The Work of WHO in the Eastern Mediterranean Region

Annual Report of the Regional Director 2015

World Health Organization
Regional Office for the Eastern Mediterranean

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Introduction and highlights of the report

This annual report covers the work of WHO in this Region in 2015 and the early part of 2016. It reflects the achievements made and the challenges encountered as well as the way forward and immediate next steps. It focuses in particular upon the five strategic priorities agreed by Member States in 2012: health systems strengthening towards universal health coverage; maternal and child health; noncommunicable diseases; health security and communicable diseases; and emergency preparedness and response.[1]

Universal health coverage is the overarching goal of our work with Member States in strengthening health systems. It is a goal that was established by the WHO Regional Committee for the Eastern Mediterranean in 2012 and since then we have been supporting countries in implementing the actions included in the regional framework for action. The level of commitment to universal health coverage shown by Member States is high. In the past 18 months, WHO has supported countries in several areas that are key to moving forward on universal health coverage, including assessments in health financing, health policy and strategic planning, health sector regulation, and capacity development to support strengthening of public health laws and regulation. The regional framework for action, covering the four areas for universal health coverage (developing a vision and strategy; improving financial protection, expanding service coverage, and ensuring population coverage) will continue to be updated based on the needs of Member States and will remain as a guide for technical support to countries and for monitoring progress.

The Regional Office also initiated strategic collaboration with an extensive network of international experts through the Disease Control Priorities 3 (DCP3) Project to develop a high-priority package of essential services for universal health coverage. The criteria used for inclusion of interventions in this package include evidence of impact, cost-effectiveness, and affordability. The progress of work in this initiative will be reviewed in a special session planned on the margins of the Regional Committee at its 63rd session.

Renewed focus was placed on developing workforce capacity, which is a major challenge across the Region. A series of consultations in the past 18 months have focused on developing a regional framework to implement the global strategy on human resources for health, endorsed by this year's session of the World Health Assembly, and a comprehensive strategic framework to strengthen nursing and midwifery which was also launched in the ministerial meeting in May 2016. A comprehensive review of medical education was

[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/

Photo: ©WHO

↑ **Participants in the Fifth seminar on health diplomacy, Cairo, May 2016**

undertaken, including an in-depth assessment of the situation in countries of the Region, conducted in collaboration with the International Federation of Medical Education, and active involvement of Member States. The Regional Committee subsequently endorsed a regional framework for action aimed at reform of medical education in the Region and this is planned to be discussed with ministers of health and higher education in a high-level meeting in 2017. To strengthen leadership in health and build public health capacity in Ministries of Health, a leadership course for senior health officials was established in 2015, and successfully implemented in two rounds, in Geneva and Muscat in collaboration with the Harvard School of Public Health. More than 50 future health leaders have graduated and the course will continue to be conducted on annual basis. The Regional Office continues to host an annual seminar on health diplomacy for senior officials of ministries of health and foreign affairs, diplomats and parliamentarians.

Work continued in other areas of strategic importance to strengthening health systems, including regulation of the pharmaceutical sector and of medical devices, promotion of the family practice approach, regulating and partnering with the private sector, strengthening of hospital management and patient safety, civil registration and vital statistics, and health information systems. The Region now has the most comprehensive information available among all WHO regions of the situation with regard to civil registration and vital statistics systems. Based on the comprehensive assessments conducted in most Member States, a regional strategy to strengthen civil registration including reporting of cause specific mortality is now available to guide countries in implementing priority actions.

WHO continued to support implementation of the regional framework on health information systems and use of the core indicators and to build capacity to strengthen collection, reporting

and dissemination of data. A practical tool has been developed to assess the gaps in the capacity of countries in generating and using reliable data for the 68 regional core health indicators. The assessment will be used to recommend actions to address the gaps and strengthen health information systems. Comprehensive health profiles, which document the current situation, challenges, gaps, opportunities and way forward in each health programme, have also been developed and updated in collaboration with Member States. Every country now has a brief sheet containing the key health indicators as well as an outline of the strengths, potential weaknesses, challenges and priorities for its own health system. These profiles are updated annually in close consultation with the Ministry of Health.

The road map for universal health coverage endorsed by the Regional Committee in 2014 will continue to guide our work in strengthening health systems. We will continue to focus on building capacity in leadership and governance. Health policy analysis and planning, health legislation and regulation, and continued strengthening of health information systems, including civil registration and vital statistics, will remain important areas of work. Strategic guidance on health workforce development will be finalized. Priority will be given to supporting countries in implementing the strategic framework on nursing and midwifery while the planned high-level meeting of ministers of health and medical education is expected to be particularly important in shaping the future of regional reform in medical education.

By the end of the year it was clear that the Region had 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 fell short of meeting the overall regional targets of MDGs 4 and 5. The regional initiative on saving the lives of mothers and children continued to target the main challenges in countries with a high burden of maternal and child deaths. The nine high-burden countries have launched maternal and child health acceleration plans, initially aimed at improving outcomes towards the MDG targets, but also preparing the way for the Sustainable Development Goals (SDGs) set for 2030. WHO also focused on quality of care, including preconception and neonatal care, which are becoming increasingly important elements of maternal and child survival in the Region.

Implementation of the United Nations global strategy and the relevant SDG3 targets will be important drivers of progress in women's, children's and adolescents' health. We will continue to focus on building capacity in countries to end preventable deaths among women, children and adolescents. In this regard, WHO will focus on supporting and monitoring progress in, and the implementation of action plans on, reproductive, maternal, newborn and child health. Special emphasis will be placed on strengthening preconception and neonatal care. A list of evidence-based public health interventions for preconception care, including high-impact interventions for the prevention and control of congenital and genetic disorders, will be finalized for recommendation to countries by the end of 2016.

Nutrition remains an area of concern. A regional roadmap was developed for countries to implement the global targets set by the World Health Assembly in 2012 and the recommendations of the Second International Conference on Nutrition (ICN-2). Most countries now have national strategies or action plans. The regional policy statement on the urgent need to fully implement the International Code of Marketing of Breast Milk Substitutes

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

was promoted while the number of nutrition stabilization centres for treatment of severe and complex cases of malnutrition was expanded in countries in emergency situations.

Noncommunicable diseases remain the biggest cause of premature death in the Region, in particular heart disease, cancer, chronic lung disease and diabetes. Despite high-level political commitments to action and some impressive achievements by some countries, progress has generally been inadequate, patchy and uneven. Tobacco use is still increasing, the rates of overweight and obesity in both adults and children are alarmingly high in most countries and there is no evidence that trends of other risk factors, including physical inactivity, are improving.

We continued to focus on supporting countries to implement the Political Declaration of the 2011 High-Level Meeting of the United Nations General Assembly *on the Prevention and Control of Non-Communicable Diseases, through the* regional framework for action endorsed by the Regional Committee in 2012. At global level, the Regional Office played an important role in advocacy for an accountability framework to measure progress, while the contribution of countries was substantial in ensuring that the 10 indicators crafted globally to measure the progress made by Member States were aligned with the indicators of the regional framework for action. Countries are now better able to monitor and report on progress in relation to the time-bound commitments set by the Political Declaration.

The regional framework addresses prevention and control through four areas: governance, surveillance, prevention and health care. In 2015, we provided each Member State with the first issue of an annual brief profile of its national response, based on the 10 process indicators. This enabled countries to see at a glance the progress made in implementation. So far, less than a third of countries have national multisectoral strategies or plans for the prevention and control of noncommunicable diseases, or have set national voluntary targets, which are essential first steps. We conducted extensive advocacy in 2015 and early 2016 to highlight the importance of these issues.

A number of key actions were also taken at regional level to support countries in a multisectoral response. These included the development, in collaboration with the WHO Collaborating Centre at Georgetown University, of a dashboard and policy briefs on best practices in health legislation for noncommunicable diseases, as well the publication of policy guidance on reducing dietary intake of sugar, complementing the policy guidance on reducing dietary intake of salt and fat. Support was also provided to countries to update tobacco control legislation and to build capacity for promotion of physical activity.

Full engagement of non-health sectors will be crucial in ensuring continued progress in implementing the regional framework for action to implement the United Nations Political Declaration on noncommunicable diseases. WHO will continue to work with Member States to achieve the progress needed by the time of the next United Nations review in 2018, but such progress will basically depend on the commitment and actions of Member States.

Also in 2015, the Regional Committee endorsed a practical and evidence-based regional framework to scale up action on mental health and operationalize the comprehensive action plan for mental health 2013–2020. Four domains of action were identified by the regional framework: governance, prevention, health care and surveillance.

Important progress was made in 2015 to improve health security in the Region. Following the rapid external assessments conducted by the Regional Office at the end of 2014 and beginning of 2015, of Member States' capacity to detect and respond to a case of Ebola virus disease, it became clear that countries' readiness to fully implement the capacities required under the International Health Regulations (IHR 2015) was considerably lower than was reported through self-assessment. In 2015, the Regional Committee decided therefore to establish a regional assessment commission to facilitate and provide technical guidance to countries and to oversee a process of independent joint external evaluation, a shift from self-assessment, in order to objectively assess the country's capacity to prevent, detect and respond to health security threats. At the same time it called for harmonization of the existing assessment tools available, as a result of which our region became a leading player in the development of the joint external evaluation (JEE) tools which are now accepted globally by all parties concerned.

Joint external evaluation for IHR capacities, using the new tools, has been conducted in four countries in the Region so far and a plan has been developed to conduct such independent and objective assessments in at least 10 countries by the end of 2016 and all countries by the end of 2017. This is a very important step forward. Nevertheless, serious challenges exist to the efforts to prevent and control emerging and re-emerging diseases and all countries will have to reinforce their capacities in dealing with threats to health security. Over the next 18 months the work will continue in order to ensure that all Member States are evaluated, that action plans are prepared based on the evaluation outcomes and that implementation to address the gaps is begun without delay.

Outbreaks of communicable disease were a continuing threat throughout 2015 as conflict and population displacement continued to escalate, posing challenges for maintenance of immunization coverage as well as other essential and life-saving public health services. Our response has been to continue to focus, and double our efforts, on helping Member States to establish effective and timely disease surveillance, for example- expanding the early warning, alert and response network (EWARN) in crisis-affected countries and enhancing the early warning surveillance system for influenza, respiratory diseases and other infectious diseases, in order to early detect and rapidly respond to these health threats. Lack of access to insecure areas to implement appropriate control interventions resulted in outbreaks of dengue fever in Sudan and Yemen, and cholera in several different countries. Nevertheless, the rapid detection and

Photo: ©WHO

↑ The Regional Centre for Health Emergencies and Polio Eradication was inaugurated in Amman, Jordan, in a ceremony held under the patronage of HRH Princess Muna Al-Hussein of Jordan

containment of these outbreaks, particularly a cholera outbreak in Iraq, as well of the frequent hospital outbreaks of MERS in Saudi Arabia, are some of the impressive examples of WHO's timely and effective response, thus preventing any major international health emergency from the continuing and widening threats to health security in the Region.

Good progress was made with regard to eradication of polio in the two remaining endemic countries of Afghanistan and Pakistan, although there are still areas where poliovirus continues to circulate. By mid May 2016, all countries had made the globally required switch from trivalent to bivalent oral poliovirus vaccine for routine and campaign use. The positive progress in polio eradication gives great cause for hope. There is now a great deal of optimism that the work we are doing in this region is now at a turning point for finishing the job of global polio eradication. We must continue to maintain our support for the programmes in Afghanistan and Pakistan and the highest commitment to ensuring all children are immunized everywhere. Likewise, in order to prevent outbreaks we must, and will, continue to ensure provision and maintenance of immunization coverage for all childhood diseases in emergency contexts, where many children remain hard to reach.

The Regional Committee endorsed the Eastern Mediterranean vaccine action plan, as a framework for implementation of the global vaccine action plan, as well as the regional malaria action plan 2016–2020 for implementation of the global technical strategy for malaria 2016–2030. We convened and engaged a broad range of stakeholders in the development of a regional action plan for viral hepatitis.

2015 saw a significant deterioration in the humanitarian situation in the Eastern Mediterranean Region. The crisis in Yemen was designated a highest threat level (Level 3) emergency by the United Nations in July 2015 and the Region now hosts three Level 3 emergencies, including the crises in Iraq and the Syrian Arab Republic. Overall throughout the Region, more than 62 million people were in need of health services as a result of emergencies by the end of 2015, placing a significant strain on already weakened and overwhelmed health systems. More than 60% of all refugees and internally displaced persons originate from the Region; in Lebanon, refugees now comprise a third of the total population.

Photo: ©WHO

↑ On a visit to Dohuk Governorate, Iraq, the Regional Director inaugurated a primary health care centre for internally displaced persons, established with WHO support

Shortages in specialized medical staff, medicines and medical equipment, and other health resources, especially in areas where access for WHO and partners was limited, had severe impact on the delivery of health services, contributing to the deterioration in the health status of some populations and an increased number of preventable deaths. Despite resource limitations and the major gaps in humanitarian funding, our regional emergency response programme was restructured in 2015 and considerably strengthened to deal with the unprecedented increase in the number, magnitude and severity of crises requiring WHO's support. Our capacity in leading humanitarian health relief has been reinforced and we continued to prioritize the WHO response to crisis in the Region ensuring the provision of essential medicines, supplies and humanitarian aid, as well strengthening disease surveillance, immunization campaigns, trauma care services, management of chronic diseases and mental health support. We continued to seek and implement approaches and strengthen partnerships to ensure people trapped in hard-to-reach areas were able to receive health care wherever possible, and to support mobile health services.

It is clear, and has been highlighted by the Regional Committee in a number of sessions, that we need to ensure a more systematic and effective approach, both within countries and across the Region, to responding to the health needs of populations affected by conflict and emergencies and to ensuring that health systems in all affected countries are strengthened and continue to deliver urgently needed health services to displaced populations and host communities. This will require improved and expanded coordination, action and engagement from other sectors and stakeholders including the affected communities themselves.

Following the endorsement in May 2016 by the World Health Assembly of the new WHO health emergencies programme, additional restructuring has taken place and a substantial increase in human resources is already planned.

The Regional Emergency Solidarity Fund was activated in January 2016 to ensure predictable financing of surge/rapid response to natural and man-made disasters in the Region and the WHO logistics hub, established in Dubai's International Humanitarian City to ensure the timely provision of critically needed medicines, medical supplies and medical equipment to countries in the Region and beyond, was operationalized. I hope that Member States in the Region will continue to support resource mobilization efforts for humanitarian and health support in affected countries, as well as in providing much needed technical and response capacity.

Throughout the past 18 months we have continued to complement our technical and operational activities with parallel actions to strengthen managerial effectiveness. This included continued emphasis on accountability, transparency and

efficiency, and on strengthening the WHO workforce, especially at country level. Compliance is now monitored through a monthly compliance dashboard and is tied in with performance appraisal mechanisms. We increased focus on capacity-building initiatives, such as an integrated training programme for budget centres, dedicated compliance forums and outreach initiatives. This has yielded positive initial results in terms of improved management, compliance and accountability, including a decrease of over 80% in overdue reports on direct financial contributions compared with 2013, a decrease of over 80% in overdue donor reports compared with 2014 and closure of the majority of outstanding external and internal audit recommendations. A project was also completed to address non-compliance in non-staff contractual modalities.

In keeping with the practice of the past few years, a high-level meeting for ministers and representatives of Member States and permanent missions in Geneva was held prior to the World Health Assembly. These meetings continue to provide an opportunity to review, with ministers of health and senior government officials, progress in addressing key priorities since the previous Regional Committee and to strengthen Member States' engagement in global discussions on health and WHO reform.

There is clear evidence that this region is leading in several programme areas within WHO. The work we are doing in health system strengthening, health security and noncommunicable diseases has laid the groundwork for many years to come and provides a strong basis for countries to move forward with confidence. It is also increasingly recognized in our region that collaboration between sectors is essential for the achievement of long-term health and development goals. Nevertheless, there is still a long way to go. As we move forward into the post-2015 era and Member States initiate work towards the SDGs, there are four key areas that will receive attention in our work: advocacy for the SDG health targets; harmonization of existing WHO health strategies with the SDG targets; identification of more effective mechanisms for multisectoral action both within countries and at the regional and global levels; and strengthening of health information systems to support progress monitoring. 2016–2017 will be crucial in laying this foundation.

Ala Alwan
WHO Regional Director for the
Eastern Mediterranean

Strengthening health systems for universal health coverage

Universal health coverage

In 2015, WHO intensified its support to Member States in order to accelerate progress towards universal health coverage, fulfil the commitments made by the WHO Regional Committee for the Eastern Mediterranean in resolution EM/RC60/R.2 (2013) and implement the regional framework for action on advancing universal health coverage (EM/RC61/R.1). The framework focuses on four key aspects: developing a vision and strategy for universal health coverage; enhancing financial risk protection; expanding the coverage of needed health services; and ensuring expansion and monitoring of population coverage.

Health financing, expanding population coverage and access to services

Despite notable progress, countries continue to grapple with inefficiencies, inequities and challenges to sustainability of financing health systems. Overcoming these obstacles is essential to fulfilling the goals of universal health coverage. In 2015, WHO's support centred around: pursuing the analysis of health financing systems in countries; undertaking high-level technical reviews of ongoing health system and financing reforms; engaging in policy dialogue to identify country-specific health financing options; and building regional and national capacities in specialized areas of health financing.

The health financing systems of seven countries were analysed using the WHO tool OASIS to assess the institutional and organizational practices with regard to the collection, pooling and purchasing functions of health financing. Two high-level

Photo: ©WHO

↑ Participants in the second round of the leadership for health programme, November 2015/January 2016

review missions were organized – to the Islamic Republic of Iran to assess the appropriateness and impact of the health transformation plan launched in 2014, and to Tunisia to inform the country's national health strategy. High-level policy dialogue sessions were organized in four countries to identify health financing options for universal health coverage. Capacity-building efforts focused on strategic purchasing for reforming provider payment methods, and on measuring financial risk protection to monitor progress towards universal health coverage.

An expert consultation and a regional meeting on expanding coverage to informal and vulnerable groups resulted in a draft roadmap for expanding health coverage to the informal sector and vulnerable groups in the Region. Policy briefs on provider payment methods and demand-side financing were produced and disseminated.

The Regional Office initiated strategic collaboration with an extensive network of international experts through the Disease Control Priorities 3 (DCP3) Project to develop a high-priority package of essential services for universal health coverage. The criteria used for inclusion of interventions in this package include evidence of impact, cost-effectiveness, and affordability. The progress of work in this initiative will be reviewed in a special session planned on the margins of the next session of the Regional Committee. Countries have demonstrated progress towards universal health coverage by expressing high-level political commitment, developing a well defined strategy and adopting innovative approaches to mobilize additional resources. There is some evidence of reduction in the share of out-of-pocket spending. The inclusion of universal health coverage as a target of Goal 3 of the Sustainable Development Goals has given further impetus to furthering progress. In 2016–2017 work will particularly focus on exploring innovative means of mobilizing resources, expanding financial risk protection that focuses on the informal and vulnerable segments of the population, reducing wastage of resources through better tracking of expenditure and improving the monitoring of country progress towards universal health coverage.

Health governance and human rights

A regional assessment of the capacity of ministries of health in policy formulation and strategic planning was completed and was followed by a capacity development workshop on strategic planning. The assessment identified some of the gaps in planning. These include: limited staff and skills in the various areas of health policy analysis and planning; multiple health plans with varying degrees of resource commitments; different planning structures within ministries and communications challenges between them; and frequent change in leadership, often affecting continuity of planning priorities.

A regional assessment of external assistance and aid effectiveness was conducted in eight countries, using specific tools and instruments for data collection from governments, development partners (bilateral and multilateral agencies) and nongovernmental organizations. The findings of the study were presented in a high-level consultation with major donors and development partners in early 2016. It is expected that coordination between donors and development partners will be improved by establishing a forum of regional development partners.

The work on health sector regulation, with a focus on the private sector, involved assessment studies in three additional countries. These were followed by a regional capacity development activity and

the development of a manual on regulation of the private sector. A regional capacity-building course on human rights and health equity, focusing on the importance of health as a human right and aimed at policy-makers and managers was piloted in Egypt and implemented in Pakistan.

