The Work of WHO in the Eastern Mediterranean Region

Annual Report of the Regional Director 2014

World Health Organization
Regional Office for the Eastern Mediterranean

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Introduction and highlights of the report

I am pleased to present my annual report of the work of WHO in the Eastern Mediterranean Region, which covers 2014 and the early part of 2015. As in the past two years, the report focuses on the strategic priorities endorsed by the WHO Regional Committee for the Eastern Mediterranean when I came into office in 2012[1]. These are: health systems strengthening towards universal health coverage; maternal and child health; prevention and control of noncommunicable diseases; health security and control of communicable diseases; and emergency preparedness and response. Together with these five strategic priorities, which represent the key challenges facing health development in the region, strong emphasis has been given to managerial reform, improving administrative processes, strengthening compliance and transparency.

[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/.

The work of WHO continued to be dominated in the past year by the escalating emergency and humanitarian situations in several countries. The magnitude of crises in the region is unprecedented. An estimated 58 million people are now affected, including 16 million refugees or internally displaced persons. WHO supported acute humanitarian responses in Iraq, Jordan, Lebanon, Libya, Palestine, Syrian Arab Republic, and Yemen, while maintaining its efforts, with partners, to strengthen the resilience of health systems in countries with prolonged complex emergencies. The destruction of health facilities, the lack of access to many areas to maintain adequate supplies for both acute and chronic medical conditions, and the fleeing of health personnel and their families have all taken a heavy toll in the past year on the ability of some countries to maintain services. While some donors have continued in their humanitarian commitment and generous support, a major challenge to our ability to maintain an adequate response, together with our health partners, is the lack of sustained funding. In 2015 this has resulted in the closure of health programmes and activities in Iraq and threatens the closure of health services and health programmes elsewhere too.

Nevertheless, we continued to step up our support as crises unfolded. WHO facilitated delivery of medicines and medical supplies to hospitals and health facilities in Gaza, both during and after the conflict in 2014, and led the health cluster in the joint health sector assessment with partners. In Iraq, the capacity of the country office was scaled up with deployment of additional international staff in all areas of expertise and WHO hubs and/or focal points are now established in 19 provinces. Ten mobile clinics were deployed in northern Iraq and, as of May 2015, 3.5 million people have been provided with direct access to essential

Photo: ©Palestinian National Authority/President's Office

↑ Returning from a visit to Gaza, the Regional Director met with HE President Mahmoud Abbas

medicines and medical equipment and more than 5 million children have been vaccinated against polio. In the Syrian Arab Republic, WHO took an innovative approach towards working with a range of partners to ensure access to areas that have been hard to reach. More than 13.8 million medical treatments were delivered, of which a third were to hard-to-reach areas, and we were able to mobilize more than 17 000 health care workers to conduct polio and measles immunization campaigns. In Yemen, following the escalation of conflict, WHO distributed 181 tonnes of medicines and medical supplies and more than 500 000 litres of fuel between March and end July 2015, as well as safe water and sanitation kits, to maintain operability of health infrastructure and facilities for communities and internally displaced people.

The Regional Committee endorsed the need to strengthen emergency preparedness and response through an all-hazard and multisectoral approach. By the end of 2014, 19 countries had received our support in reviewing their existing national plans, with a view to adopting the comprehensive approach, and two countries have now finalized national plans. Working closely with the International Humanitarian City, Dubai, WHO has now finalized an agreement with the United Arab Emirates to establish a dedicated WHO humanitarian operations/logistics hub, which will support the rapid procurement and provision of critical medical supplies and equipment to countries experiencing emergencies, both inside and beyond the Region. The regional emergency solidarity fund was established. It will be funded at US$ 4.9 million for the biennium 2016–2017 which is 1% of the WHO country budget and will be open to other voluntary contributions. Capacity-building of emergency focal points was supported, and will continue each year as we continue to build up the regional roster of trained experts able to be deployed quickly in an emergency.

Following the discussions and resolutions in the World Health Assembly in May 2015 in the wake of the outbreak of Ebola virus disease in 2014, and in relation to reform and strengthening of WHO's emergency preparedness and response capacities, we have undertaken a close review of our capacities in these areas. As a result we have now undertaken further reform by restructuring and reinforcing technical and managerial capacity in this area in order to ensure appropriate readiness and response at both country and regional levels,

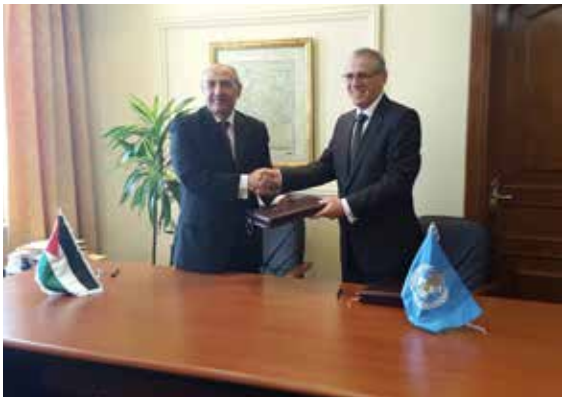


Photo: ©WHO

↑ The Government of Jordan and WHO signed an agreement establishing the WHO Regional Centre for Emergencies and Polio Eradication

as well as effective coordination. Thanks to support from the Government of Jordan, we have established a regional centre for emergencies and polio eradication in Amman. A unit focusing on organizational readiness is being established in the centre in Amman to build capacity and ensure that WHO is ready to respond to public health emergencies in the Region. A second entity based in Cairo and comprising two units, emergency response and coordination, will provide leadership and coordination and ensure an effective response mechanism and timely support to countries in crisis.

The Region has made significant reductions in maternal and child mortality since 1990, as shown by the latest monitoring data for the Millennium Development Goals. However, the levels of reduction fall short of meeting the targets of MDGs 4 and 5 by end 2015. At regional level, the under-5 mortality rate fell by 46% between 1990 and 2013 (below the global reduction of 49%), with an average annual reduction of 2.6%. However, this is below the 67% reduction required to achieve the MDG 4 target by 2015. The maternal mortality rate declined by 50% between 1990 and 2013 (above the global reduction of 45%), with an average annual reduction of 3%.This too is below the 75% reduction required to achieve the MDG 5 target by 2015. The nine countries with the highest burden of maternal and child mortality pushed ahead with implementation of their acceleration plans to reduce this burden further. Nevertheless, most of these countries are unlikely to reach the targets by end of 2015. Although weak health systems, emergencies and shortage of funding are major constraints which will need to be adequately addressed, greater attention and a higher level of political commitment and support needs to be given to reducing child and

Photo: ©WHO

↑ **Under-5 mortality in the Region fell by 46% between 1990 and 2013**

maternal mortality by these countries, and more effective support is needed from international and regional stakeholders. While WHO will continue to support the implementation of cost-effective, high-impact measures during the next biennium, more attention will be given to supporting Member States in addressing health system challenges and implementing community-based interventions.

The situation with regard to malnutrition in the Region has improved somewhat but the progress is insufficient and more work is needed to ensure that all mothers and children in all countries are adequately nourished to maintain health and development. On average, according to *World health statistics 2014*, the Region has seen a decrease in the prevalence of undernourishment from 22.6% in 1991 to 13.6% in 2012. Since 1990, 13 countries of the Region, more than half, have achieved the MDG 1 target of halving the proportion of people who suffer from hunger. However, only two of these countries (Kuwait and Oman) have also met the target set at the World Food Summit in 1996, although Tunisia is very close to meeting this also. Anaemia rates, especially among women of reproductive age and children, are still high in the Region as are the rates

for stunting and for low birth weight. Equally crucial for children, and for long-term health, the proportion of women practising exclusive breastfeeding for at least 6 months continues to be very low. WHO, in coordination with United Nations partners, is supporting Member States on how best to implement the WHO global targets in nutrition and the recommendations of the Second International Conference on Nutrition (ICN-2) held in 2014. A regional framework for action is in the process of development and will comprise a set of policy options and cost-effective interventions to scale up nutrition in the Region.

With regard to MDG 6, while there has been substantial progress in the Region in control and prevention of HIV, malaria and tuberculosis, this has not been enough to achieve the targets. The challenges to health system capacity that the Region faces in general, in particular in countries where the burden of communicable diseases is the highest, as well as the impact of the complex emergencies in the Region, are the main factors affecting further progress.

The overall prevalence of HIV remains low in comparison with other regions, but it is important to recognize that the number of new HIV infections continues to increase in key population groups who are at increased risk of HIV. Receiving antiretroviral therapy, which is crucial to maintaining quality of life and preventing new infections, remains far below global targets. We continued to support countries in 2014 to implement the regional initiative to end the HIV treatment crisis, and Member States should continue to place emphasis on this.

The regional burden of malaria has decreased substantially, with a halving of the number of deaths since 2000, along with the number of affected countries. Seven countries have achieved the malaria-related target of MDG 6, while in five countries, a reliable assessment of trends is not feasible owing to inconsistent reporting of malaria information. A regional action plan, to implement the global strategy for malaria 2016–2030 has been developed, with the aim of interrupting malaria transmission where feasible and reducing the burden by more than 90% where elimination is not immediately feasible.

While the Region has achieved the MDG targets of halting and reversing the tuberculosis incidence, it has not yet reached the STOP TB targets of halving the prevalence and the mortality. Five countries are contributing to 84.5% of the regional burden of tuberculosis. Crucially, it is estimated that 40% of cases are still missed or not reported and this has serious implications for overall control of the disease. In 2014, WHO developed guidance on control of tuberculosis in complex emergencies, as well as a package of services for cross-border patients. We hope that high-burden countries will move forward in implementing these important measures in 2015.

The situation with regard to polio eradication continued to be of concern in 2014, with the Region remaining endemic and accounting for 99% of all cases reported globally in the second half of the year. However, in 2014 the groundwork was laid for progress in polio eradication in the Region in 2015. By the end of 2014, Pakistan and Afghanistan had developed and were implementing accelerated plans for the low transmission season. The response of the Region to the outbreak in the Middle East in 2013 was swift and of high quality with 25 million children immunized, in multiple campaigns in eight countries. The outbreak was contained in 36 weeks, despite the complex emergency situation

in the Region, with the last case reported in April 2014 and so more than one year has passed with no further confirmed cases. Meanwhile the response to the outbreak in the Horn of Africa had, by the end of 2014, reduced transmission to a small pocket.

The national programmes in Afghanistan and Pakistan maintained their commitment to eradication, and health workers and volunteers continued to demonstrate great courage in carrying out immunization activities in difficult situations. As of 19 August 2015, Pakistan and Afghanistan together have reported 36 cases due to wild poliovirus, versus 123 confirmed cases as at the same date in 2014, an overall reduction of nearly 70%. With wild poliovirus now restricted to just Pakistan and Afghanistan, progress will remain fragile until all children in these last foci of endemic circulation are reached and immunized. Full implementation of the acceleration plans remains critical to making progress with eradication in 2015. The countries of the Region are committed to the global plan for the polio-endgame, with all those currently using only oral poliomyelitis vaccine (OPV) on track for introduction of IPV in 2015.

Health security continued to be high on the agenda throughout the past year, and its importance was brought home to governments and the public yet again as the outbreaks of Ebola virus disease spread in three countries in west Africa. The possibility of importation to the Region was a major concern to us. In response to a recommendation from the Regional Committee, WHO urgently undertook a comprehensive assessment of Member States' capacity to deal with a potential importation of Ebola. Between November 2014 and February 2015 rapid assessments of preparedness and readiness measures were conducted by WHO technical teams in 20 countries.

↑ *World Health Day 2014*

The assessments identified critical weaknesses in the areas of prevention, early detection and response, and a 90-day action plan was subsequently implemented in the Region, starting in May 2015, to assist countries to bridge the urgent gaps. Many of the gaps identified during the assessment concern the overall ability of countries to implement the core capacities required under the International Health Regulations (IHR 2005). The final deadline for ensuring that national core capacities are in place to implement the Regulations is June 2016. Major weaknesses remain. All countries should reinforce their efforts, in light of the assessments, to address the gaps. WHO's strategic focus for country support includes emphasis on multisectoral coordination which will be crucial to addressing these gaps.

Photo: ©WHO

↑ A WHO team deployed to Saudi Arabia during the hajj oversaw the implementation of appropriate public health measures

The fourth annual meeting of IHR stakeholders, which will take place in late 2015, will review the implementation of national and regional plans for strengthening IHR implementation in the context of Ebola.

While Ebola was a vivid and real health threat from outside the Region, there are other more immediate health threats within the Region. The Middle East respiratory syndrome coronavirus MERS-CoV and the avian influenza H5N1 virus represent emerging health threats for which countries need to be prepared as both viruses have pandemic potential. An increase of MERS-CoV cases in two countries in the Region in 2014 owing, primarily, to secondary and nosocomial transmissions in health care settings, highlighted the need to ensure the safety of patients and health workers, and to improve infection prevention and control in hospitals and other health facilities and the need to build capacity to care for patients with high-risk infections.

In view of these two emerging health threats, WHO conducted technical missions – in several countries – throughout 2014 and during the earlier part of 2015 to assess the risks and support containment of the outbreaks in hospital settings. A number of capacity-building activities were also conducted which resulted in finalization and rapid implementation of preparedness plans for enhancing surveillance for rapid detection and improving infection prevention and control practices for MERS-CoV and other novel respiratory diseases across all health care settings in the Region. Risk communication plans were developed and rapidly scaled up to raise public awareness among pilgrims, health care workers and the general public and prevent international spread, particularly during the hajj . We continue to seek to fill the gaps in knowledge about MERS-CoV so that public health understanding of the epidemiology and transmissibility of the virus and the effectiveness of the global health response can be improved. In May 2015, we held the fourth in a series of international scientific meetings on this subject since 2013. These have helped the international scientific community to pinpoint the gaps we face in knowledge and information about the mode and risk factors for transmission of this emerging viral infection in humans, as well as to identify the most essential public health measures to effectively halt the transmission and spread of the virus.

Antimicrobial resistance is a rapidly increasing risk for global health security which the Member States of the Region are only just beginning to recognize and acknowledge. The problem has serious implications in the Region and requires urgent action. In continuation of the work we began on antimicrobial resistance in 2013, a rapid country assessment of the situation in the Region was conducted in 2014 to which only 12 countries contributed. The results showed significant gaps in the systems and actions needed at country level to address the threat. The subsequent global report highlights the lack of information on the situation

in countries of the RegionWhile the work on producing a detailed country situation analysis covering human and animal health continue, we also started work on an operational framework to support countries in developing action plans for discussion in a high-level multisectoral ministerial meeting that we plan to organize early in 2016.

Member States, through the Regional Committee, have acknowledged the serious magnitude of cardiovascular disease, cancers, diabetes and chronic lung disease and have approved a regional framework of action based on the United Nations Political Declaration of 2011. However, despite the urgent need to launch strong and comprehensive action, implementation of the key commitments in the regional framework for action remains generally inadequate and is not commensurate with the seriousness of the problem in the Region. WHO is working with Member States on several important initiatives to implement the key commitments included in the four areas of the framework: governance, surveillance, prevention, and health care.

WHO's work in 2014 resulted in the development of technical guidance for implementing the most cost-effective measures or "best buys" in prevention and technical support was provided to many countries. Policy statements and guidelines on reducing salt and fat intake have been developed and are now guiding countries in taking appropriate action based on best practice. A monitoring scheme has been launched to track the progress countries of the Region are making. International experience in integrating common conditions into primary health care was reviewed in an intercountry meeting. This work will continue in 2015 with special emphasis placed on developing technical guidance based on evidence and best practice in the area of health care. We are also working with international experts, including Georgetown University, to support updating of fiscal and legal interventions to help control risk factors and promote better care.

Following endorsement in 2012 and 2013 by the Regional Committee of strategies and actions for health systems strengthening, countries were urged in 2014 to implement the framework for action for progressing towards universal health coverage. Several countries have taken important steps in this regard and all countries now have a clearer picture of what is needed to address the

Photo: ©WHO

↑ Ministers and representatives of Member States from a broad range of sectors participated in a high-level regional forum on a life-course approach to promoting physical activity

challenges. This knowledge was boosted following the development of pharmaceutical sector country profiles, which highlighted gaps in key areas related to regulations for medicines, access to medicines, selection, procurement, dispensing and rational use.

An in depth survey of medical education is providing valuable insight also on the way forward for countries to improve planning for future needs in the health sector. One area that poses a specific challenge is the acute shortage of, and the need to scale up production of, family physicians in most countries of the Region. Efforts are currently under way to identify evidence-based short- and long-term interventions to overcome the shortage of this group of health care providers. WHO has conducted a comprehensive review of the status of nursing and midwifery in the Region in 2015, to provide clear strategic directions for strengthening this area of work. A framework comprising a list of priority actions will be recommended, taking into account the range of challenges encountered by the different groups of countries. Reinforcing nursing and midwifery will continue to be a priority for WHO in 2015 and over the coming biennium.

Two key achievements were made in the area of health information, which is so critical to health planning and policy development and implementation. The Regional Committee took an important step forward in 2014 with the endorsement of the framework for health information systems and the core indicators. This product was the result of intensive work over the past 2 years with different sectors in Member States and international experts. All countries need to strengthen their health information systems and the challenge for all of them is to implement the framework and to address the gaps in generating and using data for the 68 core indicators. Assisting countries in this task will be the main task for WHO during the next biennium.

The second achievement was the work done so far in strengthening civil registration and vital statistics systems, with special focus on improving the reporting of cause-specific mortality. Rapid assessments were completed in all countries and comprehensive assessments in 17 countries. Our region currently has the most comprehensive information on the status of CRVS in Member States. Countries have been informed of the existing gaps and urged to address them based on the regional strategy, endorsed by the 60th session of the Regional Committee. While we expand the regional capacity in collaboration with other UN agencies, further focus is required within the health systems on the generation of valid mortality and cause of death data.

2014 has also been an important period for WHO management reform as we continued to implement our commitment to greater effectiveness, accountability and transparency. The timely preparation of the programme budget for 2016–2017, and the early involvement of partners through the bottom-up approach, resulted in improved joint planning, a more focused number of identified priorities and a budget allocation in line with countries' priorities. An improvement in priority-setting and planning skills has been evident.

We continued to support the strengthening of Member State's participation in the governance of WHO, providing high-level briefings for representatives of Member States and permanent missions in Geneva prior to each major meeting of WHO's global governing bodies – the World Health Assembly and the WHO Executive Board. These briefings have proved their value in the

contribution of Member States of the Region in the global discussions on health and the work of the governing bodies.

