The Work of WHO in the Eastern Mediterranean Region

Annual Report of the Regional Director 2013

World Health Organization
Regional Office for the Eastern Mediterranean

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Introduction and highlights of the report

This report focuses on the major work that has been undertaken in the past year in regard to the strategic priorities in the WHO Eastern Mediterranean Region that were endorsed by the WHO Regional Committee for the Eastern Mediterranean in 2012. These are: health systems strengthening towards universal health coverage; maternal and child health; noncommunicable diseases; communicable diseases, particularly health security; and emergency preparedness and response; as well as WHO management and reform[1]. The report also reflects some of the very great challenges facing the Region at this time, challenges which have, in some areas, created new demands to maintain the pace of progress and imposed competing priorities. I am pleased, nevertheless, to highlight the important milestones that have been achieved in the core areas.

[1] Five annexes relating to Regional Office structure, staffing, meetings, publications and collaborating centres can be found on the Regional Office web site at http://www.emro.who.int/about-who/annual-reports/

A major priority, early in 2013, was an initiative, in collaboration with United Nations partners, UNICEF and UNFPA, to accelerate progress towards achieving Millennium Development Goals (MDGs) 4 and 5, which concern reducing child mortality and improving maternal health, respectively. We called the initiative "Saving the lives of mothers and children" because this was exactly what we wanted to achieve. A high-level meeting in Dubai, attended by ministers of health, higher education and planning, among other stakeholders, resulted in the Dubai Declaration, which was subsequently endorsed by the Regional Committee and which provided a guide to the way forward for all countries. WHO then worked with nine countries where action was considered a priority to develop comprehensive acceleration plans and work was started to fund and implement these.

The acceleration plans are inevitably ambitious and some of the nine countries may not be able to achieve full implementation and meet the MDG targets. Nevertheless, they give those countries a better chance of ending 2015 with positive progress to show, and of entering the post-2015 agenda with renewed confidence and commitment. In order to initiate immediate action and to kick start implementation of the country road maps, seed funding was provided to the nine countries from WHO resources during the second half of 2013.

With this initiative, the lives of many more mothers and children will have been saved. However, the level of achievements made will undoubtedly depend to a great extent on the political commitment of governments and their ability to translate this commitment into concrete action. Solidarity and support from other

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↑ **Ministers of health, higher education and planning were among participants at the high-level meeting on "Saving the lives of mothers and children" in Dubai, United Arab Emirates**

countries and partners in the Region will remain crucial.

The Regional Committee, having identified universal health coverage as the overarching priority for health systems strengthening in 2012, endorsed a regional strategy and road map in 2013. Universal health coverage, with its emphasis on equity and quality, is now the umbrella for all our work in health systems. The current situation in the Region with regard to equitable access to health care of acceptable quality varies widely among countries. Gaps exist in every country and so every country has important work to do to improve such access and promote health. Our aim is demonstrable improvement in the three key dimensions required for universal health coverage – financial risk protection, service coverage and population coverage – as well as in prevention and health promotion services. The road map outlines, among other things, what countries can do to reduce direct out-of-pocket spending on health care by citizens, and to adopt a multisectoral approach by engaging relevant stakeholders. By the end of 2013, a regional framework for action was also in place to guide countries on the steps needed at country level, and several countries have now embarked on a path forward. This is solid progress and I look forward to seeing further development in the coming year.

Two other significant milestones were achieved in health systems strengthening, in the area of health information. Health information systems are weak and fragmented in many countries and there are major gaps in all countries. We have adopted a practical approach to strengthen health information systems in the Region by focusing on three key components: monitoring of health risks and determinants, monitoring of health status including morbidity and mortality, and assessing health systems performance. A core list of indicators covering these three key components has been developed through intensive discussions with representatives from relevant sectors of Member States and will be presented in final form to the Sixty-first Session of the Regional Committee. Based on in-depth analysis of the

current status in reporting for each of the core indicators, a regional strategy to address gaps and build national capacity will also be presented for review and approval during the Regional Committee.

Rapid and comprehensive assessments of civil registration and vital statistics, conducted in all Member States in 2013 showed major gaps and weaknesses. Most countries are not reporting accurate and complete cause-specific mortality statistics which are key for assessing health status and monitoring international commitments. Working closely with countries and regional partners, a regional strategy to strengthen civil registration and vital statistics was developed jointly with countries and other stakeholders and was endorsed by the Regional Committee.

Together, these two initiatives not only lay the foundation for stronger national health information systems but, if pursued and made full use of in countries, will enable better decision-making and strengthen national planning and monitoring of health development.

Progress in other areas was slower but important groundwork was laid for developing comprehensive guidance for countries in public health law, such laws being outdated in most countries, as well as in health workforce development, a strategic approach to family practice, better access to essential medicines and technologies, and engagement with the private sector. Considering the major role the private sector plays in providing health care in the Region, it is becoming crucial not only to ensure that appropriate governance and oversight of the private sector are in place, but also to involve it in supporting and implementing public health policy and achieving universal health coverage. At the same time, preparatory work has been done to review regional and international experiences and develop guidance for countries in strengthening the integration of prevention and management of noncommunicable diseases and mental health disorders into primary health care. Two major intercountry meetings will be organized for this purpose in 2014.

Prevention and control of noncommunicable diseases is absolutely crucial in our region, where the epidemic of cardiovascular disease, cancer, diabetes and chronic respiratory disease is rapidly increasing the toll of early death and has already overwhelmed many health systems. Having established a regional framework for action on noncommunicable diseases in 2012, with very clear and targeted outcomes based on the United Nations Political Declaration of 2011, the focus switched to putting this into action.

Not enough is being done by countries in reducing risk factors like tobacco use, unhealthy diet and physical inactivity. In order to help Member States in scaling up, much of the work done in 2013 was to provide concrete guidance to policy-makers in implementing the proven measures , especially the 'best buys' interventions. Technical guidance on salt and fat intake reduction was developed, and several countries have already started implementing the guidance. This can be expected to have a marked impact on population health.

I am hopeful that a similar consensus can be achieved on a comprehensive multisectoral approach to improving the diets of children. The Region needs to step up action on physical inactivity, for all age groups; 2013 witnessed extensive preparation for a comprehensive multisectoral forum on physical activity, held

in February 2014. Attention was also focused on advocacy and providing technical support to countries in implementing the proven tobacco control measures including tobacco taxation but, again, progress has been slow. Two countries, Morocco and Somalia, have still not ratified the WHO Framework Convention on Tobacco Control.

Communicable diseases dominated the public health headlines in 2013. Polio outbreaks in Somalia and the Syrian Arab Republic, and continuing circulation of poliovirus in Afghanistan and particularly Pakistan, were serious setbacks to the eradication programme. However, in a welcome show of unity and solidarity, Member States pulled together and agreed on action. The Regional Committee's declaration of the spread of wild poliovirus an emergency for the Region and the development of the regional action plan facilitated positive commitment and effective action in the short term to successfully contain the outbreaks. At the same time, the work on the establishment of the Islamic Advisory Group has resulted in strong support from the Islamic community to improve advocacy to reach children in security-compromised districts where militants have banned immunization and have intimidated and attacked health workers. The regional polio eradication programme witnessed considerable strengthening in terms of expertise and capacity to respond, with a technical surge unit established in Jordan. Nevertheless, while we continue to work intensively with Afghanistan and Pakistan in reaching children in security compromised areas, polio eradication will be difficult to achieve without political solutions to a situation which has, in 2014, led to polio being declared a public health emergency of international concern. The emergence of the new Middle East respiratory syndrome coronavirus (MERS-CoV), which gathered momentum throughout 2013 and into 2014, vividly highlighted the value of the International Health Regulations (2005). The priority given, and actions taken, by countries hit by MERS-CoV in investigating cases and in acting to address the issues involved are to be commended. This, together with the intensive and highly coordinated technical support provided by the three levels of WHO, has set an example that bodes well for the future of health security in the Region. Now, all Member States must focus on fulfilling the core capacity requirements for implementation of the Regulations by June 2016.

Photo: ©Government of Pakistan

↑ **The Prime Minister of Pakistan HE Mr Nawaz Sherif received the Director-General and the Regional Director to discuss the polio situation in Pakistan**

Also dominating the headlines in 2013 was the humanitarian situation, with unprecedented numbers of people needing humanitarian assistance across the Region. By the end of the year an estimated 42 million people in over half the countries were affected by natural hazards and political conflict. WHO established an emergency support team in Jordan to provide a single consolidated response to the crisis in Syrian Arab Republic and this has since been reviewed and expanded to provide a more effective response. The humanitarian situation in the Region is a huge challenge for public health, for ensuring basic health services and for long-term

rehabilitation of health systems. Not only are local communities and the displaced at risk, but health and humanitarian aid workers and health facilities are increasingly targeted also. Lack of funding remains a key challenge in ensuring an effective health response in emergencies but there are positive actions that can be taken to strengthen national preparedness and response. These include the adoption of a national disaster risk management strategy that addresses all hazards and covers all sectors. This has been a successful approach for many countries in the world but few countries in the Region have such a strategy in place and I very much hope we can move towards achieving this.

Within the context of WHO reform, we made concerted efforts to address organizational impediments to WHO performance. Structural review and reorganization continued, at both regional and country level, in order to strengthen our technical work, and administrative measures were put in place to strengthen managerial performance and compliance with rules and regulations. Ensuring the right staff are in the right place at the right time is a particular challenge. The ability to attract and retain the qualities and competencies the Organization needs in the current demanding environment has been compromised by the security situation in the Region. This is an issue that we are addressing but that needs more considered solutions than are currently on the table.

Reinforcing technical cooperation with countries is a key component of the WHO reform endorsed by the World Health Assembly in 2013. One major achievement in this regard was the shift from conventional planning to a bottom-up planning approach for the biennium 2014–2015. The Region pioneered this approach during the second half of 2013 in close and intensive consultation with Member States at the highest policy-making level. We focused on the key priorities of the 12th General Programme of Work in budgetary planning. An average of ten priority programmes was targeted for the biennium which resulted in more resources for each of them and, hopefully, real impact for the selected activities. The number of work plans resulting from this exercise was nearly half that of the 2012–2013 biennium for the whole region, including country programmes. The intensive collaborative work conducted with Member States for the biennial Joint Programme Review and Planning Missions, previously conducted over a few days, was spread over several months, culminating in two-day high-level visits to countries for strategic discussion. I myself personally conducted five of these visits, and the rest were conducted at a minimum of Director level.

Overall, I am able to report good progress in specific areas of WHO's work with Member States in 2013 through innovative approaches and scaling up action, particularly in areas of strategy development, technical guidance in translating plans into specific interventions, as well as laying the groundwork for moving forward. At the same time, we and Member States together were often constrained by unprecedented crises and events on the ground, which not only led to slowing down of progress in some cases but inevitably, also, to diversion of attention and resources to other priorities. Throughout all our work, it is clear that positive public health outcomes are rooted in the wider context of social and political development. In every one of the strategic priority areas that I have touched on, the health sector is just one player. Universal health coverage, successful primary health care, prevention of risk factors and noncommunicable diseases,

health promotion, health security and emergency preparedness and response all require partnership across government, and beyond government.

Special attention was given to this wider context in 2013 in many programmes. We sought to reach out to other sectors in government, for example in relation to moving forward on prevention of noncommunicable diseases where we have involved ministries of planning, transport, education, foreign affairs, sport, interior and finance. A similar approach was followed in WHO's work on strengthening health systems and health information. We sought to involve non-government players, from civil society, United Nations agencies and others. The regional strategy for the coming five years on health and the environment, endorsed by the Regional Committee, is a prime example of the multisectoral nature of public health. There is no substitute for clear long-term health goals articulated as part of long-term national development plans and addressed in coordination with all sectors and stakeholders, including civil society.

Finally, it is clear that many of the Region's health challenges would be well served by stronger health advocacy, health diplomacy and constructive social and political debate. An increasing number of the health challenges we are seeing can no longer be resolved at the technical level only – they require political negotiations and solutions, at global, bilateral and national level. Health diplomacy is particularly important for our region because many of the development issues it faces relate directly to health, and because it is disproportionately affected by humanitarian crises. It is essential that, together, we continue to build awareness and capacity in health diplomacy in Member States.

Ala Alwan
WHO Regional Director for the
Eastern Mediterranean

Strengthening health systems for universal health coverage

Universal health coverage

In 2013, WHO advocated with its Member States the move towards universal health coverage in order to expand population coverage, ensure the availability and accessibility of needed health services, and improve financial protection for those who use health care services. The move towards universal health coverage has created many opportunities for Member States to accelerate progress but has also highlighted gaps and challenges in the different health system components that will need to be addressed to accelerate the move.

In its 60th session, the WHO Regional Committee for the Eastern Mediterranean discussed the challenges and opportunities with regard to moving towards universal health coverage and endorsed a vision, strategy and roadmap (EM/RC60/R.2) for Member States. Short health system profiles were developed for each country which provide an overview of health system performance and a summary of the challenges and priorities for health system strengthening towards universal health coverage.

This was followed by an international event at which high-level representatives from 20 countries of the Region, as well as international and regional experts and development partners, such as the World Bank, endorsed a framework for action that will guide future support to countries in moving towards universal health coverage. Activities to build health system capacity to accelerate progress towards universal health coverage included workshops for the sub-regional group of Gulf Cooperation Council, G5 countries, and countries eligible for support from the GAVI Alliance.

Work in 2014 and beyond will focus on supporting Member States to implement the framework for action and assessing the progress that countries make in achieving universal health coverage.

Health financing

As noted in last year's annual report, the Region is characterized by a high share of direct out-of-pocket expenditures for health, which is a major impediment to the move towards universal health coverage. Many countries in all three groups of countries in the Region[2] continue to lack a clear vision as to how to improve their health financing systems. There is inadequate understanding of health financing concepts and similar lack of capacity in the conducting of health financing studies and tools, particularly national health accounts, OASIS (Organizational assessment for improving and strengthening health financing), household health expenditure and utilization surveys, and cost-effectiveness studies, and the application of these tools to inform decision-making.

[2] The three broad groups, based on population health outcomes, health system performance and level of health expenditure, are: group 1: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates; group 2: Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Syrian Arab Republic and Tunisia; group 3: Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen.

Several activities were held to build national and regional capacities in promoting concepts and the use of health financing tools to engage countries in discussions around strengthening national health financing systems. Global experiences in progress towards universal health coverage were shared at the high-level event on accelerating progress towards universal health coverage. Over 100 delegates participated, including ministers of health and policy-makers, development partners, civil society organizations and global experts. A high-level seminar was held in early 2013 on options for health care financing in the Region followed by a sub-regional meeting on health financing for the member states of the Gulf Cooperation Council (GCC), which comprise the group 1 countries. Among other issues, the particular case of expatriate populations was discussed and options on how to cover them were reviewed. Two regional capacity-building activities on national health accounts and costing using the one health costing tool were conducted. In addition, country-specific health financing workshops were held in three countries and a national health system conference was supported in Morocco, aimed at developing the vision for the future of the health system. Several policy papers were developed on key topics around universal health coverage, including multi-sectorality, and the role of strategic purchasing.

Needless to say, much work is needed in this area. Our plan is to continue to reinforce WHO's technical capacity in health financing to respond to the need to provide advice and build capacity in Member States in the development and implementation of sound health financing policies to achieve universal health coverage.

Health governance

Improving governance in health remains a major issue for all countries as they work towards increasing equity and fairness in health care delivery, updating public health laws and legislation, and improving accountability. The right to health – or health as a human right – is not yet a routine part of policy-making. As

Photo: © United Arab Emirates/Ministry of Health

↑ A regional ministerial meeting was held in Dubai, United Arab Emirates to accelerate progress towards universal health coverage

health assumes increasing importance in the global development agenda, there is an increasing realization of the need to develop capacities in health diplomacy and reinforce coordination with the foreign policy and other sectors. The second regional health diplomacy seminar was conducted for officials in foreign affairs and health to promote coordination between the two sectors in addressing health challenges that require political solutions and skills.