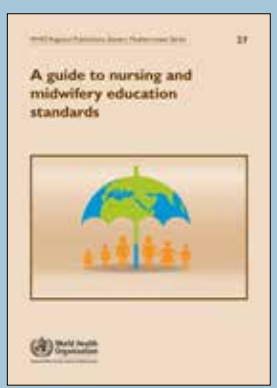
During 2016–2017 focus will be placed on building the institutional capacity of the health policy analysis and planning units in the ministries of health. Particular attention will be given to building the capacity to update health legislation, strengthening the capacity of regulatory bodies for private and public sector institutions, advocating for the value of health as a human right, and coordination among development partners and the efficient use of external assistance in development and humanitarian settings.

Health workforce development

Within the context of strengthening health systems and moving towards universal health coverage, health workforce development is a priority. The health workforce situation in the Region echoes the global trends, with overall shortages in numbers, inequitable distribution, and challenges to quality, retention and performance, accompanied by a diminishing workforce in countries with protracted emergencies. Critical shortages exist in group 3 countries while group 1 countries are heavily reliant on expatriate health workers[2]. Key issues include limited governance capacities, lack of coherent coordination among stakeholders/partners at the national level and lack of reliable information. The diverse situation in the Region means that different countries face different challenges, which have to be addressed accordingly.

To respond to the challenges and priority issues, a draft working document for health workforce development was developed through a series of consultations that have taken place since 2014. The resulting draft strategic framework is aligned with the global strategy on human resources for heath endorsed by the World Health Assembly in May 2016 and will be discussed by Member States on the margins of the Regional Committee in October 2016.

Strengthening medical education in the Region is of high priority. An assessment of the situation of medical education in different countries was conducted in collaboration with the International Federation of Medical Education, through a survey of medical schools together with a series of consultations on the subject. Based on the outcomes, a regional framework for action on medical education was developed which



↑ *A guide to nursing and midwifery education standards*

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

was endorsed by the Regional Committee. Implementation of the framework will be discussed with ministers of health and higher education in a high-level meeting planned for early 2017.

A leadership for health programme was launched in early 2015 in collaboration with the Harvard School of Public Health, to strengthen capacity among current and future public health leaders in the Region. The 4-week intensive programme was conducted in two parts, in two locations (Geneva and Muscat). Following the success of the first round, the second round was implemented in November 2015/January 2016.

In the area of nursing and midwifery, a comprehensive review of the challenges and obstacles impeding nursing and midwifery development was conducted. The findings were discussed at a regional forum on the future of nursing and midwifery in the Region, and a subsequent meeting of a group of international experts developed actions to address these challenges. The regional framework for action on strengthening nursing and midwifery 2016–2025 was presented to the ministers of health and senior health officials of Member States of the Region on the margins of the World Health Assembly in May 2016. . A consultation was also held in 2015 to review the regulation of nurses, midwives and allied health professionals. Priorities and options were identified to strengthen regulation with robust policies that will protect the health of the public.

Understanding of the situation of other health professionals is becoming an increasingly important issue. Tools and instruments have been developed to undertake a survey focusing initially on three groups – medical laboratory professionals, medical imaging professionals and rehabilitative services professionals. The survey, which is the first of its nature in the Region, will be completed in 2016.

The work on improving the quality of medical education through accreditation, among other means, and strengthening nursing and midwifery, through the implementation of the framework for action, will continue. Efforts will be intensified to strengthen national capacities on human resource for health governance, which will be necessary for implementing the regional strategic framework on human resources. Attention will be paid to strengthening the primary care workforce, regulating health workforce education and practice through accreditation and other means, improving health professional education capacities, addressing the challenges of the health workforce during emergencies and improving health workforce information and evidence through health workforce observatories.

Essential medicines and technologies

Access to quality assured and safe medical products (medicines, vaccines and medical devices) is a major challenge in the area of health technologies because of weak national regulatory systems and related functions for safeguarding the quality, safety and effectiveness of medical products circulating in local markets. The regulation of medical products is a priority for countries.

Harmonization and strengthening of post-market and vigilance regulatory functions for medicines, vaccines and medical devices were specifically promoted during the proceedings of a regional meeting on strengthening pharmacovigilance systems. In addition, regional guidance on how

Member States can develop and strengthen the regulation of medical devices through a step-wise approach was developed, based on existing regulatory practices in place in Jordan, Saudi Arabia and Sudan. Substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products are a threat to public health in all countries of the Region. Member States are actively participating in the steering committee of the Member States mechanism for combating SSFFC medical products.

Work progressed in the area of good governance for medicines (GGM) with five countries now in phase I, seven in phase II and three in phase III. Support was provided to national task force meetings in Afghanistan and Pakistan to discuss the outcome of the national transparency assessments and to draft their national frameworks. An intercountry meeting was held with phase I countries in which national action plans were developed up to the end of 2016. WHO collaborated closely with national teams in finalizing their national assessment reports. The diversity of the Region and political instability of many countries pose particular challenges. Table 1 shows vulnerability to corruption measures following an analysis of 11 country assessments conducted in 2015.

The regulatory functions of promotion and clinical trials were found to be extremely vulnerable to corruption in five and three countries, respectively. Inspection, selection and registration were found to be moderate to extremely vulnerable to corruption in most of the countries assessed. The presence of political commitment, as evidenced by having medicine laws in place and increased access to medicines, was identified as a common strength in countries. The absence of policies and standard operating procedures for conflict of interest, as well as a lack of collective adoption and implementation of codes of conduct were reported as common gaps in governance. The presence of capable national assessors was identified as a success factor, together with high-level political support leading to institutionalization of GGM in ministries of health.

The importance of building national technical capacities in health technology assessment was highlighted during the pre-session of the Regional Committee. Subsequently several countries requested support in improving or establishing assessment units within their national health systems, while interregional support to the development of programmes in other WHO regions (South-East Asia and Western Pacific)

Table 1
Good governance for medicines: vulnerability to corruption in 11 countries

Vulnerability level	Regulatory functions (no. of countries)							
	Registration	Licensing	Inspection	Promotion	Clinical trials	Selection	Procurement	Distribution
Extremely	1	–	1	5	3	1	–	–
Very	3	–	2	–	2	4	1	1
Moderately	3	5	5	6	–	5	3	1
Marginally	4	4	3	–	3	1	6	5
Minimally	–	–	–	–	–	–	1	4
Total	11	9	11	11	8	11	11	11

was also requested and the regional network established in 2014 expanded to include countries from those two regions. The network now has over 100 experts and national champions. Capacity-building on improving quality, access and use of medical devices continued, with over 70 staff trained in Afghanistan and Iraq.

A new initiative was launched on identifying low-cost priority medical devices in order to improve user access to quality health care services. During the first phase an inventory of essential medical devices was developed based on regional priorities. The initiative, which will be given priority in 2016–2017, aims to offer a solution to the unmet demand for certain medical devices and will hopefully assist potential donors and manufacturers to make them available at affordable prices. A perception-based survey on availability and affordability of anti-cancer medicines in the Region was completed, in collaboration with the European Society for Medical Oncology. Awareness campaigns were a first activity of the implementation of the global action plan on combating antimicrobial resistance in the Region. The very low availability and accessibility of controlled medicines continues to be of major concern in providing quality services, in the form of appropriate pain management, to patients undergoing cancer treatments or major surgical interventions.

In 2016, the focus will be on strengthening regulatory systems for all medical products through self-assessments followed by expert visits. Support will also be provided to overcome shortages in essential medicines and other medical products and to ensure balance in national policies on availability and accessibility of controlled medicines, especially for palliative care. The low-cost medical devices initiative will identify and compile a compendium of low-cost priority devices which will support countries in procurement. Pharmaceutical sector country profiles will be updated to identify gaps in key areas, such as regulation, policy, technical capacity, human resources and access to medicines. Building on the progress made in health technology policies, focus will be placed on establishing health technology assessment units in ministries of health to support sound decision-making and investment and on establishing medical device regulatory bodies.

Integrated service delivery

The quality of primary health care is a common challenge for all countries of the Region. In some low-income countries geographical access remains a challenge, while affordability is an issue in many low and middle-income countries. Many countries are still struggling to reconfigure primary health care to respond to the disease burden associated with noncommunicable diseases and mental

↑ *Technical guidance on patient safety*

health problems. The unregulated expansion of private health care providers poses additional challenges. In many countries affected by conflict health care systems have been disrupted and this poses serious challenges for access to primary care services.

Ensuring access to quality primary care services for all is an integral element of the strategy to achieve universal health coverage. WHO has adopted family practice as the principal approach to primary care and to promoting person-centred integrated health services in the Region. Equally, the role of community health workers, home health care and healthy cities remains critical to the work on primary health and community care. Several initiatives were supported to increase the production of family physicians and build capacities of existing providers, including the development of a strategy paper on scaling up the production of family physicians in the Region and of a 6-month course on principles and practice of family medicine for general practitioners, in partnership with the American University of Beirut. Country level support included a review of health care provision in several countries of the Region.

Work on the private health sector continued with a regional workshop focused on building country capacity in assessing, regulating and partnering with the private sector. In the area of hospital management a review of public sector hospitals was completed followed by a 10-day course on hospital management. Based on the evaluation and feedback received, the course, which is the first of its kind in the Region, will be offered to countries in 2016.

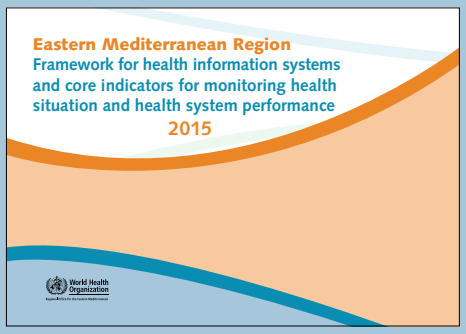
In the area of quality and safety, the patient safety assessment tool was revised and a toolkit of essential interventions published. A framework for quality improvement in primary care was developed, independently reviewed by peers and experts and piloted in 40 primary health care facilities in four countries. The tool is ready for

Photo: ©WHO

↑ HH Sheikh Dr Sultan bin Mohamed Al Qasimi, Ruler of Sharjah, receives the first WHO Healthy City Award in the Region

use by countries. In addition a tool for assessment of the Patient Safety Friendly Hospital initiative was reviewed and shared with countries during a regional consultation. An expert meeting on the principles and practice of health care accreditation critically reviewed the current evidence and the value of accreditation in improving quality of care.

The healthy city programme was successfully revived and the city of Sharjah was certified by WHO as the first healthy city in the Region following an external evaluation. WHO will continue to advocate for, and provide technical advice on the expansion of family practice programmes as the overarching strategy for service delivery towards universal health coverage. Support will be provided to improve the management and performance of hospitals and the quality of primary care. Countries in crisis will be supported to enhance health system resilience and ensure availability of health care in emergencies.



↑ ***Framework for health information systems and core indicators 2015***

Health information systems

As part of efforts to improve mortality statistics, and in line with the regional strategy on civil registration and vital statistics, technical guidance was developed to support countries in designing better mortality statistics systems and a pool of regional experts is being established to deploy to countries to support improvement in mortality statistics, working closely with the Economic and Social Commissions for Western Asia and Africa. Additional comprehensive assessments of civil registration and vital statistics systems were conducted; only three countries have not yet conducted their assessments. WHO is following up with countries with regard to reporting on their implementation plans based on the country priorities identified during the assessments. Technical support was provided in assessing the quality of cause-specific mortality data. Important progress has already been made. During 2015 more than 20 datasets from 12 countries were received and assessed for completeness using standard tools. The current death notification and registration forms used by countries were reviewed against international standards. Capacity-building was supported in death certification and ICD 10 coding in several countries.

As part of efforts to strengthen routine health information systems, to enable countries to report on the 68 regional core indicators endorsed by the Regional Committee in 2104 and the Sustainable Development Goals, a technical consultation was held to agree on the contents of a harmonized assessment tool which will be piloted in the Region in 2016. Capacity-building was supported to promote the use of the health management information system DHIS2 as a platform for data collection, reporting and dissemination. To address the major gaps in reporting indicators that are mainly generated from population-based surveys, tools were developed to support health examination surveys, covering behavioural and biological risk factors, health care unitization, health status and household health expenditure.

The survey will be implemented in 2016 in Tunisia with government support.

The work on the 68 core indicators continued with the development of a concise registry of metadata relating to the indicators, in addition to an expanded indicator list which will include the additional global list and indicators of Goal 3 of the Sustainable Development Goals. WHO will continue to support Member States in strengthening their health information systems reporting on the core indicators in the three key components of the health information system – health determinants and risks, health status including morbidity and mortality and health system response – in order to promote effective policy and decision-making processes. The regional health observatory was further enhanced to support better dissemination and use of health statistics in the Region. Comprehensive health profiles, which document the current situation, challenges, gaps, opportunities and way forward in each country and health programme, were developed in collaboration with Member States. They will continue to be updated annually.

Several challenges remain. Cause-specific mortality and ICD coding require further strengthening through continuous training and assessment of data quality. Population-based surveys and health system performance assessments need to be conducted on a regular basis. Countries will be encouraged to develop investment plans to address their capacity needs and to develop national health observatories to provide comprehensive data dissemination at subnational levels to address inequalities in health.

Research development and innovation

A number of important meetings and capacity development activities were held in the area of research development and innovation. The Eastern Mediterranean Advisory Committee on Health Research (EM-ACHR) was re-formulated and met to discuss the role of research in supporting strategic health priorities. It recommended building institutional capacity, supporting institutional research careers, promoting research and ethics for all health professionals, encouraging intersectoral collaborative and joint research (national, regional, international), developing large databases for research and using the research to brief health policy-makers.

The Eastern Mediterranean Research Ethics Review Committee met in support of ethical review of research funded by WHO which involves human subjects. The meeting focused on ensuring compatibility of its work with international guidelines for review of health research on human subjects; updating the current review process for health research supported by WHO; and addressing new health research challenges, including health policy and systems research. An expert consultation on evidence-based guideline development and adaptation was held and resulted in recommendations aimed at building capacity, meeting the needs of Member States, mapping guideline activities in the Region and developing guidelines for region-specific conditions for which no guidelines exist. The first meeting in more than 10 years of directors of collaborating centres in the Region resulted in the establishment of a network. Forty-five WHO collaborating centres are currently active in the Region.

In collaboration with the Norwegian Knowledge Centre for Health Services, capacity development was supported for researchers, focused on preparation of user-friendly summaries of systematic reviews of health system evidence for policy-makers and stakeholders in low and middle income countries, and of SUPPORT summaries. Eight well prepared summaries addressing main public health problems in the Region resulted. WHO continued to support three grant schemes: research priorities in public health; improved programme implementation through embedded research (iPIER), offered in collaboration with the Alliance for Health Policy and Systems Research; and the tropical disease research small grants scheme.

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, gender and equity, nutrition, injury prevention and disabilities. In 2015, WHO continued its efforts to protect and promote the health, safety and well-being of the population in the Region, across the life course. From conception to old age, diverse population health needs were addressed, while focusing on maternal and child health as a strategic priority.

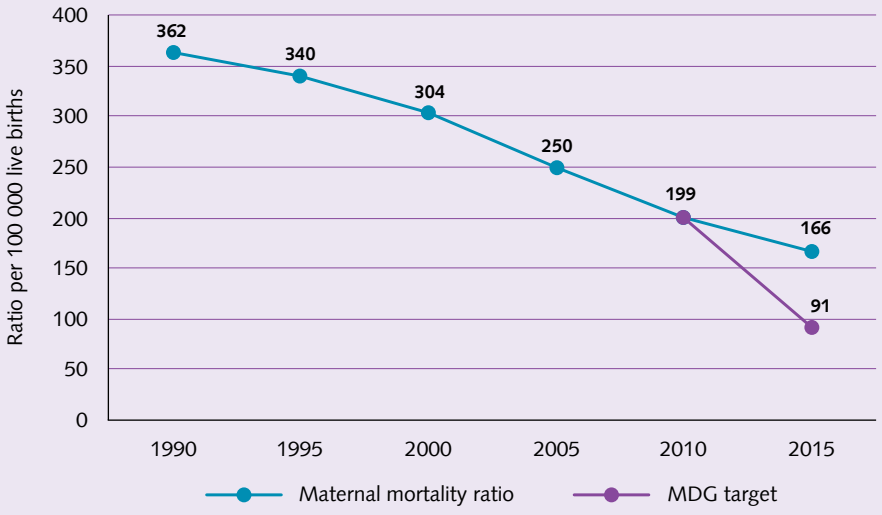
Maternal, reproductive and child health

Considerable progress was achieved towards Millennium Development Goals (MDGs) 4 and 5 in the Eastern Mediterranean Region. Between 1990 and 2015, maternal mortality ratio decreased from 362 to 166 per 100 000 live births, and under-5 child mortality rate from 181 to 91 per 1000 live births (see Fig. 1 and 2). Eight countries achieved MDG 4 and three achieved MDG 5. Following the regional initiative on saving the lives of mothers and children, launched in 2013, the reduction in maternal mortality ratio improved by 12 points from 42% (2012) to 54% (2015).

The high levels of maternal, newborn and child mortality at regional level are mainly due to weak health systems. There are insufficient numbers of well trained human resources, essential drugs and commodities are often lacking or inadequate, referral systems do not function well and the quality of care for mothers and children at the referral hospitals is inadequate. Most national programmes do not target the main causes of maternal, neonatal, and child death by implementing the evidence-based, cost-effective and high impact interventions (best buys) that are available to them. Political will and commitment to maternal and child health need are not always translated into concrete action and financing mechanisms to ensure universal coverage with maternal and child health services are inadequate. The situation is most critical in the countries affected by political instability, social unrest, acute and chronic protracted crises.

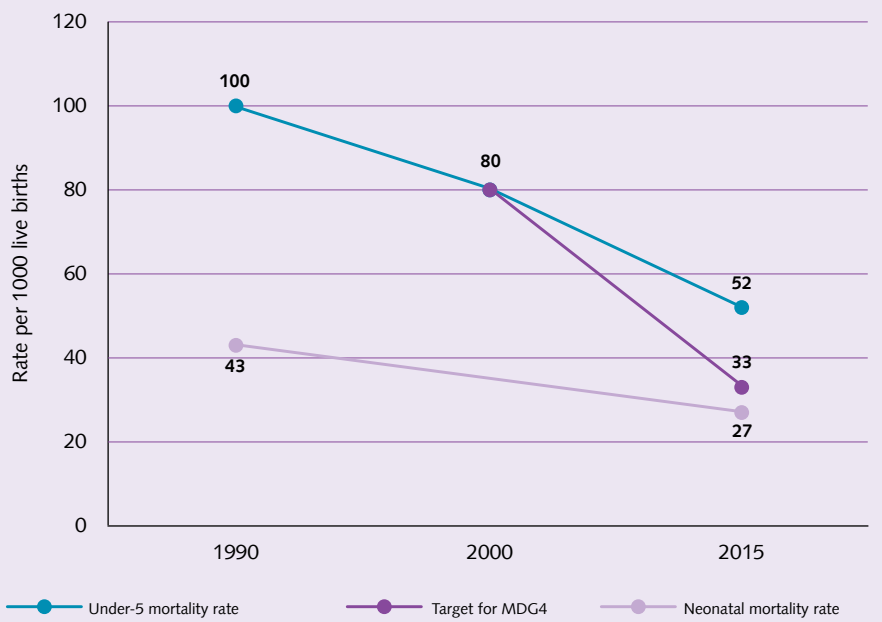
WHO maintained its support to reproductive, maternal, neonatal, child and adolescent health, with specific focus on addressing the main causes of maternal, neonatal, child deaths and targeting quality of care. The regional initiative on saving the lives of mothers and children continued to target the main challenges in countries with a high burden of maternal and child deaths, jointly with UNFPA and UNICEF, and in close collaboration with Member States and key stakeholders. Launching the maternal and child health acceleration plans strengthened national ownership and leadership towards achieving the MDG targets, and prepared the way for the new Sustainable Development Goals (SDGs).

To ensure the implementation of the acceleration plans was of sufficient quality and to address the gaps identified through the regional surveys, special attention was given to health system-related elements. These included access to and delivery of high impact interventions, the health workforce, assessment of quality and infection control services, and identifying knowledge



Source: Trends in maternal mortality: 1990–2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2015.

Fig. 1
Regional trend in maternal mortality, 1990–2015



Source: Levels and trends in child mortality. Report 2015. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. Geneva: World Health Organization; 2015.

Fig. 2
Regional trend in under-5 mortality and neonatal mortality 1990-2015

gaps to be able to determine research priorities. Technical support to Member States was focused on building national capacity in strategic planning for the period 2016–2020 in line with the global strategy and the SDGs.