Efforts to strengthen WHO country presence also continued, with emphasis on improving technical expertise and overall management. Country office capacities were assessed in relation to the six categories of work to ensure the presence of strategic and technical leadership capabilities. 2014 saw a significant expansion in technical capacity in several country offices, while in 2015 we have focused on enhancing general management and administrative capacity in the field. A specific strategy was developed to increase compliance in a number of areas of our work, across all our offices, including performance management and adherence to staff rules and regulations. Improving compliance will remain a top priority over the coming years.

The complexity of the operational and security issues in the Region continues to create challenges and constraints for WHO operations, both technically and managerially. The situation in the Region generally has also had an adverse impact on our ability to attract new experienced staff to handle the growing workload and response needs in all areas of our work with Member States. While we are taking steps to address this, we also took steps to support the future needs of countries in several key areas.

Strengthening public health capacity in Member States continued to receive priority. Following the launch in 2013 of a regional initiative to assess public health capacity in countries, two country assessments were successfully conducted, with the support of WHO and a team of international public health experts. The assessment tool was reviewed in early 2015 and will be further refined prior to expanding the initiative further. An increasing number of Member States are asking WHO to conduct the assessment and assist them in implementing its recommendations.

A leadership for health programme was also launched, in early 2015, with the aim of developing future public health leaders who can address, in a proactive way, national and local health problems that have direct impact on population health, and play active roles in the global public health sphere. The first four-week course, conducted in two parts in two locations (Geneva and Muscat), was a great success and highly rated by the participants. The second course will commence towards the end of 2015.

We have also continued to host the annual regional seminar on health diplomacy. This has proved highly successful in bringing together representatives of health and foreign affairs, parliamentarians and academia in discussions around the intersection between health and other sectors. Successive seminars have shown the continuing importance of this kind of dialogue for raising awareness and understanding of the key health issues facing our world, and the role that all sectors have in health diplomacy, globally, regionally and nationally. We will continue to support countries in their efforts to build this capacity and in their efforts to improve the health of the people in the Region.

Ala Alwan
WHO Regional Director for the
Eastern Mediterranean

Strengthening health systems for universal health coverage

Universal health coverage

In 2014 WHO focused on providing Member States with technical support in implementing the commitments made in Regional Committee resolutions EM/RC59/R.3 (2012) and EM/RC60/R.2 (2013). A framework for action for progressing towards universal health coverage, and linking the various commitments, was supported by the Regional Committee in its 61st session in October 2014.

Health financing

Health financing strategies that are evidence-based and context-specific are essential to pursuing the goal of universal health coverage. The lack of information about the institutional and organizational arrangements of the health financing systems and the flow of funds in several countries of the Region hampers efforts to develop evidence-based health financing strategies. In addition, the limited national expertise in health financing in general, and in specific health financing arrangements such as social health insurance, in particular, is critical to moving ahead.

WHO support in developing health financing strategies involved building national capacity in generating quantitative and qualitative information by following national health accounts and the OASIS (organizational assessment for improving and strengthening health financing) approach, respectively. The focus of technical support shifted from advocacy for health financing to skills development in areas such as establishment of social health insurance programmes, strategic purchasing and multisectorality and universal health coverage, by organizing regional consultations and developing policy papers. The capacity of a pool of experts and researchers is being developed in the areas of measurement of financial risk protection, as part of monitoring progress towards universal health coverage, and in undertaking economic evaluation studies.

Country-level technical support was provided to several countries to formulate a national vision, strategy and roadmap to move towards universal health coverage. This was preceded by several diagnostic studies as related to the various health financing functions.

The work in 2015 will continue to focus on key interventions for action towards universal health coverage, including a national vision, strategy and roadmap for universal health coverage that is fully integrated within the national policy framework, expansion of social health insurance schemes, extending financial protection to the informal and vulnerable segments of the population and reduction of out-of-pocket payments.

Health governance and human rights

Evidence-informed policies, strategies and plans are a cornerstone for progressing towards universal health coverage. Most countries do not have adequate capacity in ministries of health to formulate evidence-informed policies and

strategic plans, and have limited access to, and use of, quality data for informing policy and strategy development. The current political instability and social crisis seen across much of the Region, and the limited alignment and harmonization among development partners to support one national health plan, are some of the additional challenges faced by several countries in groups 2 and 3[2].

Ongoing efforts to assess the status of national health planning has provided a better picture of the overall strengths, weaknesses and challenges facing health policy and planning in ministries of health. In an effort to build the capacity of WHO country offices to support countries in their national health policy formulation and planning processes, senior WHO staff attended workshops on strategic health planning, conducted in collaboration with the Nuffield School of Public Health and Centre for International Development, University of Leeds, United Kingdom. It is planned to build national capacities in strategic health planning and health sector regulation, and to review, in selected countries, the status of coordination among development partners and the effectiveness of external assistance.

The Region has longstanding challenges in relation to gender equality, equity and human rights in health. Extended conflicts, rising levels of poverty, varying degrees of inequity and the existence of vulnerable and marginalized groups are important underlying factors. The lack of disaggregated data and vulnerability assessment to inform public health policies and guide actions through a "human rights lens" continues.

A review of the existing evidence and gaps and continued advocacy have helped to better integrate gender, equity and human rights across the work of the Organization. A course on health and human rights was developed and piloted in Egypt in collaboration with the American University in Cairo. The course has been externally evaluated and is being conducted in Pakistan and offered to other countries in 2015.

Public health law and legislation need updating, and the capacities of ministries of health in formulating, implementing and monitoring legislation need strengthening. A review of the status and capacities for regulating the private health sector was completed in four countries and a manual is currently being developed in collaboration with WHO headquarters.

During 2015, the focus will be to build ministry of health capacities in strategic planning through training of national staff and through provision of user-friendly guidance for developing effective strategic plans. Attention will be given to capacity-building in health legislation, regulation, standard-setting and enforcement, with focus on the private sector. The effectiveness of external assistance and the status of aid flow in countries, particularly those facing conflict situations, will be assessed.

Further to the request of Member States, WHO launched a regional initiative in 2013 to assess public health capacity in countries, through identification of essential public health functions relevant to the context of the Region. In 2014, two country assessments were conducted, in Qatar and Morocco, with the support of WHO and a team

[2] Three groups of countries are defined in the Region, 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, Palestine, Syrian Arab Republic and Tunisia; group 3: Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen.

of international public health experts. Through this assessment, countries led by their ministries of health, are able to identify the strengths in their public health systems as well as areas that require reinforcement. In May 2015 WHO brought together a small group of international public health experts and representatives from the two countries that conducted the assessment to discuss the experience, review the tool and refine the assessment and follow-up process. Currently, the assessment tools are being revised to make them more user friendly, following which the initiative will be offered to other countries.

Health workforce development

The health workforce situation continues to reflect global trends with regard to numerical shortages, inequitable distribution, retention and performance. Overall health workforce density is suboptimal and maldistribution, retention, migration and over-dependence on expatriate health workforce are daunting challenges that impede progress towards universal health coverage in several countries. Lack of institutional capacity for national health workforce planning is another impediment and information sources are inadequate.

While the gaps in the development of the health workforce are clear, solutions to address these gaps are not always clear. To respond to this challenge, a regional strategic framework for health workforce was developed, following a critical review by a group of international experts and a regional consultation to help move the health workforce agenda forward. The framework will be aligned with the global workforce strategy that is currently being developed by WHO headquarters and the Global Health Workforce Alliance.

After a gap of almost two decades, the area of medical education was revisited and a comprehensive online survey undertaken targeting over 300 medical schools. Among other things, the survey confirmed a move towards the privatization of medical education, while also showing inadequate regulation, lack of accreditation systems, teacher-centered curricula, and use of traditional assessment methods unlinked to learning outcomes and competencies. The results were presented at a meeting of regional and international leaders in medical education. A road map was developed to guide medical schools in becoming more socially accountable, community-oriented and accredited, in support of universal health coverage. The subject of medical education will be discussed by the Regional Committee at its 62nd session, following which countries will be expected to adapt the regional action framework based on national priorities.

Plans are under way to carry out a comprehensive review of the status of nursing and midwifery in the countries of the Region. The review is aimed at providing clear strategic directions based on practical and feasible actions that are evidence-

Photo: ©WHO

↑ The Regional Director participated in the ninth annual meeting of the International Association of National Public Health Institutes in Morocco to encourage networking and development of collaborative programmes in the Region

Photo: ©WHO

Photo: ©WHO

↑ **WHO's Leadership for Health programme, aimed at developing future public health leaders in the Region and developed in partnership with Harvard School of Public Health, was conducted in Geneva and Oman**

based and guided by reliable information and good practices.

Technical support was provided to the Arab Administrative Development Organization of the League of Arab States for the conference on migration of health workers. The Regional Office participated in the ninth annual meeting of the International Association of National Public Health Institutes, which was held for the first time in the Eastern Mediterranean Region. A side-meeting of regional public health institutes was organized to encourage networking and development of collaborative programmes to strengthen public health in the Region.

The fellowships programme continued to support countries in building national capacities in the five regional priority areas, with 74 fellows benefiting from across the Region. The programme was closely involved in organizing the Leadership for Health programme in collaboration with the Harvard School of Public Health. This was launched in early 2015 with the aim of developing future public health leaders who can address, in a proactive way, national and local health problems that have direct impact on population health, and play active roles in the global public health sphere. The programme was conducted in two parts, in Geneva and Muscat, and both components were highly rated by the participants and facilitators. Based on initial success and high demand, the second round of the programme will commence in November 2015.

Particular emphasis will be given in 2015 to helping countries develop national health workforce strategies and action plans, and to implement the strategies to strengthen medical education and nursing and midwifery. New initiatives will include assessment of continuous professional development for physicians and improved reporting by countries on the implementation of the WHO Code of Practice for the International Recruitment of Health Personnel.

Essential medicines and technologies

Pharmaceutical sector country profiles developed during 2014 highlighted gaps in key areas related to regulatory authorities for medicines, including: organizational structure and technical capacity; national medicines policies; transparency and accountability in regulation and supply of medical products; mechanisms to contain antimicrobial resistance; promotion/advertising of medical products; and access to controlled medicines, including medicines for pain management.

Photo: ©WHO

↑ WHO supported training on good manufacturing practices for junior inspectors of pharmaceutical facilities in Saudi Arabia

Approaches to strengthening regulatory capacity for medicines and medical devices were discussed during the Eastern Mediterranean Drug Regulatory Authorities Conference held in May 2014. Prior to the conference, a survey of 17 national regulatory authorities revealed that the majority (80%) of authorities have core regulatory functions in place and all are responsible for the registration of medical products. Only 40% of national regulatory authorities undertake fast-track registration of WHO prequalified medicines whereas 80% undertake fast-track vaccine registration.

Work progressed in good governance for medicines in 16 countries. In a regional meeting focus was placed on conflict of interest management as a priority issue in governance policies. The good governance for medicines programme in the Region is the most developed among all WHO regions, with 6 countries in phase I; 7 in phase II and 3 in phase III. The updated pharmaceutical sector profiles for all countries revealed that access to controlled medicines for pain management and mental disorders remains very limited and patients are therefore suffering when they should not have to. Progress was made in the area of health technology assessment, regulation and management with the creation of the Eastern Mediterranean Regional Health Technology Assessment Network for information exchange and knowledge sharing. This was an outcome of the second intercountry meeting on development of national health technology assessment. A regional survey was conducted to map health technology assessment resources. The survey, which targeted health technology-related officials and champions in 15 countries, showed that 52% of regional entities perform assessment-like actives that are mainly related to measurement of clinical effectiveness and economic evaluation of medical devices and medicines. The survey indicated the need to re-organize and/or initiate assessment activities in the Region in order to make rational investments to health technologies that are accessible for the majority of the population.

In 2014, the first two medical products produced by a local pharmaceutical company in Egypt and the first medicine quality control laboratory in the private sector in Pakistan were prequalified by WHO. National medicine quality control laboratories in two other countries are in the process of becoming prequalified by WHO.

In 2015, focus will be placed on the implementation of Health Assembly resolutions on strengthening regulatory systems for medical products, including strengthening pharmacovigilance. Reporting on counterfeit medical products will be strengthened. In line with the global action plan on antimicrobial resistance, support will be provided for development of national plans to strengthen surveillance of antimicrobial resistance and the responsible use of antimicrobial medicines.

Integrated service delivery

Most countries in the Region are committed to strengthening family practice. However, implementation is uneven and inconsistent. An assessment of the status of family practice revealed significant gaps in terms of political commitment, patient registration, packages of essential health services, essential medicines lists, referral systems and staff. Another big challenge is the insufficiency of trained family physicians and the inability of current training programmes to meet the enormous needs.

A lack of quality care at primary health care level and the unregulated expansion of the private health sector in most group 2 and 3 countries pose additional challenges. Public sector hospitals consume a significant proportion of health budgets, do not meet standards of quality and safety in many countries and in others are increasingly dependent on user fees. Hospitals are generally not integrated within the health system and do not provide referral support.

Family practice has been promoted as the principal approach to achieving people-centred integrated services. A situation analysis of the current status of family practice programmes and

Photo: ©WHO

↑ A WHO mission to Islamic Republic of Iran assessed service provision at hospital and primary health care levels

training for family physicians was presented at a regional consultation organized in collaboration with the World Organization of Family Doctors. The results of this situation analysis revealed that most countries have developed, and just over half are implementing, an essential package of services, a system of patient registration and family/individual folders is practised in half the countries, and the referral system is partially or fully functional in five countries. However, more than 90% of physicians working in primary care facilities are not trained in family medicine. Family medicine departments are available in 13 countries and the annual output of family physicians is 700, the majority of whom are from group 1 countries.

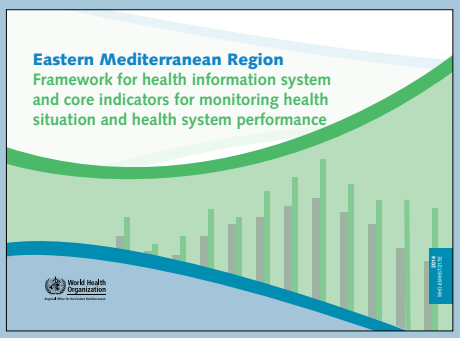
A roadmap was developed to strengthen service delivery through the family practice approach and is aligned with the framework for action for progressing towards universal health coverage. During 2015, the work on scaling up family practice as the principal approach to people-centred integrated health care will continue to be promoted. A particular task will be to share evidence on how to scale up the production of family physicians in the short and medium term.

Several studies were also undertaken to better understand the private health sector, including assessment of the quality and cost of care in the private health sector in six countries and of the status of private sector regulation in four countries, as well as a review of the lessons in public–private partnership. These studies were presented at a regional consultation which resulted in identification of a number of priorities in regard to work with the private sector.

A regional consultation on addressing the quality and safety of care was organized in collaboration with the Central Board for Accreditation of Healthcare Institutions, Saudi Arabia. The *Patient safety assessment manual*, published in 2011, was updated and field tested in two countries and a tool kit for patient safety was developed. A framework for assessing and improving quality at the primary care level is currently being piloted. Capacity building will be intensified in the areas of patient safety and quality, assessment, regulation and partnership with the private health sector and hospital care and management.

Hospital care and management is a new area of work that is being given increasing attention. The focus has been to develop a comprehensive analysis of the status of public sector hospitals in the Region. A course on hospital management was offered in collaboration with the Aga Khan University, Karachi, for countries in conflict. The course is being updated and will then be rolled out to the Region.

Technical support was also provided to eligible countries for new applications for support from the Gavi, The Vaccine Alliance for health system strengthening worth US$ 85 million. Concurrently, health system capacity development workshops were conducted in order to build capacity of programme managers from these countries.



↑ ***A framework for health information systems and core indicators***

Health information systems

Intensive work took place in reviewing health information systems in the Region through expert consultations, intercountry meetings and rapid and comprehensive assessments. Gaps and challenges were identified and an approach was developed to strengthen the national health information systems. The resultant framework for health information systems and core indicators, which were endorsed by the Regional Committee (EM/RC61/R.1), will provide clear guidance for countries. The regional health information framework and its core indicators cover three areas: health risks and determinants, health status and health system performance.

The emphasis placed on strengthening cause-specific mortality statistics, as recommended in the regional strategy to strengthen civil registration and vital statistics systems endorsed by the Regional Committee in 2013, resulted in an increase in the number of countries reporting mortality statistics, from 7 countries (Bahrain, Egypt, Jordan, Kuwait, Morocco, Oman and Qatar) to 12 countries (with the addition of

Photo: ©WHO

↑ The Regional Director met with Prime Minister HE Dr Rami Hamdallah to review strategic directions and future collaboration for the Palestinian National Institute of Public Health, a WHO-led project

Islamic Republic of Iran, Palestine, Saudi Arabia, Tunisia and United Arab Emirates). The quality of information reported improved somewhat but there is still work to be done to obtain optimal quality. A WHO collaborating centre was established in Kuwait to support further improvement in mortality statistics and better use of the WHO family of international classification.

In the next two years, WHO is committed to supporting Member States in their endeavours to strengthen their health information systems, based on the new framework, and provide reliable information that will enable them to monitor health determinants and risks and health status and assess health system response, which, in turn, will inform policy and decision-making for better health care delivery. WHO will also continue to support Member States in addressing the gaps in their civil registration and vital statistics systems, which were demonstrated by the rapid and comprehensive assessments conducted over the past two years.

Research development and innovation

A regional meeting was held for members of the Eastern Mediterranean Advisory Committee on Health Research and research experts to discuss integrating research in shaping the future of health in the Region. The meeting focused on the identification of research priorities related to the five regional strategic priorities. This exercise is expected to conclude in January 2016 and the results will guide research activities for 2016–2017. The call for proposals for the special grant for research in priority areas of public health for 2104 was also focused on the strategic priorities. Twelve awards ranging from US$ 10 000 to US$ 20 000 were granted in early 2015.

Promoting health across the life course

The life course approach

Health is the outcome of all policies, including those related to social determinants of health. In 2014, WHO continued its efforts to support countries in protecting and promoting the health, safety and well-being of the population in the Region, across the life course with special focus on maternal and child health as a strategic priority.