Support for improving governance, accountability and transparency included assessments in 12 countries to better understand the policy and planning function of the Ministry of Health. Technical support was provided to four countries to review their respective national health policies and strategies. Two assessment tools were developed to support health system development. The first was used to assess the status of the right to health in four countries, and the second to assess public health legislation in five countries. An expert meeting identified gaps in public health law in the Region and galvanized action to respond to these gaps, including the setting up of a regional network of experts on public health law. Work will continue in 2014 and beyond to develop clear guidance for countries in strengthening health legislation. Special emphasis will be given in 2014 to the prevention of noncommunicable diseases.

Of particular concern in the Region is the presence of political crisis and social unrest in several countries, a situation which has led to a domination of emergency-oriented activities in the health sector. This has contributed to further weakening of government institutions in some countries and their ability to increase and improve the predictability of external assistance, and their alignment and harmonization with government priorities.

Health workforce development

The major challenges facing countries in the area of health workforce development include shortages and maldistribution, especially of nurses, midwives and allied health professionals, training and continuing education, and retention of competent professionals. In several countries in groups 2 and 3, human resources management systems are weak and coordination in health workforce development is inadequate. An important region-wide concern is the need to ensure that the migration, movement, rights and obligations of the health workforce are consistent with the WHO global code of practice on the international recruitment of health personnel.

While the gaps in the development of the health workforce are clear, solutions to address these gaps are not always evident to Member States. To respond to this challenge, work started in 2013 to develop a comprehensive strategy to guide countries in implementing effective approaches in the production, distribution, training and retention of health professionals. The strategy, which will be based on a review of regional and international experience, will be discussed in an intercountry meeting in 2014.

It is evident from working closely with countries that most Member States do not have adequate capacity in public health. Supporting countries in this area is considered a priority by the Regional Office. Experience and skills in public health are essential for national health development. A regional consultation reviewed options for improving public health capacity, and discussed ways to develop a regional public health leadership programme and improve the quality of public health education and training, addressing the dichotomy between teaching and practice, and

improve investment in public health research. We are now working with other international public health institutions in establishing a public health leadership programme which will be open to mid-level public health managers in Member States starting in 2014.

Nursing and midwifery is another area that requires greater attention. A consultation on nursing education was convened to review and update the regional standards for nursing and midwifery education, and develop a regional framework for nursing specialization. A prototype curriculum for pre-service nursing education and a post-basic specialty mental health nursing prototype curriculum were developed.

WHO support was provided to build national capacity in areas such as leadership and management for nurses and midwives and how to conduct a health workforce projection. Nursing and midwifery regulation was strengthened in three countries. In Afghanistan, a strategic national plan for human resources for health and a strategic plan for the ten institutes of health sciences to promote educational development of nursing, midwifery and allied health sciences and increase production were finalized.

The regional fellowships programme benefited 94 fellows from countries across the Region.

We believe that WHO's work in strengthening medical education has not received adequate attention in recent years despite the important challenges that countries currently face in this area. In scaling up, we first need to conduct an accurate situation analysis, identify constraints and agree on priorities for action. For this reason, a major study on medical education in countries of the Region has been initiated in coordination with the World Federation of Medical Education. The purpose is to review the quality and appropriateness of medical education programmes across the Region, share best practices and identify areas for improvement. Our plan is to provide clear strategic directions for this area of work in 2014.

At the Third Global Forum on Human Resources for Health, 14 Member States made commitments and agreed to monitor and report progress on these. The forum is organized by the Global Health Workforce Alliance, which is hosted by WHO.

Essential medicines and technologies

Access to medical products, including essential medicines, vaccines, blood products, diagnostics and medical devices remains a challenge that is exacerbated for many countries by the failure to fully implement the use of quality-assured generic medicines, irrational use of medicines and inefficient procurement and distribution systems. In addition, countries have not fully used available tools (such as health technology assessment) to help them make informed decisions in relation to investments in health technology. Underpinning the challenges in the area of essential medicines and health technologies is the need to strengthen national regulatory authorities in most countries.

Important steps were taken in advancing the use of health technology assessment in the Region with an intercountry meeting on health technology assessment attended by 18 countries. The meeting triggered the initiation of a health technology assessment network of regional and international experts, as well as the setting up of national programmes and the mapping of existing

national and region-wide health technology assessment resources.

National medicines policy documents were updated in two countries and capacity was strengthened in 18 countries to conduct surveys to assess the national pharmaceutical sector by using WHO level II methodology.

The work in strengthening access to medicines and health technology included building up regulatory capacity. Although training was conducted for some countries in 2013, this area requires intensive work in WHO to reinforce technical support to Member States in 2014 and beyond. Capacity-building continued under the WHO good governance for medicines programme.

Integrated service delivery

The three groups of countries face varying health system challenges. The predominant challenges in the area of health service delivery are expanding access, improving quality of care and strengthening referral systems In addition to the need for improved training, deployment, distribution and development of the health workforce, capacity of health care providers in managing financial and human resources will have to be reinforced. Poor management capacity is compounded by the lack of effective hospital autonomy and public–private partnerships.

The quality of care and the level of patient safety need to be improved. Studies in some countries have shown the prevalence of adverse events to be as high as 18% of hospital admissions.

Several studies were conducted to deepen understanding of health service delivery challenges in countries. For the first time a regional analysis of the private health sector was conducted and presented during the pre-session of the Regional Committee. An assessment of the main characteristics of general operations, internal control structures and service delivery aspects of public sector hospitals was completed in all countries. The findings showed that the average length of inpatient stay across the Region is almost 5 days (range 3 to 8 days) and the average bed occupancy is 85% (range 33–100%). A mapping study on accreditation of health care institutions was also carried out in the Region.

Several tools and guidelines were developed or updated. These include a conceptual and strategic approach for establishing family practice programmes, guidelines to scale up the community health workers' programme in countries as an approach for moving towards universal health coverage, guidelines for establishing home health care programmes for the elderly, and a manual on community-based disaster risk reduction, developed in collaboration with the regional programme on emergency and humanitarian response. In addition, the patient safety assessment tool was revised and the patient safety curriculum for medical schools translated into Arabic and widely disseminated.

Photo: ©WHO/C Banluta

↑ People in many countries of the Region do not have access to essential medical products

All countries require support in building and sustaining effective family medicine programmes. This area will be given priority in 2014 by conducting an assessment of the current status of family practice in countries of the Region together with a review of international experience and development of approaches to strengthen family medicine to achieve universal health coverage.

Health information systems

The situation with regard to health information systems in the Region is highly variable. Many countries have several areas that require strengthening, including policy and legislation, human and material resources, indicators for monitoring and evaluation, and skills to collect, analyse and disseminate accurate and timely information to inform decision-making. Following the endorsement in 2012 of resolution EM/RC59/R.3 on health system strengthening, concerted efforts to support countries to improve their health information systems were undertaken. A situation analysis of civil registration and vital statistics was undertaken in all countries using a rapid assessment approach to identify major gaps and challenges. The results were discussed in a regional meeting of stakeholders with the aim of reaching consensus on ways and means to improve the level and quality of registration of births and deaths. Further in-depth assessments were conducted in nearly half of the countries, and the results were used to develop a regional strategy to strengthen civil registration and vital statistics which was endorsed by the Regional Committee (EM/RC60/R.7).

In order to help countries to strengthen their health information systems, a core list of indicators covering three key areas – health risks and determinants, health status and health system performance – was developed. This was discussed in an intercountry meeting and the initiative of having an agreed list of indicators was subsequently endorsed by the Regional Committee. The current status in countries was reviewed in relation to each core indicator, in terms of data collection, data generation, analysis, dissemination and use for policy development and evaluation. The gaps identified in these areas will be discussed with countries in an intercountry meeting planned for 2014. A regional health observatory was launched to ensure that all health-related information is accessible and used for better planning at both regional and country level, and this core list of indicators will be included in it. Some Member States have repeatedly reported differences between mortality estimates produced by the United Nations agencies and figures reported nationally. In order to reduce inconsistencies and to ensure timely and transparent consultation with national authorities, a meeting was held with countries on the maternal and child mortality estimates produced by the UN inter-agency groups for monitoring MDGs 4 and 5.

eHealth

There is only limited use of eHealth within health systems in the Region at present. National eHealth strategies need to be developed to meet the financial challenges to health systems, increasing demand for efficiency and higher expectations from citizens. The World Health Assembly (resolution WHA 66.24) has urged Member States to develop national policies and to plan for appropriate eHealth services and implementation of health data standards in their countries.

While several countries have embarked on initiatives of one kind or another, there is a recognized gap in national capacities to manage

↑ ***Recent publications in Arabic on research ethics***

the development of national strategies and policies. Progress in the adoption and implementation of health data standards is slow and the lack of national networks to support flow of information within the health system is an impediment to the development of eHealth.

The key considerations in developing a national strategy were highlighted at a regional meeting which also saw the launch of the HealthNet initiative to establish dedicated, reliable, operational national health networks. The Regional Office coordinated with national focal points to complete a survey on eHealth and innovation in women and children's health conducted by the WHO Global Observatory on eHealth. Preliminary analysis shows that two of the nine countries concerned have partially implemented national eHealth policies, which now need updating, seven have at least one electronic information system to collect and report health data at the district level, and three have major women's and children's health initiatives that are supported by eHealth.

Promoting health across the life course

Maternal, reproductive and child health

Maternal and child mortality remains a major public health problem in the Region. Several overarching factors contribute to the high burden of maternal and child mortality that exists in some countries. These include lack of sustained commitment to child and maternal health; weaknesses in health systems and in managing maternal and child health programmes; manmade and natural disasters and political upheaval; and suboptimal use of already limited human and financial resources. The health system challenges referred to in the previous section have an acute effect on delivery of health care for mothers and children. Insufficient numbers in the health workforce, maldistribution, inadequate training and high turnover at all levels are major challenges in countries with high child and maternal mortality. Other major challenges are non-functioning or inadequate referral systems, the lack or poor quality of emergency care for mothers and children at the referral hospitals, and the limited availability of essential medicines which is directly linked to the accessibility and quality of services.

Recognizing the need to strengthen the efforts of governments, partners and donors to respond to maternal and child health needs in the Region, WHO, UNICEF and UNFPA, in collaboration with Member States and other stakeholders,

Photo: ©WHO/C Banluta

↑ The Vice-President of Sudan, HE Dr Al-Haj Adam Youssef, together with the Federal Minister of Health HE Mr Bahar Idris Abu Garda, launched the national maternal and child health acceleration plan

jointly embarked on a regional initiative on saving lives of mothers and children to accelerate progress towards MDGs 4 and 5. 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

The initiative focuses on the following high-burden countries: Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Somalia, South Sudan[3], Sudan and Yemen. It was launched in a high-level meeting in Dubai, United Arab Emirates, in January 2013, which concluded with the Dubai Declaration. The Declaration provides impetus and a way forward for all Member States.

Country profiles were developed for each of the high-burden countries, together with an estimation of the likely health impact, and progress towards the MDG 4 and 5 targets, of scaling up the coverage of key interventions, and an estimation of the financial resources required to achieve such scale-up. WHO provided technical support to countries concerned, in collaboration with UNICEF and UNFPA, to develop maternal and child health acceleration plans. This included a meeting of partners, and monitoring of the process of developing the plans and initiating steps for launching the plans in countries. By the end of 2013, plans had been launched in four countries.

Maintaining the momentum created by the high-level meeting, the Regional Committee adopted a resolution (EM/RC60/R.6) endorsing the Dubai Declaration and urging the high-burden countries to: strengthen multisectoral partnership in order to implement their national acceleration plans; allocate the necessary national human and financial resources; and work on mobilizing additional resources from donors, partners and development agencies. The Regional Office allocated US$ 2.6 million to kick-start the implementation of these plans, and funds were distributed to all MDG 4 and 5 priority countries.

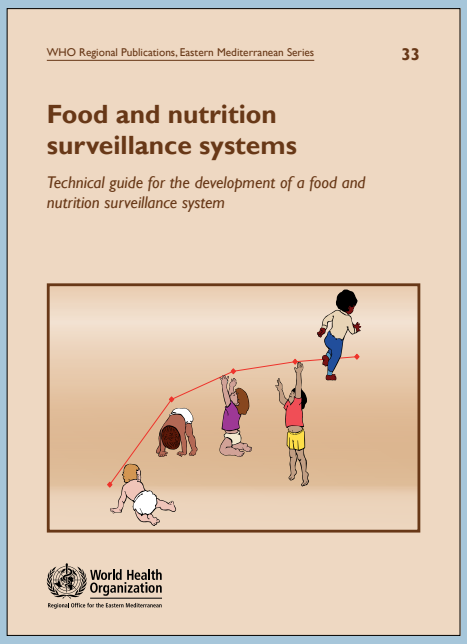
The Regional Office maintained close follow-up of and support for the implementation of the roadmaps of the Commission on Information and Accountability for Women's and Children's Health in the priority countries. Seven such roadmaps (Afghanistan, Djibouti, Iraq, Morocco, Pakistan, Somalia and Yemen), were verified with WHO headquarters and catalytic funds were disbursed accordingly.

WHO will monitor progress in implementing the regional initiative on saving the lives of mothers and children, in line with the recommendations outlined in the accountability framework of the Commission on Information and Accountability for Women's and Children's Health, and will report annually to the Regional Committee on the progress of the initiative. The outcome of the acceleration plans will be evaluated in collaboration with partners. In the meantime, WHO's work will have to be scaled up in order to provide adequate technical support to the high-burden countries.

Nutrition

The estimated prevalence of stunting and underweight among children under 5 years of age decreased from 40.4% and 22.6% in 1990 to 27.2% and 14.4% in 2011, respectively with the biggest improvements in the countries of the

[3] As of May 2013 South Sudan is a Member State of the WHO African Region.



↑ *Recent publication on nutrition surveillance*

Gulf Cooperation Council, Islamic Republic of Iran, Jordan, Lebanon, Palestine and Tunisia. The estimated prevalence of wasting increased from 9.6% in 1991 to 10.1 % in 2011, an increase attributed to disasters, food insecurity and political instability in Afghanistan, Djibouti, Iraq, Pakistan, Syrian Arab Republic, Somalia, and Yemen.

Micronutrient deficiency (iron, vitamin A and iodine) continues to be an important health problem. Studies conducted in 2012–2013 show four countries (Bahrain, Jordan, Saudi Arabia and United Arab Emirates) are now free of iodine deficiency, while ongoing surveys in three further countries (Kuwait, Oman and Qatar) are expected to show similar results, together changing the map of iodine deficiency. Clinical vitamin A deficiency is largely under control, thanks to the ongoing supplementation and fortification programmes. Mandatory flour fortification, with iron and folic acid in almost all countries, to address anaemia is still a challenge but positive impacts are reported in Bahrain and Jordan.

Several targeted nutrition interventions are part of the acceleration plans to achieve MDGs 4 and 5 in high-burden countries. These include supplementation with folic acid and iron and establishment of nutrition stabilization centres for treatment of severe and complex cases of malnutrition in Afghanistan, Pakistan and Yemen. In Iraq about 90% of the severe and acute cases of malnutrition are covered throughout the country. Scale up of nutrition interventions, including capacity-building and training of community and health workers, in coordination with UNICEF, WFP and FAO is working well. WHO provided technical support to Pakistan and Yemen under the Scaling-up Nutrition (SUN) initiative, which mobilizes additional resources from both government and the donor community, while Afghanistan is being supported under the Renewed Effort Against Child Hunger (REACH) initiative.