Priority was given to the adoption of key evidence-based, cost-effective and high impact interventions by all countries of the Region. At a meeting held jointly with UNFPA and UNICEF, national programme managers identified priority maternal, neonatal and child health and mental health interventions with high impact, focused on the health systems challenges to be addressed and determined strategic directions in preparation for the SDGs. The strategic directions are in line with the United Nations global strategy for women's, children's and adolescents' health, endorsed by the UN General Assembly in September 2015. The following month, the Regional Committee (resolution EM/RC62/1) urged all Member States to develop or update national reproductive, maternal, neonatal, child health strategic plans in accordance with the global strategy.

Supporting countries in establishing and strengthening preconception care, as part of the continuum of care, is another priority that will further improve maternal, neonatal and child health outcomes in the Region. A meeting held with Member States, with support from UNFPA, UNICEF and international and regional experts, resulted in consensus on a set of core interventions, a regional operational framework and service delivery channels for preconception care. Further work was conducted during the year, which resulted in a regional package of evidence-based interventions and programmatic steps for promoting preconception care within countries. The package of preconception care is currently being integrated into a broader package that covers care during pregnancy and after birth with special focus on the prevention and care of common congenital disorders.

Reproductive, maternal, neonatal and child health will continue to be a regional and national health priority in the post-2015 development agenda. WHO will focus on building capacity in countries

Photo: ©WHO

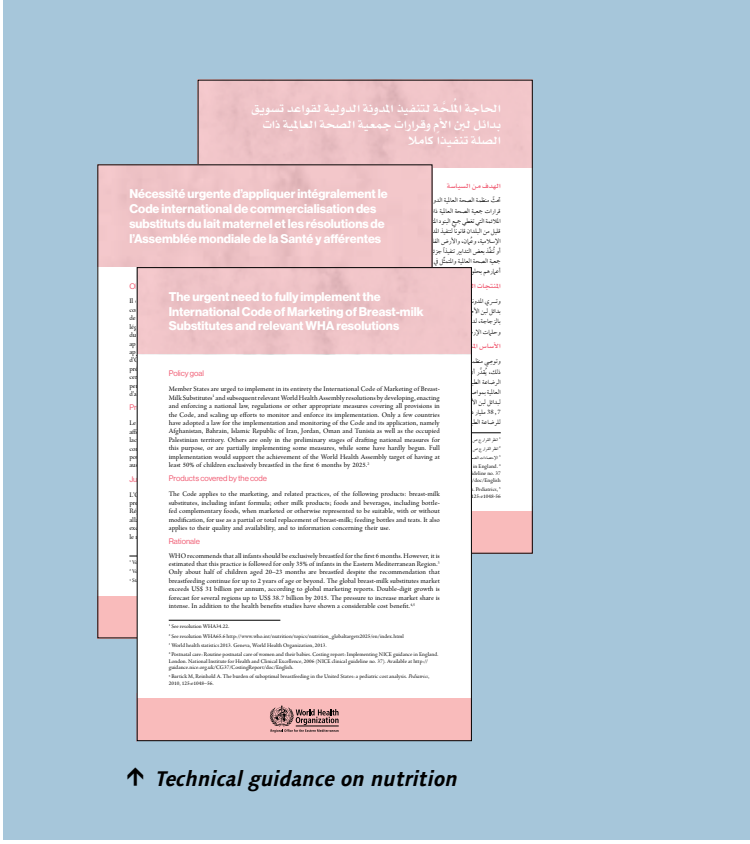
↑ Minister of Health Dr Ahmed El Saidi, WHO Director-General Dr Margaret Chan and Regional Director Dr Ala Alwan joined participants in a regional meeting to promote preconception care, Oman, March 2015

to end preventable deaths among women, children and adolescents. Implementation of the United Nations global strategy on women's, children's and adolescents' health and the SDGs will require integrated and multisectoral approaches backed by well defined targets and sustainable financing mechanisms

Nutrition

The situation with regard to malnutrition in the Region has seen some general improvement since 1990 but the progress is insufficient and the situation remains very serious in many countries of the Region, including those suffering from major crises. Much more work is needed to ensure that all mothers and children in all countries are adequately nourished to maintain health and development. According to the latest data from WHO and other UN organizations, on average, the prevalence of undernourishment in the Region decreased from 22.1% in 1990 to 13.7% in 2014. Since 1990, 13 out of 22 countries of the Region have reached MDG 1 with regard to halving the proportion of people who suffer from hunger. The estimated prevalence of children under 5 years of age affected by stunting was reduced from 39.8% in 1990 to 16.9% in 2014 as a result of economic and social development, especially in high- and middle-income countries, while the estimated prevalence of wasting increased from 9.6% in 1991 to 10.1 % in 2011, due to natural and manmade disasters and political instability in Afghanistan, Djibouti, Iraq, Pakistan, Somalia, Syrian Arab Republic and Yemen.

In 2015, a regional roadmap was developed for countries to implement the global targets set by the World Health Assembly in 2012 and the recommendations of the Second International Conference on Nutrition (ICN-2). National strategies and/or national action plans for post-2015 were developed by most countries of the Region.



↑ ***Technical guidance on nutrition***

The regional policy statement on the urgent need to fully implement the International Code of Marketing of Breast Milk Substitutes was promoted. Most countries in emergency situations expanded the number of nutrition stabilization centres for treatment of severe and complex cases of malnutrition. Supplementation and food fortification with essential micronutrients are provided in almost all countries.

The Region continues to face major challenges in tackling nutrition issues. These include the lack of quality nutrition data and indicators, as well as of national capacity to support countries in data collection and analysis, and the need for effective nutrition surveillance and a monitoring and evaluation system to enable policy-making and programme implementation. Finally, the demand for action to address malnutrition is high, while the financial resources to do so are limited.

The Regional Office is working with countries to develop a regional framework to scale up action on nutrition, with focus on cost-effective interventions. Technical support is being provided to countries to establish national targets and monitor national action plans, promote interagency and multisectoral coordination, promote a healthy diet, as well as food and nutrition security, at national and regional levels, and introduce and apply innovative approaches for delivering effective nutrition actions, including implementation of food standards and WHO guidelines.

Health of special groups

The situation prevailing in several countries is exposing the life and well-being of many older persons and schoolchildren to various levels of risk, and their unmet needs and health status should be of great concern in the provision of health support during emergencies. Despite this, the health programmes concerned with these special groups face strong competition from many other priorities.

Nevertheless, several countries were active in reviewing the draft world report on ageing and health and providing case studies, as well as the draft global strategy and action plan on ageing and health. The regional launch of the world report was organized in collaboration with Sharjah Health Authority, United Arab Emirates, during the celebration of the International Day of Older Persons (1 October). The city of Sharjah is heading firmly towards being an age-friendly city. Several countries continued activities to build capacity and multisectoral collaboration in ageing and health.

Focusing on the school setting as an important entry point for health promotion throughout the life course, the active role of countries in institutionalization of the Global School Health Initiative was reviewed in a consultation for developing updated and evidence-based criteria and an executive framework for health promoting schools. The plan is to continue this work in 2016 and to launch the new criteria in a special initiative on health-promoting schools in 2017.

One of the important steps in the way forward is to put the unmet needs of older persons and schoolchildren at the centre of relief efforts and programmes in countries in emergency situations.

Violence, injuries and disabilities

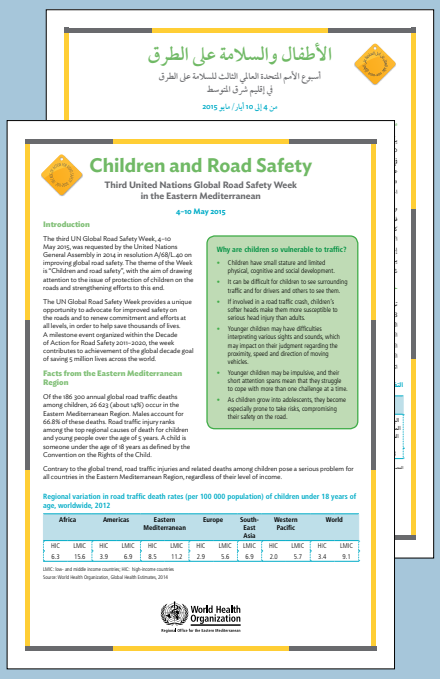
In 2015 WHO published the *Global status report on road safety 2015*, which presented the most recent data from countries across the world, including the Eastern Mediterranean Region. The report showed that road traffic injury continues to be a grave concern in the Region despite the decrease in the regional road traffic fatality rate from 21.3 to 19.9 per 100 000 population between 2010 and 2013. This fatality rate remains higher than the global rate, and still puts the Eastern Mediterranean among the WHO regions with highest fatality rates. The vast majority of deaths occur in the middle-income countries. The overall death rate in the high-income countries exceeds that of the less affluent countries and is more than double the rate of other high-income countries in the world. Despite the gravity of the issue, serious gaps persist in the comprehensive implementation of proven cost-effective interventions based on a whole safe system approach. Some aspects of these interventions have been implemented in most countries in the Region. However they have

not been implemented as a package that covers all essential elements, which seriously affects their effectiveness.

In addition, 2015 marked the mid-point in the Decade of Action for Road Safety 2011–2020 and two road safety-related targets were included in the SDGs. The Brasilia Declaration on Road Safety was endorsed by the Second Global High-level Conference on Road Safety, held in November 2015. This Declaration describes the global roadmap towards achieving the targets of the Decade of Action and the SDGs, which can only be achieved through concerted efforts across all countries.

WHO continued its efforts on different aspects of road traffic injury prevention and control from data to care. A standardized methodology for estimation of the cost of road traffic injuries was developed and piloted in the Islamic Republic of Iran. The regional instrument to profile trauma care systems was finalized based on piloting in Djibouti, Islamic Republic of Iran and Pakistan. A report documenting the exercise was prepared and peer-reviewed for publication; it recommends actions to address existing gaps and will pave the way for expansion of the exercise to other countries. A more comprehensive exercise for strengthening trauma care services was also done in Iraq.

A regional high-level ministerial meeting on road safety is planned for 2017, to increase political commitment and to agree on concrete actions for accelerated progress in the second half of the Decade of Action. In preparation, an expert consultation was held in January 2016 to review an in-depth analysis of the current burden road traffic injuries and related risk factors in the Region prepared by WHO with Johns Hopkins


الأطفال والسلامة على الطرق

أسبوع الأمم المتحدة العالمي الثالث للسلامة على الطرق
في إقليم شرق المتوسط
من 4 إلى 10 أيار/ مايو 2015

Children and Road Safety

Third United Nations Global Road Safety Week
in the Eastern Mediterranean

4–10 May 2015

Introduction

The third UN Global Road Safety Week, 4–10 May 2015, was requested by the United Nations General Assembly in 2014 in resolution A/68/L.40 on improving global road safety. The theme of the Week is "Children and road safety", with the aim of drawing attention to the issue of protection of children on the roads and strengthening efforts to this end.

The UN Global Road Safety Week provides a unique opportunity to advocate for improved safety on the roads and to renew commitment and efforts at all levels, in order to help save thousands of lives. A milestone event organized within the Decade of Action for Road Safety 2011–2020, the week contributes to achievement of the global decade goal of saving 5 million lives across the world.

Why are children so vulnerable to traffic?

- Children have small stature and limited physical, cognitive and social development.
- It can be difficult for children to see surrounding traffic and for drivers and others to see them.
- If involved in a road traffic crash, children's softer heads make them more susceptible to serious head injury than adults.
- Younger children may have difficulties interpreting various sights and sounds, which may impact on their judgment regarding the proximity, speed and direction of moving vehicles.
- Younger children may be impulsive, and their short attention spans mean that they struggle to cope with more than one challenge at a time.
- As children grow into adolescents, they become especially prone to take risks, compromising their safety on the road.

Facts from the Eastern Mediterranean Region

Of the 186 300 annual global road traffic deaths among children, 26 623 (about 14%) occur in the Eastern Mediterranean Region. Males account for 66.8% of these deaths. Road traffic injury ranks among the top regional causes of death for children and young people over the age of 5 years. A child is someone under the age of 18 years as defined by the Convention on the Rights of the Child.

Contrary to the global trend, road traffic injuries and related deaths among children pose a serious problem for all countries in the Eastern Mediterranean Region, regardless of their level of income.

Regional variation in road traffic death rates (per 100 000 population) of children under 18 years of age, worldwide, 2012

Africa		Americas		Eastern Mediterranean		Europe		South-East Asia	Western Pacific		World	
HIC	LMIC	HIC	LMIC	HIC	LMIC	HIC	LMIC	LMIC	HIC	LMIC	HIC	LMIC
6.3	15.6	3.9	6.9	8.5	11.2	2.9	5.6	6.9	2.0	5.7	3.4	9.1

LMIC: low- and middle-income countries; HIC: high-income countries
Source: World Health Organization, Global Health Estimates, 2014

World Health Organization
Regional Office for the Eastern Mediterranean

↑ *Technical guidance on road safety*

Bloomberg School of Public Health. Based on this analysis, experts will provide their views on the development of a specific framework for action at country level. This will guide the development of a resource document for the ministerial meeting outlining packages of essential cost-effective interventions for the three groups of countries in the Region, building on WHO related work, and taking into consideration recent global and regional developments.

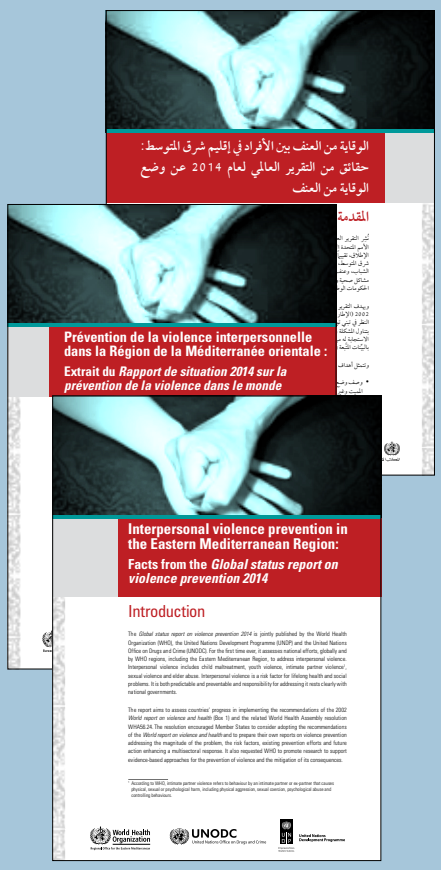
In terms of child injury prevention, a literature review on child injuries in the Region was done. Based on this, the regional strategic framework for child and adolescent injury prevention was updated and finalized.

In the area of violence prevention, the *Global status report on violence prevention 2014*, in which 16 countries of the Region participated, revealed 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 surveyed prevention strategies are available in participating countries of the Region. However their implementation has not been evaluated. A regional consultation was organized to review the draft global action plan for strengthening the health system's role in addressing interpersonal violence, in particular against women and girls, and against children, to ensure that regional and country perspectives were reflected in the final version. Prior to the consultation, a preparatory coordination meeting was held with concerned United Nations agencies and the League of Arab States to initiate discussion on a sustainable regional inter-agency coordination mechanism for the implementation of the plan.

A number of major challenges confront effective violence and injury prevention and control. Declared political commitment is not always translated into sufficient action at country level. Enforcement, implementation and evaluation of policy and legislative frameworks are weak. Coordination and multisectoral action remain insufficient. Furthermore the adoption of a whole safe system approach is inadequate, with more focus needed on individual behaviour issues. In the area of disability, several countries developed national disability strategies and action plans. Thirteen countries participated in the global survey on developing the WHO priority list of assistive products. The subject will be discussed during the forthcoming session of the Regional Committee.

WHO continued to support countries in the prevention and management of avoidable blindness in line with WHO's global initiative VISION 2020: The Right to Sight. Primary eye care activities are being integrated into the primary health care system in some countries and this is contributing to the decline in vision loss and visual impairment through early case finding, referral and eye health education. However, despite the the considerable burden of visual impairment in many countries of the Region and the increase in potentially blinding age-related eye diseases as people live longer, investment in blindness prevention remains low. Reaching the goal of eliminating avoidable blindness by 2020 will depend on the ability of health systems to scale up efforts



↑ *Fact sheets on interpersonal violence prevention*

Health education and promotion

In 2015, WHO focused on building capacity in the development of multisectoral national plans of action on physical activity and of social marketing and mass media campaign plans. 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 to support countries in implementation of the best buys related to promoting physical activity and healthy diet. Participants from both health and non-health sectors worked together to develop provisional social marketing and mass media plans which will be launched in 2016.

A toolkit was developed to guide the inclusion of physical activity in primary health care. The toolkit was developed through a systematic review and meta-analysis, which showed that primary health care is instrumental in promoting physical activity and thus it is crucial to ensure that primary health care services are adequately resourced and fit to play a major role in getting a population more active. The toolkit was reviewed by countries to ensure regional relevance and practicality based on country context. The next step is to pilot test the instrument in eight selected countries.

A bi-regional workshop to build legal capacity and advance action on the WHO recommendations on marketing of food and non-alcoholic beverages to children was held in collaboration with the Regional Office for Europe, WHO headquarters and the University of Liverpool. Participants from nine countries attended and developed a provisional roadmap to advance actions in addressing marketing of unhealthy foods in their countries.

As part of an initiative to address unopposed marketing, a series of activities was organized to sensitize the non-health sector to the issue and obtain innovative ideas in creating a social movement. A key event was an open forum which was attended by mainstream media outlets, regional celebrities and media experts and representatives of civil society organizations, including Consumer International, and which resulted in a set of actions to be promoted to non-health sectors. The biggest challenges to health promotion concerns countries' capacity to mobilize non-health sectors and work intersectorally to implement objectives, the need for research and advocacy, and the need to mobilize experts with legal backgrounds in support of the regional objectives. WHO will continue to build capacity to work with the different sectors.

Social determinants of health and gender

Focus continued to be placed on the implementation of the Rio Political Declaration on Social Determinants of Health; effective integration of social determinants of health and gender within health programmes; and strengthening country capacity to implement health-in-all policies, intersectoral action and social participation to address social determinants of health and gender. Countries agreed to implement an action framework developed at a regional consultation on reducing inequalities through action on social determinants of health, organized in 2015. In this regard four countries conducted in-depth assessments with a view to developing action plans. The results of these assessments were presented to the Regional Committee which urged Member States to assess inequalities in health and their related social determinants, identify priority actions and

monitor progress (resolution EM/RC62/R.1). Several countries have undertaken specific actions on social determinants of health.

Health and the environment

With the support of the Regional Centre for Environmental Health Action (CEHA), many countries implemented programmes and activities pertinent to health protection and the environment. Implementation of the regional strategy on health and environment and its framework of action (2014-2019) began, and several countries have taken concrete steps to develop their national strategic frameworks for action. Field missions to assess the environmental health situation and delineate priorities were undertaken in several countries.

The WHO guidelines on drinking-water quality and wastewater reuse were promoted. So far, 16 countries have updated their national standards for drinking-water quality in accordance with the guidelines, and Jordan issued national standards on irrigation water quality in line with the WHO guidelines on safe use of treated wastewater in agriculture. With WHO support, eight countries have adopted preventive water and sanitation safety management plans and 11 countries have published their national profiles under the framework of the UN-Water Global Analysis and Assessment of Sanitation and Water. All countries are participating in the WHO/UNICEF Joint Monitoring Programme. The public health risk of natural radiation in groundwater is being tackled in two countries.

Member States of the Region participated in the negotiations and adoption of World Health Assembly resolution WHA68.8 on the health impact of air pollution, to discussions on the

Photo: ©WHO

↑ The Regional Director visited Morocco in preparation for the 22nd session of the Conference of the Parties (COP 22) to the UNFCCC

road map for implementation. The special air quality needs of the Region, such as the health impact of sand and airborne dust, were addressed in a regional meeting of experts with the United Nations Environment Programme (UNEP) and World Meteorological Organization (WMO). Capacity-building was supported in the area of air pollution and health. In collaboration with the Jordan University of Science and Technology, CEHA reviewed and compiled the knowledge of all the countries of the Region in the fields of air pollution and climate change.

Joining the WHO delegation to the United Nations Framework Convention on Climate Change (UNFCCC) COP21, the Regional Office advocated with its Member States positioning of public health at the centre of climate change debate and contributed to the successful global agreement concluded in Paris in December 2015. Four countries developed, with WHO support, climate change and health national profiles which were presented at the Paris conference and several others are in process. A regional network of climate change and health experts was established.