Maternal, reproductive and child health

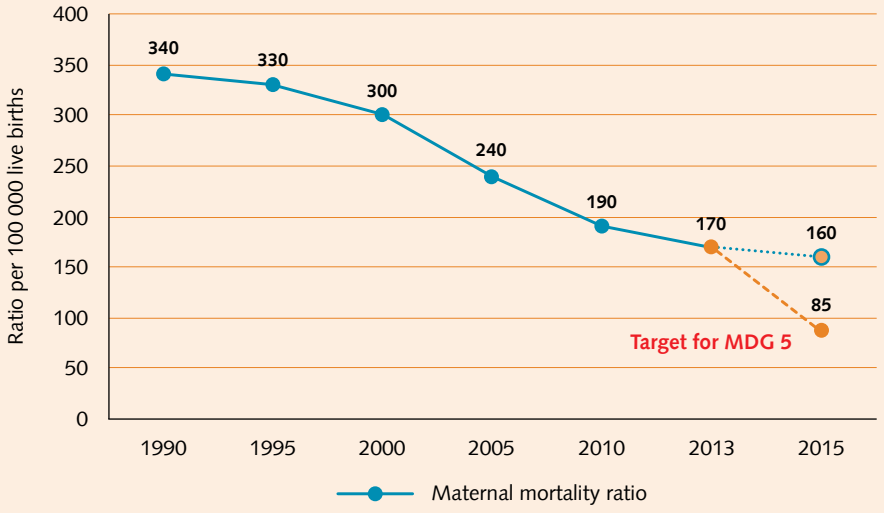
Between 1990 and 2013, maternal mortality ratio decreased by 50%, and under-5 mortality rate decreased by 46% in the Region (see Figs 1 and 2). The level of maternal mortality shifted from second highest to third highest among WHO regions, after the Africa and South-East Asia regions. Despite these achievements, the levels of reduction fall short of meeting the targets of Millennium Development Goals (MDGs) 4 (67% reduction in under-5 mortality rate) and 5 (75% reduction in maternal mortality ratio) by 2015. Moreover 26 000 mothers and 845 000 children under 5 years of age still die every year in the Region. Around 95% of these deaths occur in nine Member States with high burdens of maternal and child mortality.

Several factors contribute to the high maternal and child mortality. Weak health systems with lack of adequate numbers of well trained human resources and unsustained availability of necessary commodities, and non-functioning referral systems represent a major challenge in the high-burden countries. The situation is compounded by political instability, social unrest, and the protracted acute and chronic crises that affect these countries.

Photo: ©WHO

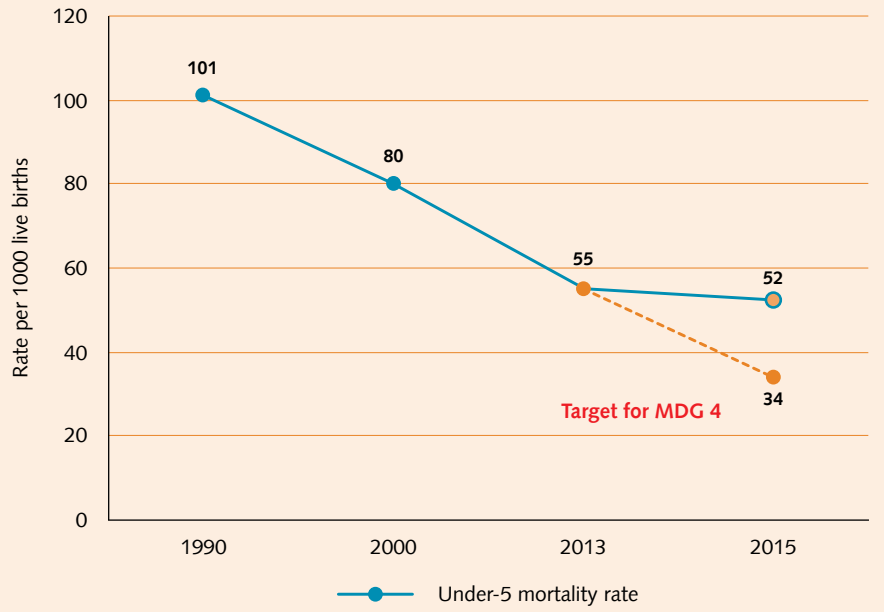
↑ The Regional Director congratulates Prime Minister HE Mr Abdiweli Sheikh Ahmed on the launch of Somalia's national maternal and child health acceleration plan

In 2014, the Regional Office maintained its support to reproductive, maternal, neonatal, child and adolescent health, with specific focus on maternal and child health in the nine priority countries, in close collaboration with UNFPA and UNICEF. The funds WHO allocated in 2013 to kick-start implementation of the national acceleration plans were absorbed by the end of September 2014. They were used to support the implementation of priority activities, including: capacity-building of health providers, procurement of life-saving commodities and strengthening of community-based interventions. All nine countries identified maternal and child health as priority programmes for the biennium 2014–2015 and so a further US$ 7 million were made available for implementation through the WHO collaborative programme. In addition, US$ 7 million and US$ 10 million were made available from trust fund resources to support



Source: Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. *Geneva: World Health Organization; 2014*

Fig. 1
Maternal mortality trend 1990-2013 and extrapolation to 2015



Source: Levels and trends in child mortality. Report 2014. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. *Geneva: UNICEF, WHO, World Bank, United Nations Population Division; 2014.*

Fig. 2
Under-5 mortality trends: 1990–2013 and extrapolation to 2015

relevant priority activities in Afghanistan and Pakistan, respectively.

The current status and challenges facing countries in the maternal, neonatal and child health area, including the main causes of maternal, neonatal and child mortality in the Region, were reviewed at an intercountry meeting for national programme managers, held jointly with UNFPA and UNICEF in June 2015. Based on this meeting, priority actions were identified for facilitating the implementation of acceleration plans in 2015, as well as strategic directions for reproductive, maternal, neonatal, child and adolescent health programmes post-2015. WHO maintained close follow-up and support for the implementation of the plans and provided technical support to cover gaps identified through country missions. Special attention is being given to strengthening the health system-related elements. These include analysing the availability of human resources for maternal and child health services, assessing services for quality and infection control, and promoting operational research activities to address gaps in the health care delivery system.

Supporting countries in establishing and strengthening preconception care is another priority for WHO's work in the Region. The aim is to further improve maternal, neonatal and child health outcomes in Member States. A meeting held with Member States and international and regional experts resulted in consensus on a set of core interventions and service delivery channels for preconception care services. Further work is planned in 2015 to examine in more depth the evidence base relating to the interventions and to develop a regional operational framework.

WHO, in collaboration with partners, embarked on analysis of achievements in countries with regard to MDGs 4 and 5. The analysis indicates

Photo: ©WHO/Rada Akbar

↑ **WHO supports mobile medical services in several countries, such as here in Afghanistan where antenatal care is not accessible to remote populations**

that seven countries have achieved low maternal and child mortality levels, of which six have achieved MDG 4 and two have achieved MDG 5. Taking this into account, five countries in addition to the nine priority countries should receive further focus on maternal and child health up to the end of 2015. The crisis in several countries has seriously affected achievements previously accomplished. Innovative approaches are required to address the health needs of mothers and children in this situation. Even in countries with low maternal and child mortality levels, strategic plans are required to sustain existing achievements and implement targeted interventions to further reduce maternal and child mortality, especially neonatal mortality.

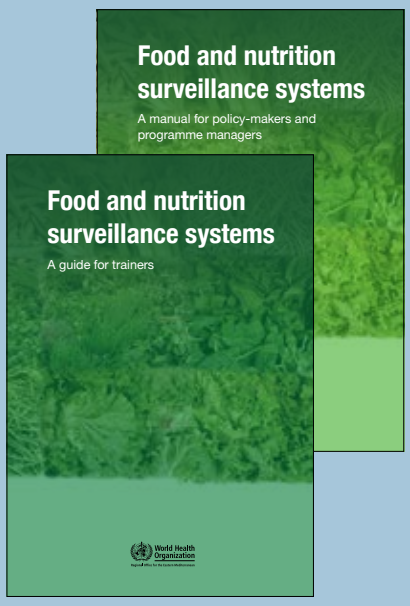
Only a few months remain to report on MDG achievements. Of the nine priority countries, several will still have high mortality levels but will have demonstrated significant progress, thanks to joint and intensified efforts. It will be critical to continue these efforts, and to prepare appropriate plans based on the post-2015 development agenda. The commitment and involvement of Member States will be essential in driving the post-2015 agenda debate and in addressing priorities related to saving the lives of mothers and children. The updated global strategy for women's, children's and

adolescents' health, which will be launched at the UN General Assembly in September 2015, builds on the 2010–2015 strategy, with lessons learned from the Millennium Development Goals, and focus on the evidence for effective investment and action. It will target equity, human rights and social determinants of health. Member States will need to align their strategic directions to this strategy and to the five-year implementation plan which will be proposed for formal endorsement at the World Health Assembly in May 2016.

Nutrition

Nutrition indicators in the Region continue to be alarming. Countries are struggling with high rates of malnutrition, poor feeding practices, micronutrient deficiencies and obesity. Malnutrition contributes significantly to child mortality. It is the main underlying cause of death in children under 5 years of age, causing 45% of all child deaths in the world, as well as the Region, in 2013. Anaemia, which impairs health and well-being in women and increases the risk of adverse maternal and neonatal outcomes, affects about 40% of women of reproductive age in the Region. WHO is working with Member States to implement the comprehensive implementation plan on maternal, infant and young child nutrition and its global targets, which were endorsed by the World Health Assembly in 2012.

With regard to undernutrition among children under 5 years of age, the weighted regional average is 28% for stunting, 8.71% for wasting and 18% for underweight. The countries of the Region with the highest burden of stunting and underweight are Afghanistan, Djibouti, Pakistan, Sudan and Yemen, where the prevalence of stunting ranges between 33.5% and 46.5% and the prevalence of underweight ranges between 25% and 39%. The annual rate of change in the prevalence of stunting indicates that several countries (Egypt, Lebanon, Morocco and Palestine) are on track towards meeting the 2025 target related to stunting



↑ *Recent publications on nutrition*

Despite global commitments to promotion of exclusive breastfeeding, its practice in the Region is still as low as 34%. The level of implementation of the International Code of Marketing of Breast Milk Substitutes remains below the global target (50%). A regional assessment conducted in 2014 showed that only five countries are fully implementing the code, 10 countries are partially implementing it and six are not implementing it. A regional consultation was held to discuss ways of accelerating implementation of the Code. This resulted in a regional policy statement and action plan on the urgent need to fully implement the Code and relevant World Health Assembly resolutions, which were disseminated to all ministries of health for implementation. WHO is working with countries to monitor implementation of the plan.

Regionally, overweight and obesity in children under 5 years of age increased from 5.8% to 8.1% between 1990 and 2012, which is above the global average of 6.7%. Overweight and obesity in adolescents (13–15 years) are highly prevalent, particularly in group 1 and some group 2 countries. Most countries in these groups have rates of overweight and obesity above the global median value of 21.7%. Data are currently only available for two age-groups in the Region: under 5 years and 13–15 years.

The challenges facing the nutrition programmes in the Region, especially in group 3 countries, are enormous. There is a pressing need to raise the commitment and priority given to nutrition in all countries. An intercountry meeting on nutrition was held in June 2015 to guide Member States on how to implement the recommendations of the Second International Conference on Nutrition (ICN-2). A set of seven priority initiatives was identified during the meeting. A regional framework will be developed in 2015 to translate the priorities into concrete action for implementation over the next biennium and beyond.

Ageing and health of special groups

Despite competing priorities several countries took steps to strengthen efforts in the field of active and healthy ageing and health of special groups. Countries are directing specific attention to strengthening programmes on active and healthy ageing and implementing the global plan of action on workers' health. The age-friendly primary health care initiative has been implemented in some countries and the outcomes are being made use of to improve the performance of the programme.

Technical support was provided to the Gulf Cooperation Council (GCC) countries to develop mechanisms for applying the occupational and environmental health standards for accrediting hospitals and other health care facilities, with clear roles identified for concerned stakeholders. A detailed action plan with process indicators and timeline was developed for scaling up workers' health services in these countries. Collaboration with the mental health programme continued with the aim of strengthening psychosocial services in the school health environment and institutionalizing school mental health promotion and services. The prevailing complex emergency situation in 16 countries of the Region underlines the need for school health programmes to incorporate a mental health component. A training package for teachers was finalized and peer-reviewed by external reviewers and during a regional consultation held in Cairo and will be tested in five countries. In light of the importance of schools as an entry point for several public health interventions, the need for developing integrated criteria for healthy schools is increasing. Work towards this direction is being continued and a new initiative will be launched during the second half of 2015.

Violence, injuries and disabilities

The Region ranks second among WHO regions in terms of road traffic fatality rate (21.3 per 100 000 population compared to a global rate of 18.03 per 100 000 population). While the majority of deaths occur in middle-income countries, the high-income countries have the highest fatality rate among similar countries across the world. Road traffic injury is clearly a grave concern for all countries of the Region regardless of their income level. Serious gaps

persist in the comprehensive implementation of proven cost-effective interventions. While some aspects of these interventions have been applied by the majority of countries, they have not been implemented as a package that covers all essential elements. This has a serious impact on their effectiveness.

Challenges include inadequate political commitment, insufficient coordination and multisectoral action, weak enforcement, implementation and evaluation of policy and legislative frameworks, widespread under-reporting and fragmented data systems, as well as significant gaps in post-injury trauma care and limited rehabilitation services. The health sector has yet to fully assimilate its role in injury prevention and control.

A regional planning meeting for injury prevention focal persons of ministries of health was held at which countries identified priority activities for incorporation in their national plans. A regional framework for road safety action was developed in consultation with countries. Countries completed the reporting exercise for the 2015 global status report on road safety which will monitor progress across the Decade of Action for Road Safety 2011–2020. A standardized methodology for estimation of the cost of road traffic injuries was developed and will be tested in 2015. A regional instrument to profile trauma care systems was tested in three countries, paving the way for expansion to others.

A high-level meeting on road safety is planned for early 2016 to increase political commitment and agree on concrete actions for accelerated progress in the second half of the Decade of Action. In preparation for this meeting, an expert consultation will be held to finalize the specific framework for action and to review the resource document for the meeting, which is being developed by WHO with Johns Hopkins Bloomberg School of Public Health. This document will present the most information on the burden of road traffic injuries in the Region as well as action-oriented recommendations for the three groups of countries, building on WHO related work, including the global status report 2015, and taking into consideration recent global developments such as the new sustainable development goals.

Photo: ©WHO/Sini Ramo

↑ **The Government of Afghanistan launched its first treatment protocol for health care providers to strengthen the health sector response to gender-based violence**

In the area of violence prevention, the *Global status report on violence prevention 2014* provided, for the first time, information on different aspects of violence prevention and control from 16 countries of the Region, representing 63% of the population. The report shows that the Region's low- and middle-income countries rank third (7 per 100 000 population) in terms of homicide rate, among similar countries in all WHO regions. Many of the prevention strategies surveyed were shown to be available. However, their implementation needs to be evaluated. In 2015 national policy dialogues will be conducted in three countries around the findings of the global report, in order to develop clear action plans to address the gaps identified.

↑ ***Recent publications on primary eye and ear care***

The draft global plan of action to strengthen the role of health systems in addressing interpersonal violence, in particular against women and girls, and against children was reviewed in a regional consultation. In preparation for implementation, a stakeholder analysis, as well as mapping of the current situation and efforts to address violence against women and girls and against children, will be pursued.

Since the launch of WHO's global initiative Vision 2020: the right to sight, there has been progress in a number of countries in developing and strengthening eye care services, including raising public awareness and uptake, integration into primary health care and inclusion of relevant indicators into health information systems. However, there is a lack of systematic evidence of the impact of the actions taken by countries on prevalence of avoidable blindness. More than half of countries (Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia and Sudan) have developed or are in process of developing national eye health plans in line with the WHO global action plan towards universal eye health, following regional capacity-building conducted in collaboration with the International Agency for the Prevention of Blindness – Eastern Mediterranean Region. Generally, the public sector in Member States is still not investing enough in the prevention and control of blindness and visual impairment.

Achieving the goal of eliminating avoidable blindness by 2020 will depend on the ability of health systems to scale up efforts. This will require development and integration of eye health care into the general health system in line with the global action plan 2014–2019 for universal eye health.

Health education and promotion

The Region has the highest prevalence of physical inactivity among adults globally. Following recommendations of the World Health Assembly and Regional Committee, a high-level multisectoral regional forum on a life-course approach to promoting physical activity was held in Dubai, United Arab Emirates. The outcome was a regional call to action on physical activity, with a set of interventions for specific sectors. A regional advisory committee was established to support implementation of the call to action.

A survey on assessing national capacity to develop and implement physical activity policies and programmes was expanded from 12 to 16 countries. In 2015, WHO focused on building national capacities in the development of national multisectoral plans of action on physical activity

↑ *Recent publications promoting physical activity*

and in development of plans for social marketing and mass media campaigns. In addition, in partnership with the WHO Collaborating Centre on Physical Activity, Nutrition and Obesity, Sydney, Australia, a training package was developed on mass media and social marketing on physical activity and healthy diet, to support countries in implementing the related "best buys".

Social determinants of health and gender

In the current biennium (2014–2015), 14 countries have social determinants of health in their work plans, focusing mainly on implementation of the Rio Political Declaration on Social Determinants of Health; effective integration of social determinants of health within health programmes; and strengthening country capacity to implement health-in-all policies, intersectoral action and social participation to address social determinants of health.

A preliminary analysis was prepared by WHO and the Institute of Health Equity linking the social and environmental determinants of health to health inequities. The review revealed wide inequities within and across countries. Challenges identified included low political commitment, inadequacy of inequity data and weak intersectoral collaboration.

In a technical meeting on social determinants of health and health inequities prior to the 61st Session of the Regional Committee, Member States concluded that the five key health priorities in the region cannot be effectively tackled without addressing the social determinants of health. They requested WHO to provide clear strategic directions and guidance to strengthen

intersectoral action and whole-of-government policies and address health inequities. Following a regional consultation held in the Islamic Republic of Iran in early 2015, four countries are currently participating in a pilot project to conduct an in-depth analysis on social determinants of health as a starting point.