The low levels of exclusive breastfeeding (less than 34%) and poor feeding practices for infants and children are contributing to the increasing prevalence of overweight and obesity. Some countries like Bahrain are integrating nutrition and growth monitoring in primary health clinics to address obesity at an early stage. Baby Friendly Hospitals have been established in many countries to promote breastfeeding. However, 33 years after endorsement of the International Code of Marketing of Breast-milk Substitutes in 1981, out of 22 countries only 7 (32%) have passed laws reflecting all of the provisions of the Code, while 11 countries have passed laws reflecting some of the provisions. A regional policy statement and action plan were developed to promote full implementation of the Code, and to promote breastfeeding in all countries. Follow up action needs to continue in the years to come.

Ageing and health of special groups

Health-promotion and preventive interventions early in the course of life are cost-effective investments for the health of schoolchildren, working adults and older persons. Support for health-promoting schools continued through developing country profiles and regional databases in seven countries. A regional guide of suggested measures in school health services was finalized and methodologies for institutionalization of mental health promotion in schools were prepared.

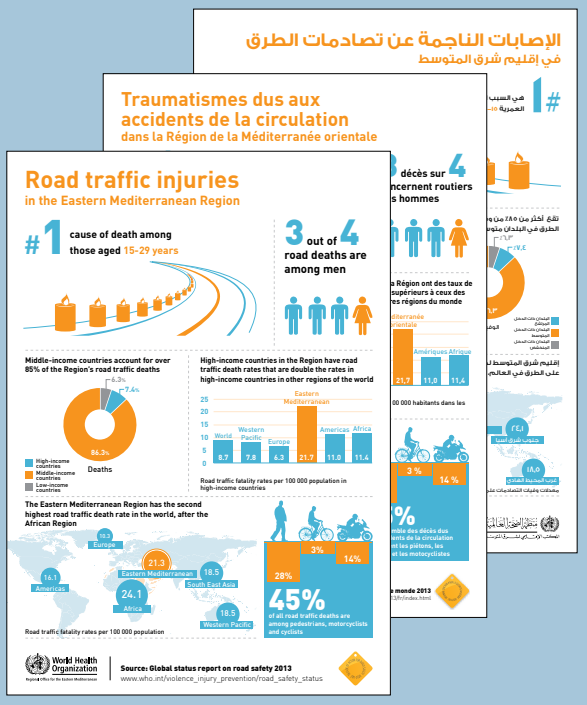
As part of regional efforts to implement the global plan of action on workers' health, technical support was provided to several countries. However, a new vision and a comprehensive strategy on occupational health is needed and will be the focus of work in 2014. As older people become a larger and more visible proportion of the general population in the Region, better strategies for responding to their special health and social needs are urgently needed. Technical support was provided to countries to create enabling environments, health-promoting settings and healthy lifestyles for all age groups. A draft regional training guide on primary health care services for older persons was reviewed in a regional consultation on age-friendly health care services.

Violence, injuries and disabilities

In 2013, implementation of the regional five-year injury prevention plan started, focusing on road traffic injuries and trauma care. With publication of the *Global status report on road safety 2013*, covering most countries of the Region, the baseline was set for monitoring the Road Safety Decade of Action 2011–2020. The second UN Road Safety Week, on pedestrian safety, was celebrated in many countries, while a pilot instrument to profile trauma systems was also developed. The survey for the global violence prevention report was completed in 88% of participating countries. In 2014–2015, more focus will be placed on supporting ministries of health to fulfil their expected roles within a broader multisectoral response in the areas of violence and injury prevention, as well as disability and rehabilitation.

Based on the Convention on the Rights of Persons with Disabilities, a draft model disability law was developed. A regional United Nations Joint Statement on Disability in Disasters declared commitment to scaling up efforts for the inclusion of persons with disabilities in all policies and programmes aimed at addressing disaster risk reduction and humanitarian situations. Member States contributed to the UN High-level Disability and Development Meeting and to development of the global WHO disability plan of action.

Many countries face challenges in addressing visual and hearing impairment, the most important of these being lack of adequate political support and of financial resources. However, following the endorsement of the global action plan for prevention of avoidable blindness 2014–2019 by the World Health Assembly, four countries developed five-year national eye health plans. A new professional staff experienced in prevention of blindness has recently been appointed in collaboration with IMPACT Eastern Mediterranean Region to strengthen the technical support provided to high-burden countries.



↑ *A series of fact sheets was published on road traffic injuries to raise awareness of the size of the problem in the Region*

Health education and promotion

Improving the health of the population throughout the life course was the main focus in the area of health education and promotion in 2013, in particular the health of children, women and adolescents and noncommunicable diseases.. A consultation with religious scholars addressing practices harmful to women resulted in an agreement with the International Islamic Centre for Population Studies and Research, Al Azhar University, Egypt and a joint plan of work to be implemented in priority countries of the Region. This will lead in 2014 to a literature review of international and regional experiences in addressing child marriage and gender-based violence, including female genital mutilation, and development of training packages and a curriculum for students of Al Azhar University.

In collaboration with the Centers for Disease Control and Prevention (CDC), Atlanta, WHO extended the implementation of the global school health survey to several new countries and conducted new rounds in others. The surveys provide countries with comparative data on behavioural risk factors among school students which can inform the development of health promotion policy and programmes for school settings. A regional programme to mainstream health promotion in the media was launched which will enhance the capacities of journalists in reporting and networking on health issues. The programme is being implemented in collaboration with Thomson Reuter Foundation and Agence France Press.

Social determinants of health and gender

Poverty and inequitable distribution of resources between urban and rural populations are major social determinants of health in the Region. Vulnerable groups, such as poor, single-household mothers and refugees are more at risk of health inequity than other population groups.

Initiatives to address the social determinants and gender in the health sector continue to be based on vertical rather than integrated programmatic approaches. The challenges also include lack of adequate sex-disaggregated data, the need to sustain intersectoral action, and lack of capacity to mainstream social determinants for health and gender into health programmes, policies and strategies. WHO has collaborated with Member States in several initiatives addressing the social determinants of health but there is, so far, no concrete comprehensive vision for a regional action-oriented plan. A substantial number of countries have decided to give this area of work a priority in the collaborative programme with

WHO in 2014 and beyond and work has been initiated to develop the action plan. We hope to report favourably on the outcome of this work in the next annual report.

Health and the environment

Despite the diversity of the Region with regard to income, development, health and environmental conditions, three groups of countries are clearly distinguished. Group 1 comprises the high-income countries with good environmental health services and direct impact of environmental risks on noncommunicable diseases; group 2 comprises middle-income countries with endeavouring environment health services, and a double burden of environmental risks for both communicable and noncommunicable diseases; and group 3 includes low-income countries which do not have adequate environmental health basic services, and where environmental risks have a clear impact, primarily on communicable diseases.

The Regional Committee endorsed a strategy for health and the environment 2014–2019 which provides a roadmap for the three groups aimed at protecting health from environmental risks in the Region. It outlines necessary actions for lowering the huge burden of environmental risk, which is estimated to account for almost 24% of the total burden of disease, including more than 1 million annual deaths regionally. The challenge now is for countries to translate the strategy into national action plans and for WHO to monitor progress.

To reinforce the capacity of WHO in delivering technical support to Member States, an organizational and structural reform mandated the Regional Centre for Environmental Health Action (CEHA) with the overall management of the regional environmental programme in the Region from 2013. Activities were carried out in the areas of drinking-water quality; wastewater reuse and safety management; chemical hazards emergencies; air quality; climate change; health care waste management; environmental

Photo: ©Jordan Environment Society

↑ Youth in Jordan lend a hand in a WHO-supported campaign led by Jordan Environment Society to combat lead poisoning

health strategies; and environmental health information management. Technical support in environmental health was provided in several emergency situations, the Syrian crisis in particular, and capacities in preparedness and response to chemical events in the Region were strengthened. Support was also provided to enable countries to meet the core capacity requirements for implementation of the International Health Regulations (2005) with regard to food safety, and chemical and radionuclear events.

In response to enquiries from several Member States, CEHA conducted a ground-breaking research study in Jordan to generating scientific evidence on the minimum domestic water requirements for health protection. The study of 2851 households explored the correlation between domestic water consumption and diarrhoea incidence among children under 5 years of age. The findings provide evidence to inform the development of national policies and/or legislative instruments for service targets and subsidy in order to secure the supply of minimum domestic water requirements for health protection. The study should be repeated in different locations to generate further evidence and subsequently a guidance recommendation from WHO.

Noncommunicable diseases

Regional framework for action

In 2013, WHO focused on putting into action the regional framework for action, endorsed by the Regional Committee in 2012, to scale up the implementation of the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases. This meant sustaining high-level commitments by Member States, supporting them in the implementation of strategic interventions agreed in the four priority areas of the framework, and building capacity to respond to the needs in each country.

The World Health Assembly endorsed, in May 2013, the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, along with a global monitoring framework with a set of nine voluntary targets and 25 indicators. All countries of the Region included noncommunicable diseases as a priority in their planning for the 2014–2015 collaborative programme with WHO. WHO also focused on developing partnerships with international and regional partners, such as the International Diabetes Federation, the International Union for Cancer Control and the World Heart Federation, all of which play an important role in advocacy for noncommunicable diseases.

The following represents an outline of the progress made in the four areas of the regional framework.

Governance

WHO focused on building national capacity and providing technical support in reviewing and updating the national plans for noncommunicable diseases through regional meetings and country assessment missions. Currently 20 countries have units and focal persons in place to manage programmes for noncommunicable diseases at the level of the ministry of health or equivalent. As part of a multi-region global WHO initiative, four countries are developing national multisectoral plans for noncommunicable diseases, including guidance on how to develop national targets and indicators and prioritize interventions, and these plans will be finalized early in 2014. 2013 also witnessed activities to build capacity and train national professionals including programme managers in ministries of health in the technical and managerial aspects of noncommunicable disease prevention. However, the need for such training is considerably higher than what has been offered. A plan for establishing a regular regional training seminar is being considered in order to accommodate a larger number of professionals involved in programme development and monitoring.

Prevention and control of risk factors

WHO accelerated its policy work on the shared risk factors for the main noncommunicable diseases, particularly aiming at scaling up the implementation of the best buys for prevention. These include interventions on tobacco use, physical inactivity and unhealthy diet.

Tobacco control continues to face important challenges with stagnation or reversal of prior gains in some countries, while some forms of

tobacco use, such as waterpipe smoking, are showing an alarming increase. Fig. 1 shows the prevalence of smoking among adults compared to other WHO Regions. WHO implemented a series of advocacy activities to stimulate national action in the two countries where the WHO Framework Convention on Tobacco Control (FCTC) has not been ratified (Morocco and Somalia). This will remain a priority and action will be sustained in 2014. A regional multisectoral meeting addressed the challenges relating to tobacco and trade and a follow-up meeting for GCC countries is planned for 2014. Technical support was provided to several countries in the areas of tobacco taxation and development of tobacco control legislation. National capacity to support implementation of article 5.3 of the WHO FCTC on tobacco industry interference was strengthened in two countries, with participation from a range of sectors. The number of countries that are now signatories to the first WHO protocol to the FCTC, the Protocol to eliminate illicit trade in tobacco products has increased to eight.

The promotion of physical activity is a strategic priority. In preparation for a high-level

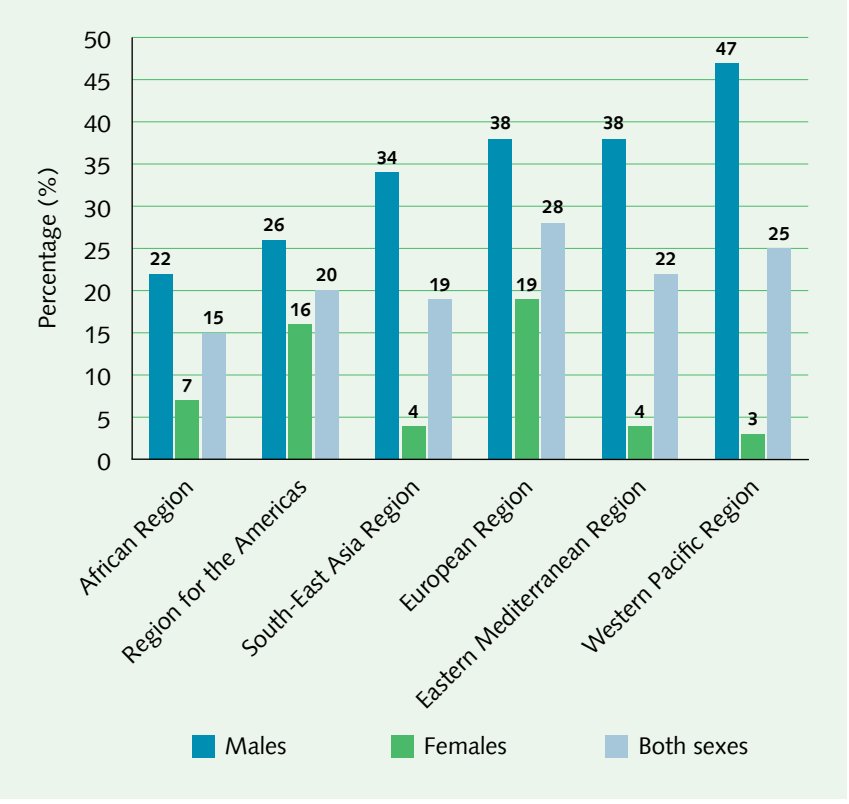


Fig. 1
Tobacco use among adults (15+ years) in the Eastern Mediterranean Region compared with other WHO region

Source: WHO report on the global tobacco epidemic 2013. Geneva: World Health Organization; 2013 (http://www.who.int/tobacco/global_report/2013/en/)

multisectoral regional forum on a life course approach to promoting physical activity in 2014, a regional mapping of policies and programmes on physical activity was conducted. The challenges identified include a lack of data on the prevalence of physical activity, limited leadership support and lack of multisectoral collaboration from the different sectors concerned. The forum, which took place in February 2014, brought together policy-makers at the ministerial level from a range of sectors, such as health, youth, education, sport, transportation, urban planning and information, to discuss ways to address these issues.

Photo: ©MAP

↑ The Regional Director called on the Prime Minister of Morocco HE Mr Abdelilah Benkirane to discuss ratification of the WHO Framework Convention on Tobacco Control

With regard to addressing unhealthy nutrition, policy statements and recommended actions for reducing salt and fat intake were developed. Two countries have started salt reduction in bread, and the Gulf Cooperation Council drafted standards and specifications on elimination of transfat in food and edible oils.

A regional protocol for measurement of population salt intake, developed in collaboration with WHO Collaborating Centre for Nutrition of the University of Warwick, was released in October 2013. Technical support and capacity-building were also provided for the development of food-based dietary guidelines and salt and fat reduction strategies, and several countries initiated implementation of these strategies.

A regional mapping study of progress in the implementation of the WHO recommendations on the marketing of foods and nonalcoholic beverages to children, conducted in collaboration with Liverpool University, showed limited awareness of the recommendations, poor development of legal frameworks to control such marketing, and lack of attention to cross-border marketing. An expert consultation, attended by representatives from consumer groups, child health protection groups, nutritionists, lawyers and media networks, recommended Member States to adopt a comprehensive approach to regulate marketing, and made key recommendations to accelerate the implementation of the WHO recommendations, including the establishment of a national multisectoral working group in each country led by the Ministry of Health. This work will be carried forward in 2014 with focus on building the capacity of consumer protection groups in this area, and on advocacy development and enforcement of marketing regulation.