The institutional capacity of countries in management of health care waste was strengthened

and technical support extended to several countries. In response to the solid waste crisis in Lebanon, a series of technical consultations were held and briefings on solid waste management master planning, landfill assessment and public health impacts of refuse were shared with stakeholders. A scientific protocol to assess the potential health effects of solid waste, and interventions, on the population in Lebanon was finalized.

A regional food safety assessment initiative was launched and national profiling missions were conducted by WHO staff and experts in 15 countries and the results, which demonstrated major gaps, were presented to the Regional Committee. The aim was 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. WHO and countries are following up on the results and regional action plan to strengthen food safety systems is being developed.

Environmental health support was provided to all countries in emergency situations. Emergency support was provided in 10 countries, including a multi-stakeholder regional meeting; technical missions and training. CEHA established a regional revolving stock for environmental health supplies to support emergencies in the Region. Capacity-building was supported for health service providers in several countries on response to chemical accidents and trauma care. National preparedness and response capacities for chemical, radio-nuclear and food safety events were strengthened in line with the International Health Regulations (2005).

↑ *World Health Day 2015*

Noncommunicable diseases

Regional framework for action

Despite declared political commitment to implement the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases, many countries are experiencing challenges in moving to concrete action. The response to the 2011 UN political declaration and to the regional framework for action which was endorsed by the Regional Committee in 2012 has been patchy and uneven. Factors responsible for this situation vary from one country to another but generally include inadequate political commitment at the highest level, competing priorities particularly in crisis-stricken countries, weak engagement of non-health sectors whose action is essential in the implementation of key measures, weak health systems including fragmented health information systems, opposing forces including the tobacco industry and the unopposed marketing of unhealthy foods, and the absence of an effective civil society movement.

In 2015, focus continued to be placed on scaling up the implementation of 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.

We continued to hold annual regional meetings on noncommunicable diseases to provide an opportunity for Member States to review the progress made with international and regional experts and to respond to their needs for technical support. In addition the Regional Office continued in 2015 and 2016 to develop concrete technical guidance that will enable countries to implement measures recommended in the four areas of the regional framework (governance, surveillance, prevention and health care) based on evidence, international experience and best practice.


Cadre d'action pour la mise en œuvre de la Déclaration politique des Nations Unies sur les maladies non transmissibles, y compris les indicateurs afin d'évaluer les progrès des pays d'ici 2018

إطار عمل لتنفيذ الإعلان السياسي الصادر عن الأمم المتحدة بشأن الأمراض غير السارية، بما في ذلك مؤشرات لتقييم التقدم الذي ستحرزه البلدان بحلول 2018

Framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases, including indicators to assess country progress by 2018

↑ ***Framework for action to implement the United Nations political declaration on noncommunicable diseases***

Governance

High-level advocacy was carried out throughout 2015 at various forums, including the World Health Assembly and the Regional Committee, to promote collaboration across sectors outside health and between government and non-state actors. Only six countries now have an operational multisectoral strategy and/or action plan, and four have set targets for 2025 based on WHO guidance. Countries of the Region are at various stages of implementation of their action plans and WHO continues to monitor the situation in collaboration with them, based on the process indicators of the regional framework.

↑ ***Technical guidance on tobacco control***

An innovative initiative was the development, in collaboration with the WHO Collaborating Centre at Georgetown University, of a dashboard and policy briefs on best practices in health legislation, based on global evidence. The work provides a guide for countries to take appropriate legislative action to tackle key risk factors in the areas of tobacco control, diet, physical activity and governance. Each of the priority interventions identified is outlined through an individual legal brief that contains tangible recommendations applicable to countries, drawing from global, regional and national experiences, and adaptable to the local economic, social and legal context.

Prevention and control of risk factors

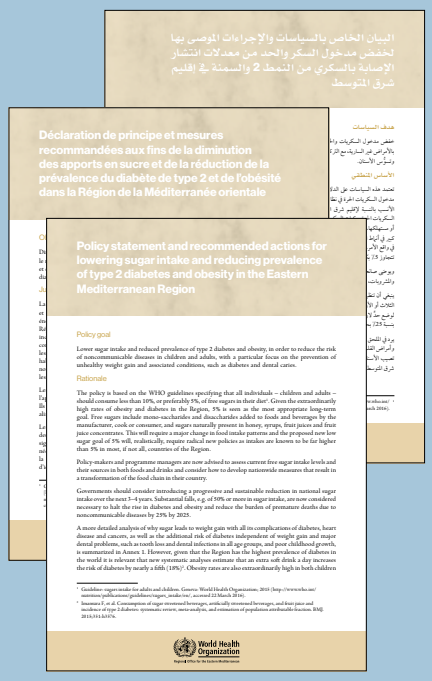
Industry interference with tobacco control policies and the limited involvement of non-health actors continue to be major challenges to operationalizing the interventions in the area of prevention and control of risk factors for noncommunicable diseases. Sixteen countries have adopted a national level target for reducing tobacco use by 30% by 2025 and 17 countries are in the process of implementing taxation increases based on the guidelines to Article 6 of the WHO Framework Convention on Tobacco Control (WHO FCTC). Support was also provided to countries for updating tobacco control legislation, specifically on the aspects of tobacco-free public places, pictorial health warnings, and banning of advertising, promotion and sponsorship.

One of the main activities undertaken was the raising of political awareness on tobacco control issues, particularly on the WHO FCTC protocol and the industry's influence on tobacco advertising, promotion and sponsorship in drama (TAPS). In this context, six projects were funded for implementation by nongovernmental organizations and completed, tackling different aspects of tobacco use in dramas aired on the

regional language networks. Two countries (Yemen and United Arab Emirates) were cited in the *WHO Report on the Global Tobacco Epidemic, 2015* as among the highest achieving countries in terms of banning TAPS, and Saudi Arabia was cited as one of the countries that had achieved full compliance with banning tobacco use in public places. Technical support was provided for capacity-building on smoking cessation and ratification of the WHO FCTC protocol in the Gulf Cooperation Council (GCC) countries. Saudi Arabia and Iraq became parties to the WHO FCTC protocol and three new countries joined the highest achieving countries in terms of monitoring (Kuwait, Pakistan and Qatar).

The burden of overweight, obesity and diet-related chronic diseases continues to increase due to nutrition transition, especially in high-income and middle-income countries. Seventeen countries have adopted the International Code of Marketing of Breast-milk Substitutes, and are monitoring its application. Nevertheless the progress on implementation is uneven. A number of policy guidance documents were developed to support the adoption of sustainable multisectoral approaches. These included policy statements and recommended actions for reducing salt, fat and sugar intakes and a protocol for measuring salt intake using 24 hour-urine collection.

Current salt intakes in the Region are very high, with an average intake of 10 g per person per day in most countries. Implementation of salt reduction strategies is progressing in several countries, and multisectoral national committees have been established in some countries with an authority to strategize and monitor implementation of salt reduction activities. Intake estimates for saturated fatty acids are also high, with most countries exceeding the 10% upper limit. Initiatives



↑ ***Policy statement and recommended actions on lowering sugar intake***

aimed at reducing total and saturated fat in food products have been undertaken in several countries (Egypt, Iraq, Islamic Republic of Iran and GCC countries). In most countries, industry participation remains voluntary and timid. Food labelling for total fat, saturated fatty acids, *trans*fat and salt in all food imported or locally produced became mandatory in GCC countries. In Egypt, the first steps were taken to reduce palm oil intake with the circulation of a draft standard on subsidized cooking oil. In several countries, private industry moved towards voluntary production of low fat and fat-free dairy products.

A draft nutrient profiling model was developed to guide countries in categorizing foods and beverages into 'healthy' and 'unhealthy'. Support was provided, in collaboration with the WHO Regional Office for Europe, WHO headquarters and Liverpool University, to several countries to develop a provisional roadmap to speed up action on marketing of unhealthy foods through building capacity for legal interventions. A

series of sensitization activities culminated in an open forum attended by mainstream media outlets, regional celebrities, media experts and representatives of civil society organizations which resulted in recommendations for non-health sectors to address marketing of unhealthy foods to children.

In order to promote physical activity, capacity development was supported in mass media and social marketing, in partnership with the WHO Collaborating Centre on Physical Activity, Nutrition and Obesity, Sydney, Australia. The first round, in which nine countries participated, resulted in development by representatives of both health and non-health sectors of provisional social marketing and mass media plans. Distance mentoring on implementation was started with four countries (Islamic Republic of Iran, Kuwait, Oman and Morocco). In addition, a toolkit was developed to guide inclusion of physical activity in primary health care.

Surveillance, monitoring and evaluation

The key priority is for Member States to implement the NCD surveillance framework with its three components (monitoring risk factors and determinants, tracking morbidity and premature cause-specific mortality, and assessing health system response and performance). The indicators included under each of the three components will enable Member States to monitor their progress in achieving the targets of the global action plan endorsed by the World Health Assembly.. A training module has been developed and will be offered to countries to build capacity in NCD surveillance and a training course for trainers is expected to be conducted before the end of 2016.

A number of surveys were completed as part of monitoring risk factors. Almost all countries completed the 2015 country capacity survey for noncommunicable diseases, and several countries are engaged at various stages of the STEPS survey to monitor the burden and trends of risk factors, the Global Adult Tobacco Survey and the Global Youth Tobacco Survey. Capacity-building in cancer surveillance was conducted in collaboration with the International Agency for Research on Cancer (IARC), with a focus on establishing population-based cancer registries in countries, while a regional course to further strengthen capacity in surveillance was piloted and is being revised. This was further supported by setting up a standardized assessment tool to identify obstacles and opportunities for countries to scale up surveillance.

Health care

The reorientation of health systems towards the integration of management of noncommunicable diseases into primary health care is a key priority. Building on the recommendations of a regional meeting held in 2014, a guide was developed for assessment of the health systems components underlying effective integration. In addition, a review of global evidence was conducted to support the development of a matrix of policy options, based on WHO health systems building blocks and tailored according to country needs. A core set of quality indicators for management of noncommunicable diseases was developed, as part of a regional initiative on quality measures in primary health care.

A regional situation analysis of care of noncommunicable diseases in emergencies was conducted in five countries focusing on refugees and displaced persons from the Syrian Arab

Republic. The findings of the analysis emphasized the importance of a consistent primary health care approach to provision of care, even in emergency contexts. Experiences in the Region have also revealed the need for a standardized set, and timely provision, of core essential medicines and technologies. An emergency health kit for management of noncommunicable diseases was therefore developed, complementing the Interagency Emergency Health Kit.

Country profiles were developed showing where each country stands in addressing the five strategic areas of cancer prevention and control. Work focused on building capacity, first, in establishing or assessing cancer registries, and second, in the development of palliative care. Many countries have invested substantially in organizing nationwide breast cancer screening and public health awareness campaigns. In 2015 WHO provided technical support for the development of screening programmes and for evaluation of public awareness campaigns.

In 2015 the Regional Office led, and played an important role in, advocacy for an accountability framework to measure progress. The contribution of countries was substantial in ensuring that the 10 indicators crafted to measure progress were aligned with the indicators of the regional framework for action. Countries are now better able to monitor and report on progress, and to meet their commitment in implementing the time-bound commitments of Member States: by 2015, to set national targets, and develop/strengthen national multisectoral action plans; and by 2016, to reduce risk factors, and strengthen health systems.

WHO will continue to work with Member States to accelerate progress, which will be measured by the progress indicators during the next United Nations review in 2018. Focus will be placed on raising political awareness and increasing the level of multisectoral involvement in implementing the provisions of the regional framework through a whole-of-government approach and on providing technical support to countries.

Mental health

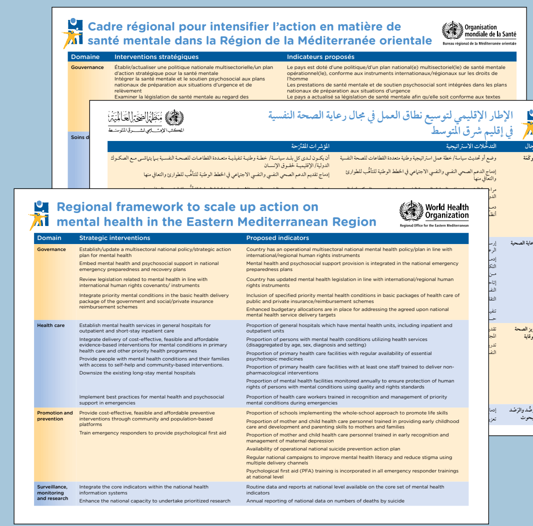
Mental, neurological and substance disorders account for the loss of 7.4% of disability-adjusted life-years, and for 22.9% of the years lived with disability globally. Illicit drug use accounts for 0·9% of DALYs lost globally. The age-standardized prevalence of drug dependence for cannabis (0.19%), amphetamines (0.25%), cocaine (0.10%) and opioids (0.22%) in the Region are similar to global estimates. However, the Region has the highest prevalence of mental disorders, specifically depressive illness and anxiety disorders, of all WHO regions. This is almost wholly accounted for by the complex emergency situations prevailing within the Region. While all countries have made some progress, irrespective of national income level, a huge treatment gap remains, ranging from 76% to 85% for severe mental disorders.

Despite the great burden, mental health continues to have a low political and public health profile while the stigma attached to it cuts across all aspects of mental health care, with widespread discrimination that has major impact on service development, delivery and utilization. Mental health has suffered chronic under-funding and consequently there is a paucity of specialist staff and services. The skills of both general health workers and mental health leaders are largely limited to the delivery of care.

Institutional care is still the dominant model of care in the majority of countries. This constrains the capacity for development of mental health staff and has led to human rights abuses. There is a lack of research evidence and information from within the Region to underpin strategic planning and service development. Nevertheless, mental health and substance abuse are starting to attract more attention, both globally and regionally, and the number of countries experiencing complex emergency situations is driving up the need and demand for support services.

In 2015, the Regional Committee endorsed an evidence-based regional framework which was developed between 2014 and 2015 by the Regional Office in consultation with Member States and top international and regional experts. The aim of the framework is to scale up action on mental health and operationalize the *Comprehensive mental health action plan 2013–2020*. Four domains of action were identified by the regional framework: governance, prevention, health care and surveillance.

Good progress has been made by some countries. In the area of governance, some countries (Kuwait, Lebanon, Oman, Qatar, Somalia, United Arab Emirates) developed or updated their mental health strategies in accordance with the global targets and indicators. Three countries (Afghanistan, Saudi Arabia and United Arab Emirates) reviewed their mental health legislation and regulations in accordance with provisions of the United Nations Convention for the Rights of Persons with Disabilities (UNCRPD). The curriculum for a regional course in leadership in mental health was developed and the first course was hosted by American University in Cairo (AUC) in September 2015.



↑ ***Regional framework to scale up action on mental health***

In the area of health care, support was provided in a number of areas. More than half the countries now have functioning mhGAP programmes aimed at bridging the treatment gap for priority mental health problems through integration within primary health care. So far three countries (Afghanistan, Jordan, Libya) have initiated the Quality and Rights project based on the provisions of the UNCRPD to ensure quality of services and observance of patient's rights in psychiatric facilities. Services for substance use disorders were strengthened in Iraq and Pakistan through capacity-building and support for the setting up of centres, in collaboration with the United Nations Office on Drugs and Crime (UNODC). Opium substitution treatment services were established in Pakistan and expanded in other countries, while a harm reduction protocol was developed in Oman.

Support was provided, in collaboration with WHO headquarters and international nongovernmental organizations, to countries undergoing humanitarian crises in mental health and psychosocial support in emergencies,

through strengthening the technical capacities of the country offices, as well as direct support. The Arabic version of a training package for psychological first aid was published, and a psychosocial intervention package to be delivered through non-specialized health workers in emergencies is being field-tested.

In the area of prevention, the Arabic version of the global report on suicide was published and launched in 2014. An assessment of resources and capacities available for diagnosis and management of autism spectrum disorders was conducted in collaboration with the Italian Public health Institute and the organization Autism Speaks. A training package on mental health for schools was finalized and is in the process of piloting in selected countries, while life skills education materials and parenting skills training materials for autism spectrum disorders are also being finalized.

Guidance was published on setting up systems for suicide registration and substance use treatment information. A core set of quality indicators for mental health care in primary health care was developed, as part of a regional initiative on primary health care quality measures.

WHO will strengthen its linkages and collaboration with regional and global partners to implement the provisions of the regional framework for action in the Region and operationalize the provisions of the global action plan 2013–2020. It will enhance its ability to provide support to countries for reviewing and developing national policies and strategies in line with the global action plan and focus on enhancing the specialist and non-specialist workforce for the integrated delivery of quality mental health care. It will also lead the development of a mental health literacy package and campaign to combat the stigma attached to mental health and substance abuse. It will continue to support countries to scale up mental health and psychosocial support in emergencies and will also promote mental health through school mental health, suicide prevention and mental health literacy programmes.

Communicable diseases

Health security and international health regulations

The incidence of emerging and re-emerging infectious diseases continues to escalate: half the countries in the Region reported a high incidence of emerging and re-emerging infectious diseases in 2015. WHO responded to an increasing number of outbreaks. These included influenza A(H1N1) pdm09 in Libya, Kuwait and Jordan; avian influenza A (H5N1) in Egypt; MERS-CoV in Saudi Arabia and Jordan; cholera in Iraq and Somalia; hepatitis A in Syrian Arab Republic; dengue fever in Yemen; and unknown viral haemorrhagic fever in Sudan. Strategic, operational and technical support was provided to countries for detection, risk assessment and rapid response to emerging infectious diseases and to prevent international spread of these infections.

In response to a Regional Committee resolution (EM/RC/61/R.2), rapid external assessments were conducted by WHO staff and experts towards the end of 2014 and in early 2015 in 20 (out of 22) countries to assess the capacity to deal with a potential importation of Ebola virus. The major gaps identified related to leadership and coordination, capacities at points of entry, surveillance and response, infection control, laboratory capacity and risk communication (Fig. 3). Following this assessment of preparedness and readiness measures, a 90-day regional action plan was developed and implemented during the first quarter of 2015 to help the countries address the critical gaps identified by WHO in the areas of surveillance and response for prevention, detection and effective containment measures. This work contributed to accelerating the progress in implementation of the core capacity requirements under the International Health Regulations (2005).

Photo: ©WHO

↑ Almost all countries conducted training for health workers on appropriate care and management of patients in the event of an outbreak of Ebola virus disease or similar highly pathogenic haemorrhagic fevers

Significant public health efforts were mounted to contain the cholera epidemic in Iraq. Surveillance systems were enhanced, the health care workforce was rapidly trained on case management, the operational response was stepped up and oral cholera vaccines were deployed to immunize over 300 000 vulnerable people and to prevent spillover of the outbreak into the hard-to-reach areas.

Work continued with a view to setting up a regional network of expert institutions within the framework of the Global Outbreak Alert and Response Network (GOARN) to respond to outbreaks and other health security threats. The guiding principles and rules of engagement for this network will be finalized and the network activated in 2016. The early warning, alert and response network (EWARN) was expanded in crisis-affected countries such as Iraq, Libya, Syrian Arab Republic and Yemen.

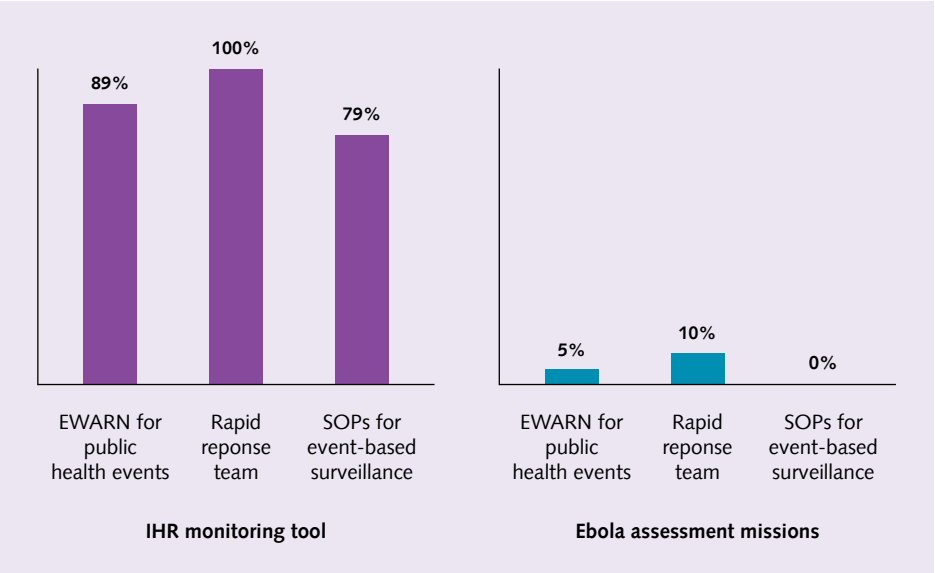


Fig. 3
Comparison of IHR monitoring assessment results and Ebola assessment results, 2014, for the core capacity of surveillance

The Region has made preparedness and response to an influenza pandemic a priority. In 2015, actions focused on enhancing the early warning surveillance system, building effective rapid response teams, improving laboratory diagnosis, improving risk communication activities, increasing the availability and use of seasonal influenza vaccine, and developing and implementing plans of action for national capacity strengthening for preparedness and response. Seven countries (Afghanistan, Djibouti, Egypt, Jordan, Lebanon, Morocco, Yemen) received funds from the Pandemic Influenza Preparedness (PIP) Framework partnership to improve capacity for pandemic influenza preparedness and response.

