully prevented from further spread within and beyond the Region. Considerable work was done also to ensure Member States have the core capacities required to implement the International Health Regulations (IHR 2005). At the end of 2014, at the request of Member States, WHO carried out rapid assessments of countries' capacity to detect and respond rapidly to a case of Ebola. The findings highlighted gaps in the outbreak prevention and control capacities of all countries, and also the limitations of the IHR self-assessment tool. The Regional Committee subsequently called for the adoption of independent assessment and the establishment of a regional assessment commission to provide technical guidance to countries and to oversee the process of independent joint external evaluation. Our region has played a leading role in harmonizing the IHR assessment tool with the Global

Health Security Agenda (GHSA) tool and the development of the Joint External Evaluation (JEE) tool which is now adopted by all WHO regions and the GHSA.

12. Emergency preparedness and response is our fifth priority. In addition to the enormity of the challenge, health workers have fled the violence, while health care facilities and infrastructure are damaged or destroyed. Medicine and medical supplies have become scarce. Even when available, medical teams have not been able to enter many conflict zones. Health care for refugees and internally displaced persons is extremely fragmented or nonexistent. Finding health care professionals willing to serve in these areas is becoming ever more difficult.

13. All countries in the Region are at risk. As I have already noted, we have experienced serious threats to public health, such as the resurgence of polio and other outbreaks. Necessary chronic and preventive care needed for major noncommunicable diseases, mostly heart disease, lung disease, diabetes and cancer, has been interrupted for large numbers of people suffering from these diseases in the conflict zones.

14. Our work in emergency preparedness and response has focused on both strengthening our capacity to respond effectively and efficiently on the ground as situations develop, and on strengthening regional and country preparedness for disasters and emergencies. This has resulted in the establishment of new internal structures and hubs to target various critical factors of the emergency situation. Stronger partnerships with health authorities, nongovernmental organizations, community leaders, academic institutions, donors, the private sector and others are being forged, to support countries. A regional solidarity fund was established to provide immediate funding in the short-term to support acute emergencies, and efforts are being made to highlight the funding gap for countries with protracted crises as they seek to rebuild infrastructure and provide health care for their populations.

15. While this introduction highlights some of our biggest challenges and the main actions we have taken, the report that follows examines in more detail the work accomplished in each of the five key regional priorities, from their adoption in May 2012 to today, May 2016. The report also highlights the way forward in tackling some of the continuing challenges.

16. Over this period, we have focused our efforts on maximizing the results. We have also managed to strengthen the technical capacity of WHO in this region and to reinforce the quality of services provided to Member States. We continue to build capacity in WHO staff and in using an expanding network of top international experts in the five priority areas. Working jointly with partners and other stakeholders has been an important strategic direction that has characterized our work in many programme areas and should continue to expand. Only collaboratively can we address the considerable health challenges faced by our countries. We are committed to supporting them as they embark on the ambitious health targets of the Sustainable Development Goals and as they build, as well as rebuild, effective and efficient health systems for all the people in the WHO Eastern Mediterranean Region.

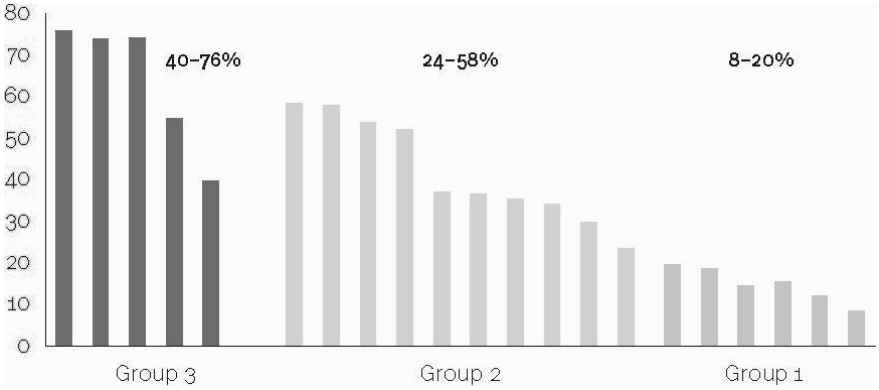


Fig.1. Share of out-of-pocket expenditure in total health expenditure 2013. It is estimated that up to 16.5 million people in the Region face financial catastrophe and 7.5 million become poor every year because of out-of-pocket payments

Health systems strengthening

Situation in 2012

17. The need for strengthening of health systems in the Region was abundantly clear in 2012, and remains so today. Inequities in health are widespread, not just among group 2 and 3 countries but also in group 1 countries[1]. Exposure to health risks is rising, particularly to the key causes of noncommunicable diseases – the Region's leading killers. Health care costs are increasing and health insurance coverage is low, leading to high out-of-pocket health expenditure which drives many families into poverty (Fig.1). Access to quality health care – and sometimes any health care at all – is beyond the reach of a significant portion of the Region's population. While modern networks of health infrastructure, skilled health care professionals and advanced medical technologies and pharmaceuticals are fully available to citizens in some countries, this is certainly not the case in all countries. Such differences in the strength of health systems contribute to divergent health outcomes, such as in life expectancy, maternal mortality and infant and child mortality.

18. Health information systems, including civil registration and vital statistics systems, are failing to capture vital information necessary for health system planning, development and monitoring. This includes reliable data on births, deaths and of causes of death, and key health indicators. While there are variations between countries in the quality of the health information system, all countries lack a comprehensive and fully functioning system that can provide the required information in a timely and reliable manner for planning and policy-making.

19. Capacity and resources for emergency preparedness and response are inadequate and fragmented. The violence, destruction of infrastructure, including health care infrastructure, and displacement of tens of millions of people, has become a severe crisis for health systems that were inadequately prepared. In direct response to these and other severe health challenges, the Regional Office, working with country offices, ministries of health, WHO headquarters and other partners, began the process of strengthening the health systems of Member States.

20. In October 2012, the Regional Committee endorsed a resolution (EM/RC59/R.3) on health systems strengthening in countries of the Eastern Mediterranean Region. The resolution, which concluded that

[1] The three groups were defined based on population health outcomes, health system performance and level of health expenditure: 1) countries in which socioeconomic development has progressed considerably over the last four decades, supported by high income; 2) countries, largely middle-income, which have developed an extensive public health service delivery infrastructure but that face resource constraints; 3) Countries which face major constraints in improving population health outcomes as a result of lack of resources for health, political instability, conflicts and other complex development challenges.

improving population health of the Region "can only be realized through well performing national health systems which assure universal access to effective and good quality health care", urged Member States to focus on seven strategic priorities (Box 1). These became the objectives for strengthening health systems.

Box 1. Priorities for health system strengthening

1. Strengthen leadership and governance in health
2. Move towards universal health coverage
3. Strengthen health information systems
4. Promote a balanced and well-managed health workforce
5. Improve access to quality health care services
6. Engage with the private health sector
7. Ensure access to essential technologies, including medicines

Progress 2012-2016

21. **Leadership and governance:** The multi-faceted area of health system strengthening began with an in-depth review of the health systems in the Region and the subsequent development of a brief health system profile for each country. The two-page profiles, which are produced annually, in consultation with Member States, provide critical information on each country and a brief assessment of strengths, weaknesses, opportunities, challenges and priorities. They are aimed at helping policy-makers to focus on the assets and challenges within their countries and provide a useful opportunity and entry point for dialogue, especially during missions to countries. A range of capacity development courses to strengthen government policy-making and decision-making, on health legislation and regulation, health and human rights, and health policy and planning, have been offered in parallel.

22. A major impediment to progress in public health in many countries has been a lack of capacity to develop and implement evidence-based health policies and programmes. As part of the efforts to strengthen leadership, a leadership for health programme was launched to promote skills among mid-level and senior level public health officials in countries. So far, more than 50 future leaders in public health have graduated. The programme, offered in collaboration with the Harvard School of Public Health, aims to develop future leaders who can address, proactively, local and national health problems that have direct impact on population health. Another leading initiative was the assessment of essential public health functions in the Region. Led by the Regional Director and advised by a global committee of renowned experts, this work established for Member States the specific functions of public health that are essential for the health and wellness of their populations. This was followed by the development of tools and self-assessment guides for countries to identify gaps in their public health capacity. The assessment was implemented in two countries as a pilot experience and will be rolled out to other countries of the Region.

