

The Work of WHO in the Eastern Mediterranean Region

Annual Report of the
Regional Director 2017



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Organization

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Introduction

I am pleased to present this report describing the work undertaken by WHO in the Eastern Mediterranean Region during 2017 and the early part of 2018.

This period pre-dates my time in office as Regional Director, which began on 1 June 2018. I would therefore like to begin by paying tribute to my predecessor as Regional Director, the late Dr Mahmoud Fikri, and to Dr Jaouad Mahjour, who took over as Acting Regional Director after Dr Fikri's sad and untimely demise. Reviewing this report, I am struck both by the enormity of the health-related challenges facing the Eastern Mediterranean Region and by the great progress that is being achieved in spite of those challenges. That progress is testament to the contribution of Dr Fikri, Dr Mahjour and previous regional directors, and to the work of WHO's staff and partners in the Region under their able leadership.

In part, the challenges that face WHO reflect the scale of our ambition. One of our major strategic aims is universal health coverage: we want to help our Member States ensure that everyone in the Region can access the health services they need

without running the risk of financial hardship in doing so. Clearly, that aim will not be achieved quickly, but efforts continued apace in 2017 and I am pleased to report some progress.

WHO undertook a range of activities with our Member States in the Region to strengthen their health systems towards achieving universal health coverage. We helped them develop and advance their distinct visions and strategies to improve health financing in each specific country context. Notable achievements included providing technical support for a landmark new social health insurance law in Egypt and for the implementation of strategic health purchasing in the Islamic Republic of Iran and Sudan.

Health workforce development received a boost in October 2017 with the endorsement by the 64th session of the Regional Committee of a framework for action. We are now working to scale up implementation of the framework, to ensure that every country has a supply of highly qualified health personnel with an appropriate skill mix to meet its current and future needs.

Another major task in ensuring access to health care for all is to define which health services and interventions should be provided and financially covered for the population. In this regard, essential health service packages were assessed and supported in six countries: Afghanistan, Egypt, Palestine, Saudi Arabia, Somalia and Yemen.

Providing those services is not just a job for the public sector. On the contrary, our Member States have recognized the crucial role of private sector health care in the Region. Responding to a mandate from the Regional Committee, WHO prepared a framework for action on effective engagement with the private health sector to

expand service coverage for universal health coverage, to be presented to the Committee at its 65th session in 2018.

Universal health coverage also requires effective and comprehensive health information systems to measure health needs and outcomes. In this regard, again, there have been encouraging results despite many challenges. Intensive work with Member States to strengthen country health data and measurement systems has led to a remarkable improvement in core indicator reporting, with an average increase of 15% in indicators reported at the regional level in the period 2014–2017.

We will continue working to improve both health systems and health information systems in the year ahead.

WHO is committed to promoting health across the life course. That means identifying and seizing opportunities for health promotion at critical stages in people's lives. Reproductive, maternal, newborn, child and adolescent health are all high priorities and received much attention during 2017 and early 2018. Progress was uneven, with clear setbacks in countries affected by humanitarian crises, but there were notable achievements too. Iraq, United Arab Emirates and Yemen launched strategic plans on maternal and child health, while Sudan became the first country in the world to apply the Accelerated Action for the Health of Adolescents (AA-HA!) implementation guidance to develop a strategic plan for adolescent health and development.

At the other end of the life course, WHO is promoting a new concept of healthy ageing that is built around the functional ability of older people, rather than the absence of disease. Several cities in the Region have embraced the Organization's

global age-friendly cities initiative, with Sharjah in the United Arab Emirates enjoying particular success.

The past year also saw significant efforts to promote health and tackle deep-seated problems such as road traffic accidents, gender-based violence and environmental risks. WHO supports the Health in All Policies (HiAP) approach to help Member States effectively address the underlying social determinants of health. These are huge challenges with no instant solution, but painstaking multisectoral efforts offer the hope of improvement over time.

For example, avoidable environmental risks cause at least 850 000 deaths each year in the Region. The Regional Committee's endorsement of a regional framework for action on climate change and health in October 2017 has paved the way for an integrated/multisectoral, evidence-based policy response, and I look forward to reporting on the implementation of the framework next year.

Closely tied to health promotion is the fight against noncommunicable diseases (NCDs) including cardiovascular diseases, cancer, diabetes and chronic respiratory diseases. NCDs take a severe toll in the Region, and unfortunately WHO's Noncommunicable Disease Progress Monitor 2017 indicated that countries are not on course to reach NCD target 3.4 of the Sustainable Development Goals by 2030.

However, there has been some progress in each of the four key areas of the regional framework for action on the prevention and control of NCDs. That includes governance, with WHO supporting our Member States to develop multisectoral NCD action plans: eight of the 22 countries in

the Region now have an operational strategy or action plan.