In view of the rapidly expanding threat of MERS-CoV, efforts continued to support the countries to improve public health preparedness measures, especially infection prevention and control measures in the health care environment. The Regional Office organized the 4th international scientific meeting on MERS-CoV in May 2015. These meetings have helped the international scientific community to pinpoint the knowledge gaps on the mode and risk factors for transmission in humans and to identify the essential public health research needed to address such gaps.

Significant progress was made in 2015 in addressing antimicrobial resistance. The regional steering committee met for the first time and outlined an operational framework for implementation of the global action plan on antimicrobial resistance, in collaboration with the Food and Agriculture Organization of the United Nations and World Animal Organization (OIE) and in line with the "One Health" concept.

WHO will continue to strategically support high-risk countries in the areas of surveillance, early

detection and response to emerging infectious disease outbreaks. Comprehensive and integrated regional preparedness and response plans and strategies will be developed for managing these outbreaks and other health security threats, with the focus on prevention wherever possible, as well as early detection and response. A concerted effort will also be made to build national capacities to strengthen disease surveillance and response in accordance with the International Health Regulations (2005), including risk communication as an integral part of public health emergency interventions.

The laboratory core capacities required under the International Health Regulations (2005) have not yet been met in about half of the countries owing to insufficient funding and inadequate access, quality of testing, equipment, supplies and workforce competency. WHO continued to provide comprehensive support in strengthening national health laboratory systems and services, with a focus on the required core capacity requirements. WHO, in consultation with national and international stakeholders, developed a draft regional health laboratory strategy 2016–2020. The strategy will guide the efforts of countries towards strengthening national health laboratory systems in a sustainable manner.

Work started on establishing a laboratory network to strengthen laboratory surveillance, detection of and response to emerging dangerous pathogens. To obtain the necessary baseline information for establishing such a network, the epidemiological situation of viral haemorrhagic fevers and emerging dangerous pathogens was analysed, and current capacities and practices in the most advanced health laboratories were mapped and analysed. The next step will be to upgrade the facilities and biosafety/biosecurity practices of the target laboratories capacity-building and mentoring, enrolment in regional external quality assessment schemes and laboratory twinning programmes.

A regional strategy for blood and transfusion services was developed through a consultative process, in collaboration with experts and institutes from within the Region and elsewhere. A project collaboration agreement is being prepared between WHO and the International Federation of Blood Donor Organizations to improve voluntary blood donation and donor care services in the Region.

North-South and South-South technical collaboration with existing regional and global partners was strengthened, and expanded to include academia at global as well as regional levels to support countries in IHR implementation. Cross-border collaboration was strengthened through the establishment of bilateral or multilateral plans to address the deficit in IHR capacities at designated land crossings, a feature compounded by conflict, porous borders, and massive displacement within and across borders in many State Parties.

Compliance with requirements related to notification and reporting, and in responding to WHO verification requests in regard to public health events of potential international concern, continued to improve among IHR national focal points. However, further improvement is still needed through effective intersectoral collaboration to ensure efficient and timely notification of public health events outside the direct purview of the health sector.

WHO continued to monitor progress in IHR implementation and report to the Regional Committee, Executive Board and World Health Assembly through the self-assessment questionnaire submitted by State Parties. The 2015 results indicated a regional implementation level of over 60% under various IHR capacities. However, the reliability and validity of the IHR progress based on self-assessment and self-reporting has increasingly been questioned at all levels of the Organization, as well as by the external stakeholders. In this respect, the Regional Committee adopted a resolution (EM/RC62/R.3) establishing a regional assessment commission (IHR-RAC), comprising regional and global experts to assess implementation of the IHR in the Region and to advise Member States on priority actions to develop and maintain core capacities. The Commission was established and had its first meeting in December 2015 at which its terms of reference and working modalities were discussed. The fourth IHR stakeholders' meeting was also held in December and introduced State Parties to the work of the Commission and to the new approach to accelerate implementation of the Regulations.

An IHR monitoring and evaluation framework was developed by WHO and a global consultation was organized, in Cairo in January 2016, to harmonize the assessment processes and tools with like-minded initiatives like the Global Health Security Agenda (GHSA), FAO and OIE, in compliance with resolution EM/RC62/R.3. Subsequently, a harmonized joint external evaluation (JEE) process and tool for the implementation of IHR capacities was also developed to complement the annual reporting by State Parties. The JEE process and tool are being finalized with input from all relevant stakeholders. Once finalized, JEE assessments will be conducted on a voluntary basis at State Party level with a view to accurately identifying the gaps and developing and implementing country action plans with clear priorities, to ensure health security for all.

Poliomyelitis eradication

The global progress towards poliomyelitis eradication in 2015 was tremendous (Fig. 4). For the first time in the history of the global initiative, the entire African continent reported no polio cases in more than a year; the date of onset of the most recent case in the continent was 11 August 2014 in Somalia. The only remaining serotype circulating, wild polio virus type 1, was limited to a few areas in only two endemic countries, Pakistan and Afghanistan, both in the Eastern Mediterranean Region. These countries reported a total of 74 cases in 2015, an 80% reduction in case load compared to the number of cases they reported during 2014.

Despite this tremendous progress, as long as wild poliovirus is circulating anywhere there is still a risk of importation for countries in the Region due to extensive population movement and the on-going complex emergency situations in several countries, which have resulted in deteriorating routine immunization coverage. In 2015, 10 polio-free countries of the Region conducted national or sub-national polio immunization campaigns to maintain high levels of immunity and reduce the risk of wild polio virus (WPV) importation or the development of circulating vaccine derived polio virus (cVDPV).

Afghanistan and Pakistan have developed robust national emergency action plans to stop polio transmission in 2016. Both countries made significant progress in reducing transmission

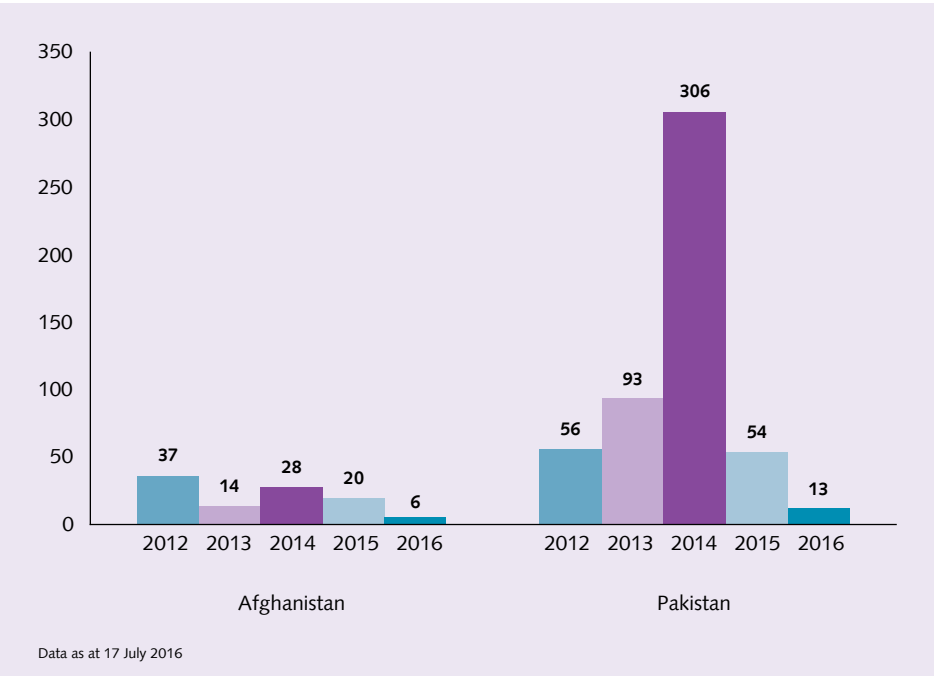


Fig. 4
Decline in cases in polio-endemic countries since 2012

through the course of 2015 and in the last 6 months of the year, the traditional high season for poliovirus transmission, only 36 cases were reported in total, the lowest burden of disease ever recorded during this period. In the last quarter of 2015, formal reviews of the multi-country outbreaks in the Middle East and the Horn of Africa that occurred in 2013–2014 concluded that both outbreaks were closed.

A major objective of the polio endgame plan is the withdrawal of oral polio vaccine (OPV) in a phased manner, starting with type 2-containing oral polio vaccine. All countries of the region have successfully switched from trivalent to bivalent oral poliovirus vaccine for routine and campaign use, and have stopped using trivalent oral polio vaccine. It is imperative that all countries of the region fully report on the validated switch process and destroy any remaining oral polio vaccine 2/ Sabin2 by 30th July 2016, as part of phase I of the Global Action Plan (GAP III) for poliovirus type 2 containment.

To achieve eradication, the Region must stop the ongoing wild poliovirus transmission in the remaining endemic foci in Afghanistan and Pakistan; maintain population immunity, including in emergency countries and among displaced populations; reach inaccessible children with vaccine; and maintain vigilance and the capacity to detect and respond to any new introduction or outbreak due to wild poliovirus or circulating vaccine-derived virus. In 2016, therefore, focus will continue to be placed on strengthening the capacity of the programmes in Afghanistan and Pakistan through assignment of highly experienced staff to both countries, and on providing strong technical support.

The programmes in Afghanistan, Pakistan and the Horn of Africa will be regularly reviewed through

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↑ Afghanistan and Pakistan are implementing national emergency action plans to stop polio transmission in 2016 which include major efforts to reach inaccessible children

technical advisory group meetings to analyse progress and advise the governments on the most effective technical interventions. Countries at risk will be supported to carry out supplementary immunization activities to maintain high levels of protection, and operational support will be provided to the endemic and at-risk countries to implement planned activities. Regular risk analysis will be conducted to identify risks and develop mitigation strategies. Technical support will be provided for capacity-building in outbreak response and for the development of national preparedness and response plans for polio-free countries. With these activities the objective of the Region is to become polio-free, and stay polio free, in 2016.

HIV, tuberculosis, malaria and tropical diseases

The number of people living with HIV (PLHIV) in the Region is still growing at a fast pace, reaching 330 000 by the end of 2015. Member States have made significant progress in increasing the number of people receiving antiretroviral therapy (ART), from 34 345 in 2014 to 46 345 at the end of 2015. Despite this progress, at 14% the regional ART coverage still remains far from the global target. By the end of 2015, all countries had updated their HIV treatment guidelines according to the latest WHO guidelines. Several countries (Egypt, Islamic Republic of Iran, Lebanon, Morocco, Pakistan/Punjab and Sudan) conducted HIV test-treat-retain cascade analyses which resulted in a deeper understanding of the gaps and lost opportunities in engaging and retaining people living with HIV (PLHIV) in a continuum of HIV testing, care and treatment.

Since the vast majority of PLHIV in the Region do not know their HIV status, much emphasis was placed on initiating an intensified dialogue with national AIDS programme managers and regional civil society networks on innovations in HIV testing policies and service delivery approaches. Implementation of the new WHO consolidated guidelines for HIV testing services was discussed at a regional consultation organized by UNAIDS and WHO and participants identified country-specific priority actions for accelerating uptake of HIV testing. WHO developed and disseminated a training course on HIV basic knowledge and stigma reduction in health care settings. The course was implemented in Morocco and Sudan and is underway in other countries.

Given the high contribution of injecting drug use to the HIV epidemic, a regional review was

↑ *Training modules on HIV*

conducted of access by PLHIV who inject drugs to HIV testing and treatment. The review findings showed that only 6% of PLHIV who inject drugs received HIV treatment in 2014. Those findings were shared and discussed with stakeholders during a regional consultation, conducted in partnership with the Middle East and North Africa Harm Reduction Association (MENAHRA), which resulted in specific recommendations to address barriers to prevention, diagnosis and treatment. Consultations also took place to solicit regional input to the development of new global health sector strategies for HIV, sexually transmitted infections and hepatitis for the period 2016–2021.

Hepatitis is a priority public health problem in the Region, with an estimated 14.8 million and 16 million people chronically infected with hepatitis B and hepatitis C, respectively. New infections in the Region result primarily from unsafe injections and medical procedures. Providing access to well-tolerated and effective medicines and diagnostics is a major challenge for all countries.

To mobilize a coherent public health response that prioritizes effective interventions and promotes equitable access to services, WHO convened and engaged a broad range of stakeholders in the development of regional action plan for viral hepatitis. The regional action plan sets targets in line with the WHO global strategy for viral hepatitis and guides national action plan development. So far, national action plan development was supported in five countries, including Egypt and Pakistan which have the highest burden of hepatitis C in the Region.

The way forward will place emphasis on universal health coverage, integrated service delivery and adapted service delivery models. Focus on the efficient use of human and financial resources

in HIV testing, linkage to care and successful treatment will continue. Concerted efforts will be made to achieve zero tolerance of stigma and discrimination against PLHIV in health care settings. Countries will be supported to develop and implement their national hepatitis plans.

During 2014[3], slightly more tuberculosis cases (all forms) were notified in the Region compared with 2013 (465 677 and 448 000 respectively). Globally and at the regional level, the main challenge for tuberculosis control continues to be the low case detection rates of all tuberculosis cases and of MDR-TB. In 2014, the case detection rate increased slightly (61 %) compared with 2013 (58%). The treatment success rate was 91%, which is higher than the global target of 85%. Management of multi-drug resistant (MDR) tuberculosis is a key challenge. Out of 15 700 estimated MDR-TB cases, 4348 were confirmed as multi-drug resistant by laboratory test and only 3423 were put on treatment. Limited resources and weak management capacity to deal with multi-drug resistance is a major impediment. Screening of HIV among tuberculosis cases is still limited. In 2014, the HIV status of only 15% of TB patients was known.

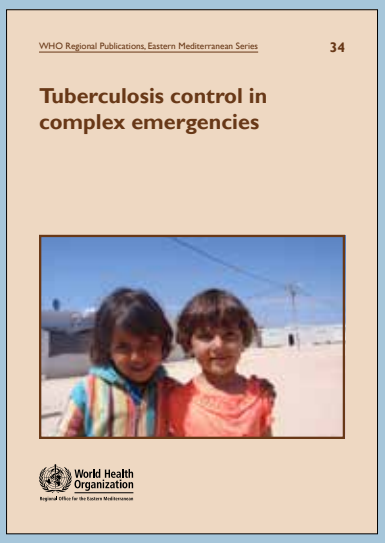
The emergency situations in many countries and the widening gap between available resources and need are exposing tuberculosis programmes to bigger threats. Syrian refugees in Jordan and Lebanon are in need of much support, while the health systems are over stretched. This has delayed implementation of the plan for tuberculosis elimination in Jordan. Effective and timely implementation of the national strategic plans for tuberculosis control in Iraq and Yemen is also

↑ *World Hepatitis Day 2015*

now impeded by the large numbers of internally displaced persons. A guide for tuberculosis control in complex emergencies was published and a package for management of cross-border tuberculosis and MDR-TB cases was made available. With WHO support, Lebanon and Jordan made successful emergency proposals to the Global Fund to manage tuberculosis among Syrian refugees.

The draft regional strategic plan for tuberculosis for 2016–2020 was developed in consultation with the programme managers. The national tuberculosis programmes were reviewed in six countries and the recommendations of the review missions were subsequently incorporated into the national strategic plans. The Regional Green Light Committee (rGLC) continued its support to ensure effective management of MDR-TB through capacity building, drug resistance surveys, and monitoring and evaluation missions.

[3] For tuberculosis case detection, WHO receives data a year later, thus case detection data relate to 2014 and treatment outcome data to 2015.



↑ ***Technical guidance on disease control***

Eight countries in the Region have continuous local malaria transmission. Two of these countries (Islamic Republic of Iran and Saudi Arabia) are implementing elimination strategies and are close to reaching the target, with only 187 and 83 local cases, respectively, reported in 2015 (Table 2). Six countries (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen) have a high malaria burden (Table 3) and face several challenges. WHO estimates that the incidence of malaria in the Region had decreased by 70% in 2015 compared with 2000. Estimated mortality decreased by 64% in the same period. Seven countries achieved the malaria targets set by MDG 6 and resolution WHA58.2, with a reduction of more than 75% in the incidence of microscopically confirmed cases between 2000 and 2014 (Afghanistan, Iraq, Islamic Republic of Iran, Morocco, Oman, Saudi Arabia, Syrian Arab Republic). During the past 15 years the Region achieved great success in reduction of malaria burden. However, in 2014 and 2015 it witnessed outbreaks and an increase in the number of reported cases in some countries. This shows the need for continuing vigilance and investment in malaria control and elimination.

The Regional Committee endorsed the regional malaria action plan 2016–2020 for implementation of the *Global technical strategy for malaria 2016–2030.* Health Assembly A regional integrated vector management strategy 2016–2020 was developed in consultation with key experts and Member States.

A new online reporting system using DHIS2 was used to support malaria surveillance. Entomological surveillance, including insecticide resistance monitoring in priority countries and drug efficacy monitoring in malaria endemic countries, was also supported. The regional training course on quality assurance of malaria diagnosis was conducted in collaboration with Gezira University, Sudan. The Regional Office has completed the implementation of the WHO-UNEP-GEF demonstration projects on sustainable alternatives to DDT. The evidence generated and the capacities developed during the projects will contribute to updating strategies for integrated vector management and strengthening vector control activities in the Region.

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

Country	2013		2014		2015	
	Total reported cases	Autochthonous	Total reported cases	Autochthonous	Total reported cases	Autochthonous
Bahrain	182	0	100	0	NA	NA
Egypt	262	0	313	22	291	0
Iran (Islamic Republic of)	1373	519	1238	376	797	187
Iraq	8	0	2	0	2	0
Jordan	56	0	102	0	59	0
Kuwait	291	0	268	0	309	0
Lebanon	133	0	119	0	125	0
Libya	340	0	412	0	NA	NA
Morocco	314	0	493	0	510	0
Oman	1451	11	1001	15	822	4
Palestine	0	0	NA	NA	NA	NA
Qatar	728	0	643	0	445	0
Saudi Arabia	2513	34	2305	51	2620	83
Syrian Arab Republic	22	0	21	0	12	0
Tunisia	68	4	98	0	88	0
United Arab Emirates	4380	0	4575	0	3685	0

NA: not available

Table 3
Reported malaria cases in countries with high malaria burden

Country	2013		2014		2015	
	Total reported cases	Total Confirmed	Total reported cases	Total Confirmed	Total reported cases	Total Confirmed
Afghanistan	319 742	46 114	290 079	83 920	350 044	103 377
Djibouti	1684	1684	9439	9439	NA	NA
Pakistan	3 472 727	281 755	3 666 257	270 156	3 776 244	202 013
Somalia	9135	7407	26 174	11 001	NA	NA
Sudan	989 946	592 383	1 207 771	1 068 506	NA	NA
Yemen[a]	149 451	102 778	122 812	86 707	96 348	68 938

NA: not available
[a]The estimated reporting completeness in 2015 was 47% due to the situation

Significant scale up of mass treatment of schistosomiasis with WHO-donated praziquantel took place in Sudan thanks to an innovative mechanism enabling domestic funding, as well as to international partnerships. Priority endemic areas in Yemen were also targeted early in the year. Planning for mapping in Somalia was finalized, and funds mobilized, following the establishment of a neglected tropical disease programme in the Ministry of Health. Support was provided to three countries (Egypt, Iraq, Oman) to plan and implement surveys aimed at confirming interruption of transmission in view of the initiation of the WHO's verification process for elimination of schistosomiasis.

In 2015, more countries applied for WHO-donated albendazole and mebendazole to treat preschool and school-age children for soil-transmitted helminthiasis, compared with 2014, including Afghanistan, Iraq, Somalia and Syrian Arab Republic. WHO's collaboration with UNRWA was strengthened to provide free medicines to schoolchildren in the Agency's five fields of operation (Jordan, Lebanon, Palestine (Gaza Strip and West Bank) and Syrian Arab Republic).