23. In the area of health governance, an initiative was launched to build capacity in health diplomacy. This concerns the negotiations that Member States engage in at global level, in particular, around health issues that affect all countries and that shape the global policy environment surrounding health. Annual seminars have brought together key players from ministries of health and foreign affairs, diplomats, parliamentarians and experts to discuss the key global health issues of the moment and to learn from each other. Year on year this has proved to be a most useful dialogue from which all participants learn and which is contributing to strengthening the relationship between health and foreign policy in the Region. Several countries are implementing national seminars and workshops.

24. **Universal health coverage:** The most important goal for strengthening health systems in countries is the achievement of universal health coverage – and that means for everyone, all countries and both citizens and noncitizens. Universal health coverage must include interventions to tackle the most important causes of morbidity and mortality for the whole population, including the marginalized and vulnerable, as well as protection against catastrophic health costs that can cause financial ruin for families. It is an important target of the health goal of the Sustainable Development Goals and vital for ensuring effective response to the growing impact of noncommunicable diseases. The endorsement, in 2012, by the Regional Committee of universal health coverage as the overarching priority led to the development and subsequent endorsement, in 2014, of the *Framework for action on advancing universal health coverage (UHC) in the Eastern Mediterranean Region*. This is a strategic policy document that will help to achieve this vitally important initiative for every individual and family in the 22 countries of the Region.

25. The framework includes a set of strategic actions to achieve universal health coverage that are evidence-based, cost-effective and feasible, and all of which would be supported by corresponding actions by WHO. They include, for example, establishing a multisectoral steering mechanism under the stewardship of each Ministry of Health. They also include actions to enhance financial risk protection, which would ultimately help reduce the share of out-of-pocket spending, and thus of catastrophic health expenditure, and impoverishment. The framework also aims to ensure that each country's social health insurance coverage scheme contains a package of essential services, including preventive and curative services. Finally, it guides countries to expand coverage to vulnerable groups, particularly the poor and those in the informal sector, and to collect data to allow monitoring of progress toward population coverage.

26. Following the endorsement of the regional framework for universal health coverage, it is now necessary for each country to implement the recommended actions (Box 2.). To that end, WHO has extended support through health system review missions aimed at identifying challenges and opportunities to create national universal health coverage strategies. By mid-2016 in-depth health system reviews had been conducted and national strategies and plans developed in 10 countries. Almost all countries, including group 3 countries, are actively exploring options for universal health coverage, including the important topic of expanding population coverage through social health insurance, and covering the informal and vulnerable groups.

Box 2. Universal health coverage: key commitments of the framework for action

1. Developing a vision and strategy
2. Enhancing financial risk protection
3. Expanding the coverage of needed health services
4. Ensuring expansion and monitoring of population coverage

27. **Health information systems:** Two interconnected initiatives are being spearheaded by WHO in the Region to address the gaps in, and fragmentation of, health information systems in countries. These initiatives, started in 2012, are vitally important for the future development of evidence-based health policy-making, planning and monitoring.

28. In the first of these initiatives, WHO has been working intensively with Member States to review and strengthen their health information systems through expert consultations, intercountry meetings and widespread consultation with countries. In 2014, a framework for health information systems was endorsed by the Regional Committee. It provides 68 core indicators to monitor health in three areas: health risks and determinants, health status, including morbidity and mortality, and health system response. For each indicator WHO has provided a detailed analysis of the attributes (meta registry) which covers the source of data, the tool used to generate them and requirements for analysis, use for policy development and dissemination. In the past two years, Member States have started to adopt and

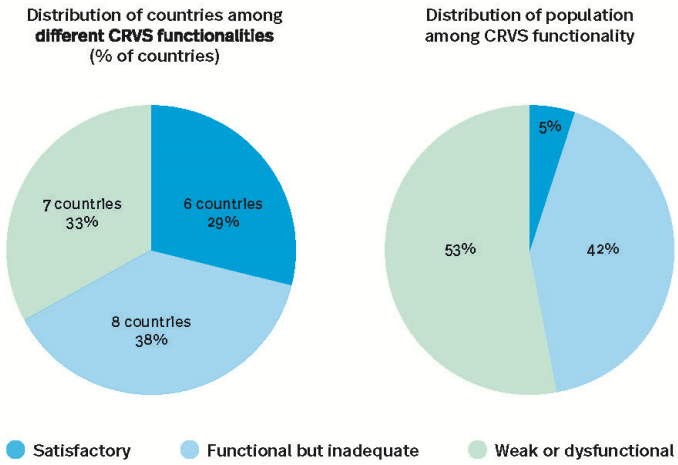


Fig. 2. Functionality of civil registration and vital statistics (CRVS) systems: results of rapid self-assessment in 21 countries of the WHO Eastern Mediterranean Region 2012-2013

report on the core indicators. However, to date, no country is able to report on all of them. Addressing this challenge is essential for all countries. A comprehensive report of the gaps in each country's data has been shared with ministers of health and a comprehensive assessment is followed to identify the priorities for addressing them. The next step for WHO is to provide technical support to countries, as required, to strengthen their health information systems.

29. The second initiative, endorsed by the Regional Committee in 2013, focuses on improving civil registration and vital statistics, with specific emphasis on strengthening cause-specific mortality statistics. As a result of the rapid and comprehensive assessments that were conducted in collaboration with the ministries of health and other national stakeholders, there is now a comprehensive picture of the strengths and weaknesses of the civil registration and vital statistics systems in all countries (Fig. 2). The gaps are considerable: more than 30% of all births were not registered in this region and just below 20% of deaths were reported with causes specified. The gaps that exist in each country were shared with Member States and technical support has been offered based on the regional strategy endorsed by the Regional Committee. Since the assessments were conducted, the number of countries reporting cause of death statistics from the Region has increased, from 7 in 2012 to 13 in 2016. Still, all countries, irrespective of their current achievement, need to do more to improve the accuracy of cause-specific mortality data, which is essential for monitoring health and also the Sustainable Development Goals.

30. **Health workforce:** This initiative involves not only developing the number of health care professionals and other health workers needed in countries but also the quality of the workforce. This is a critical area for health in the Region. Attracting quality health care workers is now very difficult in some countries where there is ongoing instability and conflict and from which many health professionals have been forced to flee with their families. In other countries, pay and working conditions are inadequate to sustain the workforce required. Working in collaboration with ministries of health, several strategies have been pursued to strengthen the health workforce.

31. A regional framework for health workforce development has been developed in consultation with Member States. The evidence-based framework, which is fully aligned with the global health workforce strategy, provides options for tackling some of the most difficult problems facing countries.

32. Strengthening medical education is key to health development in the Region. This area of work has been stalled in WHO over the past decade. Intensive work with countries and the International Federation of Medical Education was put into conducting a clear assessment of the situation of medical education in different countries and a regional framework was developed to address existing challenges,

based on international experience. The framework is an approach to scaling up the development of quality physicians, beginning with establishing and strengthening the regulatory capacities, providing standards and guidelines for new medical schools, encouraging/strengthening education development centres, building capacity of educational leaders and establishing national independent accreditation programmes. Attracting and retaining competent faculty and developing adequate resources for training are also included. For each priority, short-term and long-term actions by Member States are outlined, matched by specific technical support from WHO.

33. The development of a regional strategy aimed at strengthening nursing and midwifery has been equally important, since nurses and midwives provide a major proportion of health care services worldwide and in the Region. A significant shortage of nurses and midwives exists in this region, and the strategy recommends strategic actions in five key areas: governance and regulation; workforce management systems; practice and services; access to quality education; and research.

34. **Access to quality health care:** Delivery of quality health care services for populations is based on the values and principles of primary health care. Family practice has been promoted as the principal approach for delivering integrated, person-centered primary care in the Region. However, countries have many gaps and challenges in offering full-fledged family practice programmes that are responsive to the changing demographics and disease burden. The major efforts undertaken to strengthen primary health care have included a situation review, strategic guidance to countries, building country capacity and advising on scaling up the production of family physicians. Programmes and tools to improve the quality of care and patient safety have been developed for all levels of patient care. The patient safety assessment manual was updated and a toolkit was developed to support patient safety programmes.