Surveillance, monitoring and evaluation

All countries participated in a survey to develop country profiles for capacity and response to noncommunicable diseases and a regional report is being prepared. Five countries conducted the STEPS survey during 2013. Reporting of cause-specific mortality for noncommunicable diseases is a challenge in most countries. It is expected that the regional strategy to strengthen civil registration and vital statistics systems will help to address this. WHO continues to provide support

↑ ***World Health Day 2013 targeted high blood pressure as an important risk factor for heart disease***

to countries to strengthen cancer registries, in collaboration with the International Agency for Research on Cancer (IARC). Countries have started developing national targets and indicators and reporting on progress in line with the global monitoring framework. WHO has initiated collaborative work with the Eastern Mediterranean Public Health Network (EMPHNET), to study surveillance gaps and to develop a programme for capacity-building in surveillance in order to expand the network of regional experts who can provide high-quality expert advice to countries.

Tobacco surveillance continued to receive attention. The WHO report on the global tobacco epidemic 2013, which includes profiles of all countries of the Region, was published. Support was provided to five countries to carry out the fourth round of the Global Youth Tobacco Survey. The Global Adult Tobacco Survey was completed in Qatar, the first self-funded country to do so in the Region, and preliminary results were released. Three other countries are in different phases of the survey.

WHO also supported and/or conducted surveys and research to generate evidence to support policy work in priority areas. Research on economic evaluation of the priority interventions and 'best buys' for noncommunicable diseases – interventions that are expected to provide a high return on investment in terms of health gains – is being conducted in four countries, in collaboration with the Disease Control Priorities Network and the University of Washington. Regional capacity in this area was strengthened with a view to developing a core group of regional researchers. A multi-country study is under way to generate evidence in three areas to inform policy interventions for salt reduction: population

level salt intake through 24-hour urinary sodium excretion; salt content of commonly consumed foods; and patterns of intake of such foods. The results of both these studies will be available in 2014.

Health care

WHO sustained its support to countries to strengthen integration of noncommunicable diseases into primary health care, including through implementation of the WHO package of essential noncommunicable disease interventions for primary health care in low-resource settings and nationally approved guidelines. Tobacco cessation also received attention as a priority health care intervention, with support provided to several countries in the area of treatment of tobacco dependence.

Of the four main groups of noncommunicable diseases, cancer received particular attention in 2013. The national cancer control programmes in five countries were assessed, in collaboration with the International Atomic Energy Agency (IAEA) and IARC. To establish a clear roadmap for countries in the areas of cancer surveillance, research and early detection, a regional meeting on cancer control and research priorities was held jointly with IARC. The recommendations of the meeting were translated into an action plan that will be implemented with IARC in the areas of cancer registration, causation of cancer, and early detection/screening for common cancers. Qatar became the first country in the Region to join IARC's Executive Board, reflecting its commitment to cancer research and surveillance. With the support of regional experts, two palliative care training modules were established to build national capacities and support training of trainers in low resource countries.

Mental health

Mental, neurological and substance use disorders continue to exact an important toll in the Region, especially in countries with acute and/or chronic humanitarian emergencies and large-scale displacement of population within and across borders. Both the public health response and the service provision show important gaps. For example, 40% of countries do not have mental health policies, 30% do not have plans, and 65% do not have more recent legislation than the past 20 years. There is a large variation in availability and access to mental health professionals and services. The Region has half the global rate of outpatient facilities, and only 1% of outpatient facilities offer follow-up community care. Almost 60% of the mental health workforce is working in institutional settings and community-based mental health services are therefore scarce. Countries have made variable progress in the integration of mental health into primary care. Despite the burden and economic impact of mental, neurological and substance use disorders, the median investment in mental health care of US$ 2 per person annually in the Region is below the US$ 3–9 needed for a selective package of cost-effective mental health interventions in low- and middle income countries. This has translated into a treatment gap in countries ranging from 76% to 85%.

In 2013, WHO focused on five areas. With regard to the first, the development of policy, legislation and strategy, a comprehensive global mental health action plan 2013-2020 was endorsed by the World Health Assembly. Technical support was provided to countries in reviewing, formulating and finalizing national mental health policies, in drafting mental health legislation, in development of national substance use policies

↑ ***Recent publications on mental health***

and strategies and in developing national action plans for reducing harmful use of alcohol.

In the area of service development, WHO focused on scaling up implementation of the mental health gap action programme (mhGAP) to bridge the treatment gap though integrated service delivery. This was launched in several countries where capacity-building for integrating mental health and substance abuse in general health care using the mhGAP tools was initiated.

Mental health and psychosocial support is key in the response to humanitarian crises and emergencies. Technical capacities were strengthened in several countries, including international nongovernmental organizations operating in these settings. WHO also supported the development of a psychosocial intervention package to be delivered through non-specialized health workers in emergencies, which is currently being field tested in Pakistan. WHO is collaborating with Johns Hopkins University in setting up a capacity-building programme for psychological interventions by mental health professionals.

Guidance was developed to support countries in setting up a substance use treatment information system and for setting up a suicide registration system.

Communicable diseases

Poliomyelitis eradication

Outbreaks of poliomyelitis occurred in the Syrian Arab Republic and Somalia. These were a serious blow to the progress of the global polio eradication programme and a threat to all countries. Indeed, the outbreak in Somalia, the result of importation from Nigeria, also affected neighbouring Kenya and Uganda. In response, the Regional Committee adopted a resolution on intensifying polio eradication efforts in the Region declaring the spread of wild poliovirus an emergency for all Member States of the Region and re-emphasizing the critical importance of stopping ongoing transmission of poliomyelitis in Pakistan and Afghanistan.

In line with the resolution, comprehensive strategic plans were developed in coordination with national governments and partners to control the outbreaks. Multi-country outbreak responses were reviewed and phase II response plans developed, based on the evolving epidemiology and lessons learned.

In Somalia and Syrian Arab Republic a number of strategies were deployed to raise immediate population immunity and control the outbreaks, including use of the bivalent vaccine, short interval additional dose, permanent posts for vaccination in border transit areas, low profile vaccination teams, prepositioning of vaccine and expanding the age group for vaccination. The strong working partnership among all the partners was important in addressing the emerging issues and evolving epidemiological developments. Coordination between the WHO regional offices for Africa and the Eastern Mediterranean also had a positive impact in controlling the outbreak. Preventive vaccination campaigns were conducted in countries at particular risk, including Egypt, Jordan, Iraq, Lebanon, Palestine and Yemen, with special focus on refugees, migrants and internally displaced persons.

With regard to the two countries where poliovirus circulation continues, significant progress was made in Afghanistan, where transmission is well controlled in the southern endemic part of the country. Only one case was reported from the endemic area of the southern region. Other cases reported were from the eastern region, and genetic sequencing demonstrated a strong link with polioviruses in Pakistan. The primary challenge remains the inability to maintain high oral poliovaccine (OPV) coverage in the eastern provinces, especially Kunar. In Pakistan the situation deteriorated, largely owing to conflict, continuing ban by militants on immunization, insecurity and the continued killing of the polio workers in the field. Polio continues primarily in the Federally Administered Tribal Areas (FATA) and the neighbouring province of Khyber

Photo: ©WHO

↑ The Regional Director visited Pakistan in follow-up to the meeting of the Islamic Advisory Group on Polio

Photo: ©WHO

↑ Lebanon was among the countries that conducted supplementary polio immunization campaigns in 2013–2014, following the outbreak in Syrian Arab Republic

Pakhtunkhwa; of 93 cases reported by Pakistan in 2013, 66 were from FATA. The 2014 military operation in North Waziristan Agency of FATA has resulted in huge population migration to the neighbouring districts of Pakistan and Afghanistan. The programme is continuously monitoring this movement and vaccinating at transit points, in camps and in the host community.

WHO provided additional human resources support to Afghanistan, Pakistan and Somalia, and to the Syrian Arab Republic and neighbouring countries. All national polio laboratories were accredited and rehabilitation services continued to be supported in Pakistan for children affected by polio. The Regional Director undertook advocacy missions to infected areas and a high-level Islamic Advisory Group was established. Cross-border coordination and interregional collaboration were strengthened, several emergency consultations were held to align partner support, and additional direct financial support was provided.

HIV, tuberculosis, malaria and tropical diseases

The number of people living with HIV (PLHIV) in the Region in 2013 is estimated at 280 000, of whom 17 000 are children. With an estimated 42 000 new HIV infections in2013, the growth of the epidemic by far outpaces improvements made in terms of access to HIV prevention, diagnosis, care and treatment services. Coverage with antiretroviral therapy remains the lowest in the world, reaching almost 20% of those in need. This is attributed to an accumulation of gaps and weaknesses in the current HIV control strategies and programmes. The biggest gap lies in the ability to create and meet demand for HIV testing services, which is the primary gateway for access to treatment. In order to close these gaps political commitment, service delivery approaches and the health system all need to be strengthened, while persistent stigma and discrimination, including in health care settings, need to be addressed urgently.

In 2013, WHO launched the regional initiative to end the HIV treatment crisis, which aims at reaching universal coverage of 80% with antiretroviral therapy by 2020. Its immediate objective is to mobilize urgent action to accelerate access to treatment. For this purpose, WHO developed a guide and tools intended to assist countries in analysing gaps and lost opportunities along the continuum of prevention, testing, care and treatment in order to identify actions that may result in accelerating access. This is known as the HIV test–treat–retain cascade analysis, and, so far, five countries have carried out the analysis. WHO and UNAIDS developed a joint advocacy document which highlights the main reasons for low coverage of treatment in the Region and recommends key strategies and actions required to accelerate the scale-up of diagnosis and treatment.

↑ ***In 2103 WHO launched a regional initiative to end the HIV treatment crisis***

WHO also developed consolidated antiretroviral therapy guidelines and 15 countries have updated, or are in the process of updating, their HIV treatment guidelines accordingly. Training modules were developed on basic HIV knowledge and stigma reduction for health workers and tested in two countries. WHO continued its support to countries and civil society organizations in collecting and analysing strategic information, developing national strategic plans and implementing effective evidence-based HIV prevention activities among key populations at increased risk of HIV.

During 2012[4], over 430 000 cases of all forms of tuberculosis were notified in the Region. Case detection for all forms of tuberculosis and for multidrug-resistant tuberculosis (MDR-TB) continues to pose a major challenge in the Region, and globally, as does the slow pace of decline in incidence. The regional case detection rate for all forms was 63% in 2012 (62% in 2011). Twelve countries achieved or exceeded the 70% target for case detection rate. The treatment success rate for new cases remained at 88% for the fifth consecutive year, and 13 countries reached or exceeded the global target of 85%. WHO support to countries focused on ensuring quality in tuberculosis care through technical support, monitoring of country programme implementation, in-depth review missions and capacity-building.

The situation with regard to MDR-TB is a major concern. Of 18 000 estimated cases, only around 2300 were detected in 2012. Of these 1602 cases were put on treatment; the treatment success rate for MDR-TB cases is around 56%. Adequate scale-up of MDR-TB control is prevented by the need to strengthen health systems and the allocation of financial resources specifically to address this growing problem. WHO worked with 10 countries to develop plans for ambulatory care based on the MDR-TB planning tool kit.

Eight countries in the Region reported local malaria transmission in 2013. In 2012, the total number of parasitologically confirmed malaria cases exceeded 1.3 million, which represents only 10% of the estimated cases in the Region. The reported number of deaths attributed to malaria was 2307, 84% of which were in South Sudan and Sudan (Table 1)[5]. The need to strengthen diagnosis and surveillance systems continues to be a major challenge in the high-burden countries, especially Pakistan, Somalia and Sudan. There were some improvements in Afghanistan and

[4] For tuberculosis case detection, WHO receives data a year later, thus case detection data relate to 2012 and treatment outcome data to 2013.

[5] South Sudan became a Member of the African Region in May 2013.

Table 1
Reported malaria cases in countries with high malaria burden

Country	2011		2012		2013	
	Total reported cases	Total Confirmed	Total reported cases	Total Confirmed	Total reported cases	Total Confirmed
Afghanistan	482 748	77 549	391 365	54 840	319 742	46 114
Djibouti[a]	232	NA	25	25	1 687	939
Pakistan	4 065 802	334 589	4 285 449	290 781	3 472 727	281 755
Somalia	41 167	3 351	59 709	18 842	NA	NA
South Sudan	795 784	112 024	1 125 039	225 371	NA	NA
Sudan[a]	1 246 833	506 806	1 001 571	526 931	989 946	592 383
Yemen	142 147	90 410	165 678	109 908	149 451	102 778

NA: not available
[a]*Only cases by confirmed microscopy are reported*

Yemen, in particular the expansion of the malaria information system. A malaria outbreak in Djibouti highlighted the urgent need to strengthen programme capacity and to strengthen epidemic preparedness, particularly regarding availability of diagnostics, antimalarial medicine and vector control commodities, as well as trained staff.

Two countries, Islamic Republic of Iran and Saudi Arabia, are successfully implementing a malaria elimination strategy, despite the challenges they face in the border areas with Pakistan and Yemen, respectively. Population movement from malaria-endemic to malaria-free countries is increasing, resulting in more imported malaria and raising the risk of reintroduction of local transmission or occurrence of limited outbreaks of local cases as reported in Oman and Tunisia (Table 2). With WHO support, six countries conducted joint in-depth programme reviews involving key stakeholders and partners

Access to anti-malarial treatment, insecticides and long-lasting insecticidal nets (LLINs) is improving in all endemic countries. Almost 11 million LLINs were distributed during 2011 and 2012 in endemic countries. In Afghanistan, the operational coverage in targeted high transmission districts is expected to be above 70% and in Pakistan, the operational coverage in targeted areas was 41% at the end of 2013. Access to malaria confirmation, whether by microscopy or rapid diagnostic test, continues to be a major challenge, although there is encouraging progress in Afghanistan and Yemen.

The WHO/GEF/UNEP project on sustainable alternatives to DDT for vector control proceeded with success in Islamic Republic of Iran, Morocco, Sudan and Yemen. National capacity for integrated vector management was strengthened in several countries

Remarkable successes were seen in the area of neglected tropical diseases. The number of cases of guineaworm disease in South Sudan decreased by 78% in 2013 (121 cases), compared to 2012, although three cases were identified in Sudan (South Darfur State) after almost 10 years without cases. Preliminary surveys suggest the

Table 2
Parasitologically-confirmed cases in countries with no or sporadic transmission and countries with low malaria endemicity

Country	2011		2012		2013	
	Total reported cases	Autochthonous	Total reported cases	Autochthonous	Total reported cases	Autochthonous
Bahrain	186	0	233	0	NA	NA
Egypt	116	0	206	0	262	0
Iraq	11	0	8	0	8	NA
Iran, Islamic Republic of	3 239	1710	1 629	787	1 373	519
Jordan	58	0	117	0	56	0
Kuwait	476	0	358	0	291	0
Lebanon	83	NA	115	0	133	0
Libya	NA	NA	88	0	NA	NA
Morocco	312	0	364	0	314	0
Oman	1 531	13	2 051	22	NA	NA
Palestine	NA	NA	0	0	NA	NA
Qatar	673	0	708	0	728	0
Saudi Arabia	2 788	69	3 406	82	2 513	34
Syrian Arab Republic	48	0	42	0	22	0
Tunisia	67	0	70	0	68	0
United Arab Emirates	5 242	0	5 165	0	4 380	0

NA: not available

reintroduction of the parasite from South Sudan. With regard to lymphatic filariasis, verification of the elimination of transmission was completed in Yemen and in 80% of the former affected areas of Egypt. It is still hoped to achieve similar success in Sudan. The largest schistosomiasis control programme currently operating worldwide entered its third year in Yemen with a record number of interventions in 2013 as approximately 40 million praziquantel tablets were distributed to about 13 million people. An impact evaluation assessment, conducted in selected sentinel districts, showed that infection levels have fallen by more than half since the beginning of the project. It is hoped the programme will continue to operate successfully and to achieve its goals, as well as to provide a case-study for other programmes in the Region, such as in Sudan, and beyond.

In the last quarter of 2013, data on leishmaniasis in the Region covering the past 15 years, together with interactive maps and graphs, were made available on the WHO Regional Health Observatory. Several countries developed national guidelines for leishmaniasis control and case management. In order to assess the impact of the WHO technical guidelines on leishmania, an impact assessment project was started in Morocco.