Health and the environment

In 2013 the Regional Committee endorsed a regional strategy on health and the environment and framework for action 2014–2019. Although only nine countries indicated environmental health as a priority in 2014–2015, most countries of the Region conducted activities related to protecting public health from environmental risks. The risk-based assessment and management approach of the WHO guidelines on drinking-water quality and wastewater reuse was promoted and adapted to serve the specific regional and national needs. So far, 15 countries have updated their national standards for drinking-water quality in accordance with the guidelines, and a pilot project on wastewater use in agriculture was carried out in Jordan. Preventative water safety plans are adopted in eight countries and 11 countries strengthened their national monitoring of the water and sanitation sector under the framework of the UN-Water Global Analysis and Assessment of Sanitation and Water (GLAAS). All countries participated in the WHO/UNICEF Joint Monitoring Programme on water and sanitation the outcome of which shows that the large majority of countries have achieved or are on-track to achieve the targets of MDG 7 on water and sanitation.

The public health response to climate change and air pollution was discussed in the technical meetings prior to the 61st Session of the Regional Committee, as well as at a regional expert consultation. Member States are committed to tackling these environmental health risks within the context of the public health system, in partnership with other stakeholders. Environmental and occupational health standards for accreditation of health care facilities were developed and adopted by the GCC countries.

Development of guidelines for food safety, legislation and promotion of the global Codex Alimentarius were carried out in the Region in 2014. Several countries strengthened their capacity in the area of food safety sampling, inspection and control. A regional food safety assessment initiative was launched, which aims to profile up to 16 countries by end of September 2015. The aim is to assess strengths and weaknesses in the national food safety systems and to identify the priority actions required to address gaps identified. This "farm-to-fork" initiative will augment the capacity of countries to prevent, detect and manage foodborne health risks and outbreaks.

To support emergency preparedness and response in the Region, regional revolving stocks of key

Photo: ©WHO

↑ More than 200 public health inspectors were trained in Lebanon on standard food sampling and inspection based on good manufacturing practice and WHO standard checklists

environmental health supplies were established in Pakistan and United Arab Emirates, while many countries are now making use of the disease early warning system (DEWS) to monitor and predict environment-related diseases. Capacity-building was conducted for health service providers in eight countries on response to chemical accidents and on trauma care following exposure to harmful chemical agents. Scientific resources and training materials were made available in several languages. National preparedness and response capacities for chemical, radionuclear and food safety events were strengthened in line with the International Health Regulations (2005).

Photo: ©WHO Regional Centre for Environmental Health Action

↑ During a course on chemical exposure and trauma care organized by the Regional Centre for Environmental Health Activities (CEHA), participants from the Region were trained as first responders to chemical incidents

Noncommunicable diseases

Regional framework for action

Focus continued to be placed on scaling 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, based on the regional framework for action. Since its endorsement by the Regional Committee, in 2012, the framework has been updated annually and a set of process indicators, intended to guide Member States in measuring progress in implementing the strategic interventions, has been developed.

This region has been very engaged, and has taken important initiatives, in the follow-up to the global strategy and the 2011 Political Declaration. In 2014, the second annual regional meeting provided an opportunity for Member States not only to review the progress made in implementing the regional framework for action but also to provide an important contribution to the Member States' discussions in New York to prepare the outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases. Most of the recommendations made by Member States of the Region to the facilitators and Member States in New York were reflected in the final outcome document endorsed by the high-level meeting in July 2014. The only exception was the recommendation requesting the establishment of a monitoring mechanism, based on a specified set of indicators, to assess the progress made by countries between 2014 and the next review meeting of the General Assembly in 2018.

Photo: ©WHO

↑ A panel of experts discussed prevention of noncommunicable diseases during the Sixty-first Session of the Regional Committee in Tunis, Tunisia

The critical importance of establishing such a monitoring mechanism was subsequently raised again by Member States during the 61st Session of the Regional Committee in October. A resolution was passed inviting the WHO Executive Board to request the Director-General to publish a technical note, before the 68th World Health Assembly, on how WHO will report to the United Nations Secretary-General on the progress made by countries for submission to the next high-level meeting in New York in 2018. The process indicators set out in the regional framework contributed to the final technical note issued by the Director-General in May 2015.

In the meantime, WHO has been working very closely with Member States on several important initiatives to implement the key commitments included in the four areas of the regional framework for action: governance, surveillance, prevention and health care.

Governance

While 38% of countries have an operational multisectoral strategy and/or action plan for noncommunicable diseases, only one fifth have set targets for 2025 based on the WHO guidance on fulfilling the time-bound commitments outlined in the 2014 outcome document. WHO is working closely with a number of countries (Lebanon, Morocco, Sudan, Islamic Republic of Iran, Oman, Tunisia and Yemen) to scale up development of multisectoral action plans, including setting national targets for 2025.

WHO has developed country profiles showing where each country is in implementing the commitments, based on the process indicators of the regional framework. The profiles were reviewed by Member States during the Regional Committee session in October 2014, and will continue to be reviewed on a regular basis during the ministerial meetings prior to the World Health Assembly and forthcoming sessions of the Regional Committee.

To enhance fiscal interventions and support countries in the area of legislation, WHO, in collaboration with the WHO Collaborating Centre at Georgetown University developed a dashboard of key legal interventions to address governance, diet, physical inactivity and tobacco control. Work will continue, in 2015, in developing guidance for Member States in implementing each of the key interventions, based on international experience and best practice.

Prevention and control of risk factors

Policy work on the shared risk factors for the main noncommunicable diseases was accelerated, particularly aiming at scaling up implementation of the proven cost-effective interventions (best buys) for prevention.

Tobacco control continues to face important challenges, particularly those posed by sociopolitical transition, the influence of the tobacco industry and the emergence of new products. The number of countries that are signatories to the first WHO protocol to the WHO Framework Convention on Tobacco Control (WHO FCTC) remains at eight. Political and technical support for the ratification of the WHO FCTC and protocol needs to be sustained. The Regional Office supported Member States in drafting two decisions of the Conference of Parties to the WHO FCTC, on control and prevention of waterpipe tobacco products and the global target on reduction of tobacco use, which will allow States Parties to report to the Conference on progress towards achieving the 30% reduction target by 2025. Following a regional consultation, national observatories to track tobacco advertising, promotion and sponsorship in drama are planned in three countries for 2015. Capacity-building initiatives were supported in the area of tobacco taxation in several countries. A checklist is being developed in order to support countries in developing national legislation consistent with international obligations. A regional package was developed for World No Tobacco Day, focusing on taxation, tobacco control, MPOWER measures, and the tobacco industry.

Nutrition received sustained attention. The current salt intake in the Region averages more than 10 g per person per day, which is double the recommended level set by WHO (5 g per person per day). Technical guidance, based on in-depth review of evidence and international experience, was developed in the form of policy statements

on reducing intake of fats and salt in countries. Kuwait and Qatar reduced salt content in bread by 20% in one year. The Islamic Republic of Iran established maximum salt levels for selected food items and also issued a decree to reduce *trans*fat content to less than 2% in oil industry products. It reduced palm oil imports to 30% of total oil imports in 2014 and will further reduce it by 15% in 2015. GCC countries are developing legislation to eliminate *trans*fat in all locally produced or imported foods. Five countries now have food-based dietary guidelines, while a nutrition profiling model was developed and is being tested in seven countries, to help them to improve food labelling and promote healthy food.

The strategic priorities for WHO in the next biennium are to focus on helping countries to implement the policy statements, develop national action plans, review legislation and standards for food products that are high in fat and salt, promote research in reduction of salt and fat intake and set up regional nutrition profiling guidance. Training is being developed, in collaboration with the University of Liverpool, on the regulation of marketing of foods high in salt, sugar and fat. The aim is to enhance capacity in Member States for implementing the WHO recommendations on marketing of food and non-alcoholic beverages to children.

An initiative to counter the unopposed marketing of unhealthy products, especially to children, was announced during the Regional Committee session and will be launched in 2015. Also in collaboration with the University of Liverpool, WHO is now mapping the progress of 15 countries in implementing the WHO recommendations on marketing of food and non-alcoholic beverages to children. A 3-day course to build legal capacity and advance action on the recommendations was also developed and will be implemented in 2015. WHO worked with global experts to develop a draft roadmap to counteract unregulated and unopposed marketing of unhealthy products.

↑ *Fact sheets on tobacco control*

As reported in the previous section, a regional advisory committee was set up to support implementation of the regional call to action on physical activity and a training package is being developed on mass media and social marketing in regard to physical activity and healthy diet.

Surveillance, monitoring and evaluation

The strategic priority is to strengthen countries' capacities to implement and strengthen the WHO surveillance framework. The core indicators under the three components of the framework – tracking health risks and determinants, monitoring

outcomes (morbidity and cause specific mortality) and health systems capacity and response – have been integrated into the national health information framework endorsed by the Regional Committee at its 61st session. One priority for capacity building in surveillance is to establish a network of regional and international experts to support countries in implementing the framework as an integral part of their national health information systems. Working with the Eastern Mediterranean Public Health Network, a training workshop on surveillance for noncommunicable diseases was conducted for potential regional experts, following the development of a regional training package. This work will be followed up and strengthened in 2015.

In 2014 two countries (Kuwait and Pakistan) completed the STEPwise survey and six countries are moving forward in conducting their surveys (Djibouti, Jordan, Morocco, Somalia, Sudan and Tunisia). The Global Adult Tobacco Survey (GATS) was completed in Pakistan and Qatar, while Oman and Saudi Arabia are currently engaged in completing it. Five countries (Egypt, Iraq, Jordan, Sudan, and Yemen) completed the repeat rounds for the Global Youth Tobacco Survey (GYTS).

Analyses (SIM SMOKE) were conducted in 14 countries, the results of which will allow them to predict the health impact of full implementation of the MPOWER measures in reducing tobacco use and achieving the target set out in the global monitoring framework for noncommunicable diseases.

In collaboration with the International Agency for Research on Cancer (IARC), the cancer registry was assessed in four countries, and national capacities to develop cancer registries were strengthened.

Health care

The key strategy to improve health care for people with the four main groups of noncommunicable diseases (cardiovascular disease, diabetes mellitus, chronic respiratory disease and cancer) is to integrate their management into primary health care. Special emphasis is placed on achieving the 2025 global target 8 of 50% of eligible people receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes and target 9 of 80% availability of the affordable basic technologies and essential medicines required.

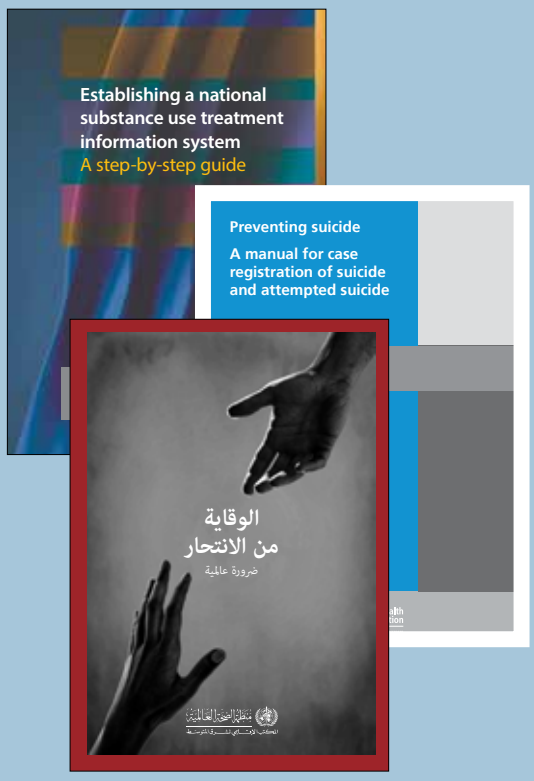
Based on an online survey conducted in 2014/2015, only eight countries used a WHO-recommended approach to identify patients at high risk for heart attack and stroke; only 60% of countries had included in their essential primary health care package a WHO-defined minimum set of seven medicines to reduce the risk of heart attack and stroke. The Regional Office has drafted a framework for strengthening the integration of the management of common noncommunicable diseases, with special focus on hypertension and diabetes into primary health care and is currently developing a package of tools to support implementation including feasible approaches to address the health system constraints.

Access to quality cancer treatment is a priority for the Region. Subsequent to an expert consultation on improving cancer care, a joint programme of work between WHO and the International Agency for Research on Cancer (IARC) was initiated in 2014. Work is in progress to develop regional policy options for practical approaches to strengthening cancer care, focusing on organization of care, essential medicines and technology, financing, monitoring and evaluation, and priority research areas.

Managing noncommunicable diseases is a major challenge during emergencies and crises which unfortunately currently affect more than half of the countries of the region. A regional situation analysis was conducted to assess challenges to the provision of essential care with a focus on countries affected by the Syrian crisis. In addition to the health system constraints which are exacerbated during crises, the lack of clear guidance and tools on improving access to life saving interventions including medicines and technologies is currently receiving the highest level of attention in WHO's work in 2015 and beyond.

Mental health and substance abuse

The huge magnitude of mental health and substance use disorders is receiving more attention as a public health problem following the adoption of the global action plan for mental health 2013–2020 by the World Health Assembly. In the Region, a major impetus to raising the profile of mental health and substance abuse programmes has been provided by the number of countries experiencing complex emergency situations, driving up need and demand for mental health and psychosocial support services. All countries in the Region have made some progress towards the integration of mental health into primary care. However, irrespective of country grouping, huge treatment gaps remain, ranging from 76% to 85%. The ATLAS survey, completed in 2014 to assess the capacities and resources available for mental health and substance abuse, helped identify the gaps in the areas of policy and legislation, service delivery, health promotion and disease prevention, and information, evidence and research.



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

In the area of policy and legislation, only 55% of countries have policies that have been developed or updated in the past 5 years while only 5 countries have legislation that was updated in the past 5 years. Technical support was therefore extended to countries to develop or update national mental health policies, strategies and legislation, in line with the global action plan and the United Nations Convention on the Rights of Persons with Disabilities.

WHO's work in the Region is guided by the global action plan. The plan is comprehensive and covers the various dimensions of the mental health problem. For the plan to address the regional priorities, it was decided to focus, in our work with Member States and partners, on the development of a regional framework containing

a set of evidence-based, high-impact strategies and interventions that are particularly relevant and can be feasibly implemented in the three groups of countries. The framework has been developed through intensive work with international and regional experts. It covers a set of evidence-based, high impact interventions in each of the four key components: governance, prevention and health promotion, health care and surveillance. The framework will be presented to the Regional Committee for consideration in October 2015.

As mentioned above, a significant proportion of countries are experiencing humanitarian emergencies. This has led to increased rates of mental disorders and distress on the one hand and resulted in downgrading of available services on the other. Support to enhance the capacities of emergency responders to provide mental health and psychosocial support (MHPSS) was provided in coordination with other United Nations agencies and international nongovernmental organizations, specifically in countries affected by the Syrian and Iraq crises. Staff were recruited for MHPSS in Iraq and the Syrian Arab Republic. However, action is also needed is to strengthen MHPSS in other countries, including Libya and Yemen.

Substance abuse is of major concern in an increasing number of countries. In order to develop a coherent response to the issue of substance use in the Region, a framework for strengthening the public health response was developed in collaboration with other United Nations and regional stakeholders. The framework is supported by policy reviews which can help countries to articulate their position at the United Nations General Assembly special session on drugs in April 2016.

Communicable diseases

Poliomyelitis eradication

The global progress towards poliomyelitis eradication in 2014 was substantial. However, the disease remains endemic in the Region. Of the 215 polio cases reported globally in the second half of 2014, 213 (99%) are from the Eastern Mediterranean Region (Pakistan 192 cases, Afghanistan 20 cases and Somalia 1 case). Iraq and the Syrian Arab Republic also reported poliomyelitis cases in the first half of 2014 (two cases and one case respectively).

Pakistan suffered from the highest levels of wild poliovirus transmission in more than a decade. It faced significant and unique challenges, including bans on immunization by militant groups in parts of the Federally Administered Tribal Areas which restricted access to children, and multiple deadly attacks on frontline workers during polio campaigns in several parts of the country. Health workers and volunteers continued to demonstrate great courage in carrying out immunization activities. In addition to access and security issues, governance, operational and communication issues hampered eradication efforts in endemic parts of the country.

In Afghanistan, both endemic transmission and importations of wild poliovirus from Pakistan occurred, and barriers to access and the inadequate quality of some campaigns hindered reaching every child with vaccine, particularly in the eastern and southern regions. Nevertheless, the national programme has continued to implement activities with great determination.

Photo: ©WHO

↑ The multi-country response to the Middle East outbreak in late 2013 averted a major epidemic with immunization campaigns in the Syrian Arab Republic and neighbouring countries

In 2015, if the trend continues, it is highly likely that Afghanistan and Pakistan will be the only two countries in the world with active wild poliovirus transmission. This transmission is currently the greatest threat to the achievement of global eradication. The spread of the virus from these reservoirs poses a significant risk to polio-free countries in the Region.

Pakistan is implementing a detailed plan of action for the low transmission season (December 2014 to May 2015), focusing on innovative strategies and on endemic transmission zones within the country. Afghanistan also has an emergency action plan which aims to ensure high levels of immunity for the whole population, while interrupting transmission in the remaining infected zones. Full implementation of these plans will be critical to making progress with eradication in 2015. Review of epidemiology during the first half of 2015 already demonstrates a positive trend with a substantial reduction of cases compared to 2014.

The challenge of the spread of poliomyelitis in the Region brought an unprecedented response from Member States. The multi-country response to the Middle East outbreak which began in late 2013 was swift, coordinated and of high quality and, despite the conflicts and population

Photo: ©WHO

↑ The Regional Director visited a camp for internally displaced persons in Mogadishu, Somalia, to observe the polio vaccination campaign

displacement in the affected countries and their neighbours, this averted a major epidemic. The Syrian Arab Republic has not confirmed a case since January 2014 and Iraq since April 2014. In the Horn of Africa, following a sustained multi-country outbreak response there is also evidence that transmission in Somalia is coming under control, with only 5 cases reported in 2014, the latest having onset in August 2014.

The polio partnership is enhancing its support to both endemic countries through multiple interventions. These include: deploying the best available professionals; mobilizing resources to comprehensively implement all the planned activities; developing strong coordination mechanisms under the umbrella of the emergency operation centres at the federal and provincial levels; monitoring progress closely through development of a comprehensive monitoring framework and regular programme review by the technical advisory group; and implementing a strict accountability framework to ensure a high level of staff performance.