35. Two new areas of work have been instituted into the strategic priorities of health system strengthening: hospital management and the role of the private health sector.

36. A situation analysis of public sector hospitals in the Region was conducted and a capacity-building workshop was developed in which senior hospital managers from inside and outside the Region shared best practices on hospital care and management. Subsequently, a network of hospital managers and policy-makers was established to promote collaboration in these areas.

37. The private health sector is one of the major health providers in most countries. It has expanded rapidly and is often under-regulated. Partnerships with the private sector to deliver publicly financed essential health services can be an important means of population health improvement. For this opportunity to be realized, however, the private health sector needs to be well regulated, based on defined standards and enforcement. Government oversight and stewardship is essential, and a laissez faire approach is not acceptable. The work on the private health sector began with an analysis of the private health sector and was followed by a series of capacity-building workshops and consultations aimed at engaging and regulating private sector health care for universal health coverage.

38. **Essential technologies, including medicines:** Access to health technologies, including medicines, vaccines, biologicals and medical devices, can mean the difference between wellness and widespread disease for populations and life and death for individuals. Yet, in many countries, a high percentage of the population lacks regular access to essential technologies, including medicines, while quality assurance is problematic and irrational use is widespread. Government capacity to regulate may be supply-driven, which can result in wasted expenditure and purchase of inappropriate products. There is growing recognition that the weak performance of national health systems in this area is a major constraint to health development.

39. In response, a robust health technology assessment tool was launched. This assessment is a multidisciplinary decision-making process that uses information about the medical, social, economic, organizational and ethical issues related to use of a health technology. It supports the formulation of safe and effective health policies that are patient-focused and seek to achieve both the best value and best

patient outcomes. The tool can provide cost–benefit evaluations to make purchase decisions within a given budget, and can help reduce waste and inefficiencies resulting from inappropriate investments. It also can be valuable to countries working towards universal health coverage.

40. Pharmaceutical sector profiles were also developed for all countries. The profiles provide a detailed description of the components of the national drug policy, with an indicator score card, as well as the challenges and priorities for action.

Way forward

41. The framework for universal health coverage and the work with health ministries in collaboration with country offices is very promising and will lead to real progress, if the commitment to this process is maintained and expanded. Special attention will be given to finalizing country-specific roadmaps for universal health coverage, including health financing and service delivery strategies. Experiences and lessons learnt from initiatives both inside and outside the Region will be shared.

42. Future work in leadership and governance will focus on strengthening of ministries of health, building their capacities for better regulation of the health sector, greater multisectoral involvement, effective decentralization and increased accountability and transparency. Strengthening the capacity of public health in ministries of health is key. The leadership for health programme, which has been successful for two consecutive years, will pay greater dividends as time goes on and as graduates progress in their careers. The programme aims to graduate up to 30 public health leaders from the Region every year. The plan is for the leadership programme to be eventually outsourced to an academic institution in the Region to ensure sustainability.

43. Accurate data from health information systems is absolutely vital to improve the health of populations. Every country of the Region needs to mobilize high-level political commitment and support from relevant sectors to fulfil the promise of health information system initiatives, especially collection of comprehensive cause-of-death data. Member States have repeatedly expressed concern about the validity of estimates that are used to report on health status in countries. While the methods to generate estimates are improving at the global level, there is no alternative to such estimates unless countries develop reliable data collection and reporting systems. WHO is developing methodologies to assess the validity of the reported indicators so that the results of the assessments will help the countries improve their information systems at a national level. Every country will need to consider the gaps in reporting on the 68 core indicators of the regional health information framework recently provided by WHO and develop a plan. Countries should also consider the areas in their civil registration and vital statistics systems that were identified by the comprehensive assessment and subsequent WHO reports as requiring strengthening.

44. Health workforce development is critical to every other health initiative. Clear strategies to build the workforce of the future have been developed and will be discussed with Member States at the 63rd session of the Regional Committee. Political and educational leadership at the country level is now necessary to move forward.

45. The support to medical schools will continue through the implementation of the regional framework for medical education. The framework will be discussed in a ministerial-level meeting for the health and higher education sectors which is planned to take place in the fourth quarter of 2016. Every country is expected to review the nursing and midwifery workforce situation based on the regional framework for action. WHO will provide technical guidance and support through a network of international and regional experts.

46. Regional programmes for capacity-building and technical support aimed at expanding access to quality health care, including enhancing primary care through expansion of family practice, should be expanded to accelerate progress towards universal health coverage and improve patient safety. Engaging

the private health sector is an essential component of the journey to universal health coverage. WHO's work in 2016–2017 will continue to provide guidance on strengthening the role of private sector in moving towards universal health coverage and regulating it.

47. Intercountry meetings on the assessment and regulation of essential technologies have begun with the purpose of establishing guidelines to support Member States. Countries need to finalize, and then implement, action plans to institute health technology assessment and regulation. WHO will continue to provide capacity-building and technical support for every step towards full implementation of the assessment for countries. In addition, international donors are potentially interested in supporting health technology assessment and regulation.

Maternal and child health

Situation in 2012

48. Maternal and child health is one of the main public health concerns in the Region. Some countries are among those with the highest maternal and child mortality rates in the world, although several countries are among those with the lowest. In 2012, 80 mothers and 2400 children were estimated to be dying every day due to preventable causes. Of the Region's maternal and child deaths, 95% occurred in nine high-burden countries, and 45% of under-5 deaths were among newborns. Between 1990 and 2012, maternal mortality decreased by 42% and under-5 mortality by 45%. However, these levels of reduction were not on track for meeting the targets of the Millennium Development Goals (MDGs) for 2015.

49. High maternal and child mortality in the Region was identified as being largely related to health system gaps and challenges, in particular inadequate health workforce, lack of access to essential medicines, non-functioning referral systems and low quality of care, as well as poor nutrition. Political will and commitment to maternal and child health remain insufficient, while financing mechanisms have been inadequate to ensure universal coverage for maternal and child health services. The situation is more critical in countries where instability, conflict and protracted crises are prevalent. Coordination and alignment of partners, stakeholders and other sectors were also identified as needed strengthening in those countries with high rates of mortality.

50. Recognizing the need to strengthen the efforts of governments, partners and donors in responding to maternal and child health needs, WHO, UNICEF and UNFPA, in collaboration with Member States and other stakeholders, jointly embarked on a regional initiative on saving the lives of mothers and children. The aim was also to accelerate progress towards achieving MDGs 4 and 5 on reduction of child and maternal mortality. The basic strategic approaches adopted in this initiative were to give priority to countries with high maternal and child mortality, to focus on proven high-impact interventions implemented in primary health care, and to strengthen partnerships.

Progress 2012-2016

51. Member States joined WHO, UNFPA, UNICEF and other stakeholders at a high-level meeting in January 2013 to launch the initiative. The meeting culminated in the Dubai Declaration "Saving the lives of mothers and children: rising to the challenge" which provided much needed impetus and a way forward for countries and partners.

