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.

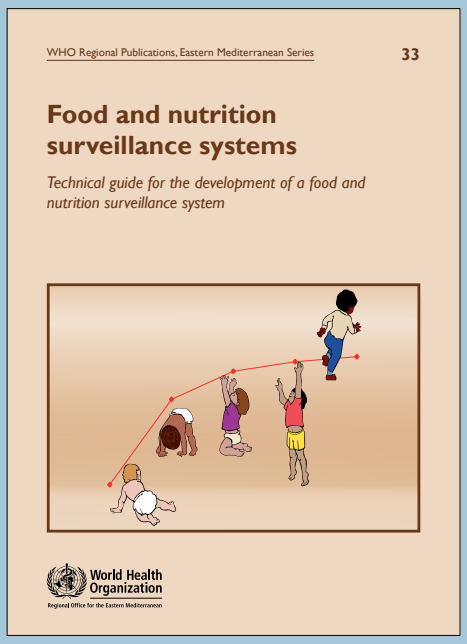
The Regional Office maintained close follow-up of and support for the implementation of the roadmaps of the Commission on Information and Accountability for Women's and Children's Health in the priority countries. Seven such roadmaps (Afghanistan, Djibouti, Iraq, Morocco, Pakistan, Somalia and Yemen),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

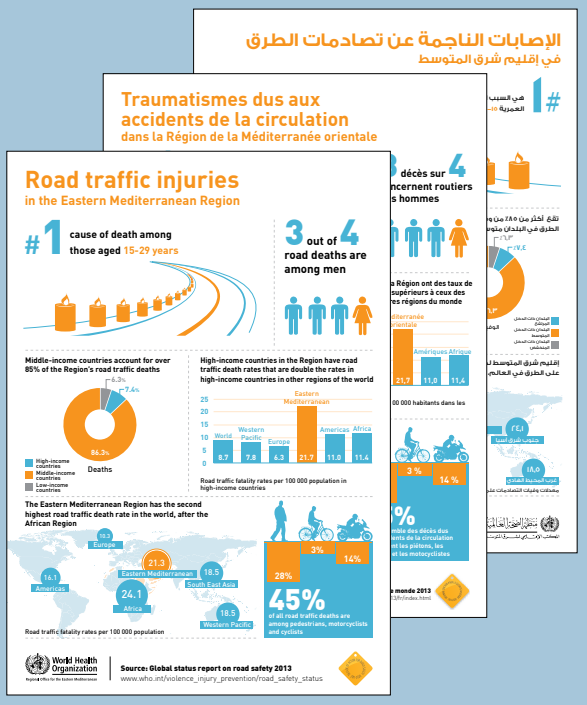
As part of regional efforts to implement the global plan of action on workers' health, technical support was provided to several countries. However, a new vision and a comprehensive strategy on occupational health is needed and will be the focus of work in 2014. As older people become a larger and more 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.