It also includes a lot of work to help prevent and control risk factors. Efforts to scale up implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) enjoyed some success in spite of the tactics of the powerful tobacco industry to undermine these efforts. Several Gulf Cooperation Council countries introduced tobacco excise tax, and WHO collaborated closely with them. Furthermore, many countries took steps to improve the nutritional content of food, including taxes on sweetened beverages, policies to reduce salt consumption, limit saturated fatty acids and virtually eliminate industrial production of trans fatty acids. Twelve countries implemented at least one national campaign to promote physical activity.

Extensive work was also undertaken to enhance surveillance, monitoring and evaluation in relation to NCDs and to reorient health services for better NCD management. Endorsement of a regional framework for action on cancer prevention and control by the 64th session of the Regional Committee was a landmark achievement, as was the deployment in the Syrian Arab Republic of a new WHO emergency kit for the management of NCDs during emergencies.

Mental health is a challenging issue in the Region. It is often stigmatized and has a low political and public health profile, with institutional care remaining the dominant model of care in most countries. The theme of World Health Day 2017 was *Depression: let's talk*, and WHO helped to develop a mental health literacy package and targeted campaigns to build on that momentum. Meanwhile, efforts to integrate mental health

treatment into primary care continued through the Mental Health Gap Action Programme (mhGAP) and school mental health package.

Reducing the transmission and impact of communicable diseases remains one of the core elements of WHO's mission, and one that saw considerable progress in the Eastern Mediterranean in 2017.

We are getting ever closer to achieving our global aim of eradicating poliomyelitis. The number of wild poliovirus cases fell to the lowest level ever recorded. However, as long as wild poliovirus is circulating anywhere, there remains a risk of it spreading or of circulating vaccine-derived polioviruses (cVDPV) emerging, especially in countries affected by complex emergencies. Effective surveillance, preparedness and response are all crucial, and we will continue to work with countries to maintain and improve these areas of work.

The prevalence of HIV in the Region remains low but is rising, and too few of those infected are receiving antiretroviral therapy. Viral hepatitis is a significant cause of mortality, especially in Egypt and Pakistan, but there have been welcome improvements in testing and treatment. Meanwhile, detection of tuberculosis is improving but remains well below the global target rate of 90%.

The reported number of confirmed malaria cases was 1.36 million in 2017. Fourteen countries in the Region are free from indigenous malaria transmission, with good progress in several others, but protracted emergencies complicate efforts to control the disease in many malaria-endemic countries. WHO is developing an integrated strategy for malaria and other vector-borne

disease interventions, particularly in countries experiencing complex emergencies.

The security situation can also make vaccination challenging. However, overall regional immunization coverage was maintained at 80%, with an increase in average coverage of diphtheria-tetanus-pertussis (DTP3) vaccine. Measles case-based laboratory surveillance is implemented in all countries, and seven countries are close to achieving the measles elimination target.

In response to a resolution of the Regional Committee in October 2017, countries are now developing national action plans on antimicrobial resistance; two had already been officially submitted to WHO by December, with eight others at an advanced stage. Extensive work was also undertaken to improve surveillance, raise awareness and promote behaviour change.

In one area, the Eastern Mediterranean Region is the uncontested global leader: health emergencies. More than 76 million of our people are directly or indirectly affected by conflict, environmental threats and natural disasters.

WHO responded to 10 graded emergencies in the Region during 2017, including four Grade 3 major emergencies in Iraq, Somalia, Syrian Arab Republic and Yemen. Somalia was classified as a Grade 3 emergency in May 2017, requiring a scaled-up Organization-wide response. The dengue fever outbreak in Pakistan was assigned a Grade 1 emergency from July 2017 to January 2018. Other graded emergency countries included Afghanistan, Libya, Pakistan and Palestine.

Our work in emergency settings faces severe constraints, not least insecurity: 80% of all attacks on health workers recorded globally by WHO in

2017 occurred in the Eastern Mediterranean. In addition, health systems are often limited or non-existent in affected areas; there are shortages of skilled personnel; and funding is insufficient.

Yet despite these challenges, WHO and our partners continue to provide life-saving support where it is most needed. In 2017, WHO's logistics hub in Dubai delivered 791 tonnes of medicines and medical supplies to 20 countries in the Region and beyond, reaching more than 23.5 million beneficiaries in Iraq, Somalia, the Syrian Arab Republic and Yemen alone.

WHO led or jointly led health sector coordination in eight countries in the Region where the health cluster has been activated. In the Gaza strip, the health cluster prevented the closure of 14 public hospitals and 18 nongovernmental organization hospitals by providing fuel for generators. In Iraq, health cluster partners immunized 99% of target children in newly accessible areas. In Yemen, health partners were able to reach 6 million people with life-saving health services. In Pakistan, health partners are underpinning the transition from emergency to development in the Federally Administered Tribal Areas (FATA). In the Syrian Arab Republic, health partners supported 14.4 million medical procedures and provided 8.6 million courses of treatment.