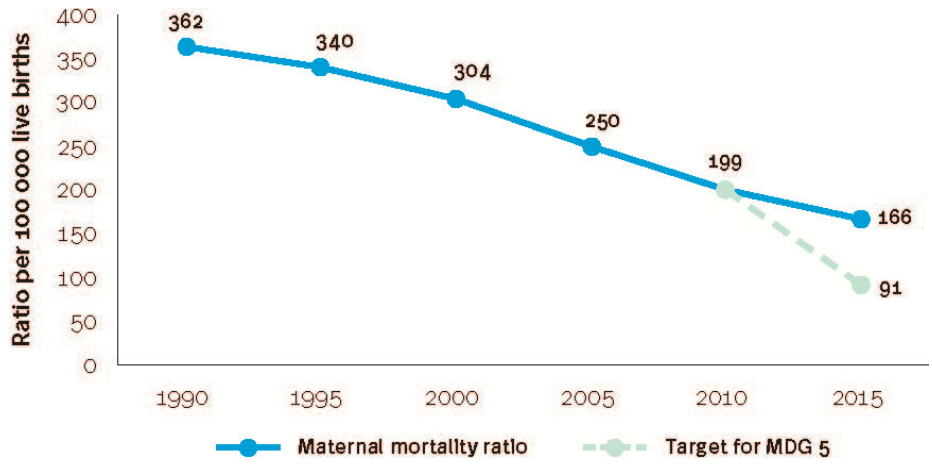
52. The Dubai Declaration was endorsed by the Regional Committee in October 2013, demonstrating the commitment by Member States to support maternal and child health as a priority on the national health agenda. The nine countries with a high burden of maternal and child deaths conducted situation analyses of maternal and child health, identifying gaps and determining cost-effective interventions to address maternal and child deaths. Acceleration plans were developed in these countries to ramp up evidence-based, high impact reproductive, maternal, neonatal and child health interventions. Seven out of the nine countries launched their plans with senior political leaders, using start-up funds allocated

from domestic and donor sources, along with funds from the Region and the WHO country collaboration programme. Regional surveys were launched to assess the initiative and capacity-building was instituted for reproductive, maternal, neonatal and child health programme managers. Tools were developed to improve infection assessment and control and to assess quality standards for maternal and child health services. An assessment of maternal and child health workforce was conducted for all high-burden countries, with key recommendations to address existing gaps in availability, distribution and quality of training.

53. Strengthening of health information systems continues to be a critical factor in improving maternal and child health. Maternal death surveillance is at very different levels of implementation among countries in the Region. Initiatives have been launched to strengthen this surveillance, and surveillance tools for perinatal death are being tested at country level. To accelerate maternal and child health plans, intercountry meetings and country missions have been jointly held with UNFPA and UNICEF to identify priority interventions targeting the main causes of preventable deaths.

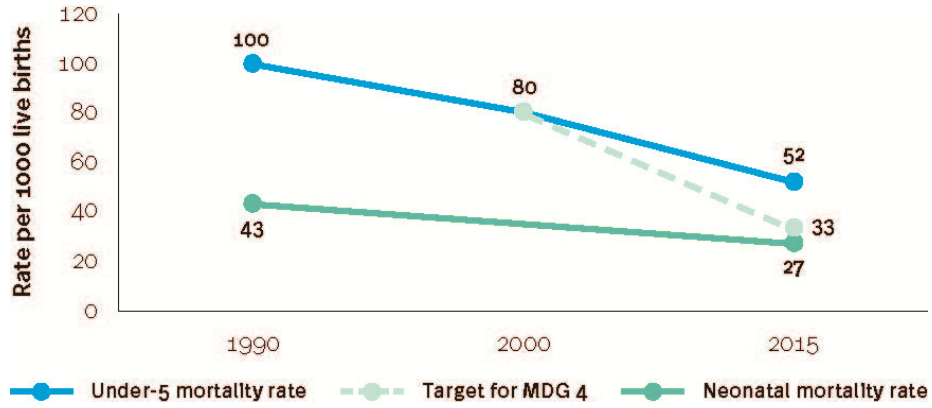
54. Continuing with the partnership in improving maternal and child health outcomes in the Region, and in line with the importance of the continuum of care throughout the life span, preconception care is being promoted within maternal and child health programmes. Member States are committed in reinforcing the implementation of a preconception care package, by adopting and implementing evidence-based, cost-effective and culturally-sensitive interventions that have a high impact on maternal and child health – the so-called "best buys".

55. By the end of 2015, much progress had been made towards achieving MDGs 4 and 5 in the Region. Between 1990 and 2015 maternal mortality ratio decreased by 54% (Fig. 3) and under-5 mortality by 48% (Fig. 4). Eight countries achieved MDG 4 and three achieved MDG 5. Of the nine countries with a high burden of maternal and child deaths, two achieved MDG 4.



Source: Trends in Maternal Mortality: 1990-2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division

Fig.3 Regional trend in maternal mortality, 1990–2015



Source: Levels & Trends in Child Mortality: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation, Report 2015

Fig.4 Regional trend in under-five child mortality, 1990–2015

Way forward

56. Maternal, newborn and child health must remain a priority in all countries, regardless of income and development. Progress must be maintained in the programmes already launched, while timelines for future implementations must also be maintained. WHO will continue to support high-burden countries and countries in emergencies. Because of their impact on morbidity and mortality, newborn health, early childhood development, adolescent health and preconception care are emerging as priorities in the Region. Initiatives to achieve universal health care and to improve the quality of care are also critical to maternal and child health.

57. All countries must be committed to developing or updating their reproductive, maternal, newborn and adolescent strategic plans for 2016-2020, as adopted by the Regional Committee in October 2015 and in accordance with the United Nations global strategy on women's, children's and adolescents' health. Addressing health inequities through tackling the social determinants of health must begin in the planning stages of all maternal and child health initiatives.

Noncommunicable diseases

Situation in 2012

58. Noncommunicable diseases are the biggest killers worldwide, including in the Eastern Mediterranean Region, where all types of noncommunicable disease accounted for 57% of all deaths – more than 2.2 million people –across the Region in 2012. In group 1 and many group 2 countries up to 75% of deaths are due to these diseases. It is estimated that up to half of these deaths occur prematurely in some countries. The majority of death and disability is preventable, through evidence-based interventions that address the four main groups of diseases – heart disease, chronic lung disease, cancer and diabetes – and their related risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.

59. Recognizing the devastating social, economic and public health impact of noncommunicable diseases, world leaders gathered at the United Nations General Assembly in 2011 and agreed on a roadmap of concrete commitments to address the global burden. Therefore the main priority for WHO and Member States, in 2012 and beyond, was to focus on implementation of that roadmap. Priorities included advocacy for higher levels of political commitment and multisectoral engagement and provision of technical support in developing multisectoral plans and implementing the actions

recommended in the declaration, and to develop monitoring frameworks, including a set of national targets and indicators.

Progress 2012-2016

60. In October 2012, the Regional Committee endorsed a framework for action to implement the United Nations Political Declaration on Prevention and Control of Noncommunicable Diseases. The framework comprises a set of strategic measures that countries should take in four areas of work: governance, prevention and reduction of risk factors, health care and surveillance. The regional framework approved by the Regional Committee is a milestone as it commits countries to very specific, evidence-based progress measures in the four areas. All the measures included in the framework are high-impact, evidence-based, cost-effective and affordable (best-buys) and can be implemented by all countries irrespective of income. The progress indicators include:

- developing and implementing an operational multisectoral national strategy/action plan;
- setting time-bound national targets and indicators based on WHO guidance;
- implementing four demand-reduction measures of the WHO Framework Convention on Tobacco Control at the highest level of achievement: taxation, smoke-free policies, health warnings and advertising bans;
- implementing four measures to reduce unhealthy diet: policies to reduce population salt intake; policies to reduce saturated fat intake and eliminate industrially produced *trans*fats; guidelines on marketing to children; and recommendations of the International Code of Marketing of Breast-Milk Substitutes;
- implementing a national public awareness programme on diet and/or physical activity;
- implementing, as appropriate, according to national circumstances, the three evidence-based measures to reduce the harmful use of alcohol: developing and enacting regulations; advertising and promotion bans; and pricing policies;
- strengthening monitoring of noncommunicable diseases and their risk factors by implementing the WHO NCD surveillance framework, including a functioning system for generating reliable cause-specific mortality data on a routine basis;
- integrating the management and health care of people with noncommunicable diseases into primary health care and provision of drug therapy (including glycemic control) and counselling to people at high risk of heart attacks and strokes.

61. A dashboard of priority legal interventions to address noncommunicable diseases has been produced by the Region. It includes raising tobacco taxes and banning tobacco advertising and promotion, eliminating artificial *trans*fat from the food supply and reducing salt in processed foods, and protecting public health policies from the interference of vested interests. Brief profiles are produced annually by the Region on each country's national noncommunicable disease response based on the progress indicators outlined in the regional framework.