In 2015, WHO will escalate its support to the governments of Afghanistan and Pakistan to stop endemic transmission of poliovirus. WHO will continue to support other countries of the Region to enhance the sensitivity of the surveillance system and to improve the capacity to detect early and effectively respond to poliovirus importations. The mechanisms of the International Health Regulations (IHR 2005) are being used in order to reduce the risk of the international spread of poliovirus and to ensure a robust response to new polio outbreaks in polio-free countries. Support will be provided to Member States in developing plans for phased withdrawal of oral polio vaccine and containment of wild and vaccine-derived polio viruses.

The Islamic Advisory Group established at the regional level and a national advisory group in Pakistan are promoting polio eradication and immunization in general. The scope of work of the Islamic Advisory Group will be expanded to help in addressing other key health issues in the Region.

HIV, tuberculosis, malaria and tropical diseases

The HIV epidemic is still growing despite the overall prevalence remaining low. Regionally, the number of people living with HIV (PLHIV) who are receiving antiretroviral therapy (ART) increased from 32 000 in 2013 to 38 000 in 2014. Despite this progress, ART coverage has not increased significantly and at 10% still remains far from global targets.

Within the framework of the regional initiative to end the HIV treatment crisis, WHO provided technical and financial support to priority countries to revise their treatment guidelines and train health care providers. Thirteen countries now have national guidelines in line with the current WHO recommendations. Five countries received support to conduct HIV test–treat–retain cascade

analysis, to establish evidence-based HIV testing and treatment targets and to develop treatment acceleration plans. Six countries developed national strategic and operational plans.

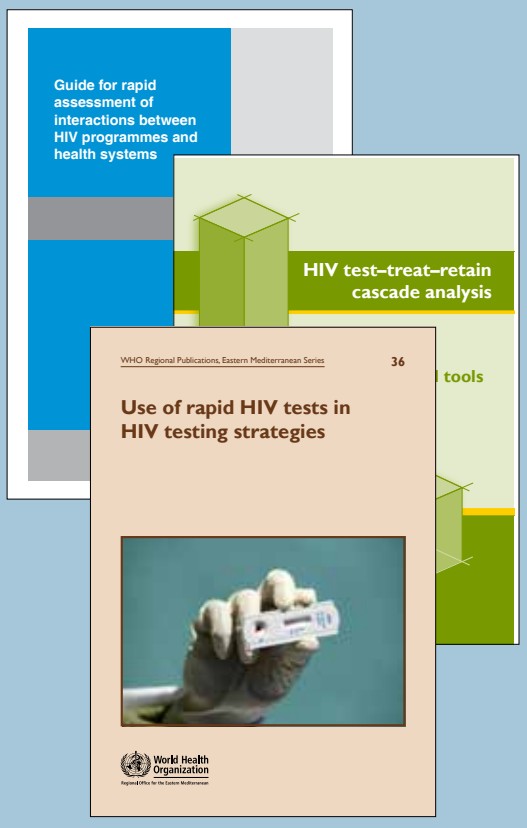
A regional viral hepatitis plan for 2014–2015 was developed and funds are being sought to enable implementation. The focus of activities is on the two high-burden countries, both of which developed national hepatitis strategies.

WHO is developing three related global health sector strategies for HIV, viral hepatitis and sexually transmitted infections. Two regional consultations will be organized in the first half of 2015 to provide regional inputs to the HIV and viral hepatitis strategies.

During 2013[3], over 448 000 cases of all forms of tuberculosis were notified in the Region. Nearly half of these were in two high-burden countries, Afghanistan and Pakistan. Still, 40% of estimated cases are missed or not reported in the Region. The treatment success rate was 87%, slightly higher than the global target of 85 %, and this has been maintained for 2 years.

10 countries have achieved or exceeded the 70% target of case detection and 9 countries have reached or exceeded the global target of 85% treatment success rate. There was slow but steady improvement in regard to management of multidrug-resistant tuberculosis (MDR-TB). Out of 17 000 estimated cases, only around 3687 were detected and 2013 were put on treatment. The treatment success rate reached 64%.

[3] For tuberculosis case detection, WHO receives data a year later, thus case detection data relate to 2013 and treatment outcome data to 2014.



↑ *Recent publications on HIV*

The current crises have had an impact on tuberculosis control. Population movements, the destruction of many health facilities, including tuberculosis facilities, and the deterioration of the economic situation have affected both patients and human resources. One of the implications of the current situation is the decrease in case detection (58% compared to 63% in 2012). Meanwhile, further scale-up of MDR-TB treatment is hindered by lack of proper infrastructure and financial constraints.

In response to the regional challenges, WHO developed guidance on control of tuberculosis in complex emergencies, as well as a package of tuberculosis services for cross-border tuberculosis and MDR-TB patients. The Green Light

Table 1
Reported malaria cases in countries with high malaria burden

Country	2012		2013		2014	
	Total reported cases	Total Confirmed	Total reported cases	Total Confirmed	Total reported cases	Total Confirmed
Afghanistan	391 365	54 840	319 742	46 114	290 079	83 920
Djibouti	25	25	1684	1684	NA	NA
Pakistan	4 285 449	290 781	3 472 727	281 755	3 666 257	270 156
Somalia	59 709	18 842	60 199	43 317	NA	NA
Sudan	1 001 571	526 931	989 946	592 383	1 207 771	NA
Yemen*	165 678	109 908	149 451	102 778	70 679	49 336

NA: not available
**The estimated reporting completeness is 30% in 2014 due to current situation in Yemen*

Committee supported countries to improve diagnostic capacity and scale up treatment of MDR-TB. Monitoring missions to seven countries reviewed the MDR-TB management situation and advised on challenges. Access to new diagnostics continued to increase in the Region, with 4% of tuberculosis laboratories now using LED microscopy. However, domestic financing for tuberculosis controls continues to be less than 30%.

Within the strategic direction to scale up planning for tuberculosis control, review missions were conducted in several countries in 2014. Countries were supported technically to ensure smooth access to better financing from the Global Fund.

In 2014, six countries had areas of high malaria transmission (see Table 1) while transmission is focal in Islamic Republic of Iran and Saudi Arabia. The number of deaths due to malaria in the Region has more than halved since 2000 (from 2166 deaths compared with 1027 in 2013). In 2014, Pakistan and Sudan accounted for over 90% of the deaths (67% and 24%, respectively). The number of confirmed malaria cases reported in the Region decreased from 2 million in 2000 to 1 million in 2013, with Sudan and Pakistan accounting for 84% of cases (57% and 27% respectively).

Seven countries (Afghanistan, Iraq, Islamic Republic of Iran, Morocco, Oman, Saudi Arabia and Syrian Arab Republic) have achieved MDG6 and the targets of resolution WHA58.2 as related to malaria. Elimination programmes have been successfully implemented in Islamic Republic of Iran and Saudi Arabia, with only 370 and 51 local cases, respectively, reported in 2014 (Table 2). Iraq has not reported any local cases since 2009. However, it has been difficult to measure the progress towards MDG6 in five of the countries with a high burden of malaria owing to the weakness of diagnostic and surveillance systems. The limited WHO capacity at country level to ensure sustained technical support, as well as inadequate allocation of funds from national resources in priority endemic countries and dependency on external funds, have also affected progress.

In 2014, in-depth programme reviews, updating of national strategic plans and development of insecticide resistance management strategies were

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

Country	2012		2013		2014	
	Total reported cases	Autochthonous	Total reported cases	Autochthonous	Total reported cases	Autochthonous
Bahrain	233	0	NA	NA	NA	NA
Egypt	206	0	262	0	313	22
Islamic Republic of Iran	1629	787	1373	519	1238	370
Iraq	8	0	8	0	2	0
Jordan	117	0	56	0	102	0
Kuwait	358	0	291	0	268	0
Lebanon	115	0	133	0	119	0
Libya	88	0	NA	NA	NA	NA
Morocco	364	0	314	0	493	0
Oman	2051	22	1451	11	1001	15
Palestine	0	0	0	0	NA	NA
Qatar	708	0	728	0	643	0
Saudi Arabia	3406	82	2513	34	2305	51
Syrian Arab Republic	42	0	22	0	21	0
Tunisia	70	0	68	4	98	0
United Arab Emirates	5165	0	4380	0	4575	0

NA: not available

supported in different countries. The global technical strategy 2016–2030 was developed through a comprehensive consultative process with all countries; seven regional consultations were conducted in 2014. A regional action plan to implement the strategy will be presented to the Regional Committee in 2015. The goal of this plan is to interrupt malaria transmission in areas where it is feasible and to reduce the burden by more than 90% in areas where elimination is not immediately possible, so that malaria is no longer a public health problem or a barrier to social and economic development.

Promising achievements have been made in schistosomiasis control and elimination, with Yemen an excellent example of how a strong partnership among national and international institutions can contribute to overcoming the most difficult challenges. In 2014, Yemen treated over 7.2 million children and adults with praziquantel and albendazole, despite the difficult security situation. Nationwide surveys have shown a sharp decrease in infection indicators and have indicated that schistosomiasis can be eliminated as a public health problem. In Sudan, 2.4 million people were treated with praziquantel

↑ *Recent publications on neglected tropical diseases*

following an increase in financial commitment by the Government and new partnerships.

Immunization and vaccines

Fourteen countries continued to achieve the target of 90% routine DTP3 vaccination coverage, but around 3 million children did not receive DTP3 vaccination, around 90% of which are in four countries (Afghanistan, Pakistan, Somalia and Syrian Arab Republic). Thirteen countries achieved above 95% coverage with MCV1 (first dose of measles-containing vaccine) at national level and in the majority of the districts, while 21 countries provided a routine second dose of measles vaccine with variable levels of coverage. To boost population immunity, national or subnational measles supplementary immunization activities were conducted in Afghanistan, Iraq, Pakistan and Syrian Arab Republic. Measles case-based laboratory surveillance has been implemented in all countries, with 20 countries performing nationwide surveillance and 2 countries conducting sentinel surveillance. As a result, measles incidence was significantly lower than in 2013. Eight countries reported very low incidence of measles (<5 cases/million population) with two of these continuing to achieve zero incidence and scheduled to verify measles elimination in 2015.

2014 marked achievement of completing the introduction of *Haemophilus influenzae* type B (Hib) vaccine in all countries. Rotavirus vaccine was introduced in the United Arab Emirates and rubella vaccine in Yemen as part of the measles/rubella vaccination campaign. Yemen is expected to introduce MR vaccine into routine immunization in 2015. Sudan implemented the first phase of a yellow fever campaign. Inactivated poliomyelitis vaccine (IPV) was introduced in Libya and Tunisia and all the countries using only oral poliomyelitis vaccine (OPV) are on track for introduction of

IPV in 2015. Currently, pneumococcal vaccine is being used in 14 countries, rotavirus vaccine in 9 countries and IPV in 12 countries of the Region.

Achieving the various programme targets was constrained by several challenges. These included the current security situation that hindered access, as well as insufficient visibility of the immunization targets in many countries, inadequate managerial capacity and commitment to routine immunization, and lack of financial resources. In order to overcome these challenges, WHO intensified its support to countries, through comprehensive immunization programme reviews and assessment of effective vaccine management that were conducted in several countries. Support was also provided for development and updating of multi-year plans, resource mobilization, measles immunization campaigns, surveillance of vaccine-preventable diseases, data quality, monitoring and evaluation, and introduction of new vaccines. Special attention was given to establishing and strengthening national technical advisory groups (NITAGs), which are now available in 21 countries. The Regional Office continued to provide technical and financial support to the regional surveillance networks for new vaccines introduction and measles/rubella surveillance in most countries.

WHO will continue to provide the necessary technical support and mobilization of resources for strengthening immunization programmes and achieving the targets. Priority activities for 2015 will include: ensuring access to high quality and safe vaccines through improving the procurement systems, support for comprehensive EPI reviews and updating of comprehensive multi-year plans (cMYP) in several countries; supporting proper planning and implementation of the reach every district (RED) approach in all districts with vaccination coverage below 80% in the low coverage countries, introduction of IPV in the 10 remaining countries, measles supplementary immunization activities, and hepatitis B serosurveys to document progress towards achieving the regional target; and strengthening EPI monitoring and evaluation. Advocacy for raising visibility of the EPI targets, especially measles elimination, and mobilization of high-level government support and commitment to routine immunization will be central.

Health security and regulations

The incidence of emerging and re-emerging infectious diseases continues to escalate in the Region as evidenced by the fact that half the countries of the Region reported high incidence of emerging infectious diseases in the past year, sometimes with explosive outbreaks. These included avian influenza A (H5N1) in Egypt, Crimean-Congo haemorrhagic fever in Afghanistan, Oman and Pakistan, dengue fever in Oman, Pakistan and Sudan, acute hepatitis A and E in Jordan, Lebanon and Sudan, and severe acute respiratory infection caused by influenza A (H1N1) pdm09 virus in Egypt and Pakistan. These events, apart from taking a huge toll of lives, have weakened the public health systems considerably. Infections caused by the Middle East respiratory syndrome coronavirus (MERS-CoV), which emerged in the Region in 2012, continued to expand geographically, with persistent transmission, and cases have now been reported in 10 countries in the Region. Cases spiked in two countries last year owing, primarily, to secondary and nosocomial transmissions in health care settings and triggering heightened international concern for the emergence of a global public health emergency.

Photo: ©WHO

Photo: ©WHO

↑ **WHO supported capacity-building in a number of countries to strengthen outbreak preparedness and response, including Qatar and Saudi Arabia**

The ongoing humanitarian crisis in a number of countries has also weakened their public health systems, while displacing a large number of populations and exposing them to poor environmental health conditions and limited access to health care services. This provides ideal ground for proliferation of diseases and repeated outbreaks of epidemic-prone diseases have reported from these countries in crisis.

Towards the end of last year, the threat of introduction of Ebola virus disease (EVD) increased significantly owing to the connectivity of the Region with west African countries. The threat of importation of EVD into the already weakened and fragile health systems of countries affected by either humanitarian crisis or repeated epidemics, and the resultant public health implications, required public health preparedness and readiness measures across all countries to be stepped up in order to prevent any introduction of the disease and its spread in the Region.

In response to such frequent health security threats in the Region, WHO continued to work with the countries with a view to building, strengthening and expanding a sustainable public health system that is required under the International Health Regulations of 2005 to monitor detect, assess and contain acute and emerging health threats in the Region.

In response to Regional Committee resolution EM/RC/61/R.2, rapid assessments were conducted in 20 out of 22 countries to assess their capacity to deal with a potential importation of EVD. The assessments reviewed level of preparedness and readiness, identified critical gaps or areas of concern, and recommended urgent measures to mitigate risk of importation and spread. Following these assessments, a 90-day regional action plan was developed and implemented during the first half of 2015 to help countries address the critical gaps identified in the areas of surveillance and response, in order to be able to prevent, detect and undertake effective containment measures for control of EVD threats.

Because of the rapidly expanding threat from MERS-CoV, efforts continued to be made to support countries to improve public health preparedness measures, especially infection prevention and control in the health care environment. In view of the existing knowledge gaps regarding the mode of transmission of MERS-CoV, WHO provided support to finalize

Photo: ©WHO

Photo: ©WHO

↑ WHO teams supported national health authorities in Saudi Arabia to investigate an upsurge in MERS-CoV cases

and implement a public health research protocol for understanding the risk factors that result in human infection. The results of this research initiative are expected, not only to unravel the mystery of the origin of this virus, but also to pave the way for preventing a human infection which is currently presumed to be of animal origin.

In view of the need to detect epidemic health threats in the countries that are affected by the ongoing crisis early, support was continued for scaling up and enhancing disease early warning systems and improving readiness measures for rapid and timely response to contain epidemics. The activities of WHO in the area of health security contributed significantly to accelerating progress in the implementation of the core capacities required under the International Health Regulations (IHR 2005). However, concerns remain for the countries that have yet to meet the deadline or achieve compliance with the requirements. By June 2014, which marked the expiry of the first two-year extension for IHR (2005) implementation, only eight States Parties in the Region had declared compliance with the requirements while the remaining 14 requested and were granted a second extension. With the expiry of the second extension due in June 2016, and in view of the recurrent health security threats in the Region, the sustainability, functionality and quality of the core capacities attained by the countries under the IHR (2005) are gaining increasing importance.

Also in response to Regional Committee resolution EM/RC61/R.2 as well as the recommendations of the IHR emergency and review committees, a set of strategic priorities at regional level, and a corresponding implementation plan, are being developed to plug the important gaps identified through the assessment of preparedness and readiness measures for EVD and to strengthen the required capacities. The third annual meeting of IHR stakeholders critically reviewed the gaps and the progress achieved so far and made pragmatic and targeted recommendations from a strategic perspective to push the IHR and global health security agenda forward. The strategic focus for country support under IHR now targets multisectoral coordination, legislative sufficiency, surveillance, response, infection control, zoonoses and food safety, all of which are key core capacity deficits that are common to States Parties.

Important steps were taken in 2014 to contain the threat posed by antimicrobial resistance. A

Photo: ©WHO

↑ Lebanon was among a number of countries in the Region that conducted training on preparedness against the introduction of Ebola virus disease, including the use of personal protective equipment

rapid country assessment launched in 2013 was finalized, the findings of which were published in the WHO global report in 2015. A regional steering committee has been established to provide policy and strategic advice to the Regional Director on containing the threat of antimicrobial resistance and also to develop a regional framework for action in line with the One Health approach agreed between WHO, FAO and the World Organisation for Animal Health (OIE). Country support will now be provided for developing and implementing national plans for curbing the threats of antimicrobial resistance, based on countries' health systems, in support of the global action plan and the regional framework for action.

Progress was also made in strengthening national laboratory capacity to support disease-specific programmes. However, substantial challenges remain, principal among which is the need to develop a comprehensive national laboratory policy encompassing issues like funding, human resources, quality assurance as well as bio-risk management. The assessments for EVD highlighted gaps in bio-safety and quality management, and intensive efforts have therefore been undertaken for a number of countries in regard to shipment of biological materials as well as effective bio-safety procedures for handling of dangerous pathogens. Regional strategies for laboratory services and blood safety were developed through a consultative process, in collaboration with experts in the related fields from Member States, institutes and ministries from the Region and from WHO headquarters and other regions.