Immunization and vaccines

The main challenge for immunization programmes in 2013 was political instability and insecurity, which affected the implementation of mobile and outreach activities in Afghanistan, Pakistan and Yemen and seriously affected routine immunization in the Syrian Arab Republic. The need to strengthen managerial capacity and commitment to routine immunization in addition to competing priorities are a challenge in some countries. The availability of financial resources also needs to be assured for implementation of supplementary immunization activities for measles and tetanus, introduction of new vaccines in middle-income countries and co-financing in GAVI eligible countries, as well as activities related to improving vaccination coverage in countries with low performance.

Despite such challenges, achievement of the regional expected results for routine immunization stayed on track for the vast majority of the indicators in 2013. Fourteen countries in the Region have achieved the target of 90% routine DTP3 vaccination coverage andYemen is close to doing so.

Eleven countries achieved at least 95% coverage with MCV1 (first dose of measles-containing vaccine) at national level and in the majority of the districts, and 21 provided a routine second dose of MCV with variable levels of coverage. To boost population immunity, nationwide measles immunization campaigns targeting a wide age range were conducted in Iraq, Jordan, Lebanon, Morocco, Pakistan, Syrian Arab Republic and Sudan and child health days in Somalia. Measles case-based laboratory surveillance is implemented in all countries. Despite the current challenges in the Region, six countries have reported very low incidence of measles (<5 cases/million population), with three of these continuing to achieve zero incidence and close to verifying measles elimination. The crisis in the Syrian Arab Republic resulted in outbreaks of measles in Iraq, Lebanon and Syrian Arab Republic, as well as Jordan which had been free of measles for 3 years. In response, measles supplementary immunization activities were conducted with strong support from WHO and in close collaboration with several partners. In line with consolidating the efforts to achieve the measles elimination target, the third regional Vaccination Week focused on measles elimination under the theme “Stop measles now”.

Elimination of maternal and neonatal tetanus was documented in Iraq. Five countries have not yet achieved elimination (Afghanistan, Pakistan, Somalia, Sudan and Yemen) and Djibouti has still to document it.

Progress with regard to the introduction of new vaccines was substantial. Hib vaccine is now in use in 20 countries, pneumococcal vaccine in 14 countries and rotavirus vaccine in 8 countries. These figures exceeded the target for 2013. Hib vaccine was introduced in Somalia, pneumococcal vaccine in Afghanistan and Sudan, and rotavirus vaccine in Saudi Arabia. Libya introduced pneumococcal, rotavirus, HPV and meningococcal vaccine and Sudan successfully implemented the second phase of the meningococcal A conjugate vaccine campaign (reaching more than 95% coverage).

In order to maintain achievements, WHO extended substantial support to countries. Comprehensive immunization programme reviews, reviews of vaccines surveillance networks, and assessment of effective vaccine management were conducted

in several countries. Substantial support was also provided to countries preparing to introduce new vaccines. Capacity was strengthened in countries in regard to data quality, surveillance of vaccine-preventable diseases, monitoring and evaluation, as well as laboratory surveillance for measles, bacterial meningitis, bacterial pneumonia and rotavirus. WHO continued to coordinate the external laboratory quality control system and accreditation of measles laboratories.

The implementation of vaccine regulation and production faces a number of challenges relating to the lack of human resources with appropriate skills, as well as a lack of financial resources. Regulatory capacity was strengthened in the five countries producing vaccines, especially in the area of vaccine pharmacovigilance, vaccine safety communication and vaccine licensing. In terms of post marketing surveillance, four countries – Islamic Republic of Iran, Morocco, Sudan and Tunisia – are currently contributing to the global vaccine safety initiative that was initiated in 2012.

Health security and regulations

The incidence of emerging and re-emerging infectious diseases poses a perennial threat to regional health security. Substantial support was provided by WHO to manage outbreaks of hepatitis E in South Sudan, hepatitis A in Jordan and northern Iraq, dengue fever in Pakistan, meningococcal meningitis in South Sudan, yellow fever in Sudan and Crimean-Congo haemorrhagic fever in Afghanistan and Pakistan. In addition, the Middle East respiratory syndrome coronavirus (MERS-CoV), the novel respiratory virus that emerged in 2012, continued to spread further geographically. Six countries in the Region have now reported laboratory-confirmed cases of MERS-CoV.

In 2013, WHO provided strategic and technical support for risk assessment, field investigation and detection of widespread outbreaks across many countries which resulted in limiting their spread and minimizing health impact. Field missions were conducted in Qatar, Saudi Arabia and Tunisia for control of the outbreaks caused by MERS-CoV. Outbreaks of hepatitis A were effectively contained in Jordan and northern Iraq by the national health authorities following implementation of public health measures recommended by WHO after joint field investigations. Epidemic readiness measures were scaled up in all countries affected by the Syrian crisis through establishment of early

Photo: ©WHO/C. Banluta

(a)

Photo: ©WHO

(b)

Photo: ©WHO

(c)

↑ WHO provided support to several countries to manage outbreaks, including yellow fever in Sudan (a), dengue fever in Pakistan (b) and hepatitis A in Iraq (c)

Photo: ©WHO

↑ The Regional Office hosted several technical consultations on the new Middle East respiratory syndrome coronavirus (MERS-CoV)

warning surveillance systems for disease outbreaks in Iraq, Jordan, Lebanon and Syrian Arab Republic, as well as strengthening of laboratory diagnostic capacities for epidemic detection.

In view of the persistent threat from MERS-CoV virus, the sentinel surveillance system for severe acute respiratory infections (SARI) was expanded in several countries with a view to sustaining the capacity to detect diagnose, and respond to outbreaks caused by any novel influenza or respiratory viruses. Public health vigilance for MERS-CoV was maintained throughout the year through enhancing surveillance and improving other regional public health preparedness measures. Technical meetings, consultations and training courses were organized while strategic guidance and advisories were produced collectively with other national health authorities to improve regional preparedness for this novel infection.

Owing to the lack of representative data, the burden and magnitude of the resistance patterns of pathogens to different micro-organisms remains poorly understood in the Region. In response to Regional Committee resolution EM/RC 60/R.1, a set of strategic directions was developed through a consultative process to translate WHO's six policy package on antimicrobial resistance into a framework for action on containment of antimicrobial resistance. A strategic framework was developed for early detection, diagnosis and control of zoonotic diseases. Progress was made also in developing a strategic framework for prevention and control of cholera and other epidemic diarrhoeal diseases, and a strategic framework for prevention and control of acute respiratory infections with epidemic potential.

By June 2012, only one country (Islamic Republic of Iran) was ready for implementation of the International Health Regulations (2005); all other Member States obtained a 2 year extension for implementation to June 2014, except Somalia which was not able to meet the requirements. Despite progress in meeting the requirements (estimated at 70% across the Region by end 2013), particularly in surveillance, response, laboratory and zoonotic capacities, many remain a challenge. This is especially the case with regard to capacities to handle chemical, radiological and nuclear events and for points of entry and preparedness. This is due to the lack of supportive public health laws and other legal and administrative instruments; insufficient coordination among the different stakeholders at country level and with neighbouring countries; high turnover of qualified personnel; insufficient financial capacity to cover planned activities; and geopolitical instability in some States Parties. Fig. 2 shows the implementation level with regard to capacities across the Region by end 2013.

The emergence of MERS-CoV further highlighted the importance of the Regulations and that epidemic and pandemic threats are on the rise. WHO worked closely with States Parties to raise awareness about the Regulations and associated commitments and facilitated

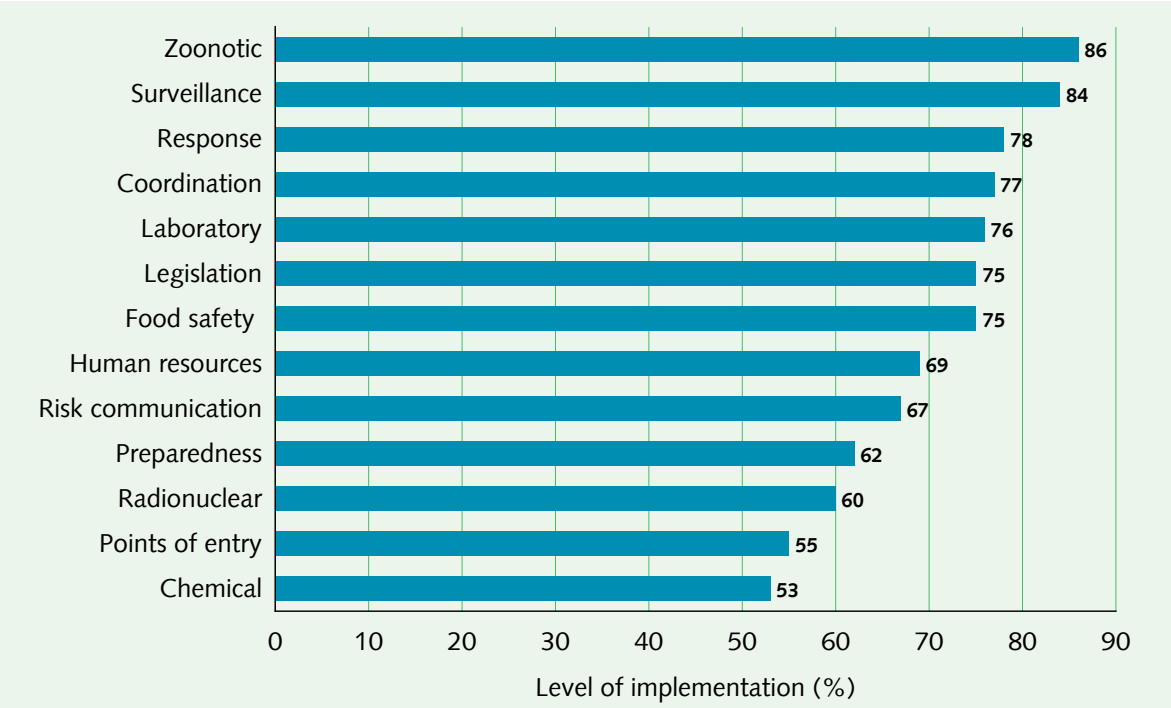


Fig. 2
International Health Regulations (2005): level of core capacity implementation in the Eastern Mediterranean Region, 2013

Source: Summary of States Parties 2013 report on IHR core capacity implementation. Geneva: World Health Organization; 2014.

experience sharing between countries and with other WHO regions. Collaboration was strengthened with international organizations, United Nations agencies, nongovernmental organizations and WHO collaborating centres and networks of excellence to support countries to step up the implementation of the Regulations. Support for national authorities in their efforts to respond to outbreaks, including the MERS-CoV outbreak, was managed within the framework of the Regulations.

WHO continued to provide technical support to States Parties to review the status of implementation and to develop national plans to address the gaps in capacity requirements. It is expected that a considerable number of State Parties in the Region will request further extension to implement the requirements by June 2016.

Emergency preparedness and response

Overview

Humanitarian action in 2013 entered uncharted territory in terms of the scale, magnitude and number of people requiring assistance. This was mainly as a result of the crisis in the Syrian Arab Republic, where almost 6.8 million people inside the country and 2.3 million Syrian refugees in the neighbouring countries were in need of humanitarian assistance by the end of December 2013. Overall, more than 42 million people in 13 countries in the Region are currently affected by natural hazards or violence resulting from political conflict.

Flooding affected parts of Afghanistan, Palestine, Pakistan and Sudan, while earthquakes struck areas of Afghanistan, Islamic Republic of Iran and Pakistan, affecting millions of people and threatening public health. WHO contributed to relief actions in disaster-affected countries by participating in assessment missions to identify health needs, ensuring the provision of essential medicines and technical support, enhancing disease surveillance, and coordinating activities of health partners on the ground.

Impact of protracted emergencies

Some populations in countries and territories facing protracted emergencies continue to lack access to basic health services as a result of weakened health systems, including shortages of qualified health workers and of medicines and medical supplies. Up to 8.6 million people lack access to health services in Yemen and 13 million – more than half the population – have no access to improved water sources. As a result, Yemenis run a high risk of outbreaks of water-borne disease, such as cholera and dysentery.

Photo: ©WHO

↑ A Palestinian patient waits to cross the border from Gaza into Egypt

In the Gaza Strip, shortages in basic supplies are straining the health system's ability to maintain a good standard of health care for the population of 1.7 million Palestinians. Lack of access is impeding people's right to health. WHO's office for West Bank and Gaza released a report on the difficulties faced by thousands of Palestinian patients in obtaining Israeli permits to access specialized health care in East Jerusalem, Israel and Jordan. One in five West Bank applicants were denied health access permits in 2012. The study used available data from the Palestinian National Authority and from non-profit health providers to show how Israeli-imposed restrictions on movement in the West Bank and Gaza reduce access to health services for Palestinian patients and health providers, especially to East Jerusalem where the main Palestinian referral centres are located.

Maternal and child morbidity and mortality remain unacceptably high in Somalia. According to WHO, one out of five children in Somalia dies before their fifth birthday, and one out of 12 women dies due to pregnancy-related causes, with haemorrhage and hypertension the leading causes of maternal death. One of the key contributing factors is the low access to quality health services, especially in rural communities and remote areas. WHO and the Saudi National Campaign for the Relief of the Somali People initiated an 18-month project to provide life-saving interventions for women and children, including the establishment of mobile clinics in remote areas; provision of medicines and medical supplies; immunization activities for children below the age of 5 years; and capacity-building for maternal and child health care workers.

Health care in danger

In countries where conflict is ongoing, one of the main challenges facing humanitarian aid workers is the threat to their safety. Despite international humanitarian laws and the Geneva Conventions calling for their protection, humanitarian aid workers and health facilities remain at risk. This is especially acute in the Eastern Mediterranean Region, where the majority of attacks in recent years have taken place. Health workers in Pakistan and Somalia continue to face serious threats of violence, while in Yemen and the Syrian Arab Republic, health facilities have been bombed, ambulances burned or stolen, and hundreds of health care workers killed, attacked or kidnapped. Patients are also at risk.

Ensuring the provision of health care services and supplies in emergencies

To ensure that the needs of countries experiencing emergencies are met immediately and efficiently, WHO currently manages US$ 94 million worth of emergency medicines, medical supplies and equipment in Dubai's International Humanitarian City, under agreement with the

Photo: ©WHO

↑ WHO is developing the capacity of health workers in Somalia to respond to health emergencies, and providing essential health kits for trauma and surgical care

World Food Programme. In 2013, these stocks were replenished three times to reach populations affected by emergencies in the Syrian Arab Republic and neighbouring countries (Egypt, Iraq, Jordan and Lebanon) as well as Afghanistan, Somalia and Sudan.

Decades of neglect and the 2011 conflict in Libya have resulted in reduction in the availability of mental health services. WHO and the Libyan Ministry of Health launched two post-graduate diplomas in primary mental health care and clinical psychotherapeutic interventions in 2013, based within the national centre for disease control, with the goal of filling the human resource gap in mental health and psychosocial support, especially in remote and underserved areas.

Health impact of the crisis in the Syrian Arab Republic and WHO response

March 2013 marked the beginning of the third year of the crisis in the Syrian Arab Republic, the scale and impact of which is unprecedented in recent history. According to the United Nations, by the end of December 2013, an estimated 120 000–130 000 lives had been lost and over 625 000 persons injured. Inside the country, 9.3 million people are estimated to be in need of assistance, including 6.5 million internally displaced persons.

Much of the impact of this crisis can be seen in the collapse of health services and the deteriorating health outcomes, either directly due to death and injury or indirectly through exacerbation of disease and escalation of mental health problems. The health system has been severely disrupted, compromising the provision of primary and secondary health care, the referral of injured patients, treatment of chronic diseases, delivery of maternal and child health services and the provision of mental health care, vaccination programmes and infectious disease control.