62. Heart disease, lung disease, cancer and diabetes all require chronic care services for positive health outcomes and population health. Two areas are critically important: integrating health care for common conditions into primary care and continuity of treatment during crises and emergencies. A regional framework on the integration and management of noncommunicable diseases into primary care has been developed with policy options for all three groups of countries to consider. Maintaining health care during national emergencies is a difficult process, especially for displaced persons and in areas where health care facilities have been damaged or destroyed and health care workers have fled. In this respect, an emergency health kit for noncommunicable diseases is under development that includes the necessary essential medicines and technologies to maintain continuity in treatment for 10 000 people for 3 months, in areas when regular supply of medicines and technologies has been disrupted.

63. Mental health disorders are also a leading cause of disease burden in the Region. The majority of people with moderate to severe mental health disorders have no access to essential health and social care. The global strategy on mental health provides a comprehensive list of interventions to strengthen national mental health programmes and to improve access to care. Intensive work with international and regional experts resulted in the development of a more focused regional framework to scale up action on mental health which is now available to countries. The framework provides a set of evidence-based cost-effective and affordable interventions which, if implemented, will have a high impact on improving the mental health of populations. The framework covers measures in four areas: governance, health care, promotion and prevention, and surveillance and monitoring. All countries can implement these measures, irrespective of their income.

64. Environmental health is an area of growing importance for the Region. Air pollution, unsafe drinking-water, inadequate sanitation, contaminated food and chemical exposures are particular concern, together with the anticipated impacts on health of climate change. In 2013 the Regional Committee approved a regional strategy on health and the environment with a framework for action for 2014–2019. Subsequently, several countries have developed national frameworks for action while others are embarking on implementation of the regional strategy. A regional food safety assessment and national profiling mission was completed in 15 countries. WHO and countries are following up on the findings and recommendations, and a regional action plan to strengthen food safety systems is being developed.

Way forward

65. In 2018, all Member States will be reporting to the third United Nations high-level meeting on noncommunicable diseases on the progress made in implementing the key commitments included in the 2011 political declaration, which are included in the regional framework for action. Clear indicators have been developed and will be used to measure progress. A recent review of progress on the indicators shows that a lot of work still needs to be done. For example, only 9% of countries have achieved full implementation on tobacco taxation, 18% on marketing restrictions to children, and 27% on risk factor surveys. In perhaps no other areas are targeted and time-bound actions so clear as in noncommunicable diseases response.

66. Progress has begun and momentum is building for political and health leaders. The way forward for Member States in confronting the world's biggest killers is to ramp up the progress made so far to meet the goals between now and 2025. For 2018, countries need to deliver on the commitments included in the regional framework.

Communicable disease

Situation in 2012-2016

67. The public health response to the threats of emerging and other endemic-prone communicable diseases in the Region has remained a constant challenge since 2012. The Region has faced repeated outbreaks from emerging diseases, while the complex humanitarian emergencies and protracted conflicts have heavily damaged already fragile health systems, making communicable disease control and elimination efforts extremely difficult and challenging.

68. In 2012, communicable diseases were estimated to be still responsible for around a third of all deaths and a third of all illnesses in the Region, seriously hampering health and socioeconomic development in some countries. Of the three remaining polio-endemic countries in the world, two were in the Eastern Mediterranean Region and accounted for most of the reported cases, threatening the gains made in global polio eradication. HIV continued to spread fast, while the burden of malaria and tuberculosis remained high, particularly in group 3 countries. The coverage and quality of HIV, malaria and tuberculosis programmes needed improvement. While new HIV infections in the Region are still increasing, treatment coverage was the lowest among all WHO regions. More than half of all

tuberculosis cases were estimated to be unreported. Viral hepatitis was a silent epidemic in some countries.

69. The Region has experienced a rise in the number of emerging and re-emerging communicable diseases, including avian influenza, brucellosis, cholera, dengue and other viral haemorrhagic fevers, diphtheria, measles, yellow fever, Middle East respiratory syndrome coronavirus (MERS-CoV), West Nile virus and hepatitis A. Immunization and control programmes for vaccine-preventable diseases have faced daunting challenges in several countries, leading to rising rates and incidence of vaccine-preventable diseases. The regional elimination goal for measles faced a major setback owing to the drop in vaccination coverage of susceptible populations.

70. Health security is a critical concern. Adherence to the core capacities required under the International Health Regulations (2005), an international legal agreement binding on all Member States, remain severely compromised owing to critical gaps in countries' health systems. As the security situation has worsened, control and elimination efforts for many high-burden communicable diseases have halted and prevention efforts deteriorated. Country capacity for surveillance to detect and respond to outbreaks, evaluate programmes and project future needs was identified as a particular challenge, especially in group 3 and group 2 countries.

Progress 2012-2016

71. Any examination of the Region's response to controlling the burden of communicable diseases must take into account the Region's worsening and perpetual security situation. The fact that outbreaks of communicable diseases have been rapidly contained so that they did not escalate into epidemics or pandemics, and did not spread internationally from the Region, is in itself a measure of considerable success and significant public health achievement. The critical challenges to disease control have been, and remain: widespread displacement of populations, damage and destruction to health care facilities, disruption of essential public health services, and migration of health care workers fleeing violence, decreasing access to health care services including medical supplies and vaccines, and the targeting of health care workers through armed attack.

72. The Eastern Mediterranean Region is now the only WHO region where polio continues to be endemic. In 2012 Afghanistan and Pakistan implemented national emergency plans, demonstrating high commitment to improving programme performance and accountability. This was supported by a surge in technical support from WHO and international partners, and enhanced advocacy from community and religious leaders to counter disinformation campaigns on the part of some groups. In 2013 outbreaks of polio in the Horn of Africa and in the Middle East were immediately recognized as a serious threat to health security, and a public health emergency of international concern was declared by the IHR emergency committee. A monumental effort ensued by national governments throughout the Region and health partners to drive out the virus. Since 2012, the number of polio cases has dropped significantly (Fig. 5). There are still areas in Afghanistan and Pakistan where poliovirus continues to circulate due to vaccination coverage gaps caused by inaccessibility, refusal by parents to have their children vaccinated, and programme operational deficits in accessible areas. Insecurity and attacks on polio workers, and spread of misinformation, also continue to hinder efforts to reach children with vaccines in some areas.

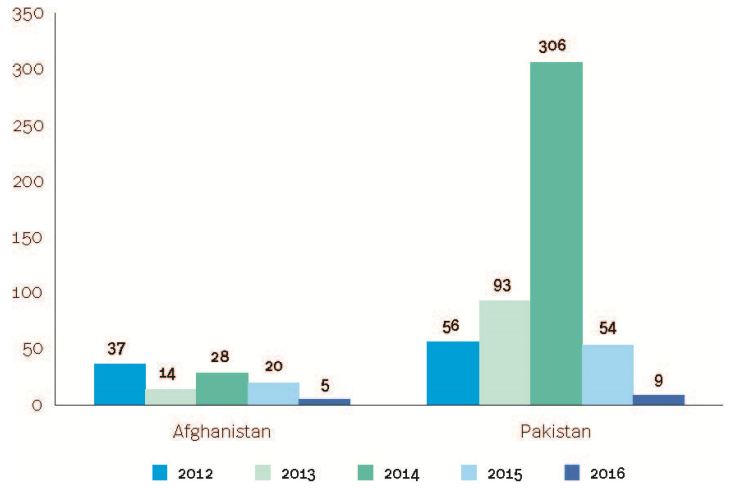


Fig. 5. Decline in cases in polio-endemic countries since 2012

73. Compliance with the International Health Regulations (2005) has been strongly advocated among Member States and stakeholders as necessary for national, regional, and global health security. Following the outbreak of Ebola in west Africa, and at the request of Member States of the Region, WHO carried out rapid assessments of countries' capacity to detect and respond rapidly to a case of Ebola. The findings highlighted gaps in the outbreak prevention and control capacities of all countries, including in countries that had previously reported readiness to implement IHR 2005 (Fig. 6). The assessments carried out by WHO also revealed the limitations of the IHR self-assessment tool, which led the Regional Committee at its 62nd session in 2015 to call for the adoption of an independent assessment and the establishment of a regional assessment commission on IHR to facilitate and provide technical guidance to countries and to oversee the process of independent joint external evaluation. Our region has been leading in harmonizing the IHR assessment tool with the Global Health Security Agenda (GHSA) tool and the development of the Joint External Evaluation (JEE) tool which is now adopted by all WHO regions and the GHSA.