Emergency preparedness and response

Overview

2014 saw an escalation in emergencies and associated health needs of affected populations in a number of countries. A total of 58 million people are affected by emergencies in the Region, including 16 million refugees or internally displaced persons. More than half of the world's refugees come from three countries of the Eastern Mediterranean Region (Afghanistan, Somalia and Syrian Arabic Republic) and are hosted in just four countries (Islamic Republic of Iran, Jordan, Lebanon and Pakistan). As a result of the Syrian crisis, in 2014 the refugee population in Jordan doubled and that in Lebanon tripled. Today, almost 25% of Lebanon's total population comprises refugees. The Region also hosts the largest number of internally displaced persons as a result of conflict, with Iraq, Sudan and Syrian Arab Republic among the top five countries globally hosting internally displaced persons.

In Iraq, almost 5.2 million people across the country were in need of humanitarian assistance by May 2015, of whom more than 2.9 million were internally displaced, one of the largest internally displaced populations in the world. In security-compromised governorates an estimated 80% of health facilities were partially functional and 4% were non-functional as of December 2014. The departure of almost half of all health professionals, created a gap in the provision of primary health care, trauma surgery and obstetric care in areas where violence was ongoing. Supplies

Photo: ©WHO

↑ The Regional Director visited a camp for internally displaced people in northern Iraq and urged donors to contribute to life-saving health services

of medicines and equipment were irregular due to road inaccessibility and power/fuel shortages. In the three governorates forming the Kurdistan region, the rapid and massive influx of internally displaced persons overwhelmed the health system, causing critical medical shortages and overburdening health facilities. Due to the unprecedented scale, urgency and complexity of the conflict, in August 2014 the Inter-Agency Standing Committee declared the Iraq crisis a Grade 3 emergency, representing the highest level of emergency, and the second in the Region following the designation of the crisis in the Syrian Arab Republic as Grade 3 in 2012.

In the Syrian Arab Republic, by December 2014, almost 12.2 million people had been affected inside the country, including 7.6 million internally displaced and 4.8 million living in hard-to-reach or besieged areas. An additional 4 million were refugees taking shelter in Egypt, Iraq, Jordan, Lebanon and Turkey. By the end of March 2015, out of 113 public hospitals assessed, 44% were reported fully functioning, 36% partially functioning and 20% non-functioning. Populations had increasingly limited access to basic services, including life-saving health care, and functioning health facilities were unable

to cope with the increasing needs of affected populations in conflict areas. Overcrowded living conditions, together with a significant drop in the overall vaccination coverage, left populations increasingly vulnerable to communicable diseases such as measles, typhoid and whooping cough.

In March 2015, the conflict in Yemen escalated, with violence reaching 19 out of Yemen's 22 governorates. By June, more than 20 million people were affected, with almost 15 million people requiring health care services. The number of internally displaced persons almost doubled in May, reaching more than 1 million people. Serious shortages of medicines and medical supplies, as well as lack of fuel to operate hospital generators and maintain the vaccine cold chain, resulted in a gradual collapse of the health system. Fuel shortages also resulted in an estimated 9.4 million people with no or limited access to safe water. Surges in suspected cases of malaria and dengue fever were reported, with more than 3000 suspected cases and a number of deaths. Lack of access prevented WHO and partners from assessing the situation and providing vector control measures. Significant incidence of diarrhoeal diseases and pneumonia also continued to be reported. Delays and cancellations of vaccination campaigns increased the risk of measles outbreaks, and risked the reintroduction of polio into the country, although as of June, no polio cases were reported. A 5-day humanitarian pause in May allowed WHO and partners to scale up the response around the country. However, calls for a second pause during the month of Ramadan failed.

In Pakistan, military operations in the North Waziristan Agency resulted in the displacement of 500 000 people in June 2014, bringing the total number of displaced persons to 1 million, 74% of whom were women and children. Bad weather conditions, overcrowded housing in host communities, and poor nutrition increased the risk of waterborne diseases, such as cholera and other diarrhoeal diseases, as well as airborne diseases, such as pneumonia and measles.

In Libya, in June 2014, clashes between rival forces erupted in the cities of Tripoli and Benghazi. By December 2014, more than 2.5 million people were in need of humanitarian aid, including 400 000 displaced. Shortages in medicines and medical supplies, together with the evacuation of many of the country's international health workforce left the health system weak and functioning health facilities overwhelmed.

In Palestine, 51 days of fighting in Gaza during July and August 2014 left 2333 Palestinians dead and 15 788 injured. Half a million people were displaced and up to 22 000 homes were

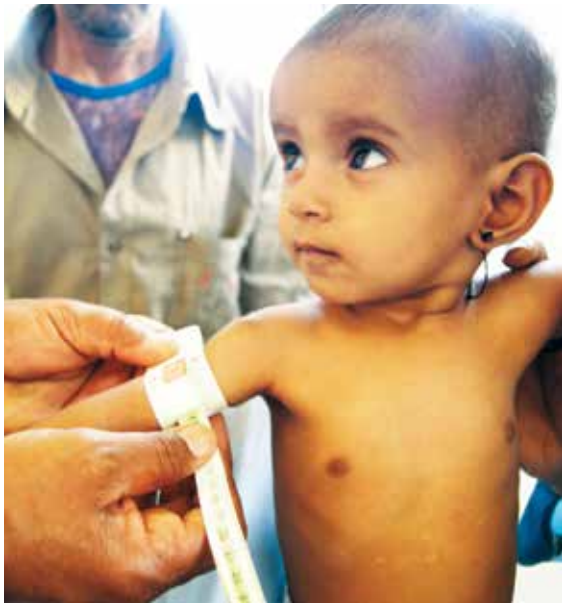


Photo: ©WHO

↑ A child is checked for wasting as part of acute severe malnutrition management in the WHO-supported therapeutic feeding centre in Al-Sadaqa Teaching Hospital, Aden, Yemen

destroyed or rendered uninhabitable, with 100 000 people remaining homeless at the end of the year. The conflict caused widespread damage to infrastructure, including hospitals, clinics and ambulances, as well as water and sanitation facilities, resulting in limited access to basic services.

In Afghanistan, as the armed conflict grew in intensity and geographical scope, the number of people in need of access to health services rose from 3.3 million in 2013 to 5.4 million in 2014, with the conflict continuing to cause critical disruptions to the provision of health services. More than 30% of the population in Afghanistan still has no or difficult access to essential health care.

In Somalia, the United Nations warned in June 2014 of a "looming humanitarian emergency". Almost half of the country's population lack access to basic services and about 3.2 million women and men require emergency health services. The health care system remains weak and there is a critical shortage of qualified health workers. The impact of this lack of basic services is felt most strongly among the internally displaced people who continue to be affected by disease outbreaks due to overcrowded and unsanitary living conditions and limited health services.

Natural disasters claimed additional lives. In September 2014, floods in Sudan resulted in the displacement of more than 320 000 men, women and children, while monsoon rains and flash floods in Pakistan affected almost 1.8 million people and resulted in 282 deaths and 489 injuries. More than 42 000 houses were estimated to be damaged or destroyed, while an estimated 976.5 million hectares of farmland were flooded at a time when crops were almost ready to be harvested. Some areas affected were those that had previously experienced flooding in 2013.

WHO has been fully mobilized in responding to the above mentioned emergencies by leading the work of the UN health cluster and implementing its functions in strengthening disease surveillance and early warning systems, strengthening other public health functions including control of disease outbreaks and immunization and helping to sustain basic health care and life-saving services.

Challenges and WHO response to emergencies in the Region

One of the biggest challenges impeding WHO's ability to respond is limited access as a result of insecurity. In the Syrian Arab Republic, limited access has required more innovative ways to reach populations in need. In Yemen, restricted access into the country via all ports delayed the delivery of urgently needed health supplies. Inside the country, violence and insecurity made some areas inaccessible, and increased the risk of diseases such as malaria and dengue fever as patients lack access to health care and thus timely diagnosis and treatment. Additional challenges included repeated and targeted attacks on health care workers, health facilities and health infrastructure. In 2014, WHO's Regional Office publically condemned such attacks in Afghanistan, Iraq, Palestine, Sudan, Syrian Arab Republic and Yemen. Lack of sustainable funding for health in emergency response also posed a key challenge, impeding WHO and health partners' capacity to respond, and risking the closure of existing health services and health programmes**.** In 2014, health was funded at 45.6% in the Region while coordination was funded at 84.8% and food at 61.8%. Despite increasing needs, health was only funded at 12.5% for 2015 as of May. There

continues to be a heavy dependence by countries in crisis on external humanitarian and financial aid, which may not always arrive when it is most critically needed.

While trauma care needs have increased, there is decreasing capacity among partners to respond due to the insecurity. In the Syrian Arab Republic, where 1 million people were injured in the first quarter of 2015, health partners have been forced to completely withdraw from "hot" areas, leaving a critical gap in the provision of trauma care. Mass population movement, coupled with low immunization rates and vaccine shortages place the entire region at risk of disease outbreaks. The outbreak of polio and measles in the Syrian Arab Republic as a result of the crisis led to the re-introduction of polio in Iraq in 2014 after 14 years of being polio-free.

Operational challenges faced by WHO and health partners included disrupted health systems, an increasing number of patients requiring trauma care (especially in hard-to-reach areas), growing numbers of internally displaced persons, severely reduced health workforces as health staff fled with their families, disrupted referral systems as a result of insecurity and blocked roads, and critical shortages of essential medicines and vaccines. Mass population movements increased the risk of communicable diseases as IDPs sought shelter in overcrowded camps and public spaces, and damaged water and hygiene infrastructure increased the risk of water-borne diseases. Disease surveillance systems were disrupted as a result of limited data and information. Patients with chronic noncommunicable diseases were forced to find alternate locations for treatment as health facilities shut down or reported shortages in essential medicines. As a result of the violence, mental health needs also increased.

Photo: ©WHO

↑ **Mobile medical clinics, procured by WHO and the World Food Programme, were mobilized to address the health needs of displaced populations in Iraq**

Following the Grade 3 designation of the crisis in Iraq , which signified a global organizational response, WHO's country office was scaled up with the deployment of more than 21 international staff in all areas of expertise, as of May 2015 and WHO hubs and/or focal points were established in all 19 provinces. Through funding from Saudi Arabia, WHO procured and operationalized 10 mobile clinics in northern Iraq covering 300 000 internally displaced people and host communities. The project is part of WHO's broader response of providing a timely basic package of primary and secondary health care services. As of May 2015, 3.5 million people in Iraq had been provided with direct access to essential drugs and medical equipment procured and supplied by WHO.

Two cases of poliomyelitis were confirmed in Iraq in early 2014. Together with national and United Nations health partners, WHO was able to vaccinate more than 5 million children against poliomyelitis in three national immunization campaigns, as of May 2015.

In the Syrian Arab Republic in 2014, WHO delivered more than 13.8 million medical

Photo: ©WHO

↑ On a visit to Gaza the Regional Director highlighted the health challenges, including the referral of patients to hospitals outside Gaza for life-saving treatment

treatments to people in need across the country, with more than 32% of the deliveries distributed to hard-to-reach and opposition-controlled areas. WHO also mobilized more than 17 000 health care workers to vaccinate approximately 2.9 million children against poliomyelitis through 10 immunization campaigns and 1.1 million children immunized against measles.

In Yemen, from March to June 2015, WHO distributed almost 130 tonnes of medicines and medical supplies and more than 500 000 litres of fuel to maintain the functionality of main hospitals, vaccine stores, ambulances, national laboratories, kidney and oncology centres, and health centres in 13 governorates, reaching a total of more than 4.7 million beneficiaries, including 700 000 internally displaced people and 140 000 children under the age of 5 years. WHO also provided safe water and sanitation kits and supplies to health facilities and to internally displaced people hosted in affected communities, as well water trucking services to health facilities and communities with high numbers of internally displaced people. WHO also delivered medicines for tuberculosis and malaria and supported disease outbreak response and control.

During and after the Gaza conflict, WHO facilitated the delivery of medicines and medical supplies to hospitals and health facilities for hundreds of thousands of patients. The health cluster system was reactivated and led by WHO, together with the Ministry of Health. WHO took the lead in conducting the health component of the multi-cluster assessment, and led the health cluster in completing the joint health sector assessment. Despite the conflict, WHO ensured ongoing advocacy for access for patients with referrals abroad, working at a policy level to facilitate access for these patients.

Health risk management

The Regional Committee endorsed the need to strengthen emergency preparedness and response through an all-hazard and multisectoral approach (EM/RC61/R.1) and requested enhanced technical support from WHO to scale up national emergency risk management capacity. By the end of 2014, 19 countries had received support in reviewing their existing national plans for emergency preparedness and response, with a view to adopting the comprehensive approach. Two countries finalized a national plan for all-hazard emergency preparedness and response for health. To support the planning process, the comprehensive all-hazard risk assessment protocol was piloted in the Islamic Republic of Iran, along with comprehensive vulnerability analysis. In Afghanistan mass casualty management capacity was scaled up, in collaboration with partners.

In 2014, WHO's work in emergencies in the Region was made possible with the support of many donors, including Australia, Canada, China, the European Commission, Finland, Italy, Japan, Korea, Kuwait, Norway, Russian Federation, Saudi Arabia, Switzerland, Turkey, United Arab

Photo: ©WHO / Sini Ramo

↑ In Afghanistan a simulation exercise was conducted to develop national capacity in mass casualty management

Emirates, United Kingdom and United States of America.

Implementing the strategies endorsed by the Regional Committee

Progress was made in regard to implementing resolutions endorsed by the Regional Committee. The process of establishing a regional emergency solidarity fund was initiated with the aim of ensuring predictable financing of surge/rapid response to natural and man-made disasters in the Region. This was strengthened by the Regional Committee which urged Member States to contribute to the Fund by allocating to it a minimum of 1% of the WHO country budget, in addition to other voluntary contributions whenever possible.

With the goal of establishing a regional roster of trained experts who are able to quickly and effectively respond to any emergency, including disease outbreaks, capacity-building of emergency focal points was supported on surge training in emergencies , and will continue to be supported each year. To ensure the timely procurement and provision of critical medical supplies and equipment to countries experiencing emergencies in the Region and beyond, WHO has finalized an agreement with the Government of the United Arab Emirates to establish a dedicated WHO humanitarian operations/logistics hub.

WHO will continue to work with Member States to strengthen the capacity of health systems to prevent, mitigate, prepare for, respond to and recover from emergencies and crises following a whole-health and multisectoral approach, with special emphasis on reinforcing technical capacity in preparedness.

Implementing WHO management reforms

Programmes and priority-setting

WHO continued to implement, and strengthen, its commitment to the global and regional strategic priorities. Its programmatic reform objective is to improve global and regional health outcomes by focusing on its comparative advantages. Accordingly, the regional and country offices began implementing the programme budget 2014–2015 in key priority areas, concentrating 76% of the budget for base technical programmes (excluding emergencies) in the country offices. By the end of 2014, the allocated programme budget was 76% financed (66% for base programmes and 81% for emergencies), with an implementation rate of 58% against funds available and 44% against the allocated programme budget.

The operational planning process for 2016–2017 began. The bottom-up approach first used in operational planning for 2014–2015 was strengthened and a clear focus was placed on country priorities. Referring to the new results chain framework introduced in the 12th General Programme of Work 2014–2019, country offices and Regional Office departments selected up to 10 priority areas of work in which they planned to use at least 80% of the programme budget 2016–2017. The programme budget 2014–2015 was used as a reference for budget allocation but the process allowed for greater flexibility than in the previous biennium, and for readjustments among categories according to regional priorities.

In order to ensure the highest level of alignment with country priorities, regional and country teams were given the opportunity to propose amendments or additions for consideration by the programme area networks and category networks at global level before the draft was finalized and then reviewed by the regional committees. This interactive process resulted in a draft programme budget 2016–2017 for approval by the World Health Assembly in May 2015.

Governance

High-level meetings for ministers and representatives of Member States and permanent missions in Geneva continued to be held prior to meetings of WHO's governing bodies (World Health Assembly, Executive Board). These meetings provided an excellent opportunity to review with ministers of health and senior government officials progress in addressing key priorities since the previous Regional Committee and have had a positive impact in strengthening Member States' engagement in global discussions on health and WHO reform. Daily meetings during the Executive Board meeting and Health Assembly provided additional opportunities for Member States from the Region to interact and agree on common positions that affect the Region. A mid-term report was presented to the ministerial meeting held prior to the World Health Assembly on progress in implementing the commitments made in the five strategic priorities, and subsequently to the Regional Committee.

At its 61st Session, the Regional Committee endorsed three resolutions covering key areas of work. The reduction in the number of resolutions is in line with governance reform and the efforts of the Committee to focus on priorities and actions to which Member States can realistically

commit. Immediately prior to the session, a day of technical meetings was held to discuss current issues of interest. Where pertinent, the outcome of the discussions was taken forward to the Regional Committee for further discussion. This process, which follows from the revised rules of procedure endorsed by the Regional Committee at its 59th session, is developing into a useful forum for high-level technical discussion with Member States.

Management

WHO continued to follow up on its commitment to strengthen technical and managerial capacity in countries, and to carry out a process of comprehensive reform in regard to its work in the Region. Despite the surge in emergencies and continuing crisis in parts of the Region, which present unique challenges, and despite the limited resources available, pursuit of overall excellence continued to be the guiding theme for implementing WHO reform in the Region.

The regional reform agenda was translated into a plan to improve administration and management based on increased empowerment of staff and creation of an enabling environment for sharing best practices and developing future practices. A senior management retreat was held to review the progress and challenges in relation to the regional priorities, including management reform. This resulted in the establishment of a task force with representation from all departments which looked at ways and means to simplify processes and reduce bottlenecks.

A number of actions were implemented to improve management operations. Harmonized structures were put in place across all budget centers, and staff rosters created for generic technical and administrative support posts. Key performance indicators were agreed in order to better monitor technical and management performance, as well as compliance. A range of administrative procedures were simplified and streamlined to improve compliance and performance, particularly in relation to recruitment and contracting, travel and organization of meetings, while public procurement procedures were strengthened. Efforts were made to strengthen ownership and accountability by departments and country offices through increased delegation of authority to budget centres.

Following on from steps initiated in 2013, major focus was placed on strengthening internal controls and compliance. A compliance and risk management function was established, reporting directly to the Regional Director. Compliance is monitored at the level of the budget centre by means of an electronic 'compliance dashboard' that is visible to managers and is updated each month. In order to encourage and improve performance in this area, efforts were made to engage with staff through provision of better guidance and direct interaction, including teleconferences.