In the first quarter of 2013, the early warning system for disease outbreaks, which covers all 14 governorates, reported significant increases in acute watery diarrhoea, hepatitis A and enteric fever (typhoid). New cases of vaccine-preventable diseases have also reappeared due to a fall in national vaccination coverage from 95% in 2010 to an estimated 45% in 2013. As vaccination coverage rates decrease inside the country, cases of communicable diseases are being reported among Syrians and host communities outside the country, leading to an increased risk of outbreaks. A clear demonstration of the consequences of the deteriorating health indicators and living conditions among Syrians is the polio outbreak. This required multicountry, regionally-coordinated surveillance and multiple rounds of mass vaccinations in the largest-ever immunization response in the Middle East, aiming to vaccinate more than 23 million children in 2013 and 2014 across several countries.

Key prevention and control measures by WHO and partners to respond to public health threats from infectious diseases included supplying safe drinking-water and sanitation, strengthening early warning systems for the detection of diseases, and pre-positioning medicines and medical supplies, in addition to emergency mass vaccination campaigns, both inside the Syrian Arab Republic and in neighbouring countries.

The increasing number of Syrians with chronic diseases, destruction of local pharmaceutical capacity and embargo on imports have led to shortages in life-saving, essential medicines. With the support of experts in the Region, the national essential medicines list was updated to reflect needs based on updated patient profiles and demand as a result of the crisis, and taking

Photo: ©WHO

↑ **WHO supports mobile clinics in Homs, Syrian Arab Republic, to ensure access to health care for populations affected by the crisis**

into consideration the stocks already available in the country and planned WHO supplies. Beside supplies for treatment of conflict-related injuries, the list includes life-saving medicines and medical supplies needed for cardiovascular conditions, diabetes and reproductive health, as well as critical hospital equipment. Following reports that chemical weapons had been used against civilians, WHO supported the UN chemical weapons inspection missions to Syrian Arab Republic with two health experts, as well the provision of health equipment. WHO also distributed information and guidance to partners and the general public on chemical exposure, symptoms and protection, and held a series of trainings for health professionals to build capacity in chemical weapons awareness and case management.

Inside the county, WHO works in government-controlled areas and also across lines, using a network of nongovernmental organizations and the Syrian Red Crescent Society. Such an approach has been key in reaching the maximum number of civilians in need, especially children for immunization during the polio vaccination campaign. While generally successful, the approach, conducted in conformity with humanitarian principles, has faced setbacks on several occasions when access to vulnerable populations in opposition-controlled areas has been denied or made difficult and vital medicines have been withdrawn from humanitarian convoys.

With the above in mind, and in order to provide an effective health response to the crisis, WHO identified five strategic priorities for 2014: ensuring that patients have access to the health services they need, and that health care workers can report for work in areas where they are most needed, as well as protection of health facilities (through advocacy); ensuring the provision of trauma and injury care (including mental health

trauma); monitoring and controlling infectious diseases through establishment of early warning systems; ensuring the continuous provision of vital essential medicines and medical supplies as well support to the supply chain; and addressing gaps in the provision of health care services, such as mother and child health services, chronic illnesses and water and sanitation services.

Regional impact of the crisis in the Syrian Arab Republic and WHO response

In neighbouring countries, the increasing number of refugees, reaching 2.3 million by the end of 2013 according to UNHCR, has placed an immense strain on the host communities in terms of infrastructure and resources. In addition to the Syrians needing assistance, an estimated 2.7 million people among the host populations of neighbouring countries are also at risk.

The high financial costs associated with hosting an increasing number of displaced persons poses a risk to the social stability of countries such as Iraq, Jordan and Lebanon. As pressure on health services, water, sanitation, shelter, jobs and education continues, tensions between displaced communities and host communities are also high, especially in Jordan and Lebanon where the majority of refugees live within host communities. Political insecurity and unpredictability in Iraq and Lebanon have further added to the challenges in the provision of humanitarian aid and health services to affected populations.

WHO's response in the neighbouring countries in 2013 included supporting health authorities by: strengthening the early warning, alert and response system (EWARS) in order to minimize outbreaks of communicable diseases among refugees and host communities; supporting immunization campaigns for refugees and host communities; building the capacity of primary health care health professionals; assisting in health facility assessments, strengthening health information systems; and supporting the provision of essential medicines and medical equipment.

WHO's Emergency Support Team (EMST), which was established in January 2013 in Amman, Jordan, with the goal of aligning and harmonizing regional response activities for the Syrian crisis in six affected countries, continues to coordinate health sector inputs with other regional humanitarian organizations. Almost 12 months after its establishment, EMST went through a major reform in terms of its structure and focus in order to enhance its ability to support WHO's regional response and the evolving health needs.

Donor support

In 2013, WHO was able to continue its activities and life-saving humanitarian relief in countries experiencing emergencies through the support of the Governments of Kuwait and Saudi Arabia, charitable organizations in Saudi Arabia, and the League of Arab States (Council of Arab Ministers of Health). However, the need for increased

Photo: ©WHO

↑ WHO checks water quality in a refugee camp in Erbil, Iraq

funding continues to have an impact on WHO's efforts to reach affected populations. Pledging conferences, such as those hosted by Kuwait for the regional humanitarian response to the Syrian Crisis and by Qatar for reconstruction and development in Darfur, have supported resource mobilization for humanitarian efforts in those countries. Countries facing ongoing emergencies, such as Afghanistan, Somalia and Yemen, remain critically underfunded. In Somalia and Yemen, for example – both of which are experiencing among the worst humanitarian crises – only 24% to 27% of the funding requirements for the health sector were met in 2013, leaving millions still struggling to gain access to even the most basic health services.

The Syria Humanitarian Assistance Response Plan (SHARP) and the Regional Response Plan for the Syrian crisis was launched at the end of 2013 and discussed with Member States and international donors at a WHO donor meeting in Geneva. WHO requires a total of US$ 246 million in 2014 (US$ 186 million for the Syrian Arab Republic and US$ 60 million for the surrounding countries) to meet the urgent life-saving needs of the Syrian people and the host communities. These requirements are part of the biggest UN appeal to date for a single humanitarian emergency at a total cost of US$ 6.5 billion. More than US$ 450 million is needed to provide essential and life-saving medicines and medical supplies to 9.3 million people in both in government- and opposition-controlled areas.

Preparing countries for disaster and emergency risk management

In the area of disaster and emergency preparedness, a range of challenges affect the ability to implement actions on the ground. Overall regional instability is a major factor, while at national level shifting priorities, high turnover of personnel and lack of allocation of resources are factors. In some countries, the need to respond to acute emergencies overshadows development of emergency risk management in the health sector.

Nevertheless, progress was made in moving from policy to action. Most countries have embraced the all-hazard based risk management approach within their national emergency preparedness and response actions. WHO is providing technical support to countries to develop and review their national plans for emergency preparedness and response as required by the International Health Regulations to enhance health security in the Region.

Ensuring the safety and preparedness of health facilities and health workforces in the response to any public health emergency remained a priority in all countries. Five countries are implementing the hospital safety programme. Considering the critical nature of this issue, WHO joined the Health Care in Danger Network set up by the International Committee of the Red Cross.

WHO continued to advocate in countries for linking the health sector within the disaster risk reduction framework. It is working with regional and global partners to support countries aiming to establish national health platforms to coordinate health actions for disaster risk reduction. The first Arab conference on disaster risk reduction was held in Jordan to launch the Arab Platform for Disaster Risk Reduction. At the same conference, a multisectoral forum underscored health as a priority area for the post-2015 development framework.

Implementing WHO management reforms

Programmes and priority-setting

WHO increased its commitment to the global and regional health strategic priorities and engaged the organization at regional and country levels in a comprehensive effort to improve the management, to strengthen the technical expertise and to focus on priority areas.

The 2012–2013 biennium closure at the end of the year indicated a 52% increase in the allocated programme budget for the Region compared to that initially approved, the increase being largely in the outbreak and crisis response and the Special Partnership Agreements segments. By the end of the biennium, the allocated programme budget was 88% financed, with an implementation rate of 91% against received funds.

Following the approval of the 12th General Programme of Work 2014–2019 (GPW12) and programme budget 2014–2015 in May 2013, a coordinated operational planning process was implemented to ensure all three levels of the organization were aligned to deliver on the commitments made to Member States. The Regional Committee adopted a resolution advocating for an operational planning process which promotes a bottom-up approach and prioritization that focuses on key priorities. The objective is to achieve the highest level of alignment with country priorities. The Region then successfully piloted the first bottom-up approach to operational planning of the programme budget 2014–2015 in all countries keeping these two objectives in mind: planning according to the country needs and special focus on key areas of work (for which at least 80% of the total budget space is allocated). The intention was to increase the impact of WHO's support to countries and avoid the fragmentation of the past biennia. The successful experience of our region in planning for the 2014–2015 was followed by the rest of the Organization in planning for the following biennium (2016–2017).

Governance

The Regional Office continued its programme of management reform. High-level meetings for representatives of Member States and permanent missions in Geneva prior to each major meeting of WHO's governing bodies (World Health Assembly, Executive Board) and concise and timely briefings continued to be provided in order to strengthen the contribution of Member States of the Region in global discussions on health and the work of the governing bodies . In line with the revised rules of procedure of the Regional Committee, a meeting took place one day before the Session to discuss pertinent technical issues. This practice, which has been appreciated by Member States, will continue in 2014.

Management

Efforts to strengthen WHO country presence continued, with emphasis on improving technical expertise and overall management in line with WHO reform. Country office capacities were assessed in relation to the six categories of work to ensure the presence of strategic and technical leadership capabilities. 2013 witnessed significant expansion in technical capacity in several country offices.

The overall security challenges continued to pose significant challenges for the safety and security of personnel and implementing partners. Nevertheless, work environments were enhanced in a number of country offices to make them more healthy, productive and safe. The overall level of compliance of WHO offices throughout the Region with the minimum operating security standards (MOSS) of the United Nations had increased from 41% in 2012 to 74% by the end of 2013.

A number of initiatives to upgrade premises were undertaken, including construction of a sub-office in Garowe, Somalia, relocation of the country office in Djibouti to new premises, and completion of the country office, Tunisia, to accommodate the staff and the Global Training Centre.

Substantial support to all countries in the Region included procurement of supplies and services worth US$ 307 million. Special attention was given to countries facing emergencies for the procurement of medicines, equipment and services worth US$ 216 million. To ensure rapid response to emergency needs, a regional stock was established in the United Nations Humanitarian Response Depot (UNHRD) in Dubai.

An internal communication strategy was launched to increase compliance in a number of areas including performance management and adherence to staff rules and regulations. Improving compliance will remain a top priority over the coming three years. A newly appointed senior compliance officer will lead the work in 2014 under the direct supervision of the Regional Director. Development of a policy framework for the rotation and mobility of staff was initiated in order to address the deteriorating effect of staff remaining in one duty station for too long.

↑ *Advocacy days provide opportunities to raise awareness of public health issues*

The risk management framework introduced earlier in the biennium is in operation across the Region and a risk register was approved by the Regional Director, resulting in active management of strategic and operational risks and mitigation measures. A regional business continuity plan was developed and operationalized.

The complexity of the operational and security issues continued to create challenges and constraints not faced in other regions. Nevertheless, good progress was made in implementing audit recommendations, resulting in improvement in overall financial records. A temporary finance officer was recruited and based in the Somalia country office to oversee the financial controls in several countries in the Region. Although the number of outstanding technical and financial reports relating to direct financial cooperation decreased, stricter control and follow-up is required. This is a concern which is constantly being highlighted in audit reports and is also high on the agenda of the various governing bodies. WHO continues to urge Member States to play an active role in ensuring the provision of quality reports in a timely manner.

Conclusion

This annual report on the work of WHO in the Eastern Mediterranean Region in 2013 reflects the first full year in which we sought to move forward to implement the commitments I agreed with Member States of the Region. Having established the health situation, the needs and the priorities the previous year, strategic plans were laid down to move towards universal health coverage, to save lives of mothers and children, to agree core indicators for measuring health development, to implement the regional framework for noncommunicable diseases, and to improve health security. I sought to involve the Regional Committee throughout these strategic decisions to ensure that our proposals were practical and feasible for Member States. Some of our work was constrained by crises around the Region and the need to respond to emergencies, nevertheless a lot was achieved in the circumstances. With important groundwork now completed, we will continue to move forward to implement global and regional commitments with ever greater focus on the strategic priorities at country level, full transparency, and a higher level of technical competence. We will stay the course and there is much for WHO and Member States to do in the coming year, and beyond.

The focus in the area of health system strengthening will be on supporting countries in the strategic areas outlined in the road map endorsed by the Regional Committee in 2012: move towards universal health coverage; strengthen leadership and governance in health; strengthen health information systems; promote a balanced and well managed health workforce; improve access to quality health care services; engage with the private health sector; and ensure access to essential technologies (essential medicines, vaccines, medical devices and diagnostics). Particular emphasis will be directed at development of national strategies for universal health coverage and national plans to strengthen

Photo: ©WHO

↑ **The WHO Regional Committee for the Eastern Mediterranean met for its Sixtieth Session, in Muscat, Oman, and discussed key issues for the future of public health in the Region**

health information systems, including civil registration and vital statistics. Strengthening of national regulatory authorities and development of laboratory support to primary and secondary care will also be important. A regional strategy on health information systems and a regional strategic framework to promote a balanced and well managed workforce will be developed to support and provide guidance to Member States in these areas.

Emphasis will continue to be placed on accelerating progress towards achievement of MDGs 4 and 5 under the initiative on saving the lives of mothers and children. It is essential that Member States maintain high-level advocacy for the maternal and child health acceleration plans in order to sustain commitment at different levels of the government and among partners and mobilize resources to bridge funding gaps. The quality of implementation of acceleration plans needs to be monitored and appropriate operational research conducted. WHO will invest in strengthening further joint work with UNFPA and UNICEF and partnership with key stakeholders.

Despite the high-level political commitment to the UN Political Declaration on noncommunicable diseases and the regional framework for action, it is clear that there are important gaps in implementation and countries are facing challenges in moving to concrete action. We will continue to provide the sound and evidence-based technical guidance required for the implementation of the key interventions and measures included in the regional framework but progress will mainly depend on political commitment and the initiatives of governments. Unless serious action is taken, the epidemic of heart disease, diabetes and cancer will continue to escalate in the Region.