74. A strategic revamping of IHR implementation with a new monitoring and evaluation framework has been developed with four components: annual self-reports from Member States, after-action reviews in response to outbreaks/crisis, simulation exercises, and independent joint external evaluations. Every Member State has now established an IHR national focal point. Countries have developed plans for IHR implementation, and there has been increasing recognition of the critical importance of strengthening measures at points of entry for managing health threats.

75. Major and widely threatening infectious diseases that were investigated and rapidly contained over the past five years include yellow fever in Sudan; hepatitis A in Iraq and Jordan; cholera in Iraq; epidemic influenza in Iraq, Jordan, Kuwait, Libya, Egypt, Tunisia, Yemen and Pakistan; avian influenza A (H5N1) infection in Egypt; Middle East respiratory syndrome (MERS) in Saudi Arabia and other countries; and dengue fever in Pakistan, Yemen and Sudan. Timely and effective response efforts helped avert major international health emergencies from these threats. An early warning, alert and response network system was established and rapidly expanded for early detection and response to health threats in all the countries affected by the Syrian crisis and other emergencies. The value of establishing this network was exemplified by the fact that major epidemics were averted. A regional network of experts and technical institutions was established to facilitate support for international outbreak response.

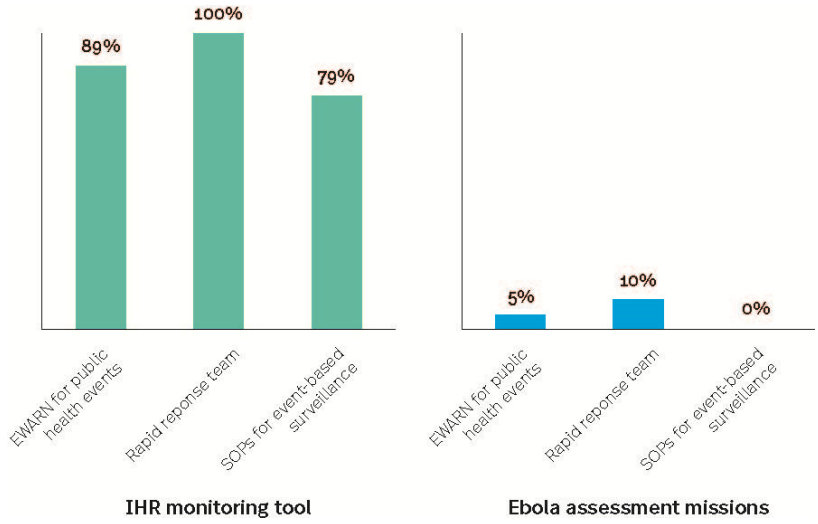


Fig. 6. Comparison of IHR monitoring assessment results and Ebola assessment results, 2014, for the core capacity of surveillance

76. Surveillance systems for influenza-like illness and severe acute respiratory infections were established to build local capacity for early detection, recognition and response to any novel influenza virus with pandemic potential. A total of 16 national influenza centres have been established in the Region for influenza virus isolation, sequencing and antiviral resistance testing. In addition, the Pandemic Influenza Preparedness Framework, a unique public – private partnership initiative, was rolled out to strengthen the capacity of countries for detection and response to influenza with pandemic potential and to increase access to vaccines and other pandemic-related supplies. Laboratories for disease prevention, detection, and control have also been strengthened.

77. Despite the continuing challenges, regional average of DTP3 coverage was maintained at 82% and 14 countries maintained DPT3 routine vaccination coverage above 90% in 2014. Despite outbreaks in several countries, overall, the number of reported measles cases fell by half between 2011 and 2014. Measles campaigns were implemented in 12 countries during 2015, reaching over 65 million children with measles-containing vaccine. Considerable progress was made in capacity-building and planning and evaluation for immunization programmes and national immunization technical advisory groups now established in almost all countries. A new regional vaccine action plan was endorsed for implementation by the Regional Committee in 2015. In crisis zones where health facilities were damaged, destroyed or nonexistent, including camps for displaced persons, innovative mobile and community-based approaches to care were implemented with success. Such innovations resulted in closing the gaps in immunization coverage, including for measles.

78. A regional operational framework has been developed to implement the global action plan for combating anti-microbial resistance in the Region. Data and evidence has been generated on the burden, scale and magnitude of the threat of antimicrobial resistance in the Region and public health actions have been harmonized with the animal health sector for an integrated and coordinated approach to combat this emerging threat to mankind.

79. Treatment coverage for HIV care nearly doubled from 2011 to 2014, although overall coverage for antiretroviral therapy of eligible people is still below 20%. A steady increase in notification of new TB cases has occurred since 2012, while the treatment success rate improved, reaching 91% in 2015, well above the global target of 85%. The estimated incidence and death rates due to malaria decreased from 2010 to 2015.

Way forward

80. In addition to stepping up response efforts to control communicable disease outbreaks, action must be focused on health security, namely, full compliance by all countries with the International Health Regulations (2005). Capacities that are required under the IHR (2005) must be achieved. Although self-assessments indicated fairly high implementation levels with the regulations, subsequent assessments in response to potential importation of Ebola found many critical gaps in countries. These gaps, such as the absence of operational coordination structures, emergency operating centres and real-time monitoring of acute health threats, need to be filled through concerted efforts by Member States. WHO, with Member States, has defined specific steps countries must take and provided technical support and capacity building to support full IHR (2005) compliance. Using the new harmonized Joint External Assessment and working jointly with the Global Health Security Agenda, IHR core competencies will be assessed in all countries. We have set a target of 10 countries to be assessed in the remaining part of 2016, starting with Pakistan which completed the assessment in early May 2016.WHO and countries need to roll out the strategic framework for prevention and control of emerging diseases, and develop a framework for integrating the early warning system for disease outbreaks in countries affected by humanitarian crises. The network of trained experts and technical institutions will be expanded to provide support to Member States in outbreak detection, field investigation and response. WHO's institutional readiness must be enhanced for rapid and comprehensive response to emerging health threats. Border coordination between countries must also be strengthened. Combating the growing threat of antimicrobial resistance will be a major priority.

81. Immunization programmes provide significant contribution to safeguarding public health and promoting overall health and socioeconomic development. While government contribution to immunization programmes has increased in all countries, the level of funds available through global donors can be expected to decrease in coming years and countries need to step up efforts to ensure that comprehensive immunization programmes are adequately funded.

82. The persistence of violence, civil disruption, displaced persons and humanitarian crises in many countries in the Region may have delayed the ability to eradicate certain communicable diseases, instead temporarily changing the focus to containing them. However, comprehensive, evidence-based plans remain in effect for the ultimate goal of eradication, which will be attained through continued collaboration among all parties.

Emergency preparedness and response

Situation in 2012-2016

83. The social and political conflicts of 2011-2012 exploded into the unprecedented scale of humanitarian crises and health needs that more than half of the countries are facing today. In 2012 it was estimated that 40 million people were in need of health services as a result of emergencies. Today that figure stands at more than 62 million (Fig. 7). Since 2012, three countries - Syria, Iraq and Yemen - have been designated Level 3 emergencies, the highest level under the United Nations emergency designation system. Neighbouring countries have been severely affected.

84. More than half of the world's refugees come from the Eastern Mediterranean Region, and the Region also hosts the largest number of internally displaced persons as a result of conflict. 30 million people are now displaced, two thirds within their own countries and the rest in other countries. Registered Syrian refugees in Lebanon now account for a third of the total population of 4 million, while in Jordan they make up 10% of the population. Most refugees are living within host communities (Fig. 8).