The final steps towards elimination of lymphatic filariasis as a public health problem were taken in Egypt and Yemen. Sudan completed mapping and finalized operational planning to scale-up mass treatment with WHO-donated albendazole and ivermectin in 2016. Elimination of onchocerciasis was demonstrated in one focus in Sudan and actions were taken to achieve the same goal in the three remaining ones. In Yemen, a pilot survey to delimitate the onchocerciasis endemic area was carried out, funds for treatment were mobilized through partners, and planning for mass treatment was finalized.

With regard to leishmaniasis, WHO continued to contribute to provision of case management to all affected country programmes: Afghanistan, Iraq and Syrian Arab Republic, Somalia and Sudan.

In 2014, 213 899 new leprosy cases were detected. Elimination as a public health problem (less than 1 prevalent case per 10 000 population) has been reached at national level in all countries of the Region. However, five countries (Egypt, Pakistan, Somalia, Sudan and Yemen,) still have pockets of intense transmission, and need to strengthen case-detection activities. A steady decline in the proportion of grade 2 disabilities among newly-detected cases has been observed in recent years, confirming that cases are being detected at progressively earlier stages. Multidrug therapy for leprosy was provided by WHO to all requesting countries.

Trachoma mapping was completed in Sudan, is ongoing in Egypt, Pakistan and Yemen, and was planned for Afghanistan and Somalia. Treatment activities with azithromycin and tetracycline, and other components of the SAFE strategy (surgery, facial cleanliness and environmental improvements) were scaled up in Pakistan and Sudan.

Sudan is the only country in the Region which remains to be certified free from dracunculiasis. No cases have been reported since 2014 and the country is in pre-certification. Field activities aimed at assessing readiness to undergo the certification process were implemented in 2015.

Immunization and vaccines

The regional average of DTP3 coverage was estimated at 80% in 2015. While 14 countries have maintained the target achievement of ≥90%

coverage, in Syrian Arab Republic it dropped to 41% in 2015 (WHO–UNICEF estimates). An estimated 3.3 million children missed DTP3 immunization in 2015, 94% of whom were in countries facing difficult situations: Afghanistan, Iraq, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen.

Eight countries have achieved ≥95% coverage with the first dose of measles-containing vaccine (MCV1), and 21 countries provided the routine second dose of measles vaccine with variable levels of coverage. Eight countries reported very low incidence of measles (fewer than 5 cases per million population), four of which continued to achieve zero incidence and are ready for verification of elimination. Jordan restored its measles-free status following a major outbreak with incidence in 2013.

With regard to new vaccines, Yemen introduced rubella vaccine into its routine immunization and Sudan implemented the second phase of a yellow fever campaign. Inactivated polio vaccine (IPV) was introduced in nine countries where it was not previously part of routine immunization. As a result, IPV is now in use in all countries of the Region except Egypt which was not supplied with IPV vaccine because of the global shortage. The Region completed the switch from using trivalent (tOPV) to bivalent (bOPV) oral polio vaccine in routine immunization by mid May 2016.

The national immunization programmes continued to face several challenges in 2015, including complications related to vaccine delivery to conflict-affected areas, procurement and management systems and stock-out of several vaccines. Support was provided to countries with low routine immunization coverage, including intensifying outreach activities, implementation

Photo: ©WHO/S. Ramo

↑ Inactivated polio vaccine (IPV) was introduced in Afghanistan by Dr Feroz Firozuddin, Minister of Public Health

of acceleration campaigns to increase coverage and sustaining cold chain and vaccine management capacity. Support was also provided for development and implementation of national plans to reach unvaccinated and under-vaccinated populations

In Somalia support was provided in implementing a coverage improvement plan, human resource capacity building and developing a comprehensive multi-year plan (cMYP). In the Syrian Arab Republic, support was provided for a comprehensive programme review, development of cMYP, assessment of vaccine management and capacity-building on vaccine management. Iraq conducted programme reviews at the governorate level and implemented plans to vaccinate refugees, internally displaced persons and hard-to-reach children, especially in inaccessible areas. Huge support was provided to Yemen to maintain the immunization programme, including implementation of five rounds of intensified outreach activities to districts with low coverage or that were hard to reach and strengthening and maintenance of the cold chain. Five countries assessed the status of measles elimination and nine

↑ ***Technical guidance on immunization***

countries implemented supplementary measles immunization at national or subnational levels.

Support was provided to countries for improvement of immunization data management systems and data quality, for accreditation of national measles/rubella laboratories, and capacity-building in effective vaccine management. WHO continued to support and monitor the regional network for measles/rubella case-based surveillance. Support continued to be provided also to the regional surveillance network of bacterial meningitis, bacterial pneumonia and rotavirus. This included provision of laboratory supplies, capacity-building, monitoring and evaluation of performance and coordinating the external laboratory quality control system.

The Eastern Mediterranean vaccine action plan (EMVAP) was endorsed by the Regional Committee as a framework for implementation of the global vaccine action plan (GVAP). WHO will continue to provide the necessary technical support and mobilization of resources for updating, implementation, monitoring and evaluation of cMYP and annual plans of action, with special focus on countries and areas with low vaccination coverage.

Six countries continued to achieve the target of a functional national regulatory authority WHO is supporting countries to strengthen the required regulatory functions, particularly the registration of vaccines such as IPV and bOPV as part of the polio endgame strategy, as well as to strengthen the implementation of a quality management system for some national regulatory authorities in countries that are supported by the Pandemic Influenza Preparedness (PIP) Framework partnership in order to improve regulatory capacity for pandemic influenza preparedness and response.

Significant progress continued to be made in vaccine safety, and the regional pharmacovigilance network was launched in a regional meeting on pharmacovigilance held in September 2015. Achieving a functioning national regulatory authority is inhibited in some countries by a number of challenges, including lack of clear vision, staff turnover and lack of financial resources to allow the authorities to perform their duties independently, as recommended by WHO.

Emergency preparedness and response

Overview

2015 saw a significant deterioration in the humanitarian situation in the Eastern Mediterranean Region. The crisis in Yemen was designated a Level 3 emergency by the United Nations in July 2015 and the Region now hosts three Level 3 emergencies, including the crises in Iraq and the Syrian Arab Republic. Overall throughout the Region, more than 62 million people were in need of health services as a result of emergencies by the end of 2015, placing a significant strain on already weakened and overwhelmed health systems. Shortages in specialized medical staff, medicines and medical equipment, and other health resources, especially in areas where access for WHO and partners was limited, had severe impact on the delivery of health services, contributing to the deterioration in the health status of some patients and an increased number of preventable deaths.

Following the escalation of violence in Yemen in March, the humanitarian and health situation rapidly deteriorated into one of the worst humanitarian crises in the world. More than 14 million people, including 2.4 million internally displaced, were in need of health services by the end of the year. Shortages in health workers and medicines, coupled with fuel shortages, led to a gradual collapse of the health system. By December, almost 25% of all health facilities were non-functional, and immunization coverage had decreased by 15% compared to the same period in 2014. Limited access to health care services and the breakdown in safe water supplies and sanitation services led to increased cases of endemic diseases, such as malaria, dengue fever and acute diarrhoeal diseases.

As a result of the conflict in Iraq, a total of 3.2 million people were forced to flee their homes in several big waves of displacement, and multiple smaller ones between January 2014 and January 2016. This is in addition to 1.1 million people already displaced from earlier violence. It is estimated that about 10 million Iraqis are in need but only 7.3 million in greatest need are targeted for assistance by humanitarian partners, due to limited available resources. Meanwhile, more

Photo: ©WHO/Sini Ramo

Photo: ©WHO

↑ **WHO-supported mobile clinics are providing basic health care services in several countries, including Afghanistan *(left)* and Syria *(right)***

than 220 000 Syrian refugees are now residing in Iraq, mainly in the Kurdistan region.

In the Syrian Arab Republic, 2015 was the most challenging year for both Syrians and humanitarian responders since the beginning of the crisis, with the number of people in need increasing from 12.2 million in 2014 to 13.5 million in 2015 and more than 1.2 million people internally displaced during the course of the year. The health system continued to face challenges in the provision of health care as a result of damage, with more than half of all public hospitals and public primary health care centres closed or partially functioning. Syrians faced increasing needs for trauma and injury care, with more than 25 000 injured each month, as well as increasing needs for mental health services, reproductive health services and treatment for noncommunicable diseases, such as diabetes and kidney diseases. Malnutrition rates increased, especially among children under 5 years of age. Almost two thirds of the population had no access to safe water, increasing their risk of waterborne diseases.

The health situation in Libya rapidly worsened due to expanding conflict and political disagreements, the inherited weaknesses of the health system and the decreasing investment in the health sector. To better reflect the scale of needs, the crisis in Libya was designated a Grade 2 emergency in early 2016. A total of 2.8 million people were in need of humanitarian assistance by year-end, including 1.9 million people in need of health services. More than 430 000 people were internally displaced as a result of ongoing violence. Hospitals are both overcrowded and functioning at severely reduced capacity, essential medicines and supplies are lacking, electricity and water supplies are frequently disrupted and foreign health workers have left the country. Patients with noncommunicable diseases and mental health disorders have limited access to health care, and there is a marked absence of services for the disabled and tens of thousands of war-wounded patients.

In Sudan, almost a quarter of a million newly displaced were added to the already massive protracted caseload in 2015. By the end of the year, a total of 420 000 internally displaced persons in need remained in Darfur states, with limited access to essential primary health care services. In the five states of Darfur, 36% of public health facilities are non-functional, and only 24% of those functioning are providing a standard service package. Shortages of medicines and supplies and insufficient staff and facilities continued to hamper the quality of health services.

In Pakistan, the sudden influx of internally displaced persons from North Waziristan to Bannu resulted in an overburdening of health resources and services and an increased need for management of risks related to environmental health and communicable disease outbreaks.

Natural disasters continued to have a devastating effect on populations in the Region. In October 2015, a 7.5 magnitude earthquake struck northern Afghanistan and Pakistan, killing hundreds, injuring thousands and damaging and destroying thousands of homes. Access was the most significant challenge in reaching people in need in at least 194 villages affected by the earthquake. A second 6.3-magnitude earthquake struck the Afghanistan-Tajikistan border region in December, injuring tens of people.

Challenges and WHO response

The Region is the world's biggest producer of displaced populations, mainly as a result of the Syria crisis. More than 60% of all refugees and

internally displaced persons originate from the Region. Refugees originated mainly from Syria, Afghanistan and Somalia, while Syria, Iraq, Sudan and Yemen hosted the greatest number of internally displaced persons. While Turkey became the largest host of Syrian refugees in 2015, Lebanon, a country of four million people, remains the highest per capita host of refugees in the world, with refugees comprising a third of the total population. In Jordan, Syrians make up 10% of the population.

In November, WHO organized a high-level meeting on refugee and migrant health in Rome. Countries agreed on the need to develop a framework for collaborative action on refugee and migrant health and acknowledged the urgent need to strengthen collaboration among the countries of origin, transit and destination. To build on this interregional collaboration, a technical consultation was hosted in Cairo in May 2016.

Significant demand for health services across the Region by refugees and vulnerable host communities continued to place enormous strain on public health infrastructure, resulting in overwhelming caseloads, overworked health staff and shortages of medicines and equipment. In some health facilities serving Syrian refugees and displaced Iraqis in northern Iraq, heath staff reported that their patient caseload had increased by almost 200%.

Priority needs for Syrian refugees included mental health care, reproductive, maternal and child health services (including immunization), communicable disease surveillance, care for noncommunicable diseases, environmental health services and care for trauma and burn injuries. Trauma and surgical care continued to be a priority for the refugee population. Acute malnutrition in refugee children under the age of 5 years and women of reproductive age was a key issue. Additional problems included low use of antenatal care and high rates of caesarean section, child diarrhoea, acute respiratory infections and micronutrient deficiencies.

Photo: ©WHO

Photo: ©WHO Iraq

Photo: ©WHO

↑ **WHO supports delivery of public health and health care services for internally displaced persons and host communities in several countries, including Iraq *(left)* and Yemen *(right)***

With the majority of refugees living outside camp settings, both refugees and host communities were at increased risk of infectious diseases due to overcrowded living conditions, limited access to safe water and sanitation and varying degrees of access to primary health care services. In countries hosting Syrian refugees, WHO provided technical support to ministries of health and other partners on priority public health issues. It also supported the provision of trauma care services, management of noncommunicable diseases, and scaling up of urgently needed mental health programmes. WHO also strengthened and expanded communicable disease early warning alert and response systems (EWARS). To scale up national capacity, partners, front-line health workers and surveillance officers were trained on detection and rapid response to outbreaks and public health threats.

In all countries experiencing political conflict, the provision of humanitarian aid was impeded by security constraints and limited access for health partners to populations in some areas, as well as blocked roads and points of entry preventing the transportation and provision of medicines and medical supplies. In Syria, Iraq and Yemen, an average of 30% of affected populations were located in hard-to-reach or besieged areas.

As part of the Whole-of-Syria approach adopted as a result of UN Security Council resolutions 2165 and 2191, in 2015 WHO led the health sector/cluster coordination in three hubs (Damascus, Amman and Gaziantep). WHO's emergency health response aimed to reach Syrians in all parts of the country, including hard-to-reach and besieged areas.

Across the country, WHO expanded and strengthened its partnerships with a total of 67 local nongovernmental organizations in Syria, many of them operational in hard-to-reach and opposition-controlled areas; 34 mobile clinics were donated to nongovernmental organizations to support the provision of basic health care services across the country. WHO also decentralized its presence in Syria through a system of 59 medical focal points, including 36 in hard-to-reach and besieged areas, providing regular situation updates to WHO.

Since January 2016, greater access to hard-to-reach and besieged areas in Syria has been granted. For the first time in over two years, WHO was able to deliver life-saving medicines and medical supplies to 11 out of 18 besieged locations. In 2015, 27% (4.2 million) of medical treatments provided were delivered for people in need in 127 hard-to-reach and besieged locations across the country.

In Iraq, WHO continued to lead the humanitarian health cluster in different parts of the country and to provide health support, including provision of basic health care through mobile clinics and health centres in camps, as well as ambulances and medical supplies to the federal and local health authorities. WHO continues to meet its mandate as the provider of last resort as the humanitarian situation worsens and the number of internally displaced increases. More than 4 million medical consultations were provided throughout the year, exceeding the initial target of 3.2 million consultations. More than 1.8 million people directly benefited from medicines/supplies and medical equipment procured by WHO and distributed across the country. Access to primary health care services in camps and host communities, including in hard-to-reach areas was made possible through the deployment of 27 mobile clinics.

In Yemen, humanitarian pauses allowed WHO to increase its provision of medicines and medical supplies to affected areas. WHO was also able to provide mobile clinics in areas hosting large numbers of internally displaced persons, as well as ensure the functionality of health services through the provision of fuel and safe water. In early 2016, following months of blocked access to Taiz City, and in response to mounting emergency health needs, WHO successfully delivered life-saving medicines and medical supplies. The supplies included trauma kits, interagency emergency health kits, diarrhoeal disease kits and oxygen cylinders, as well as dialysis solutions. WHO and cluster partners were able to reach 7 million people from March to December 2015 through provision of medicines, medical supplies, mobile medical teams and clinics. To ensure the functionality of the health system, WHO provided more than 1 million litres of fuel to support the operation of 72 health facilities including 51 hospitals, 7 major centres, 6 vaccine depots and 8 renal dialysis centres. To reduce the risk of water-borne diseases, WHO provided 19 million litres of safe

Photo: ©WHO

Photo: ©WHO

Photo: ©WHO

Photo: ©WHO Yemen

Photo: ©WHO

↑ **WHO provided life-saving medicines and medical supplies, mobile clinics, water, fuel and other essentials to support the humanitarian mission in Yemen**

drinking-water, hygiene supplies and cleaning materials to internally displaced people in all affected governorates.

Escalating conflict and the massive scale of humanitarian needs across the Region continued to place health care workers at great risk. In 2015, attacks against health workers and facilities in Afghanistan increased by 50%, and Syria is now the deadliest place in the world for health workers. In Pakistan, five rounds of immunization campaigns were cancelled in 2015 alone because of serious security threats. The disturbing trend continues, with attacks on health care workers and health facilities in the Region reported almost every month. In a number of countries, WHO, in collaboration with health partners, is maintaining a real-time database on attacks against health care facilities and health care workers as a pilot project to provide feedback for advocacy action to stop such attacks and protect health workers.

Vaccine shortages and low vaccination rates, coupled with growing mass population movement, increased the risk of outbreaks of polio and measles among children. In the three Level 3 emergency countries more than 13 million children in total were vaccinated against polio in 2015, including in hard-to-reach, opposition-controlled and high-risk areas. For the first time in a decade, a nationwide measles immunization campaign was conducted in Somalia in 2015, targeting 4.4 million children. Following the eradication of polio in Somalia, with the last reported case in August 2014, polio vaccination campaigns are ongoing. In Afghanistan, more than 9 million children were vaccinated against polio through national and sub-national immunization in addition to 1.2 million children at the border with Pakistan. More than 6 million children were vaccinated against measles in 2015. In response to the ongoing measles outbreak in Sudan, a nationwide campaign successfully vaccinated 8.6 million children aged 6 months to 15 years.

Enhancing disease surveillance in collaboration with national authorities continues to be a priority for WHO in crisis-affected countries. In Syria, the disease early warning and response system based in Damascus was expanded from 650 sentinel sites in 2014 to 995 sentinel sites in 2015, while disease early warning and response network managed by WHO's office in Gaziantep covered 517 sentinel sites in northern Syria. Together, these surveillance systems aim to cover all governorates and people in Syria. Also in 2015, the water pollution alert and response system was introduced in Damascus and rural Damascus. In Iraq, an early warning, alert and response network (EWARN) with about 80 sentinel sites continues

Photo: ©WHO

Photo: ©WHO

↑ More than 13 million children were vaccinated against polio in the three level 3 emergency countries in 2015

to be expanded. Preparedness efforts were also stepped up in neighbouring countries to prevent a spread of the disease across borders. For the first time in Libya, a disease early warning system was instituted in 100 sentinel sites throughout the country.

The number of patients requiring treatment for trauma injuries is progressively growing. In Syria alone, 1 million people were injured in the first quarter of 2015, an average of 25 000 injuries per month. In Yemen, the number of deaths and injuries caused by explosive weapons from January to July 2015 was recorded as the world's highest. This increase, together with a reduced presence on the ground by aid agencies as a result of the insecurity, placed more demands on WHO and partners to fill critical gaps and ensure the availability of trauma care and surgical services, as well as referral services. More than 17 million medical treatments were delivered for patients with chronic diseases, communicable diseases, trauma injuries, primary and secondary care diseases. In northern Syria, health partners in northern Syria were provided with technical, financial and/or material support to conduct 1.7 million medical consultations and deliver nearly 25 000 babies. WHO donated surgical supplies to support around 2000 major surgical interventions in an underground trauma hospital.

In Libya, WHO provided trauma kits, emergency health kits and life-saving medicines, including insulin, HIV medicines, vaccines, anaesthetics and medicines for leishmaniasis and tuberculosis, sufficient to cover 300 000 people.

In Afghanistan, more than 1.2 million people received primary health care services through temporary sub-health centres and mobile clinics supported by WHO, and more than 300 000 people benefited from delivery of emergency health kits and medical supplies.

In Djibouti, WHO provided trauma kits, emergency health kits, drugs for diarrhoeal, antibiotics, antimalarial drugs and medical equipment and supply to Obock Regional Hospital, which is facing a 20% increase in demand for health care services due to the Markazi refugee camp for Yemeni refugees established near that town.

In Sudan, WHO delivered around 600 tonnes of medicines, medical supplies, and WASH equipment and supplies enough to cover the needs of 1.8 million people. WHO supported the functioning of 24 static and mobile clinics in nine states covering more than 500 000 people.

WHO supported capacity-building to enhance skills of health staff and fill gaps as a result of staff shortages. In Syria, more than 20 000 managers and health workers across the country were trained in areas such as trauma management, first aid, primary health care, reproductive health, disease surveillance and the management of noncommunicable diseases. In Yemen, more than 50 mobile medical teams and 20 fixed medical teams in 11 governorates were trained and deployed to provide an integrated primary health care package. Support was provided to 18 hospitals in seven of the most affected governorates, including support for physicians, surgeons, gynaecologists, psychiatrists and nutritionists. In Iraq, more than 10 000 health professionals were trained in emergency medicine-related fields and 58 medical professionals were deployed to refugee camps in northern Iraq.