↑ ***The Eastern Mediterranean Health Journal is published monthly***

With regard to health security, events around the Region in the past year demonstrate vividly the continuing need to focus on ensuring readiness to implement the International Health Regulations in all countries by the agreed deadlines. The emergence and re-emergence of infectious diseases, often in explosive outbreaks, have once again exposed the vulnerability of the Region to infections that can spread rapidly. Such vulnerability is amplified by the situations of protracted conflict and humanitarian crisis prevailing in many parts of the Region. Sharing of information is key. In addition, antimicrobial resistance is rapidly growing in magnitude and poses a threat that may have profound impact and economic consequence for health systems across all countries. Concerted and coordinated efforts to solve the specific political, societal and security challenges affecting access to children for polio vaccination in Pakistan and Somalia remain essential. The support advanced by the Islamic Advisory Group is making a great difference and must continue and should be complemented by further regional health diplomacy. All countries,

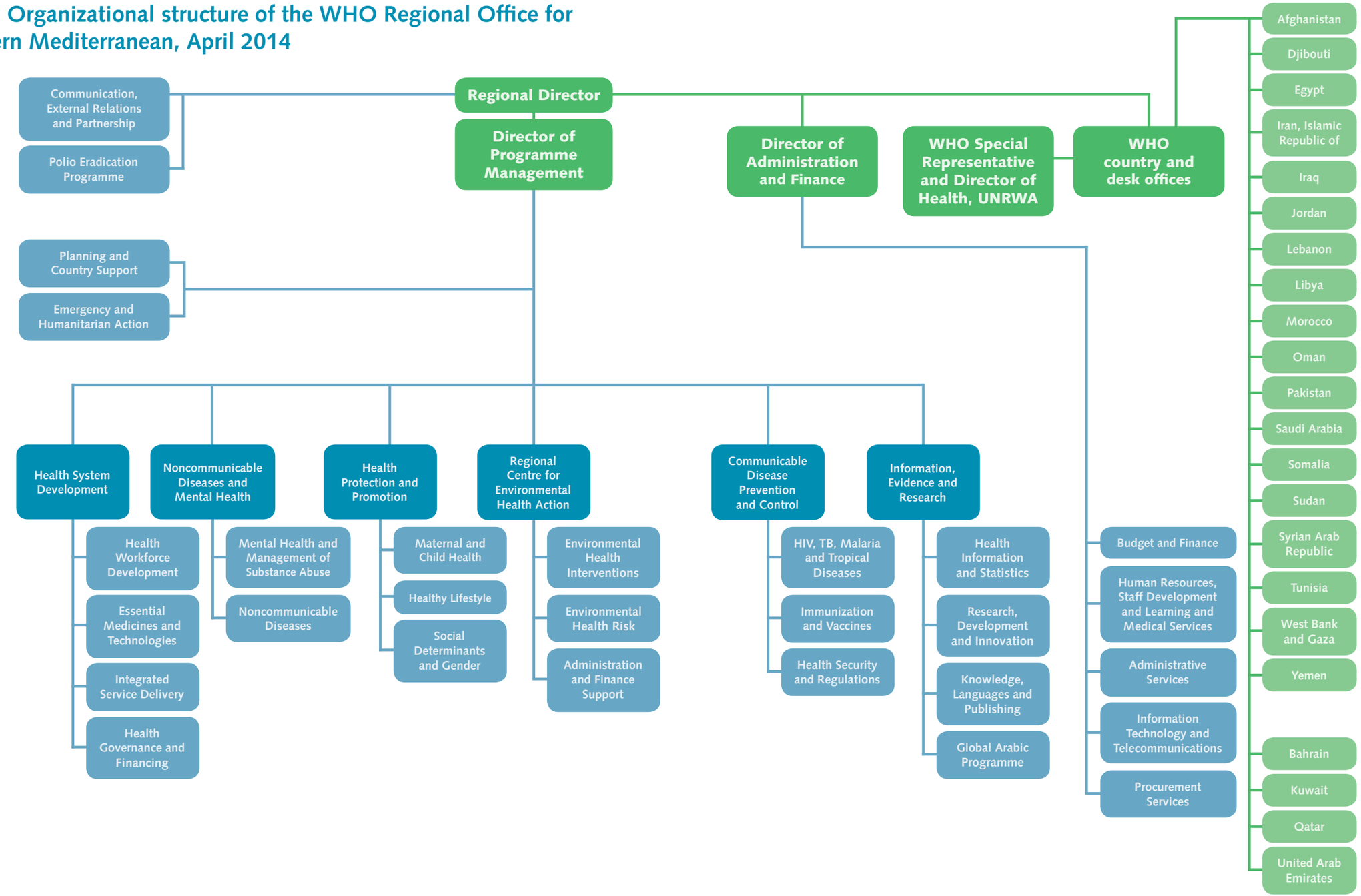
without any exception, need to do more in expanding coverage, not only in relation to access to quality health care but also in strengthening prevention and health promotion work.

With regard to emergency preparedness and response, the development of clear policies and legislation based on an all-hazard and 'whole health' approach will continue to be the main focus. WHO will provide technical support to Member States that are committed to developing an effective emergency preparedness programme with emphasis on communities most at risk. With regard to regional emergency response, a means to activate the long-planned regional emergency solidarity fund will be sought in order to ensure sustained funding and continued implementation of life-saving activities for the health needs of affected populations. It will also be important to strengthen WHO's country offices to manage graded events.

WHO has worked to improve its own performance in a range of areas, in line with the commitments made under WHO management reform. The achievements noted in this report were complemented and facilitated by structural reorganization, particularly in the area of health systems, noncommunicable diseases and evidence and information for health. Measures taken in 2013 to improve transparency and accountability will continue. Country offices are being strengthened to assure more efficient managerial processes, better linkage between the country cooperation strategies and operational planning, and an adequate control environment. Greater attention has been given to performance management, especially to managerial aspects of performance at senior level, with the aim of improving compliance and adherence to the WHO regulatory framework. Ongoing work on reinforcing internal control mechanisms will continue through quality assurance processes and a more effective regional compliance function. Funding remains a challenge and, together with Member States, we must make greater efforts to address the low level of resource mobilization from within the Region, which remains the lowest among WHO regions.

We are all witness to the rapidly changing political, social and economic scenarios unfolding in the Region. There are days when our work seems to be driven by the imperatives of crisis management, emergency response and adjustment to new realities. Undoubtedly we must remain flexible, but looking at what we have been able to achieve in the past year, I believe we have established some solid foundations on which to build a brighter health future, in partnership with our Member States. These are challenging times but also times of great opportunity. Let us not miss those opportunities.

Annex 1. Organizational structure of the WHO Regional Office for the Eastern Mediterranean, April 2014



Annex 2. Professional staff in the Eastern Mediterranean Region as at 31 December 2013

a) Professional staff in the Eastern Mediterranean Region, by number and nationality as at 31 December 2013

Nationality	Regional/Intercountry	Country	Total
Egypt	16	4	20
Pakistan	5	9	14
United States of America	5	3	8
Lebanon	3	3	6
Sudan	2	4	6
Tunisia	5	1	6
Iran, Islamic Republic of	5	–	5
Netherlands	3	2	5
United Kingdom	4	1	5
Yemen	1	4	5
Canada	2	2	4
Iraq	2	2	4
Syrian Arab Republic	3	1	4
Bangladesh	2	1	3
Belgium	1	2	3
Germany	2	1	3
Italy	2	1	3
Jordan	2	1	3
Morocco	2	1	3
Somalia	2	1	3
Afghanistan	–	2	2
Bahrain	2	–	2
Denmark	1	1	2
Ethiopia	–	2	2
Finland	2	–	2
France	–	2	2
India	–	2	2
Philippines	2	–	2
Eritrea	–	1	1
Georgia	–	1	1
Japan	–	1	1
Kenya	–	1	1
New Zealand	1	–	1
Nigeria	–	1	1
Republic of Moldova	1	–	1
Romania	–	1	1
Saudi Arabia	–	1	1
Seychelles	1	–	1
South Sudan	1	–	1
Sweden	–	1	1
Switzerland	1	–	1

Nationality	Regional/Intercountry	Country	Total
Trinidad & Tobago	1	–	1
Uganda	–	1	1
Total	82	63	145

Note: The above figures a) do not include staff on leave without pay (LWOP), nor interregional staff who are located in the Regional Office, b) are funded from all sources.

b) Professional staff from Eastern Mediterranean Region Member States, by number and nationality as at 31 December 2013

Country	Global recruitment priority list[1]	Global range[2]	Total in World Health Organization	Of which in the Eastern Mediterranean Region
Egypt	C	003-012	46	20
Pakistan	C	005-014	32	14
Sudan	C	001-010	20	6
Iran, Islamic Republic of	C	004-012	16	5
Tunisia	C	001-008	15	6
Jordan	C	001-008	14	3
Lebanon	C	001-008	13	6
Morocco	B1	001-010	10	3
Somalia	B2	001-008	9	3
Iraq	B1	002-009	7	4
Syrian Arab Republic	B1	001-008	5	4
Yemen	B1	001-008	5	5
Afghanistan	B1	001-008	4	2
Saudi Arabia	A	005-011	2	1
Bahrain	B1	001-007	2	2
Djibouti	B1	001-007	1	1
South Sudan	A*		1	1
Kuwait	A*	001-008	–	–
Libya	B1	001-008	–	–
Oman	A*	001-008	–	–
Qatar	A*	001-007	–	–
United Arab Emirates	A*	002-008	–	–
Total of regional nationalities			202	86
Total of other nationalities			2493	59
Grand total			2695	145

Note: The above figures a) do not include staff on leave without pay (LWOP), nor interregional staff who are located in the Regional Office, b) are funded from all sources.

[1]A Countries from which recruitment of professional posts is to be encouraged as a first ranking priority
B1 Countries from which recruitment of professional posts is to be encouraged as a second ranking priority
B2 Countries from which recruitment for professional posts is permissible
C Countries from which recruitment for professional posts is restricted
[2]Current range of recruitment permitted based on assessed contribution

Annex 3. Meetings held in the Eastern Mediterranean Region, 2013

Meeting title, location and date
High level seminar on options for health care financing in the Eastern Mediterranean Region: moving towards universal health coverage, Cairo, Egypt, 8–9 January 2013
Technical consultative meeting on novel coronavirus, Cairo, Egypt, 13–15 January 2013
Intercountry training workshop on surveillance of measles and other vaccine-preventable diseases and monitoring and evaluation of national programmes on immunization, Sharm El Sheikh, Egypt, 13–18 January 2013
Consultation on addressing harmful practices regarding women's and children's health, Cairo, Egypt, 14–15 January 2013
High level meeting on saving the lives of mothers and children: accelerating the progress towards achieving MDGs 4 and 5 in the Eastern Mediterranean Region, Dubai, United Arab Emirates, 29–30 January 2013
Civil registration and vital statistics workshop, Dubai, United Arab Emirates, 30 January–1 February 2013
Second regional seminar on health diplomacy, Cairo, Egypt, 16–17 February 2013
Tenth intercountry meeting of national malaria programme managers, Sharm El Sheikh, Egypt, 18–20 February 2013
Intercountry meeting of national malaria programme managers from HANMAT and PIAM-net countries, Sharm El Sheikh, Egypt, 21–22 February 2013
Consultation with Islamic scholars on polio eradication, Cairo, Egypt, 6–7 March 2013
Technical partners' meeting on country maternal and child health acceleration plans, Cairo, Egypt, 6–7 March 2013
Meeting on influenza at the human–animal interface, Cairo, Egypt, 19–21 March 2013
Subregional training workshop on tobacco control and trade, Cairo, Egypt, 19–21 March 2013
Twenty-seventh meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication, Cairo, Egypt, 26–28 March 2013
Technical workshop on salt and fat intake reduction, Cairo, Egypt, 10–11 April 2013
First regional meeting of WHO and the International Diabetes Federation on collaborating for action on noncommunicable diseases, Cairo, Egypt, 11–13 April 2013
First meeting of the Technical Advisory Committee to the WHO Regional Director for the Eastern Mediterranean, Cairo, Egypt, 15–17 April 2013
Subregional training workshop on laboratory quality management, Muscat, Oman, 15–18 April 2013
Capacity building workshop in costing: introduction to One Health costing tool, Cairo, Egypt, 21–25 April 2013
Regional training course on data management for surveillance of influenza and severe acute respiratory infections, Cairo, Egypt, 21–25 April 2013
Regional meeting on prevention and control of noncommunicable diseases and risk factors, Kuwait City, Kuwait, 29–30 April 2013
Meeting on civil registration and vital statistics and the health information system, Cairo, Egypt, 7–10 May 2013
Intercountry meeting on good governance in medicines-phase II, Kuwait City, Kuwait, 13–15 May 2013
The second Guidelines Development Group meeting of the WHO project on development of WHO guidelines on public health response to radiation emergencies, Amman, Jordan, 6–8 June 2013

Annex 3. Meetings held in the Eastern Mediterranean Region, 2013 *(continued)*

Meeting title, location and date
Emergency meeting on the response to the polio outbreak in the Horn of Africa, Cairo, Egypt, 9–10 June 2013
Intercountry meeting on good governance in medicines-phase I, Cairo, Egypt, 10–12 June 2013
Consultative meeting on strategic guidance for control of emerging infectious diseases with zoonotic origin, Cairo, Egypt, 11–13 June 2013
WHO-GAVI health system strengthening applications peer review capacity building programme, Cairo, Egypt, 17–20 June 2013
Subregional workshop on health system strengthening, Islamabad, Pakistan, 19–22 June 2013
Intercountry meeting on the Middle East respiratory syndrome coronavirus (MERS-CoV) outbreak in the Eastern Mediterranean Region, Cairo, Egypt, 20–22 June 2013
Training workshop on cost–effectiveness analysis of new vaccines, Sharm El Sheikh, Egypt, 22–24 June 2013
Subregional introductory workshop on networking for strengthening of maternal and neonatal health surveillance, Cairo, Egypt, 23–24 June 2013
Regional technical consultation on eHealth standardization for data exchange and interoperability, Cairo, Egypt, 24–26 June 2013
Subregional training on the use of real-time polymerase chain reaction (RT-PCR) technique for diagnosis and detection of novel coronavirus, Cairo, Egypt, 24–26 June 2013
Subregional training on the use of real-time polymerase chain reaction (RT-PCR) technique for diagnosis and detection of novel coronavirus, Muscat, Oman, 24–26 June 2013
Meeting of regional experts on surveillance and strategic information for WHO EMR/UNAIDS MENA region, Cairo, Egypt, 24–26 June 2013
Sixth meeting of the Scientific and Technical Advisory Committee of the regional WHO/UNEP/GEF project on sustainable alternatives to DDT, Khartoum, Sudan, 25–27 June 2013
GLAAS 2013: project team and implementation meeting, Amman, Jordan, 2–4 July 2013
Second regional meeting on strengthening vaccine pharmacovigilance: strengthening vaccine safety communication capacities, Tunis, Tunisia, 2–4 July 2013
Regional consultation on maternal and child mortality estimates, Tunis, Tunisia, 22–23 July 2013
Technical consultation with civil society organizations and networks on ending the HIV treatment crisis in the Eastern Mediterranean Region, Beirut, Lebanon, 19–20 August 2013
Regional training and analysis workshop on the global tobacco surveillance system, Beirut, Lebanon, 20–22 August 2013
Subregional meeting on improving public health preparedness for epidemic influenza, Amman, Jordan, 20–22 August 2013
Expert meeting on developing a health promotion programme for media professionals, Sharm El Sheikh, Egypt, 3–5 September 2013
Regional workshop for the dissemination of new WHO consolidated guidelines on HIV treatment and care, Casablanca, Morocco, 9–10 September 2013
Regional workshop on salt and fat intake reduction, Amman, Jordan, 10–12 September 2013
Twenty-first intercountry meeting of national AIDS programme managers, Casablanca, Morocco, 11–13 September 2013
Subregional training on the use of real time polymerase chain reaction (RT-PCR) technique for diagnosis and detection of novel coronavirus, Amman, Jordan, 16–18 September 2013