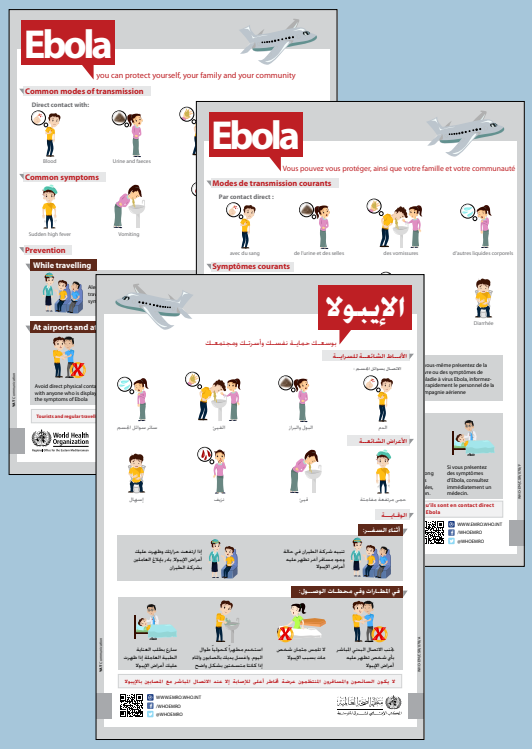
↑ *The Eastern Mediterranean Health Journal is published monthly*

These interactions proved useful for sharing information, experiences and solutions.

At country level, significant progress was made in a number of targeted areas relating to audit recommendations. The number of outstanding technical and financial reports relating to direct financial cooperation was further decreased, from about 500 at the beginning of the year to about 100 at year end. Reform in the use of special services agreements as a mode of contract for technical cooperation was implemented. This resulted in an overall reduction in the number of such agreements from 1200 to about 600, and improved compliance with the intent of this type of contract. At the same time, efforts were made to build capacity and raise awareness on correct procedures and accountability in these areas. Country office capacity was further strengthened in the areas of planning and project management.

With regard to further strengthening of technical and managerial capacity at country level, and following restructuring and significant expansion in technical capacity in several country offices in 2013, action to strengthen WHO country presence continued in several countries. The current reporting period focused on enhancing general management and administrative capacity in the field.

The Regional Committee acknowledged the efforts made to shift resources from regional to country level (EM/RC61/R.1) and requested the Regional Director to advocate for the implementation of a full staff rotation and mobility scheme across the Organization, and not only within the Region. Further increase in the country allocation has been planned for the next biennium to ensure that the process of strengthening country presence, which was started in 2012, is consolidated over the coming 2 years.



↑ ***Effective management of threats to health security includes timely public health messages***

A review was conducted with a view to restructuring the administrative services in early 2015. The main objective is to increase the efficiency of the support provided for delivery of technical programmes by making better use of the Global Service Centre and the Global Management System. The review also looked at ways of strengthening the administrative and management functions of the Regional Office and options for establishing common service functions and structures at the sub-regional level. Implementation of the recommendations of the review in this regard will be completed by end 2015.

In addition to the general management challenges resulting from the increase in emergencies in the Region, the Regional Office and the country offices are struggling to handle the surge in workload. This is due to lack of capacity compounded by the current difficulties in attracting the talent and skills needed to the Region.

In an effort to accelerate WHO reform implementation at country level, two WHO country offices (Pakistan and Iraq) have been selected to take part in a pilot project on reform of human resources, in cooperation with the Bill & Melinda Gates Foundation. The aim of reform in this area will be to promote local decision-making and bottom-up planning for human resources, based on needs. Lessons learned from these pilot projects will be used to identify best practices which can be shared and replicated across WHO.

Addressing the many challenges in management reform requires a systems approach, including continuing harmonization of structures, simplification of processes, open communication channels, and an enabling environment to strengthen organizational health. The focus in 2014 was on achieving visible progress and outcomes in areas where there was a clear way forward, with careful prioritization of improvement actions thereafter. In 2015, WHO will continue to build on the intensive preparatory work started in 2014, focusing on three major areas: people (input), processes (systems), and products (impact).

Conclusion

This report reflects the work of WHO in the past year in supporting health development in the Member States of the Region. It also highlights key challenges that need to be addressed and reflects continued work and next steps for both Member States and WHO for 2015 and beyond. To be brief and focused, the report presents the progress made over the past year in tackling the five key health challenges shared and endorsed by all Member States in 2012. WHO's work during 2014 also covered other initiatives of specific relevance to health development in the various countries of the Region. I am confident many of them will be raised and discussed during the different sessions and events of the 62nd session of the Regional Committee in October 2015.

It is impossible to report on health support without recognizing the impact of the humanitarian crises on national health systems and health status, and on WHO's overall capacity in the Region. Health facilities and programmes have been badly affected in the increasing number of countries in crisis and the lack of adequate donor funding is a very real concern. All Member States, without exception, will need to place more emphasis on building resilient health systems, with improved access to health services. Emergency medical services need to be strengthened in most countries. These are areas of work that will be given special priorities in WHO's collaboration with Member States over the coming years.

As the world makes the transition from the Millennium Development Goals to the post-2015 agenda and new sustainable development goals,

Photo: ©WHO

↑ The Sixty-first session of the Regional Committee for the Eastern Mediterranean took place in Tunis, Tunisia

it will be important to build on the momentum generated in regard to maternal and child health in the Region in the past three years. Maternal and child health concern all countries of the Region. We will continue to focus on the high-burden countries and countries that are affected directly or indirectly by complex emergency situations. However, all countries of the Region will be developing strategic and operational plans for reproductive, maternal, neonatal and child health for the period 2016–2020, in accordance with the updated Global Strategy on Women's, Children's and Adolescent Health, endorsed in September 2015. In particular, WHO and its partners must maintain focus on countries in crisis, to avoid falling back on the gains achieved.

In 2015 and going forward WHO will focus more on how to tackle the need for better preconception care in the Region and the persistent inequities in access to quality health care for mothers and children. We will also work with Member States to implement the key recommendations of the Second International Conference on Nutrition (ICN-2) based on the priorities agreed in a recent intercountry meeting on nutrition. This will include a special focus on promoting breast-feeding, treatment of undernutrition and preventing childhood obesity.

It will also be important to maintain commitments at regional and national levels to make further progress in reducing the burden of HIV, tuberculosis and malaria. We are already developing regional action plans for 2016–2020, in line with the post-2015 WHO global strategies and proposed sustainable development goal for health, and we will continue to work with countries to ensure continued progress.

Polio eradication in our region, and globally, is now within reach. We have intensified our support to affected countries in the final push to eradicate polio. I urge all countries, as we approach the final hurdle, to ensure the highest possible levels of immunization and surveillance until global eradication is achieved and certified. I also call on all countries to continue their crucial and valuable support to Pakistan and Afghanistan to achieve the goal of eradication as quickly as possible.

The focus placed on the importance of effectively managing health security threats, following the Ebola crisis needs to be maintained. All countries, with no exception, have to reinforce their core capacities under the International Health Regulations. The situations with regard to transmission of Middle East respiratory syndrome coronavirus MERS-CoV and avian influenza A(H5N1) will continue to be closely monitored at national and regional levels. There are gaps in our knowledge concerning both diseases and it is vital that research into these, and other, high-risk diseases is supported and the results shared in a timely manner. Above all, countries need to ensure they are prepared to handle cases in a manner that places emphasis on the safety of patients and health workers alike.

The growing antimicrobial resistance to previously effective drugs is extremely worrying. It is clear that our region, and we are not alone in this regard, is not well prepared to tackle the problem. WHO is co-sponsoring a high-level ministerial conference in the Region in early 2016, during which a detailed situation analysis and a concrete regional plan will be presented. We are working with Member States and other stakeholders to prepare for it. The Region is witnessing a rapid acceleration in the magnitude and devastating consequences of noncommunicable diseases. We have sound vision and a robust road map to guide us; we can stop this epidemic through the implementation of the regional framework

for action. I will continue to scale up our work in this area so that we can increase capacity for technical support to countries but the ultimate responsibility is with Member States. Heart disease, cancers, diabetes and chronic lung diseases will not be checked unless declared commitments are translated into concrete action. In May 2015, WHO developed a list of process indicators that will be used to assess the progress made by countries in realizing the national commitments included in the United Nations political declaration of 2011. The assessment will be published during the United Nations high-level meeting which will be held in New York in 2018. We will use the indicators to monitor progress on an annual basis and will work with Member States to ensure that they are adequately prepared to monitor implementation in this regard.

Universal health coverage is now part of the sustainable development goals. A regional road map was supported last year by the Regional Committee. The next step for WHO is to support countries to develop their own plans, focusing on the key interventions recommended by the regional framework. Special emphasis is being given in WHO's work to building national capacities in strategic health planning and health sector regulation, strengthening service delivery through the family practice approach, hospital care and management, patient safety, and more effective contribution from the private sector. A plan for reform of medical education will be discussed by the Regional Committee which, I hope, will lead to a commitment to effective action from Member States.

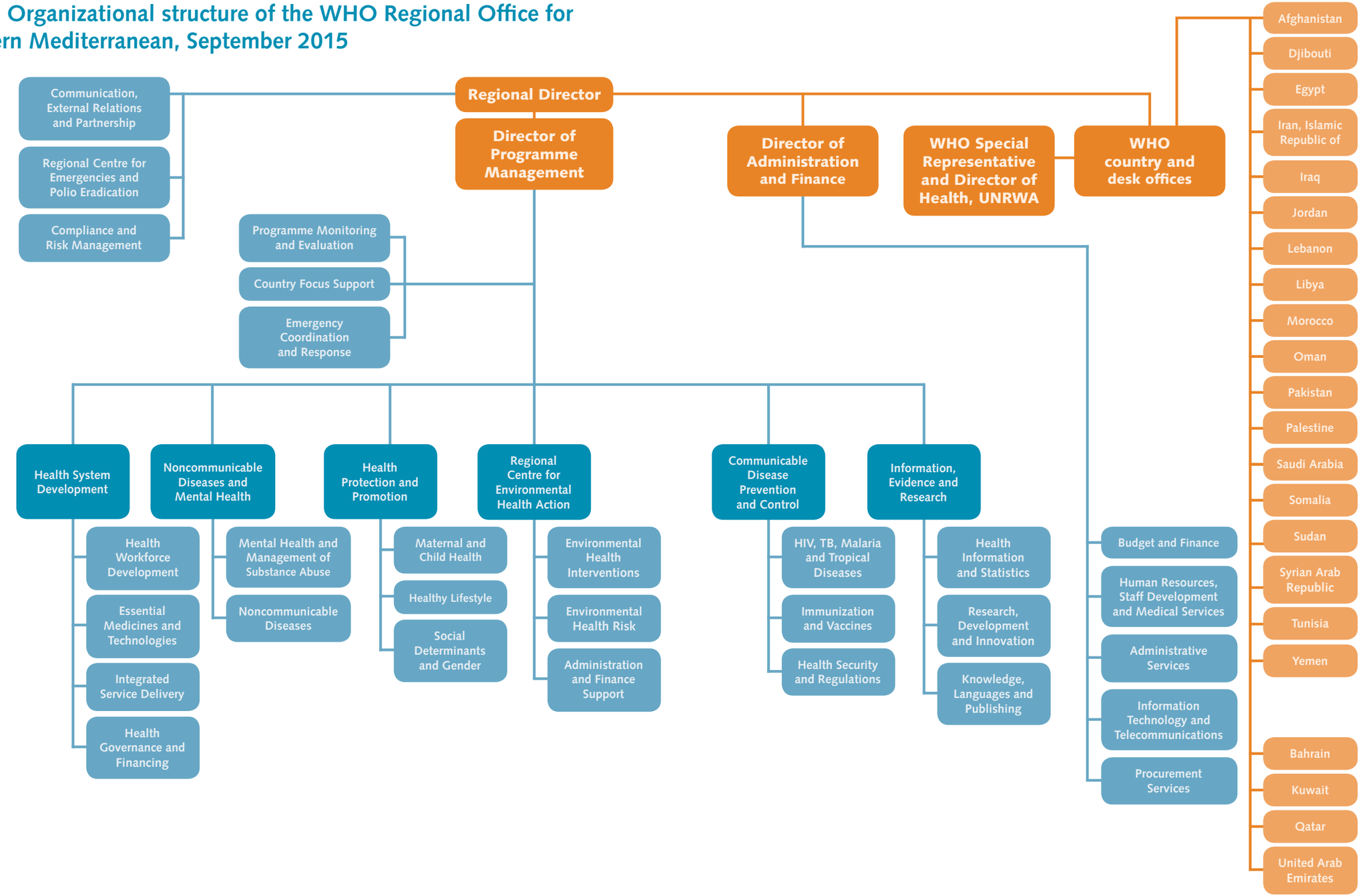
Health information systems will continue to be an important priority. Building on the achievements made over the past three years, we will be working closely with the different groups of countries, and with United Nations partners, to have stronger national health information systems in order to monitor health trends and health system performance, based on the new health information framework.

We have witnessed difficult times in the past year in many parts of our region. Health systems and the people who work in them are facing enormous challenges and pressures. The development of public health leadership capacity in our region has never been more crucial to health development than now.

I remain fully committed to managerial reform. I am pleased with the progress we have made so far but clearly more needs to be done in improving our performance and support to Member States, based on efficiency, accountability and transparency. Country offices have been a major focus of my attention in the past year and while positive progress has been made in several countries, our plan is to continue expanding WHO's presence in other countries. We will continue to listen to our Member States and to respond. We, in turn, need the support of Member States to address the priorities.

As I stated last year, I believe we have established some solid foundations on which to build a brighter future, in partnership with our Member States. These are challenging times, but also times of great opportunity. Let us not miss these opportunities. Let us all – Member States, international organizations and civil society – continue to strengthen our partnership in health.

Annex 1. Organizational structure of the WHO Regional Office for the Eastern Mediterranean, September 2015



Annex 2. Professional staff in the Eastern Mediterranean Region as at 31 December 2014

a) Professional staff in the Eastern Mediterranean Region, by number and nationality as at 31 December 2014

Nationality	Regional/Intercountry	Country	Total
Egypt	16	9	25
Pakistan	7	4	11
United States of America	7	3	10
Tunisia	7	1	8
Lebanon	5	2	7
Sudan	3	4	7
United Kingdom	6	–	6
Belgium	2	3	5
Jordan	4	1	5
Yemen	1	4	5
Germany	2	2	4
Iran, Islamic Republic of	4	–	4
Iraq	3	1	4
Netherlands	2	2	4
Stateless	4	–	4
Syrian Arab Republic	3	1	4
Bangladesh	2	1	3
India	2	1	3
Italy	1	2	3
Somalia	2	1	3
Switzerland	3	–	3
Afghanistan	–	2	2
Bahrain	2	–	2
Canada	2	–	2
Denmark	1	1	2
Ethiopia	–	2	2
Finland	2	–	2
France	1	1	2
Morocco	2	–	2
Philippines	1	1	2
Uganda	–	2	2
Algeria	–	1	1
Austria	–	1	1
Australia	–	1	1
Eritrea	–	1	1
Georgia	–	1	1
Hungary	1	–	1
Japan	–	1	1
Kenya	–	1	1
Malawi	1	–	1
New Zealand	1	–	1
Nigeria	–	1	1
Norway	–	1	1

Nationality	Regional/Intercountry	Country	Total
Republic of Moldova	1	–	1
Romania	–	1	1
Saudi Arabia	–	1	1
Senegal	1	–	1
Seychelles	1	–	1
South Sudan	1	–	1
Sweden	–	1	1
Tanzania	–	1	1
Trinidad & Tobago	1	–	1
Total	105	64	169

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 2014

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	33	25
Pakistan	C	005–014	23	11
Iran, Islamic Republic of	C	004–012	15	4
Tunisia	C	001–008	13	8
Lebanon	C	001–008	13	7
Jordan	C	001–008	12	5
Sudan	C	001–010	12	7
Iraq	B1	002–009	6	4
Morocco	B1	001–010	6	2
Yemen	B1	001–008	5	5
Syrian Arab Republic	B1	001–008	4	4
Somalia	B2	001–008	4	3
Afghanistan	B1	001–008	3	2
Bahrain	B1	001–007	2	2
Saudi Arabia	A	005–011	2	1
Djibouti	B1	001–007	–	–
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			153	90
Total of other nationalities			1851	79
Grand total			2004	169

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, 2014

Meeting title, location and date
Statutory and advisory meetings
Expanded meeting for members of the Advisory Committee on Health Research to discuss integrating research in shaping the future of health in the Eastern Mediterranean Region, Cairo, Egypt, 16–18 February 2014
First meeting of the Global Islamic Advisory Group on Polio eradication, Jeddah, Saudi Arabia, 26–27 February 2014
Twentieth meeting of the Eastern Mediterranean Regional working group on the GAVI Alliance, Lahore, Pakistan, 25–26 March 2014
Third meeting of the EMR Green Light Committee, Cairo, Egypt, 7–9 April 2014
Twenty-eighth meeting of the Eastern Mediterranean Regional Commission for Certification of Polio Elimination (RCC), Amman, Jordan, 21–24 April 2014
Meeting of the Technical Advisory Group on poliomyelitis eradication for Pakistan, Islamabad, Pakistan, 2–3 June 2014
Technical Advisory Group meeting on poliomyelitis eradication for Afghanistan, Islamabad, Pakistan, 5–6 June 2014
Second meeting of the Technical Advisory Committee (TAC) to the Regional Director, Cairo, Egypt, 14–15 June 2014
Horn of Africa Technical Advisory Group meeting, Amman, Jordan, 12–14 August 2014
Consultation of the regional steering committee and the regional technical working group on physical activity, Cairo, Egypt, 28–29 September 2014
Sixty-first Session of the Regional Committee for the Eastern Mediterranean, Tunis, Tunisia, 19–22 October 2014
Fourth meeting of the Eastern Mediterranean Regional Green Light Committee, Cairo, Egypt, 10–12 November 2014
Consultations
High level forum on a life course approach to promoting physical activity in the Eastern Mediterranean Region, Dubai, United Arab Emirates, 24–25 February 2014
Consultative meeting to determine the public health research agenda on MERS-CoV, Riyadh, Saudi Arabia, 2–3 March 2014
Technical meeting on maternal and child health acceleration plans, Cairo, Egypt, 6–7 March 2014
Meeting to discuss the progress achieved in implementation of the Russian Federation funded project "strengthening policy frameworks to reduce the premature death toll from noncommunicable diseases in Lebanon, Morocco, Sudan and Yemen", Cairo, Egypt, 16–17 March 2014
WHO meeting on exchange of experience in increasing access to and demand for immunization in areas with insecurity and/or other complex circumstances, Tunis, Tunisia, 20–21 March 2014
Regional meeting for the global health initiatives/health system strengthening (HSS) focal points, Lahore, Pakistan, 27–28 March 2014
Expert workshop to prepare a new edition of the WHO advisory note on waterpipe tobacco smoking, Cairo, Egypt, 30–31 March 2014
Regional consultation on strengthening chemical safety capacities for the implementation of International Health Regulations, Amman, Jordan, 1–4 April 2014