Capacity-building was also supported in Afghanistan, Libya, Somalia and Sudan, to enhance

capacity of health personnel in emergency-related and diagnostic services, surveillance, mental health and prevention and control of disease.

WHO and the health sector/cluster in emergency countries continue to be underfunded. In 2015, health sector/cluster requirements in UN response plans for eight countries in the Region were funded at 39%, while WHO was funded at 36%. As a result, several health programmes and services in Iraq and Somalia were reduced and mobile clinic services for vulnerable communities in Area C of the West Bank stopped functioning for 6 months.

Health risk management

To standardize the emergency preparedness and response actions in countries, a comprehensive all hazard emergency preparedness framework was developed through an international technical consultation, underscoring 10 priority actions to be implemented at country level and aligning with IHR. Operational research was then conducted in five countries for validation of the framework.

A generic package including standard operating procedures was developed to support contingency planning for preparedness and response to Ebola or any other infectious disease in countries. A full scale simulation package was also developed to support countries in testing the emergency preparedness of the health sector. The package was shared with all countries to accelerate the planning process.

Considerable attention was given to strengthening the capacity of health facilities and hospitals for emergency preparedness and response. A comprehensive curriculum on emergency and disaster risk management was developed to support the capacity training for hospital managers and the first round of training was conducted. The WHO health facilities safety assessment tool was finalized and translated into Arabic and French, addressing the regional need.

A public health emergency pre-deployment training package was developed and five trainingsare planned to enhance the surge capacity in the Region. This has been linked to the roster of experts for deployment in humanitarian crisis.

Implementing the strategies endorsed by the Regional Committee

The area of emergencies in the Regional Office was strengthened through restructuring and the scaling up of the emergencies team. Additional restructuring will take place as needed to ensure alignment with global reforms endorsed by the Executive Board in January 2016. The Regional Centre for Emergencies and Polio Eradication was inaugurated in Amman in January 2016 to continue WHO's work in polio eradication, as well as to ensure organizational readiness for graded and public health emergencies.

The Regional Emergency Solidarity Fund was activated in January 2016 to ensure predictable financing of surge/rapid response to natural and man-made disasters in the Region. The WHO logistics hub, established in Dubai's International Humanitarian City to ensure the timely provision of critically needed medicines, medical supplies and medical equipment to countries in the Region and beyond, was operationalized in 2015.

A regional emergency advisory group on emergency preparedness and response was

established to provide the Regional Director with independent advice and assistance on policy and strategic matters. The regional surge roster of internal and external experts for deployment in emergencies was expanded through pre-deployment trainings in the area of public health and risk communications.

As emergencies continue to cross borders, there is a need to ensure a more systematic and effective approach, both within countries and across the Region, to responding to the health needs of affected populations and to ensuring that health systems in all affected countries continue to deliver urgently needed health services to displaced populations and host communities. WHO is progressively recognizing that solutions to major heath challenges require improved and expanded coordination, action and engagement from other sectors. An effective health strategy involves including the affected communities themselves, as well as stakeholders from different disciplines, government, non-state actors and parliament. This includes stronger partnerships with health authorities, nongovernmental organizations and community leaders, and engagement with academic institutions and medical students. For efforts to succeed, WHO will continue to strengthen the humanitarian system and support ongoing reforms to improve the way it works in emergencies.

WHO is increasing advocacy for the protection of health care workers and health facilities as afforded under international law, including the Geneva Conventions, as well as for access in conflict countries.

Implementing WHO management reforms

Programmes and priority-setting

WHO continued to strengthen its implementation of reform in programme strategy and priority-setting, with the objective of improving global and regional health outcomes by focusing on its comparative advantages. The Regional Office provided support for the strategic aspects of WHO's work at country level through regular liaison with WHO country offices and relevant regional stakeholders in developing, monitoring and evaluating the country cooperation strategies (CCS). New CCS guidelines were launched. An initial pilot group of four countries was established and training conducted. The new guidelines advocate for strong national ownership and an inclusive and consultative process of negotiation and development. Development of partnerships was promoted, including with the League of Arab States, the regional United Nations Development Group, the Organization of Islamic Cooperation, and regional UN organizations and institutions. The regional bottom-up operational planning process took place in good time for the WHO Financing Dialogue held in Geneva in November 2015 and was thus operational for an equally early start to implementation for the 2016–2017 biennium.

The outcome of the end-of biennium reporting on the Programme Budget Performance Assessment for 2014–2015 showed that the regional base budget of USD 268 million had been funded to the level of 84% while the allocated emergency budget of USD 585 million had been funded at 89%. The base programme budget utilization (expenditures and encumbrances) was 83% and utilization of actual available funding reached 99%. Budget utilization in the emergency programme for the Region as a whole was 85% and utilization of funding was 96%, leaving WHO at the regional level with a high overall funding utilization of 97% at the close of the biennium. The investment in priority work at the country level saw 85% of flexible funding allocated to country priorities.

Photo: ©League of Arab States

↑ WHO and the League of Arab States joined hands in a regional consultation to enhance the role of civil society organizations in the health and sustainable development agenda, Cairo, August 2015

Delivery of technical outputs was also high, particularly when viewed against the continued efforts of the regional and country offices to respond to and support event-driven emergency situations, with 78% of outputs fully achieved and 22% partially achieved.

The Regional Office was an active partner in the strengthening of the global category and programme area networks which contribute to programmatic and technical coherence at global,

regional and country level. Both the category and programme area networks play a key role in harmonizing the priorities from the country level bottom-up planning with commitments emanating inter alia from regional and global resolutions to ensure the comprehensiveness and completeness of work plans.

In anticipation of the adoption in September 2015 by the United Nations General Assembly of the new development agenda for the period 2016–2030 expressed within the 17 Sustainable Development Goals (SDG) including one specific goal (Goal 3) for health with 13 targets, work was initiated to prepare plans for addressing the unfinished MDGs and the integrated SDG agenda. This was presented at the 62nd Session of the Regional Committee.

As part of ongoing periodic programmatic reviews, an expert consultation was held in early 2016 on the Global Arabic Programme. Regional participants with expertise in translation, publishing and public health reviewed the work of the programme and the achievements of the past two decades. Taking into account the current context, the pressure on available resources and the need to streamline the strategic focus of the programme, it was recommended that resources should be concentrated on translation of WHO publications in the strategic priority areas, and on updating of the Unified Medical Dictionary.

Governance

In keeping with the practice of the past few years, a high-level meeting for ministers and representatives of Member States and permanent missions in Geneva was held prior to the World Health Assembly. These meetings continue to provide an opportunity to review, with ministers of health and senior government officials, progress in addressing key priorities since the previous Regional Committee and to strengthen Member

Photo: ©WHO

↑ The 62nd session of the Regional Committee for the Eastern Mediterranean took place in Kuwait

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.

At its 62nd Session in October, the Regional Committee endorsed five resolutions in relation to the regional strategic priorities. 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, has proved to be a useful forum for high-level technical discussion with Member States.

Management

The Regional Office continued to develop essential instruments for the enhancement of the WHO reform process, with special emphasis on managerial reform, working closely with all other levels of the Organization to achieve the goals of the 12th General Programme of Work. It also continued to improve its planning, forecasting, implementation, monitoring and evaluation capacity aimed at more efficient use and distribution of limited resources, with a view to making WHO in the Region more fit for purpose.

The managerial actions associated with the reform process with respect to staff mobility and rotation, performance management and human resources planning and management were complemented by the promotion of an accountability culture. Accountability and controls continued to be at the heart of improvement efforts with focus on the five compliance areas, which were repeatedly mentioned in internal and external audit observations of preceding years: direct financial contributions, direct implementation, imprest purchase orders, asset inventories and non-staff contractual arrangements. These areas were closely monitored throughout the year by means of the monthly compliance dashboards. The aim of reducing audit observations to a minimum, and of closing all long-standing audit observations, was fully achieved by year end, with over 230 recommendations closed. This was accomplished while welcoming an unprecedented number of audit missions to the Region (seven, of which two in the Regional Office) within the same year. All audits resulted in satisfactory or partially satisfactory ratings, showing a clear improvement in controls compared to previous years, and a deep commitment to zero tolerance to non-compliance across the Region.

A number of initiatives have been undertaken in the past two biennia that have also proved useful to other regions. These include: a dedicated compliance and risk management role; improved compliance monitoring and reporting through dashboards; accountability compacts with budget centre managers and administrative officers tied in with performance management mechanisms; self-assessment questionnaires for managers in support of the management assertions on internal control; capacity-building initiatives, such an integrated training programme for budget centres, compliance forums and many more outreach initiatives; pilot projects as a basis for programmatic and administrative reviews; establishment of surge support capacity

in the Region, with special focus on emergency countries; targeted country visits to provide on-site support; and strengthened managerial support to emergency preparedness and response, including the establishment of a regional solidarity fund.

WHO will address a number of specific challenges in 2016–2017, including the need for: capacity-building in institutions to support Member States in remaining aligned with evolving requirements; strengthening country level perspectives in responding to acute and protracted emergencies; consideration to deploy and deliver on a no-regrets basis; a regional risk register in addition to the corporate risk register; and continual improvement in accountability and control, as embedded in the regulatory frameworks.

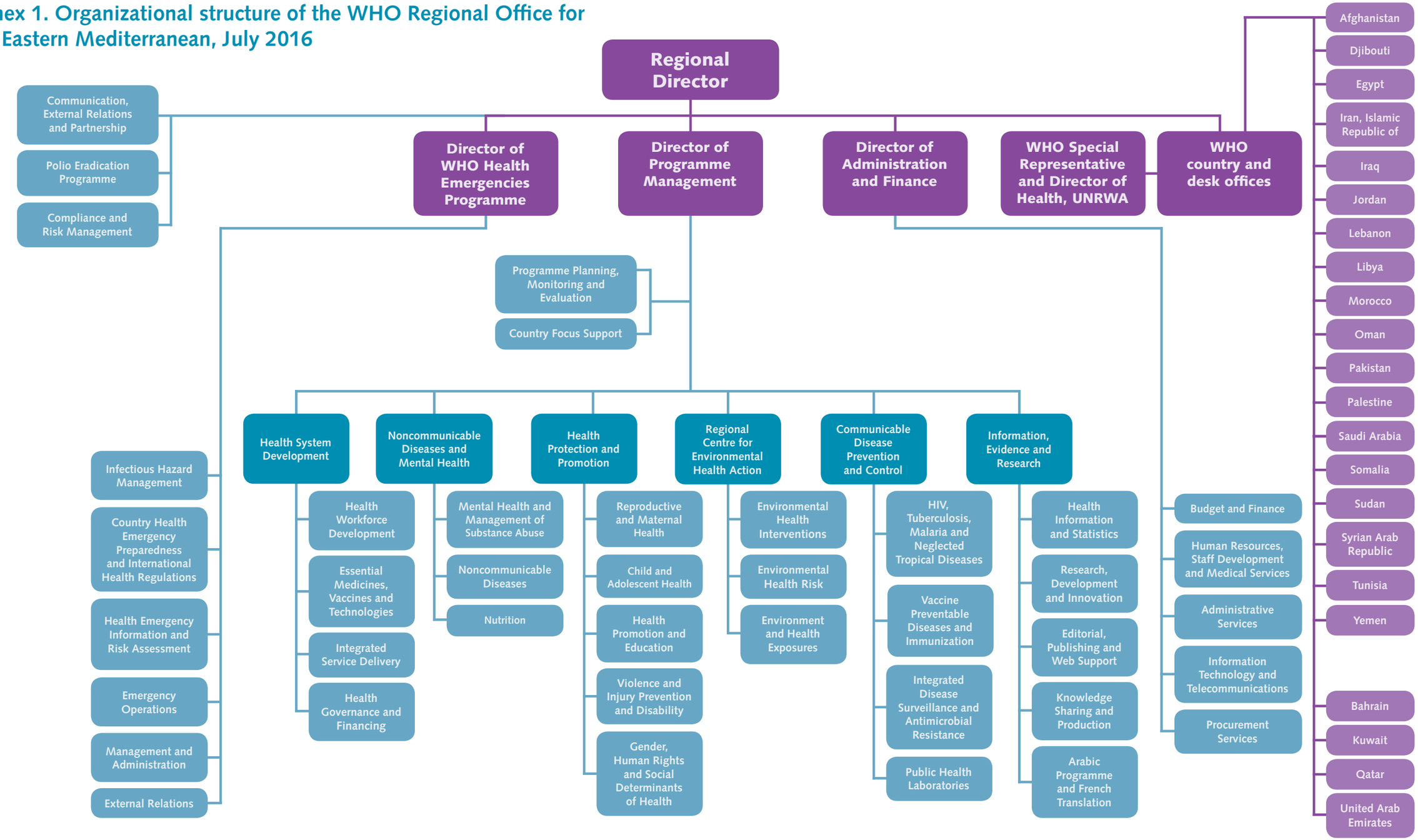
Conclusion

There can be no doubt that 2015 was a year of considerable challenge and achievement for our Member States and for WHO's work in the Region. Nevertheless, because of a clear vision of what is needed and the ability to double our collective efforts, we were able to respond to emerging needs and at the same time continue our adherence to implementing the programme of strategic priorities that we have followed since 2012. I hope that this report has succeeded in highlighting the progress and continuing challenges.

As we move forward, one of the most important influences on our work with Member States will be the Sustainable Development Goals endorsed by the United Nations in September 2015. The goals are comprehensive in scope and, if achieved, will have profound impact on health development regionally and globally. The goals have been developed with the stated aim of ensuring that 'no one will be left behind'. While SDG 3 is the main goal associated with health, in practice all the goals are of importance to health development, while SDG 3 itself is a key element of achieving sustainable development. Universal health coverage is at the heart of SDG3 and strengthening health systems towards achieving universal coverage will remain the key pillar of all our work.

Let us remain united in our commitment to health in the Region.

Annex 1. Organizational structure of the WHO Regional Office for the Eastern Mediterranean, July 2016



Annex 2

a) Professional staff in the Eastern Mediterranean Region, by number and nationality as at 31 December 2015

Nationality	Regional/Intercountry	Country	Total
Egypt	14	4	18
Pakistan	8	3	11
United States of America	6	5	11
United Kingdom	7	1	8
Lebanon	6	1	7
Sudan	3	4	7
Tunisia	4	3	7
Jordan	4	2	6
Belgium	2	3	5
Canada	5	–	5
Germany	3	2	5
Iran, Islamic Republic of	5	–	5
Yemen	1	4	5
India	2	2	4
Iraq	2	2	4
Morocco	4	–	4
Stateless	4	–	4
Syrian Arab Republic	3	1	4
Bangladesh	2	1	3
Italy	1	2	3
Netherlands	1	2	3
Somalia	2	1	3
Switzerland	3	–	3
Afghanistan	–	2	2
Denmark	1	1	2
Ethiopia	–	2	2
Finland	2	–	2
France	1	1	2
Kenya	–	2	2
Spain	1	1	2
Uganda	–	2	2
Algeria	–	1	1
Armenia	1	–	1
Austria	–	1	1
Australia	–	1	1
Bahrain	1	–	1
Eritrea	–	1	1
Georgia	–	1	1
Hungary	1	–	1
Ireland	1	–	1
Japan	–	1	1
Malawi	1	–	1
New Zealand	1	–	1
Norway	–	1	1

Nationality	Regional/Intercountry	Country	Total
Romania	–	1	1
Saudi Arabia	–	1	1
Senegal	1	–	1
Sri Lanka	–	1	1
Sweden	–	1	1
Tanzania	–	1	1
Trinidad & Tobago	–	1	1
Turkey	1	–	1
Total	105	67	172

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 2015

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	30	18
Pakistan	C	005–014	24	11
Iran, Islamic Republic of	C	004–012	15	5
Lebanon	C	001–008	13	7
Sudan	C	001–010	13	7
Jordan	C	001–008	11	6
Tunisia	C	001–008	10	7
Morocco	B1	001–010	9	4
Iraq	B1	002–009	6	4
Yemen	B1	001–008	5	5
Syrian Arab Republic	B1	001–008	4	4
Somalia	B2	001–008	4	3
Afghanistan	B1	001–008	2	2
Saudi Arabia	A	005–011	2	1
Bahrain	B1	001–007	1	1
Djibouti	B1	001–007	1	–
Total of regional nationalities			150	85
Total of other nationalities			1895	87
Grand total			2045	172

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, 2015

Meeting title, location and date
Statutory and advisory meetings
First consultation of the Regional Advisory Committee on Noncommunicable Diseases and Public Health Law, Cairo, Egypt, 11–12 February 2015
Twenty-ninth meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication, Muscat, Oman, 19–21 April 2015
First meeting of the regional steering committee and task force on antimicrobial resistance, Cairo, Egypt, 26–28 April 2015
Twenty-first meeting of the Eastern Mediterranean regional working group on GAVI, the Vaccine Alliance, Djibouti, Djibouti, 27–29 April 2015
Fifth meeting of the Eastern Mediterranean Regional Green Light Committee, Cairo, Egypt, 25–26 May 2015
Meeting of the Technical Advisory Group on poliomyelitis eradication for Afghanistan, Islamabad, Pakistan, 1–2 June 2015
Meeting of the Technical Advisory Group on poliomyelitis eradication for Pakistan, Islamabad, Pakistan, 4–5 June 2015
Meeting of the Eastern Mediterranean Advisory Committee on Health Research, Cairo, Egypt, 6–7 July 2015
Meeting of the Eastern Mediterranean Research Ethics Review Committee, Cairo, Egypt, 6–7 September 2015
Third meeting of the Technical Advisory Group Committee to the Regional Director, Cairo, Egypt, 10–11 September 2015
Sixty-second Session of the WHO Regional Committee for the Eastern Mediterranean, Kuwait City, Kuwait, 5–8 October 2015
Consultations
Third regional stakeholder's meeting to review the implementation of IHR (2005) with focus on Ebola disease, Cairo, Egypt, 11–13 January 2015 and Tunis, Tunisia, 4–5 February 2015
Review meeting for Phase II and planning for Phase III of the Middle East polio outbreak response, Beirut, Lebanon, 26–27 January 2015
Consultation workshop on the United Nations child and maternal mortality estimates, Tunis, Tunisia, 9–11 February 2015
Consultative meeting on strategic planning for tuberculosis elimination, Cairo, Egypt, 10–12 February 2015
Technical consultation on polio eradication in Pakistan, Islamabad, Pakistan, 14–15 February 2015
Expert group meeting on medical education, Cairo, Egypt, 9 March 2015
Consultation for updating the regional integrated vector management strategic framework, Cairo, Egypt, 11–12 March 2015
Expert consultation on expanding universal health coverage to the informal sector and vulnerable groups in the Eastern Mediterranean Region, Rabat, Morocco, 15–16 March 2015
Second eHealth taskforce meeting, Cairo, Egypt, 19–20 March 2015
Technical consultation on salt and fat reduction strategies in the Eastern Mediterranean Region, Tunis, Tunisia, 30–31 March 2015
Meeting of the Informal working group on promoting preconception care in the Eastern Mediterranean Region, Amman, Jordan, 5–7 April 2015