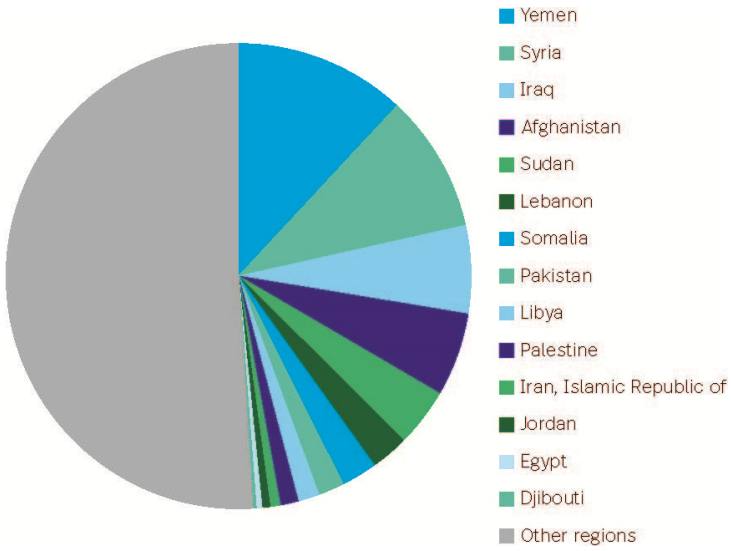


Fig. 7. Out of a total of 125 million people globally in need of health services as a result of emergencies, almost half are in the Eastern Mediterranean Region, as at end 2015

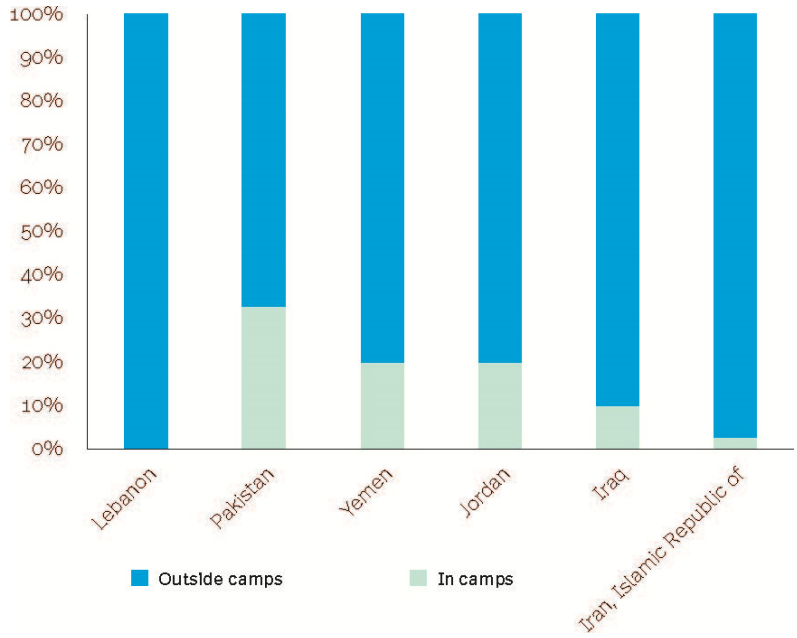


Fig 8. Displaced populations in host countries living in camps and among host communities

85. The deteriorating situation has meant that both displaced populations and host communities are at increased risk of infectious diseases due to overcrowded living conditions, limited access to safe water and sanitation, and varying degrees of access to primary health care services. Outbreaks of disease have been a major concern, highlighting the need for improved detection and response capacities to public health threats.

86. In countries with ongoing conflict and violence, mental health services are largely unavailable due to a lack of qualified health staff. The delivery of basic and emergency health care services has often been impeded as a result of shortages in basic and life-saving medicines and medical supplies, as well as supplies of fuel to ensure continuing functioning of health facilities. Incapacitated health systems and

shortages in medicines increase the burden of noncommunicable diseases as populations are no longer able to get regular treatment or access to essential, life-saving medicines.

87. Among the main challenges preventing an effective response in emergency settings have been lack of access to hard-to-reach populations and reduced humanitarian space (Fig. 9). In a worrying new trend, in some countries health care workers and health facilities have been directly targeted, or otherwise indirectly affected, resulting in vulnerable populations having little or no access to health care services. Many health workers have fled with their families.

88. Funding is a major impediment to effective emergency response. In 2012 only 47% of health sector requirements were met, emphasizing the need for a more coordinated approach by partners to address the health needs of affected populations. In 2013, funding increased but by 2015 had fallen back to below 40% (Table 1).

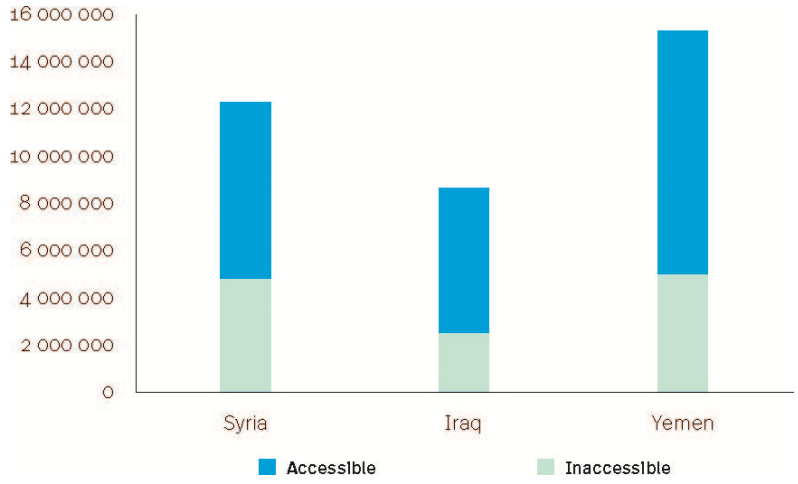


Fig. 9. Number of people in need living in accessible and inaccessible or hard-to-reach areas in countries facing Level 3 emergencies

Table 1. Funding for the health sector component of UN strategic response plans 2011-2015 for countries of the Region

	US$ requested	US$ received	% funded
2016 (as of 16 May)	1.3 billion	124 million	9%
2015	1.2 billion	470 million	39%
2014	1 billion	560 million	54%
2013	795 million	512 million	64%
2012	774 million	366 million	47%
2011	537 million	417 million	78%

89. Despite the large number of acute and protracted emergencies in the Region and the vulnerability to natural disaster, many countries lacked, and continue to lack, the necessary policies and legislation to support or facilitate emergency preparedness and response at all levels across sectors and only a third have institutionalized emergency preparedness and response programmes within the health sector.

Progress 2012-2016

Leadership

90. An ambitious programme of reform has been ongoing since 2014 following the request of the Regional Committee to enhance the emergency and humanitarian action capacity in the Region. A new organizational structure rolled out in 2015 is comprised of dedicated capacity for emergency response, partner coordination and emergency core services. A regional centre for emergency readiness and polio eradication was established in Amman. The work of the centre has also focused on building capacity and developing mechanisms to deploy external experts during emergencies.

91. A regional solidarity fund has been established to ensure the immediate availability of financial resources and to trigger action as early as possible when crisis strikes. A dedicated WHO regional logistics hub in Dubai's International Humanitarian City has been established and pre-positioning of critical medical supplies in Dubai is now helping ensure the timely provision of critically-needed medicines, medical supplies, medical equipment, vehicles, and ambulances to countries in the Region. For example, in the Gaza war in July-August 2014, WHO and partners were able to respond timely to urgent needs for medical and surgical supplies through an air bridge from Dubai.

Response

92. WHO has been leading the health sector response in all countries in crisis, including Iraq, Syria and Yemen. In order to ensure the availability of health services for vulnerable populations, especially women and children in the most affected areas, WHO scaled up the provision of medical supplies, strengthened early warning systems to monitor and control disease outbreaks, established mobile clinics to increase access to health services, and provided fuel to keep health facilities running. The provision of obstetric and gynaecological health services was supported, as well as vaccinations for children below the age of 5 years. Mental health services were also supported and an emergency health kit was developed to respond to the needs of populations affected by emergencies for management of noncommunicable diseases.

93. Partnerships with nongovernmental organizations were forged and strengthened on the ground to ensure access to health care for populations living in hard-to-reach areas and WHO continued to advocate for unhindered access to health care for all patients.