Annex 3. Meetings held in the Eastern Mediterranean Region, 2013 *(continued)*

Meeting title, location and date
Consultation on the finalization of a substance use information system, Amman, Jordan, 16–19 September 2013
Expert consultation on marketing of foods and nonalcoholic beverages to children in the Eastern Mediterranean Region, Amman, Jordan, 18–19 September 2013
Regional workshop on health promotion and leadership (PROLEAD), Manama, Bahrain, 22–23 September 2013
Ninth meeting of the Regional Advisory Panel on Nursing and consultation on nursing education in the Eastern Mediterranean Region, Amman, Jordan, 29 September–1 October 2013
Intercountry capacity-building workshop for health system strengthening, Sharm El Sheikh, Egypt, 1–4 October 2013
Expert group meeting on the development of a post-basic psychiatric nursing programme in the Eastern Mediterranean Region, Amman, Jordan, 2–3 October 2013
Consultative meeting on developing a strategic framework for cholera prevention and control in the Eastern Mediterranean Region, Sharm El Sheikh, Egypt, 5–6 October 2013
Regional consultation on assessing public health capacity and performance in countries of the Eastern Mediterranean Region, Dubai, United Arab Emirates, 5–7 October 2013
Consultant training workshop on effective vaccine management assessment, Luxor, Egypt, 5–10 October 2013
Regional meeting on maternal death surveillance and response, Rabat, Morocco, 7–9 October 2013
Regional meeting on cancer control and research priorities, Doha, Qatar, 20–22 October 2013
Consultation on the finalization of a regional guideline document on food safety laws, Amman, Jordan, 21–23 October 2013
Meeting of the regional programme review group on lymphatic filariasis elimination and other preventive chemotherapy programmes, Sharm El Sheikh, Egypt, 21–23 October 2013
Sixtieth session of the WHO Regional Committee for the Eastern Mediterranean, Muscat, Oman, 27–30 October 2013
First expert consultation on public health law in the Eastern Mediterranean Region, Cairo, Egypt, 6 November 2013
Training workshop on ship inspection and issuing of ship sanitation certificates as required under the International Health Regulations-2005, Doha, Qatar, 10–14 November 2013
First intercountry meeting on health technology assessment: a tool for evidence-informed decision-making in health, Hamamat, Tunisia, 11–13 November 2013
Consultative meeting on antimicrobial resistance for countries in the Eastern Mediterranean Region: from policies to action, Sharm El Sheikh, Egypt, 12–14 November 2013
Regional workshop for road safety decade of action focal points in the Eastern Mediterranean Region, Cairo, Egypt, 13–14 November 2013
Follow-up meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication, Tunis, Tunisia, 13–14 November 2013
Training workshop on the Global Student-Based School Health Survey, Sharm El Sheikh, Egypt, 17–19 November 2013
Regional workshop on pharmaceutical sector assessment survey-level II, Sharm El Sheikh, Egypt, 17–20 November 2013

Annex 3. Meetings held in the Eastern Mediterranean Region, 2013 *(concluded)*

Meeting title, location and date
Meeting of the Regional Technical Advisory Group (RTAG) on Immunization, Amman, Jordan, 17–21 November 2013
Regional workshop on strengthening and integrating the ear and hearing care programme within primary health care and health systems, Doha, Qatar, 18–20 November 2013
Subregional workshop for G5 countries on health systems strengthening, Islamabad, Pakistan, 18–20 November 2013
Sixteenth intercountry meeting of directors of poliovirus laboratories in the Eastern Mediterranean Region, Muscat, Oman, 18–21 November 2013
Second intercountry meeting on the Eastern Mediterranean Acute Respiratory Infection Surveillance (EMARIS) network, Sharm El Sheikh, Egypt, 24–27 November 2013
Consultation on developing a curriculum framework for public health risk management, Amman, Jordan, 25–28 November 2013
Intercountry meeting on death certification, ICD coding and analysis of causes of death, Kuwait City, Kuwait, 25–28 November 2013
Regional workshop on establishment, promotion and coordination of care and management of programmes for substance use disorders, Abu Dhabi, United Arab Emirates, 25–29 November 2013
Meeting of the Technical Advisory Group on Polio Eradication in Pakistan, Islamabad, Pakistan, 27–28 November 2013
Meeting of the Technical Advisory Group on Polio Eradication in Afghanistan, Kabul, Afghanistan, 30 November–1 December 2013
Regional consultation on age-friendly health care services, Cairo, Egypt, 2–3 December 2013
Regional meeting on accelerating progress towards universal health coverage: global experience and lessons for the Eastern Mediterranean Region, Dubai, United Arab Emirates, Egypt, 5–7 December 2013
Consultative meeting to develop a strategic public health laboratory plan, Amman, Jordan, 9–11 December 2013
Health system capacity development workshop: supporting Member States' efforts towards universal health coverage, Sharm El Sheikh, Egypt, 9–13 December 2013
Programme managers' meeting on leprosy elimination in the Eastern Mediterranean Region, Islamabad, Pakistan, 10–12 December 2013
Regional stakeholders meeting to review the implementation of the International Health Regulations, Amman, Jordan, 12–14 December 2013
Consultation to finalize a training curriculum for mainstreaming health promotion in media, Tunis, Tunisia, 12–15 December 2013
Consultative meeting on development of a public health leadership programme and strengthening the network of academic institutions in the Eastern Mediterranean Region, Cairo, Egypt, 13–14 December 2013
Consultative meeting to determine a public health research agenda on MERS-CoV, Cairo, Egypt, 15–16 December 2013
Training workshop for countries affected by the Syria crisis, Cairo, Egypt, 15–19 December 2013
GLAAS 2013 regional project meeting for data validation and review, Amman, Jordan, 17–19 December 2013
Subregional training workshop on establishing national external quality assurance system central public health laboratory, Muscat, Oman, 22 December 2013 – 2 January 2014

Annex 4. New publications issued in 2013

Title	Originator
Publications	
Accelerating HIV treatment in the WHO Eastern Mediterranean and UNAIDS Middle East and North Africa regions Language: Arabic/English/French	Regional Office
Assessment and management of conditions specifically related to stress: mhGAP intervention guide module (version 1.0) Language: Arabic	Headquarters
Atlas: substance use in the Eastern Mediterranean Region 2012 Language: English	Regional Office
Casebook on ethical issues in international health research Language: Arabic	Headquarters
Demographic, social and health indicators for countries of the Eastern Mediterranean 2013 Language: English	Regional Office
Ending the HIV treatment crisis: A regional initiative for increasing access to antiretroviral therapy in the Eastern Mediterranean Region Language: English	Regional Office
Food and nutrition surveillance systems: technical guide for the development of a food and nutrition surveillance system for countries in the Eastern Mediterranean Region Language: English	Regional Office
HIV treatment works: Treat more, Treat better Language: Arabic/English/French	Regional Office
I'm prepared for emergencies Language: Arabic/English/French	Regional Office
Increasing access to health care services in Afghanistan with gender sensitive health service delivery Language: English	Regional Office
International Ethical Guidelines for Epidemiological Studies Language: Arabic	Headquarters
List of basic sources Language: English	Regional Office
Mental health atlas 2011:resources for mental health in the Eastern Mediterranean Region Language: English	Regional Office
mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings Language: Arabic	Headquarters
Promoting ear and hearing care through CBR Language: Arabic/French	Headquarters
Research ethics committees: basic concepts for capacity-building Language: Arabic	Headquarters
Road safety in the Eastern Mediterranean Region: facts from the global status report on road safety 2013 Language: Arabic/English/French	Headquarters

Annex 4. New publications issued in 2013 *(concluded)*

Title	Originator
Publications	
Road safety in the Eastern Mediterranean Region: highlights from the Global status report on road safety 2013 Language: Arabic/English/French	Headquarters
Standards and operational guidance for ethics review of health-related research Language: English	Headquarters
T3: Test, Treat, Track: scaling up diagnostic testing, treatment and surveillance for malaria Languages: Arabic	Regional Office
The work of WHO in the Eastern Mediterranean Region. Annual report of the Regional Director 2012 Language: Arabic/English/French	Regional Office
Tobacco advertising promotion and sponsorship Language: Arabic/English/French	Regional Office
Fact sheets	
Global Adult Tobacco Survey: Qatar 2013 Language: English	Regional Office/ Government of Qatar/CDC
Periodicals	
Eastern Mediterranean Health Journal; Vol.19 No.1 –No.12 Supplements 1–3 Languages: English/Arabic/French	Regional Office
IMEMR current contents Vol. 11 No. 1–No.3 Language: English	Regional Office
Publications online	
Health-promoting schools initiative in Oman: a WHO case study in intersectoral action Language: English	Regional Office
HIV Surveillance in the WHO Eastern Mediterranean Region: regional update 2012 Language: English	Regional Office
Introduction to HIV/AIDS and sexually transmitted infection surveillance: module 4: introduction to respondent-driven sampling Language: English	Regional Office

Annex 5. WHO collaborating centres in the Eastern Mediterranean Region as at December 2013

Field	Title	Country	Institution name
Biomedical equipment	WHO Collaborating Centre for Biomedical Equipment Services, Maintenance, Training and Research	Jordan	Ministry of Health
Blindness	WHO Collaborating Centre for Eye Health and Prevention of Blindness	Islamic Republic of Iran	Shahid Beheshti Medical University
Blindness	WHO Collaborating Centre for Prevention of Blindness	Pakistan	Al-Shifa Trust Eye Hospital
Blindness	WHO Collaborating Centre for Prevention of Blindness	Saudi Arabia	King Khaled Eye Specialist Hospital
Cancer	WHO Collaborating Centre for Research on Gastrointestinal Cancer	Islamic Republic of Iran	Digestive Diseases Research Centre
Cancer	WHO Collaborating Centre for Cancer Education, Training and Research	Jordan	King Hussein Cancer Centre
Cancer	WHO Collaborating Centre for Metabolic Bone Disorders	Lebanon	American University of Beirut
Cardiovascular disease	WHO Collaborating Centre for Research and Training in Cardiovascular Diseases Control, Prevention, and Rehabilitation for Cardiac Patients	Islamic Republic of Iran	Isfahan Cardiovascular Research Centre
Diabetes	WHO Collaborating Centre for Research and Education on Management of Osteoporosis and Diabetes	Islamic Republic of Iran	Teheran University of Medical Sciences
Diabetes	WHO Collaborating Centre for Diabetes Research, Education and Primary Health Care	Jordan	National Centre for Diabetes, Endocrine and Inherited Diseases
Diabetes	WHO Collaborating Centre for Treatment, Education and Research in Diabetes and Diabetic Pregnancies	Pakistan	Diabetic Association of Pakistan
Educational development	WHO Collaborating Centre for Educational Development	Bahrain	Arabian Gulf University
Educational development	WHO Collaborating Centre for Research and Development in Medical Education and Health Services	Egypt	Suez Canal University
Educational development	WHO Collaborating Centre for Educational Development	Islamic Republic of Iran	Shahid Beheshti University of Medical Sciences and Health Services
Educational development	WHO Collaborating Centre for Training in Research and Educational Development of Health Personnel	Pakistan	College of Physicians and Surgeons

Annex 5. WHO collaborating centres in the Eastern Mediterranean Region *(continued)*

Field	Title	Country	Institution name
Educational development	WHO Collaborating Centre for Research and Training in Educational Development	Sudan	University of Gezira
Educational development	WHO Collaborating Centre for Education Development for Health Professions	Sudan	University of Khartoum
E-Health	WHO Collaborating Centre on E-Health	Saudi Arabia	King Faisal Specialist Hospital and Research Centre
Emerging and re-emerging infectious diseases	WHO Collaborating Centre for Emerging and Re-emerging Infectious Diseases	Egypt	US Naval Medical Research Unit No. 3
Health management	WHO Collaborating Centre for training and research on Health Management	Islamic Republic of Iran	Tabriz University of Medical Sciences
Health promotion	WHO Collaborating Centre on Health Promotion and Behavioural Science	Lebanon	American University of Beirut
Health promotion	WHO Collaborating Centre for Emergency Medicine and Trauma Care	Pakistan	Aga Khan University
Hearing loss	WHO Collaborating Centre for Research and Education on Hearing Loss	Islamic Republic of Iran	Iran University of Medical Sciences
HIV/AIDS	WHO Collaborating Centre for HIV surveillance	Islamic Republic of Iran	Kerman University of Medical Sciences
HIV/AIDS	WHO Collaborating Centre for Acquired Immunodeficiency Syndrome	Kuwait	University of Kuwait
HIV/AIDS and tuberculosis	WHO collaborating centre for research on HIV/AIDS, tuberculosis and lung diseases	Sudan	The Epidemiological Laboratory (Epi-Lab)
Infection prevention and control	WHO Collaborating Centre for Infection Prevention and Control	Saudi Arabia	King Abdulaziz Medical City, King Fahad National Guard Hospital
Leishmaniasis	WHO Collaborating Centre for Leishmaniasis Control	Syrian Arab Republic	Leishmaniasis Control Center
Mass gatherings	WHO Collaborating Centre for Mass Gatherings Medicine	Saudi Arabia	Ministry of Health, Saudi Arabia
Mental health	WHO Collaborating Centre for Mental Health	Islamic Republic of Iran	Teheran University of Medical Sciences
Mental health	WHO Collaborating Centre for Mental Health	Morocco	Ibn Rushd University
Mental health	WHO Collaborating Centre for Mental Health Research, Training and Substance Abuse	Pakistan	Rawalpindi Medical College

Annex 5. WHO collaborating centres in the Eastern Mediterranean Region *(continued)*

Field	Title	Country	Institution name
Nursing	WHO Collaborating Centre for Nursing Development	Bahrain	College of Health Sciences, Ministry of Health
Nursing	WHO Collaborating Centre for Nursing Development	Jordan	Jordan University of Science and Technology (JUST)
Nutrition	WHO Collaborating Centre for Research and Training in Nutrition	Islamic Republic of Iran	National Nutrition and Food Technology Research Institute, Ministry of Health and Medical Education
Nutrition	WHO Collaborating Centre for Research, Training and Outreach in Food and Nutrition	Lebanon	American University of Beirut
Nutrition	WHO Collaborating Centre for Nutrition	United Arab Emirates	College of Food and Agriculture-United Arab Emirates University
Oral Health	WHO Collaborating Centre for Training and Research in Dental Public Health	Islamic Republic of Iran	School of Dentistry, Shahid Beheshti University of Medical Sciences (SBMU)
Oral Health	WHO Collaborating Centre for Primary Oral Health Care	Kuwait	University of Kuwait
Pharmaceutical	WHO Collaborating Centre for Drug Registration and Regulation	Tunisia	Directorate for Drugs and Pharmacy, Ministry of Public Health
Pharmaceutical	WHO Collaborating Centre for Pharmacovigilance	Morocco	Centre Anti Poison et de Pharmacovigilance du Maroc
Quality assurance	WHO Collaborating Centre for Quality Control and Clinical Chemistry	Islamic Republic of Iran	Reference Laboratories of Iran, Ministry of Health and Medical Education
Rabies	WHO Collaborating Centre for Reference and Research on Rabies	Islamic Republic of Iran	Pasteur Institute of Iran
Reproductive Health	WHO Collaborating Centre for Training and Research in Reproductive Health	Tunisia	International Training and Research Centre in Reproductive Health and Population
Schistosomiasis	WHO Collaborating Centre for Schistosomiasis Control	Egypt	Theodor Bilharz Research Institute
Tobacco	WHO Collaborating Centre on Tobacco Control	Islamic Republic of Iran	National Research Institute of Tuberculosis and Lung Disease (NRITLD)

Annex 5. WHO collaborating centres in the Eastern Mediterranean Region *(concluded)*

Field	Title	Country	Institution name
Traditional medicine	WHO Collaborating Centre for Traditional Medicine	United Arab Emirates	Zayed Complex for Herbal Research and Traditional Medicine (ZCHRTM)
Transfusion medicine	WHO Collaborating Centre for Research & Training on Blood Safety	Islamic Republic of Iran	Iranian Blood Transfusion Organization (IBTO)
Transfusion medicine	WHO Collaborating Centre for Training and Research in Blood Transfusion	United Arab Emirates	Sharjah Blood Transfusion and Research Centre
Transfusion medicine	WHO Collaborating Centre for Transfusion Medicine	Jordan	National Blood Bank, Ministry of Health
Transfusion medicine	WHO Collaborating Centre for Transfusion Medicine	Tunisia	National Blood Transfusion Centre of Tunis, Ministry of Health
Tuberculosis	WHO Collaborating Centre for Tuberculosis Education	Islamic Republic of Iran	Shahid Beheshti University of Medical Sciences & Health Services
Water supply	Centre collaborateur de l'OMS en matière de Formation et de Recherche dans le domaine de l'Eau potable et de l'Assainissement	Morocco	National Office of Electricity and Water Supply (ONEP)