Annex 3. Meetings held in the Eastern Mediterranean Region, 2015 *(continued)*

Meeting title, location and date
Consultations
Expert consultation on regional hospital strategy development and capacity-building of hospital managers, Cairo, Egypt, 6–7 April 2015
Regional consultation on reducing health inequities in the Eastern Mediterranean Region through actions on the social determinants of health, Teheran, Islamic Republic of Iran, 21–23 April 2015
Regional consultation to review the draft global plan of action to strengthen the role of health system in addressing interpersonal violence, in particular against women and girls, and against children, Cairo, Egypt, 27–28 April 2015
Regional consultation on noncommunicable disease and public health, Cairo, Egypt, 2-4 May 2015
International scientific meeting on Middle East respiratory syndrome coronavirus (MERS-CoV), Cairo, Egypt, 5–6 May 2015
Expert consultation on improving the quality of care at primary health care level through the implementation of quality indicators and standards, Cairo, Egypt, 11–12 May 2015
GEF final meeting, Amman, Jordan, 20–21 May 2015
Expanded meeting of the Editorial Board of the Eastern Mediterranean Health Journal, Cairo, Egypt, 6–7 June 2015
Regional consultation on the prevention and control of childhood overweight and obesity in the Eastern Mediterranean Region, Cairo, Egypt, 2–3 July 2015
Technical consultation on reducing sugar intake in the Eastern Mediterranean Region, Amman, Jordan, 26–27 July 2015
Joint WHO and League of Arab States regional consultation to enhance the role of civil society organizations in the health and sustainable development agenda in the Eastern Mediterranean Region, Cairo, Egypt, 23–24 August 2015
Brainstorming session for the "What Is Needed Now in Tobacco Control" (WINN) Initiative, Cairo, Egypt, 7–8 September 2015
Technical consultation on all hazard emergency preparedness in the Eastern Mediterranean Region: applying lessons learned in the operational action plan, Cairo, Egypt, 8–10 September 2015
Open forum on addressing unopposed marketing of unhealthy foods and beverages to children in the Eastern Mediterranean Region, Amman, Jordan, 13–14 September 2015
Expert group meeting on water governance for health securing water requirements for health protection, Amman, Jordan, 14-17 September 2015
Expert consultation on the marketing of foods and non-alcoholic beverages to children in the Eastern Mediterranean Region, Amman, Jordan, 18–19 September 2015
Fourteenth meeting of the regional programme review group on lymphatic filariasis elimination and other preventive chemotherapy programmes, Cairo, Egypt, 12–14 October 2015
Follow-up meeting of national poliovirus containment coordinators on implementation of GAPIII, Beirut, Lebanon, 13–14 October 2015
Meeting to establish a regional network for outbreak alert and response, Casablanca, Morocco, 19–21 October 2015
Review meeting for Phase III of the Middle East polio outbreak response, Beirut, Lebanon, 22–23 October 2015
First Africa/Middle East expert meeting and workshop on the health impact of airborne dust, Amman, Jordan, 2–5 November 2015

Annex 3. Meetings held in the Eastern Mediterranean Region, 2015 *(continued)*

Meeting title, location and date
Consultations
Consultative meeting on a strategic approach for cholera preparedness and response in the Eastern Mediterranean Region, Amman, Jordan, 17–19 November 2015
Expert consultation on evidence-based guideline development and adaptation in the Eastern Mediterranean Region, Cairo, Egypt, 18–19 November 2015
Expert group meeting on regulation of nurses, midwives and allied health professionals, Cairo, Egypt, 8–10 December 2015
Consultation on developing updated criteria and executive framework for health promoting schools in the Eastern Mediterranean Region, Cairo, Egypt, 19–20 December 2015
Intercountry meetings
Seventeenth intercountry meeting of directors of national and regional polio reference laboratories in the Eastern Mediterranean Region, Amman, Jordan, 26–28 January 2015
Intercountry meeting of the directors of public health laboratories in the Eastern Mediterranean Region, Tunis, Tunisia, 24–27 February 2015
Meeting on promoting preconception care in the Eastern Mediterranean Region, Muscat, Oman, 25–27 March 2015
Meeting of national maternal, neonatal and child health programme managers: addressing main causes of maternal, neonatal and child mortality, Amman, Jordan, 29 March –2 April 2015
Regional meeting on food safety, Amman, Jordan, 5–7 April 2015
Intercountry meeting on strengthening the public health response to substance use, Cairo, Egypt, 14–16 April 2015
Third annual regional meeting to scale up implementation of the United Nations Political Declaration on Prevention and Control of Noncommunicable Diseases, Cairo, Egypt, 27–29 April 2015 and Beirut, Lebanon, 27–28 June 2015
Third meeting of the WHO collaborating centres in the Eastern Mediterranean Region, Cairo, Egypt, 29–30 April 2015
Meeting of national coordinators for poliovirus containment on the WHO global action plan to minimize poliovirus facility-associated risk (GAPIII), Tunis, Tunisia, 12–13 May 2015
Regional nursing forum: the future of nursing and midwifery in the Eastern Mediterranean Region, Amman, Jordan, 24 May 2015
Intercountry meeting on nutrition, Amman, Jordan, 7–9 June 2015
Regional meeting on achieving the global target of 30% reduction in tobacco use by 2025, Tunis, Tunisia, 8–9 June 2015
First meeting of national hepatitis focal points, Cairo, Egypt, 8–10 June 2015
Meeting on sustainable alternatives to DDT and strengthening of national vector control capabilities in the Eastern Mediterranean Region, Teheran, Islamic Republic of Iran, 9–11 June 2015
Regional meeting on patient safety and health care quality in Eastern Mediterranean Region: from assessment to improvement, Tunis, Tunisia, 14–16 June 2015
Meeting of the national public health associations and institutions in the Eastern Mediterranean Region, Cairo, Egypt, 29–30 June 2015

Annex 3. Meetings held in the Eastern Mediterranean Region, 2015 *(continued)*

Meeting title, location and date
Intercountry meetings
Intercountry meeting on Good Governance for Medicines for phase I countries in the Eastern Mediterranean Region, Amman, Jordan, 16–19 August 2015
Regional meeting on strengthening partnership with civil society organizations for the prevention and control of noncommunicable diseases, Cairo, Egypt, 1–2 September 2015
Regional meeting on expanding universal health coverage to the informal sector and vulnerable groups in the Eastern Mediterranean Region, Cairo, Egypt, 1–3 September 2015
Sixteenth meeting of the national tuberculosis managers in the Eastern Mediterranean Region, Cairo, Egypt, 6–8 September 2015
Regional meeting on strengthening pharmacovigilance systems, Rabat, Morocco, 7–10 September 2015
Third intercountry meeting on the Eastern Mediterranean Acute Respiratory Infection Surveillance network, Amman, Jordan, 14–16 September 2015
"Eye on the earth" summit 2015, Abu Dhabi, United Arab Emirates, 6-8 October 2015
Fourth intercountry meeting of polio staff, Amman, Jordan, 18–20 October 2015
Annual intercountry meeting on the implementation of the WHO Framework Convention on Tobacco Control, Cairo, Egypt, 26–28 October 2015
Twenty-third intercountry meeting of national AIDS programme managers, Beirut, Lebanon, 27–29 October 2015
Eleventh intercountry meeting of national malaria programme managers of countries of the Eastern Mediterranean Region, Amman, Jordan, 22–24 November 2015
Intercountry meeting on analysis and assessment of drinking-water, sanitation and hygiene in the Eastern Mediterranean Region, Amman, Jordan, 24–26 November 2015
Seventh intercountry meeting of national malaria programme managers from HANMAT and PIAM-net countries, Amman, Jordan, 25–26 November 2015
Twenty-ninth intercountry meeting of national managers of the Expanded Programme on Immunization and sixteenth intercountry meeting on measles and rubella control and elimination, Amman, Jordan, 29 November–3 December 2015
Meeting on prevention and control of Crimean–Congo haemorrhagic fever in the Eastern Mediterranean Region, Muscat, Oman, 7–9 December 2015
Regional meeting on the principles and practice of health care accreditation, Cairo, Egypt, 13–15 December 2015
Workshops and trainings
Regional capacity building workshop on health inequality monitoring of national health data, Cairo, Egypt, 22-25 February 2015
Fourth seminar on health diplomacy, Cairo, Egypt, 2–4 May 2015
Regional workshop on strategic purchasing for Universal Health Coverage: how to implement innovative provider payment method, Cairo, Egypt, 10–12 June 2015
Regional CEHA training workshop on the safe management of health care wastes including highly infectious and contagious wastes generated by health facilities, Amman, Jordan, 27-29 July 2015

Annex 3. Meetings held in the Eastern Mediterranean Region, 2015 *(concluded)*

Meeting title, location and date
Workshops and trainings
Capacity-building workshop on the role of the private sector in moving towards universal health coverage in the Eastern Mediterranean Region, Cairo, Egypt, 9–12 August 2015
Workshop on new CCS guidelines, Cairo, Egypt, 30 August–1 September 2015
Workshop on mass media and social marketing campaigns for physical activity, Amman, Jordan, 23-25 September 2015
Intercountry training/certification workshop on laboratory specimen collection, transportation, shipment of influenza other pandemic prone respiratory viruses as per IATA regulations, Cairo, Egypt, 12–14 October 2015
Intercountry workshop on national regulatory authority self-assessment, Amman, Jordan, 25–27 October 2015
On-site training course on family practice for regional master trainers, Al-Yarmouk, Kuwait, 15–18 November 2015
Training course on managing programmes to improve child health, Cairo, Egypt, 22–26 November 2015
Capacity development workshop for hospital managers in the Eastern Mediterranean Region, Cairo, Egypt, 28 November–7 December 2015
Training workshop on the Baby Friendly Hospital Initiative for policy-makers in the Eastern Mediterranean Region, Amman, Jordan, 15–17 December 2015

Annex 4. New publications issued in 2015

Title	Originator
Publications	
A guide to nursing and midwifery education standards Language: English	Regional Office
Documenting the impact of hepatitis B immunization: best practices for conducting a serosurvey Language: Arabic	Headquarters
Donor Update 2015 (Q1): Syrian Arab Republic Language: English	Country Office
Donor Update 2015 (Q2): Syrian Arab Republic Language: English	Country Office
Eastern Mediterranean Region: framework for health information systems and core indicators for monitoring health situation and health system performance 2015 Language: English	Regional Office
Global recommendations on physical activity for health 18-64 years old Language: Arabic	Regional Office
Global recommendations on physical activity for health 5-17 years old Language: Arabic	Regional Office
Global recommendations on physical activity for health 65 years and above Language: Arabic	Regional Office
HIV basic knowledge and stigma reduction in health care settings. Handout for participants Language: English/French	Regional Office
HIV basic knowledge and stigma reduction in health care settings. Introduction to the course Language: English/French	Regional Office
HIV basic knowledge and stigma reduction in health care settings. Module 1. HIV epidemiology, transmission and prevention Language: English/French	Regional Office
HIV basic knowledge and stigma reduction in health care settings. Module 2. Natural history and clinical aspects Language: English/French	Regional Office
HIV basic knowledge and stigma reduction in health care settings. Module 3. HIV testing and counselling and ethics Language: English/French	Regional Office
HIV basic knowledge and stigma reduction in health care settings. Module 4. HIV care and psychosocial support Language: English/French	Regional Office
Friends power series 2 I lead a healthy life Language: French	Regional Office

Annex 4. New publications issued in 2015 *(continued)*

Title	Originator
Publications	
Interim infection prevention and control guidance for care of patients with suspected or confirmed filovirus haemorrhagic fever in health-care settings, with focus on Ebola Language: Arabic	Regional Office
Interpersonal violence prevention in the Eastern Mediterranean Region: facts from the Global status report on violence prevention 2014 Language: Arabic/English/French	Regional Office
Managing disaster risks in communities: a community-based approach to disaster risk reduction: training manual for the trainers of cluster representatives and volunteers Language: English	Regional Office
Patient safety tool kit Language: English	Regional Office
Practices to improve coverage of the hepatitis B birth dose vaccine Language: Arabic	Headquarters
Turning the tide against infectious disease threats: preparedness redefined Language: English	Regional Office
Principles and considerations for adding a vaccine to a national immunization programme. From decision to implementation and monitoring Language: Arabic	Headquarters
Promoting physical activity in the Eastern Mediterranean Region through a life-course approach Language: French	Regional Office
Promoting physical activity through the life course: a regional call to action Language: French	Regional Office
Test procedures for insecticide resistance monitoring in malaria vector mosquitoes Language: Arabic	Headquarters
The growing need for home health care for the elderly Home health care for the elderly as an integral part of primary health care services Language: English	Regional Office
The status of the illicit tobacco trade in the Eastern Mediterranean Region Language: Arabic/English/French	Regional Office
Tuberculosis control in complex emergencies Language: English	Regional Office
The work of WHO in the Eastern Mediterranean Region: annual report of the Regional Director 2014 Language: Arabic/English/French	Regional Office
World Health Organization Syrian Arab Republic Annual Report 2014 Language: English	Country Office
Periodicals	
Eastern Mediterranean Health Journal; Vol.21 No.1 –No.12 Languages: Arabic/English/French	Regional Office
IMEMR current contents; Vol.14 No.1 –No. 4 Language: English	Regional Office

Annex 4. New publications issued in 2015 *(continued)*

Title	Originator
Fact sheets	
Assessing essential public health functions in the Eastern Mediterranean Language: English	Regional Office
Better Health for people with disabilities Language: Arabic	Headquarters
Care for your liver: think about hepatitis World Hepatitis Day 2015 Language: Arabic/English/French	Regional Office
Children and road safety Language: Arabic/English	Regional Office
Fact sheet: HIV testing services: fact sheet to the WHO consolidated guidelines of HIV testing services Language: Arabic	Headquarters
Frequently asked questions About tobacco control Policies for the prevention and control of noncommunicable diseases Alternative crops to tobacco Illicit tobacco trade Raise taxation on all tobacco products Enforce a total comprehensive ban on tobacco products advertising, promotion and sponsorship Protect people from second hand smoke through enforcing a total ban on tobacco use in all public places, with no designated areas for smokers Warn people of the hazards of tobacco use through displaying large clear graphic health warnings Offer help to quit, enact cessation services Language: English	Regional Office
Illicit tobacco trade Best practices around the world Facts and figures on the illicit tobacco trade Immediate action in 10 steps Taxation and illicit trade The tobacco industry's role The Protocol to Eliminate Illicit Trade in Tobacco Products Language: Arabic/English/French	Regional Office
MPOWER in the Eastern Mediterranean Region Enforce bans on tobacco advertising, promotion and sponsorship (TAPS) Monitor tobacco use and prevention policies Offer help to quit tobacco use Overview of the WHO Framework Convention on Tobacco Control (WHO FCTC) and MPOWER Protect people from tobacco smoke Raise taxes on tobacco Warn about the dangers of tobacco Language: English	Regional Office

Annex 4. New publications issued in 2015 *(concluded)*

Title	Originator
Fact sheets	
Policy brief: HIV testing: WHO recommends HIV testing by lay providers Language: Arabic	Headquarters
Policy brief: HIV testing: WHO recommendations to assure HIV testing quality Language: Arabic	Headquarters
Violence against women Language: Arabic	Headquarters

Annex 5. WHO collaborating centres in the Eastern Mediterranean Region as at December 2015

Field	Title	Country	Institution name
Blood safety	WHO Collaborating Centre for Research and Training on Blood Safety	Islamic Republic of Iran	Iranian Blood Transfusion Organization (IBTO)
Blood transfusion	WHO Collaborating Centre for Training and Research in Blood Transfusion	United Arab Emirates	Sharjah Blood Transfusion and Research Centre
Cancer	WHO Collaborating Centre for Cancer Education, Training and Research*	Jordan	King Hussein Cancer Center
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
Dental public health	WHO Collaborating Centre for Training and Research in Dental Public Health	Islamic Republic of Iran	Department of Community Oral Health, School of Dentistry Shahid Beheshti University of Medical Sciences (SBMU)
Diabetes	WHO Collaborating Centre for Diabetes Research, Education and Primary Health Care	Jordan	National Centre for Diabetes, Endocrine and Inherited Diseases
	WHO Collaborating Centre for Treatment, Education and Research in Diabetes and Diabetic Pregnancies	Pakistan	Diabetic Association of Pakistan
Drug registration and regulation	WHO Collaborating Centre for Drug Registration and Regulation	Tunisia	Directorate for Drugs and Pharmacy, Ministry of Public Health
Educational development	WHO Collaborating Centre for Health Professionals' Educational Development*	Bahrain	Arabian Gulf University
	WHO Collaborating Centre for Research and Development in Medical Education and Health Services	Egypt	Suez Canal University (SCU)
	WHO Collaborating Centre for Training in Research and Educational Development of Health Personnel	Pakistan	College of Physicians and Surgeons
	WHO Collaborating Centre for Research and Training in Educational Development	Sudan	University of Gezira
Endocrine science	WHO Collaborating Centre for Research and Training on Endocrine Science*	Islamic Republic of Iran	Shaheed Beheshti University of Medical Sciences (SBUMS)
Evidence-informed policy and practice	WHO Collaborating Centre for Evidence-Informed Policy and Practice	Lebanon	American University of Beirut
Eye health	WHO Collaborating Centre for the Eye Health and Prevention of Blindness Programme	Islamic Republic of Iran	Shahid Beheshti Medical University

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

Field	Title	Country	Institution name
Health information	WHO Collaborating Centre for Family of International Classifications	Kuwait	National Centre for Health Information
Health management	WHO Collaborating Centre for Training and Research on Health Management	Islamic Republic of Iran	National Public Health Management Centre (NPMC), Tabriz University of Medical Sciences
Hearing loss	WHO Collaborating Centre for Research and Education on Hearing Loss	Islamic Republic of Iran	Otolaryngology, Head and Neck Research Centre
HIV/AIDS	WHO Collaborating Centre for Acquired Immuno-deficiency Syndrome	Kuwait	University of Kuwait
HIV surveillance	WHO Collaborating Centre for HIV Surveillance	Islamic Republic of Iran	Regional Knowledge Hub for HIV Surveillance, Kerman University of Medical Sciences
HIV/AIDS, tuberculosis and lung diseases	WHO Collaborating Centre for Research on HIV/AIDS, Tuberculosis and Lung Diseases	Sudan	The Epidemiological Laboratory (Epi-lab)
Mass gatherings	WHO Collaborating Centre for Mass Gatherings	Saudi Arabia	Office of Assistant Deputy Minister for Preventive Medicine, Ministry of Health
Mental health	WHO Collaborating Centre for Mental Health	Islamic Republic of Iran	Iran University of Medical Sciences
	WHO Collaborating Centre for Mental Health	Morocco	Ibn Rushd University
Mycetoma	WHO Collaborating Centre on Mycetoma	Sudan	University of Khartoum
Metabolic bone disorders	WHO Collaborating Centre for Metabolic Bone Disorders	Lebanon	American University of Beirut
NCD prevention and control	WHO Collaborating Centre for Research on NCDs and Gastrointestinal Cancers*	Islamic Republic of Iran	Digestive Diseases Research Institute
	WHO Collaborating Centre for NCD prevention and control*	Kuwait	Ministry of Health, Kuwait
Nursing	WHO Collaborating Centre for Nursing Development	Bahrain	College of Health Sciences, Ministry of Health
	WHO Collaborating Centre for Education and Research in Nursing and Midwife	Islamic Republic of Iran	Iran University of Medical Sciences, Center for Nursing Care Research
	WHO Collaborating Centre for Nursing Development	Jordan	Jordan University of Science and Technology (JUST)

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

Field	Title	Country	Institution name
Nutrition and Food Technology	WHO Collaborating Centre for Research on Nutrition and Food Technology*	Islamic Republic of Iran	National Nutrition and Food Technology Research Institute (NNFTRI)
Occupational health	WHO Collaborating Centre for Occupational Health	United Arab Emirates	Institute of Public Health, UAE University
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
Pharmacovigilance	WHO Collaborating Centre for Pharmacovigilance	Morocco	Centre Anti Poison et de Pharmacovigilance du Maroc
Prevention of blindness	WHO Collaborating Centre for Prevention of Blindness	Pakistan	Al-Shifa Trust Eye Hospital
	WHO Collaborating Centre for Prevention of Blindness	Saudi Arabia	King Khaled Eye Specialist Hospital
Primary oral health care	WHO Collaborating Centre for Primary Oral Health Care	Kuwait	University of Kuwait
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 Center in Reproductive Health and Population
Substance use disorders and mental health	WHO Collaborating Center for Research and Training on Substance Use Disorders and Mental Health*	Islamic Republic of Iran	Iranian National Center for Addiction Studies (INCAS), Tehran University of Medical Sciences
	WHO Collaborating Centre for Mental Health Research, Training and Substance Abuse	Pakistan	Rawalpindi Medical College
Tobacco control	WHO Collaborating Centre on Tobacco Control	Islamic Republic of Iran	National Research Institute of Tuberculosis and Lung Disease
	WHO Collaborating Centre for Treating Tobacco Dependence*	Qatar	Hamad Medical Corporation
Tuberculosis	WHO Collaborating Centre for Tuberculosis Education	Islamic Republic of Iran	Shaheed Beheshti University of Medical Sciences and Health Services

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

Field	Title	Country	Institution name
Transfusion medicine	WHO Collaborating Centre for Transfusion Medicine	Jordan	National Blood Bank, Ministry of Health
	WHO Collaborating Centre for Transfusion Medicine	Tunisia	National Blood Transfusion Centre of Tunis, Ministry of Health
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	Office National de l'Eau Potable (ONEP) Bou-Regreg Complex, Station de Traitement
Women health	WHO Collaborating Center for Women Health*	Jordan	The National Women Health Care Center

** Under designation/re-designation*