94. Across the Region the number of health staff trained was increased to enhance national capacity, including 20 000 health staff trained in Syria alone since 2012. Trainings covered the areas of trauma care, basic routine immunization services and vaccine management, infection control, chronic disease care and management, mental health care, disease surveillance, nutrition and reproductive health care.

95. The Region introduced pioneering approaches for strengthening routine public health surveillance through mobile technology and an online platform. The number of sentinel sites for the early warning alert and response network (EWARN) was expanded in hard-to-reach areas.

96. Following outbreaks of polio and measles in the Region, the Middle East Polio Outbreak campaign immunized more than 27 million children in eight countries from 2013 to 2015. This multi-country campaign, which successfully stopped the transmission in Syria and Iraq, is seen by the Polio Independent Monitoring Board as an example of a very well managed outbreak control. Partnerships

were strengthened and expanded with key religious institutions and nongovernmental organizations, especially those working in opposition-controlled areas.

Preparedness

97. A comprehensive emergency preparedness framework was developed highlighting 10 priority actions to be implemented at country level. Emphasis was placed on capacity development with curricula, tools and training courses developed to support emergency preparedness and response in health, including the first regional emergency pre-deployment training course conducted in early 2016 to enhance the surge capacity in the Region.

Way forward

98. Tens of millions of displaced persons, large cities heavily damaged or destroyed, ongoing hostilities and targeting of sub-populations, and all the related humanitarian disasters ensure that the health problems associated with these crises will be with us for years to come. As such, strategies and groups developed to specifically deal with crises-related health problems must be institutionalized and sustained. Restructuring of country and regional health entities, including the Regional Office itself, must be accomplished in a way that allows us to face both acute and protracted health crises in an adequate manner.

99. In the coming years, WHO will continue to scale up its work to support Member States in the Region to develop effective emergency preparedness programmes with emphasis on communities most at risk. Stronger partnerships between health authorities, nongovernmental organizations, community leaders, academic institutions, donors and other stakeholders will need to be fostered.

100. The funding gap is a major issue, as countries with protracted crises and destroyed urban infrastructure and housing will not have the resources to rebuild or to provide health care for their populations. More innovative and sustainable resource mobilization approaches with non-traditional donors will be needed to bridge this gap.

101. Increased advocacy for the protection of health care workers and health facilities, as afforded under international humanitarian law, including the Geneva Conventions, is necessary. Targeting of health care workers and facilities must be stopped. Greater advocacy is also required for increased access to besieged populations. Humanitarian pauses can be used to advocate for health as a bridge for peace.

Implementing WHO management reforms

Situation in 2012

102. It was clear in 2012 that a key priority for reforming WHO's work in this region is to reinforce managerial processes and strengthen the effectiveness and transparency of administrative actions. The humanitarian crises within the Region also necessitate the most effective and efficient regional management and governance possible in order to assure to the best possible help and support for millions of people in need. The underlying goals of the reforms are to develop and implement plans that result in defined, concrete actions with measurable public health outcomes and clear accountability framework. Governance, management and administrative processes are being significantly streamlined; priorities are being refined and reduced in number to only those with the realistic expectation of valuable results.

Progress 2012-2016

Programmes and priority-setting

103. At the regional and country level, strategic directions were set to the five technical areas reflected in this report: health systems strengthening towards universal health care; maternal and child health;

noncommunicable diseases; health security and communicable diseases; and emergency preparedness and response. These priorities reflect the regional needs and are also consistent with the priorities endorsed by the World Health Assembly as part of the Twelfth General Programme of Work for 2014-2019.

104. Supported by the Regional Committee and working closely with national health authorities at the highest level, the Region was the first to implement the bottom-up planning process, starting with the planning for 2014-2015 , and focusing on a realistic set of programme areas and deliverables in order to achieve more tangible results and closer alignment with needs at country level. With this specific aim, the Region has steadily increased its budget to the country programme over successive biennia. In comparison with the biennium 2014-2015, the approved programme budget for 2016-2017 includes a 36% increase for the country offices while the increase for the Regional Office is only 7%. The intention has been to increase the impact of WHO's support to countries and avoid the fragmentation of the past years. The successful experience of the Region in the planning for 2014–2015 was used to guide the planning processes in the rest of the Organization in planning for 2016–2017.

Governance

105. Based on guidance from Member States, reforms have focused on harmonization of governance processes, strengthened oversight, greater strategic decision-making by governing bodies and more effective engagement with other stakeholders. Reforms also address the need for improved links between regional committees and global governing bodies, and between Member States and the Regional Director.

106. A number of actions and initiatives have been undertaken since to 2012 to strengthen the governance process. High-level meetings for Member States' representatives and permanent missions in Geneva were instituted prior to each major meeting of the WHO governing bodies (World Health Assembly, Executive Board), supported by concise and timely briefings to representatives. These meetings have been well attended and have strengthened the engagement of Member States in the work of the governing bodies, as well as providing valuable orientation for new delegates and representatives. The rules of procedure of the Regional Committee were revised to ensure alignment with best practice in the Organization, and a one-day pre-session meeting was initiated to allow for less formal discussion of up and coming issues on the regional health agenda.

107. The agenda of the Regional Committee itself was streamlined with regular agenda items on the key strategic priorities of health system strengthening, health security and noncommunicable diseases, and annual updates on maternal and child health and emergency preparedness and response. A concerted effort was also made to reduce the number of resolutions that Member States need to implement to a practical level. The Regional Committee decided to retire 79 resolutions, which it considered to be implemented, superseded or otherwise closed, and to introduce an accountability mechanism to monitor active resolutions and regularly report on their implementation.

108. A technical advisory committee was established to provide advice to the Regional Director on matters relating to strengthening technical cooperation among and between Member States of the Region, providing support in evaluating programmes and assisting with resource mobilization.

Management

109. Management reform has been aimed at more efficient use and distribution to priority areas of limited resources for the purposes of sharpening the focus of the Region on the immense needs of countries, while ensuring greater efficiency, transparency and accountability. . Capacities at country level were strengthened and additional training and support was provided to country teams. In particular, emphasis was placed on technical and managerial capacity through appropriate selection of WHO representatives in order to ensure effective support at country level, and on review and revision of

country offices structures in some countries. Similar processes have been enacted at regional level. Internal structures were reviewed and revised, and programmes streamlined and relocated as necessary to achieve optimal effectiveness.

110. The managerial actions associated with the reform process with respect to staff mobility and rotation, performance management and human resources planning and management were complemented by the promotion of an accountability culture. Accountability and controls continued to be at the heart of improvement efforts with focus on the five compliance areas, which were repeatedly mentioned in internal and external audit observations of preceding years: direct financial cooperation, direct implementation, imprest purchase orders, asset inventories and non-staff contractual arrangements. These areas are now closely monitored throughout the year by means of the monthly compliance dashboards.

111. Other management reforms include a dedicated compliance and risk management role; improved compliance and performance monitoring and reporting through dedicated dashboards; accountability compacts with budget centre managers and administrative officers tied in with performance management mechanisms; self-assessment questionnaires for managers in support of the management assertions on internal control; capacity-building initiatives, such as an integrated training programme for budget centres, compliance forums, and other outreach initiatives including joint capacity-building activities with Member States.

112. Measurable progress has been achieved in regard to accountability and internal control. For example, the number of outstanding reports on direct financial cooperation was reduced from over 500 in 2014 to about 60 by mid May 2016; a specific reform project addressed the non-compliant uses of special service agreements as a contracting method; and all overdue audit recommendations emanating from internal and external audits were fully addressed by May 2016, which is unprecedented, with new audit recommendations being largely being addressed before they become due.

Way forward

113. WHO in the Region is fully committed to reform. Substantial progress has been made so far but clearly more needs to be done in improving WHO performance and support to Member States, based on efficiency, accountability and transparency. Country offices have been a major focus of attention and while positive progress has been made in several countries, continued expansion of WHO's presence is planned in others. The planned reform in the WHO emergency programme is expected to have substantial impact within the Region, given the magnitude of the situation, and has the potential to bring concrete benefits.

114. The support of the Regional Committee has been invaluable in the period 2012-2016, both in guiding the work of WHO in the Region and also in its willingness to support change. The ownership of WHO's work by Member States will remain crucial to success in continuing reform.