Annex 3. Meetings held in the Eastern Mediterranean Region, 2014 *(continued)*

Meeting title, location and date
Consultations
Regional consultation on global technical strategy for malaria control and elimination 2016–2025 and the regional consultation on the second global malaria action plan 2016/2025, Casablanca, Morocco, 14–16 April 2014
Expert meeting on strengthening noncommunicable diseases surveillance and monitoring in the Eastern Mediterranean Region, Cairo, Egypt, 15–16 April 2014
International consultation on workers health: "caring for all working people-interventions, indicators and service delivery, Semnan, Islamic Republic of Iran, 28–30 April 2014
Expert consultation on regional core indicators, Cairo, Egypt, 1–2 May 2014
Selection committee meeting of the joint EMRO/TDR Small Grants Scheme, Cairo, Egypt, 11–14 May 2014
Consultation to develop a package on management for tuberculosis and MDR-TB care among refugees and internally displaced population in Syria and surrounding countries, Cairo, Egypt, 2–4 June 2014
Regional consultation on improving quality and safety of health care in countries, Jeddah, Saudi Arabia, 9–11 June 2014
Seventh meeting of the regional Scientific and Technical Advisory Committee of the WHO/EMRO/UNEP/GEF-supported project, Cairo, Egypt, 16–19 June 2014
Expert consultative meeting to develop a regional strategic plan on blood safety and self-sufficiency (2014–2018), Amman, Jordan, 18–20 June 2014
Meeting on strengthening the health information systems strategy and core indicator list, Cairo, Egypt, 3 July 2014
Expert meeting to prepare for a high-level ministerial meeting to scale up cancer care in the Eastern Mediterranean Region, Cairo, Egypt, 21–22 July 2014
Consultative meeting to finalize a manual for influenza/acute respiratory infection surveillance in displaced population settings, Tunis, Tunisia, 15–17 August 2014
Consultative meeting on tobacco advertising, promotion and sponsorship (TAPS) in drama, Cairo, Egypt, 24–25 August 2014
Review meeting of phase II of the Middle East polio outbreak response, Beirut, Lebanon, 6–7 September 2014
Consultation to finalize WHO package for tuberculosis control in complex emergencies, Cairo, Egypt, 8–9 September 2014
Meeting with the heads of Hajj medical missions, Jeddah, Saudi Arabia, 16–17 September 2014
G5 Meeting on strengthening cross-border collaboration to facilitate the implementation of the International Health Regulations (2005), Teheran, Islamic Republic of Iran, 30 September – 1 October 2014
Meeting of the regional programme review group on lymphatic filariasis elimination and other preventive chemotherapy programmes, Khartoum, Sudan, 18–20 November 2014
Regional consultation on strengthening service provision through the family practice approach: towards universal health coverage in the Eastern Mediterranean Region, Cairo, Egypt, 17–19 November 2014
Consultative meeting on strategic planning for TB elimination in low burden countries of the Eastern Mediterranean Region, Cairo, Egypt, 23–27 November 2014
Project evaluation and team meeting of GLAAS 2013/2014 regional project, Amman, Jordan, 25–27 November 2014
Consultation on health workforce development in the Eastern Mediterranean Region, Cairo, Egypt, 2–4 December 2014

Annex 3. Meetings held in the Eastern Mediterranean Region, 2014 *(continued)*

Meeting title, location and date
Consultations
Consultation on development of a draft regional nutrient profiling module, Tunis, Tunisia, 8–10 December 2014
Consultation for review and finalization of the school mental health package, Cairo, Egypt, 17–19 December 2014
Intercountry meetings
Technical meeting on maternal and child health acceleration plans, Cairo, Egypt, 14 April 2014
Second annual regional meeting to scale up implementation of the UN Political Declaration on Noncommunicable Diseases Prevention and Control, Cairo, Egypt, 24–25 April 2014
Intercountry meeting on care for children in the community: component of the maternal and child health plans, Alexandria, Egypt, 27–29 April 2014
Eastern Mediterranean Drug Regulatory Authorities Conference, Amman, Jordan, 5–8 May 2014
Regional meeting to establish event based surveillance in countries as required under the International Health Regulations (IHR) 2005, Cairo, Egypt, 13–15 May 2014
Regional meeting on strengthening the implementation of social health insurance schemes for universal health coverage, Amman, Jordan, 1–4 June 2014
Regional meeting of Ministry of Health focal persons for injury prevention, Amman, Jordan, 23–25 June 2014
Regional meeting on engaging private health sector for accelerating progress towards universal health coverage, Cairo, Egypt, 23–25 June 2014
Sixth intercountry meeting of national malaria programme managers from HANMAT and PIAM-net countries, Cairo, Egypt, 13–14 August 2014
Third intercountry meeting for polio staff, Muscat, Oman, 1–3 September 2014
Health information system strengthening meeting, Cairo, Egypt, 1–4 September 2014
Annual meeting of reproductive and maternal health programme managers: addressing main causes of maternal mortality, Cairo, Egypt, 7–10 September 2014
Regional meeting on strengthening the integration and management of noncommunicable diseases in primary health care, Cairo, Egypt, 8–10 September 2014
Twenty-second meeting of national AIDS programme managers, Cairo, Egypt, 8–11 September 2014
Intercountry meeting to scale up action on mental health in the Eastern Mediterranean Region, Cairo, Egypt, 15–17 September 2014
Intercountry meeting for the development of an action plan for the Code of Marketing for Breast-milk Substitutes, Cairo, Egypt, 22–24 September 2014
Intercountry meeting on Good Governance for Medicines for best performing phase II countries in the Eastern Mediterranean Region, Muscat, Oman, 22–25 September 2014
Intercountry meeting on the implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC): What is next?, Cairo, Egypt, 23–25 September 2014
Programme managers' meeting on leprosy elimination in the Eastern Mediterranean Region, Rabat, Morocco, 29–30 October 2014
Intercountry meeting on pandemic preparedness plan for influenza, Amman, Jordan, 10–13 November 2014
Twenty-eighth intercountry meeting of national managers of the expanded programme on immunization and the twenty-ninth meeting of the Regional Technical Advisory Group on Immunization (RTAG), Amman, Jordan, 16–19 November 2014

Annex 3. Meetings held in the Eastern Mediterranean Region, 2014 *(continued)*

Meeting title, location and date
Intercountry meetings
Fifteenth intercountry meeting on measles/rubella control and elimination, Amman, Jordan, 22–25 November 2014
Intercountry meeting on strengthening medical education in the Eastern Mediterranean Region, Cairo, Egypt, 25–27 November 2014
Second intercountry meeting on health technology assessment (HTA): guidelines on establishment of HTA programmes within national health systems, Cairo, Egypt, 1–4 December 2014
Regional meeting on the implementation of the regional strategy on health and environment and framework for action, 2014–2019, and regional consultation on air quality and health, Amman, Jordan, 8–11 December 2014
Workshops and trainings
Subregional training on the use of real-time polymerase chain reaction technique for diagnosis and detection of influenza H7N9 virus, Cairo, Egypt, 17–19 February 2014
Subregional training on the use of real-time polymerase chain reaction technique for diagnosis and detection of influenza H7N9 virus, Cairo, Egypt, 3–5 March 2014
Regional workshop to guide Member States on developing and implementing a national plan for preventing avoidable blindness 2014–2019, Cairo, Egypt, 18–20 March 2014
Regional workshop on health financing analytical tools: informing country strategies, Cairo, Egypt, 4–8 May 2014
Workshop to support the implementation of WHO recommendations on salt and fat reduction in Gulf Cooperation Council countries, Al Ain, United Arab Emirates, 6–7 May 2014
Joint WHO/FFI/smarter futures training for millers and regulatory staff from countries in north Africa and the Middle East on quality assurance and quality control for flour fortification, Casablanca, Morocco, 12–15 May 2014
First subregional training on laboratory diagnosis of viral haemorrhagic fevers, NAMRU-3, Cairo, Egypt, 18–22 May 2014
AFP surveillance data management (IFA) training workshop (Group A), Cairo, Egypt, 1–5 June 2014
Second subregional training on laboratory diagnosis of viral haemorrhagic fevers, Cairo, Egypt, 1–5 June 2014
AFP surveillance data management (IFA) training workshop (Group B), Cairo, Egypt, 8–12 June 2014
AFP surveillance data management (IFA) training workshop (Group C), Cairo, Egypt, 15–19 June 2014
Training workshop on bio-risk management and shipping of infectious substance for tuberculosis laboratories in the Eastern Mediterranean Region, Cairo, Egypt, 22–26 June 2014
Regional training workshop on the revised WHO methodology for assessment of adverse events following immunization, Muscat, Oman, 23–26 June 2014
Workshop on development a national plan for all hazard emergency preparedness, Amman, Jordan, 11–19 August 2014
Regional training workshop on integrated vector management, Cairo, Egypt, 16–21 August 2014
Global learning programme on national health policies and strategic planning workshop, Cairo, Egypt, 24–28 August 2014
Workshop to enhance surveillance for SARI with the focus on early detection and response for MERS-CoV, Tunis, Tunisia, 3–5 September 2014

Annex 3. Meetings held in the Eastern Mediterranean Region, 2014 *(concluded)*

Meeting title, location and date
Workshops and trainings
AFP surveillance data management (IFA) training workshop (Group A), Cairo, Egypt, 7–11 September 2014
Regional capacity-building workshop on health system strengthening for GHI/HSS eligible countries and other selected countries, Sharm El Sheikh, Egypt, 14–18 September 2014
Laboratory information for action (IFA) system update training workshop, Amman, Jordan, 14–18 September 2014
Workshop on strengthening noncommunicable disease surveillance and monitoring in the Eastern Mediterranean Region (in collaboration with EMPHNET), Cairo, Egypt, 21–25 September 2014
Subregional workshop on ship inspection and issuing of ship sanitation certificates as required under the International Health Regulations 2005, Tangier, Morocco, 22–25 September 2014
Subregional training on laboratory management of Ebola virus disease, NAMRU-3, Cairo, Egypt, 28–30 October 2014
Second global learning programme; national health policies and strategic planning (GLP-NHPSP) workshop, Cairo, Egypt, 16–20 November 2014
Regional workshop on developing a national plan for all-hazard emergency preparedness and response in line with the International Health Regulations, Manama, Bahrain, 8–11 December 2014
Training of epidemiologists and virologists on integrating epidemiological and virological surveillance under the pandemic influenza preparedness (PIP) framework, Cairo, Egypt, 14–16 December 2014
Regional workshop on cost-effectiveness analysis: tools for decision-making in health, Cairo, Egypt, 14–18 December 2014

Annex 4. New publications issued in 2014

Title	Originator
Publications	
Communicable diseases in the Eastern Mediterranean Region: prevention and control 2012–2013 Language: English	Regional Office
Core indicators for adolescent health: a regional guide Language: English	Regional Office
Demonstration of sustainable alternatives to DDT and strengthening of national control capabilities in Middle East and North Africa: mid-term review Language: English	Regional Office
Establishing a national substance use treatment information system: a step-by-step guide Language: English	Regional Office
Food and nutrition surveillance systems: a guide for trainers Language: English	Regional Office
Food and nutrition surveillance systems: a manual for policy-makers and programme managers Language: English	Regional Office
Framework for action on cutaneous leishmaniasis in the Eastern Mediterranean Region 2014–2018 Language: English/French	Regional Office
Framework for health information systems and core indicators for monitoring health situation and health system performance 2014 Language: English	Regional Office
Guide for rapid assessment of interactions between HIV programmes and health systems Language: English	Regional Office
Health diplomacy: policy brief Language: Arabic/English/French	Regional Office
Health inequities in the Eastern Mediterranean Region: selected country case studies Language: English	Regional Office
HIV test-treat-retain cascade analysis: guide and tools Language: English	Regional Office
Malaria in the Eastern Mediterranean Region 2013 Language: English	Regional Office
Manual for case management of cutaneous leishmaniasis in the WHO Eastern Mediterranean Region Language: Arabic/English/French	Regional Office
Preventing suicide: a global imperative Language: Arabic	Headquarters
Preventing suicide: a manual for case registration of suicide and attempted suicide Language: English	Regional Office
Primary ear and hearing care training resource: advanced level Language: Arabic	Headquarters
Primary ear and hearing care training resource: basic level Language: Arabic	Headquarters

Annex 4. New publications issued in 2014 *(continued)*

Title	Originator
Publications	
Primary ear and hearing care training resource: student's workbook intermediate level Language: Arabic	Headquarters
Primary ear and hearing care training resource: trainer's manual intermediate level Language: Arabic	Headquarters
Promoting physical activity in the Eastern Mediterranean Region through a life-course approach Language: Arabic /English	Regional Office
Promoting physical activity through the life course: a regional call to action Language: Arabic /English	Regional Office
Regional strategy for the improvement of civil registration and vital statistics systems 2014-2019 Language: English	Regional Office
Right to health: crossing barriers to access health in the occupied Palestinian territory, 2013 Language: English	Country Office
The work of WHO in the Eastern Mediterranean Region: annual report of the Regional Director 2013 Language: Arabic /English /French	Regional Office
Use of rapid HIV tests in HIV testing strategies Language: English	Regional Office
Periodicals	
Eastern Mediterranean Health Journal; Vol. 20 No.1 –No.12 Languages: Arabic/English/French	Regional Office
IMEMR current contents Vol. 13 No.1–No.4 Language: English	Regional Office
Fact sheets	
Raise taxes on tobacco Language: Arabic/English/French The WHO Framework Convention on Tobacco Control Protecting tobacco control from tobacco industry interference Tobacco taxation Second-hand smoke Tobacco product regulation Tobacco packaging and labelling Tobacco advertising, promotion and sponsorship Tobacco use in films Tobacco cessation The illicit trade in tobacco products Tobacco cultivation Tobacco surveillance The effects of tobacco use on health Waterpipe tobacco use Smokeless tobacco use	Regional Office

Annex 4. New publications issued in 2014 *(concluded)*

Title	Originator
Publications	
Young people and tobacco use Women and tobacco use Tobacco and poverty Tobacco use and religion Health professionals and tobacco control Further reading Language: English	Regional Office
Publications online	
Analysis of the private health sector in countries of the Eastern Mediterranean: exploring unfamiliar territory Language: English	Regional Office
Assessing the regulation of the private health sector in the Eastern Mediterranean: Egypt Language: English	Regional Office
Assessing the regulation of the private health sector in the Eastern Mediterranean: Yemen Language: English	Regional Office
Health system profile: Afghanistan 2012 Language: English	Regional Office
Health system profile: Lebanon 2012 Language: English	
Health system profile: occupied Palestinian territory 2012 Language: English	Regional Office

Annex 5. WHO collaborating centres in the Eastern Mediterranean Region as at December 2014

Field	Title	Country	Institution name
Cancer	WHO Collaborating Centre for Research on Gastrointestinal Cancer	Islamic Republic of Iran	Digestive Diseases Research Centre
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
Classifications of diseases	WHO Collaborating Centre for Family of International Classifications	Kuwait	Ministry of Health
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 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
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
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 Sciences	Lebanon	American University of Beirut
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

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

Field	Title	Country	Institution name
Infectious diseases	WHO Collaborating Centre for Emerging and Re-emerging Infectious Diseases	Egypt	US Navy Medical Research Unit No. 3
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
Metabolic bone disorders	WHO Collaborating Center for Metabolic Bone Disorders	Lebanon	American University of Beirut
Nursing	WHO Collaborating Centre for Nursing Development	Bahrain	College of Health Sciences, Ministry of Health
Nursing	WHO Collaborating Centre for Education and Research in Nursing and Midwifery	Islamic Republic of Iran	Iran University of Medical Sciences
Nursing	WHO Collaborating Centre for Nursing Development	Jordan	Jordan University of Science and Technology (JUST)
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
Occupational health	WHO collaborating centre for occupational health	United Arab Emirates	United Arab Emirates University
Oral Health	WHO Collaborating Centre for Primary Oral Health Care	Kuwait	University of Kuwait
Osteoporosis and diabetes	WHO Collaborating Centre for Research and Education on Management of Osteoporosis and Diabetes	Islamic Republic of Iran	Teheran University of Medical Sciences
Pharmaceutical	WHO Collaborating Centre for Pharmacovigilance	Morocco	Centre Anti Poison et de Pharmacovigilance du Maroc
Pharmaceutical	WHO Collaborating Centre for Drug Registration and Regulation	Tunisia	Directorate for Drugs and Pharmacy, Ministry of Public Health

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

Field	Title	Country	Institution name
Prevention of blindness	WHO Collaborating Centre for the Eye Health and Prevention of Blindness Programme	Islamic Republic of Iran	Shahid Beheshti University of Medical Sciences and Health Services
Prevention of blindness	WHO Collaborating Centre for Prevention of Blindness	Pakistan	Al-Shifa Trust Eye Hospital
Prevention of blindness	WHO Collaborating Centre for Prevention of Blindness	Saudi Arabia	King Khaled Eye Specialist Hospital
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
Tobacco control	WHO Collaborating Centre on Tobacco Control	Islamic Republic of Iran	National Research Institute of Tuberculosis and Lung Disease (NRITLD)
Traditional medicine	WHO Collaborating Centre for Traditional Medicine	United Arab Emirates	Zayed Complex for Herbal Research and Traditional Medicine (ZCHRTM)
Transfusion medicine	WHO Collaborating Center for Research & Training on Blood Safety	Islamic Republic of Iran	Iranian Blood Transfusion Organization (IBTO)
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
Transfusion medicine	WHO Collaborating Centre for Training and Research in Blood Transfusion	United Arab Emirates	Sharjah Blood Transfusion and Research Centre
Tuberculosis	WHO Collaborating Centre for Tuberculosis Education	Islamic Republic of Iran	Shahid Beheshti University of Medical Sciences and 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 (ONEE)