Outbreaks of emerging infectious disease were successfully contained in Pakistan (dengue fever), Somalia (cholera), Sudan (acute watery diarrhoea) and the United Arab Emirates (travel-associated Legionnaire's disease), thanks to rapid field investigation and deployment of surge staff from the Regional Office, the involvement of Global Outbreak Alert and Response Network (GOARN) partners, and swift implementation

of public health containment measures in the affected countries.

Meanwhile, efforts also continued to tackle longer-term capacity issues. The Emergency Medical Team (EMT) initiative was launched to establish a cadre of skilled national multidisciplinary medical teams to act as first responders when emergency strikes; the WHO Emerging and Dangerous Pathogens Laboratory Network was established to develop high-security laboratories for the timely detection, management and containment of outbreaks; and work is underway to develop new partnerships and new models of funding.

Emergency preparedness is another crucial aspect of our work. In 2017, support was provided to Egypt, Iraq, Jordan and Pakistan to conduct risk assessments and develop their all-hazards preparedness and response plans; a hospital emergency course was conducted in Bahrain, Libya and Sudan; Kuwait, Oman, Saudi Arabia and United Arab Emirates were supported to undertake additional voluntary joint external evaluations (JEEs); and Iraq, Libya, Syrian Arab Republic and Yemen were helped to prepare for JEEs.

The role of WHO's staff and Member States in the Eastern Mediterranean is not limited to the

Region; we also help to shape the Organization's global strategy. In 2017, that included contributing very actively to WHO's Thirteenth General Programme of Work, which was finalized and launched in May 2018, and Member State representatives also attended high-level meetings at WHO headquarters in Geneva, contributing to setting the agenda on a range of issues.

Improving WHO's own management and performance remains a strategic priority. During 2017, the Organization continued to improve its planning, forecasting, implementation, monitoring and evaluation capacity aimed at more efficient use and distribution of limited resources. All audits of WHO in the Region resulted in satisfactory or partially satisfactory ratings, showing continued improvement in controls and a deep commitment to compliance with established standards and procedures. We will continue our efforts to optimize performance going forwards.

Dr Ahmed Al-Mandhari
WHO Regional Director for the
Eastern Mediterranean

Strengthening health systems for universal health coverage

Universal health coverage

In 2017, WHO intensified its efforts to support countries of the Region in developing their visions, strategies and roadmaps towards universal health coverage. Key strategic cross-cutting activities included the development of a priority benefit package for universal health coverage, enhancing engagement with the private sector and focusing on synergizing efforts through the so-called humanitarian–development–peace nexus approach, to enhance health system resilience in emergency contexts.

Health governance and financing

Clear vision, strong governance structures, functioning regulatory and financing institutions and effective partnerships are all critical to enhance health system performance towards universal health coverage.

Many countries of the Region have weak governance arrangements and limited accountability and transparency, hampering health system performance. Several countries continue to lack a clear vision and comprehensive roadmap to strengthen their health systems towards universal health coverage. In addition, insufficient public funding for health, non-existent or weak prepayment arrangements and inefficient

use of scarce financial resources compromise the performance of health financing systems.

To address these challenges, special attention was given to supporting the development of national health policies, strategies and plans by undertaking governance and financing assessments and focusing efforts on building institutional capacity. Technical support was also provided to several countries to review their new national health strategies. In addition, several diagnostic tools were developed or adapted to inform health system reform and transformation. Specifically, tools for assessing accountability and public health were developed. Support was provided to countries to conduct health system governance and legal reviews, and to apply the joint framework to mitigate the risk of corruption in the health sector. In addition, work was initiated in the areas of decentralization, resilience and engagement with non-state actors. Regional training on the rule of law and HiAP was organized in collaboration with the Social Research Centre at the American University in Cairo and the League of Arab States.

Work on health financing continued to be guided by the regional framework for action for advancing universal health coverage to strengthen the performance of health financing systems and enhance the goal of financial protection. Specifically, support was provided to countries to develop their own health financing visions and strategies according to the country context, while also supporting the generation of necessary evidence. Technical cooperation with Egypt contributed to the enactment of a historic comprehensive social health insurance law, ensuring more public money for health. Support was also provided to Kuwait to review its health financing system and integrate a health financing strategy into the country's national strategic

health plan. Special support was provided to the Islamic Republic of Iran and Sudan to strengthen the strategic purchasing function of their health insurance organizations. Particular attention was given to the development of benefit packages for universal health coverage.

In the area of health partnerships, joint missions and coordinated support with Gavi, the Vaccine Alliance, and the Global Fund resulted in increased funding for health system strengthening in the form of increased immunization coverage and better control of HIV/AIDS, tuberculosis and malaria. Joint efforts with the Federal Ministry of Health of Sudan and other development partners culminated in the endorsement of a funding proposal to support governance reforms in the National Health Insurance Fund. Collaboration continued with the United Nations Development Programme (UNDP) to combat corruption in the health system.

Health workforce development

A well-qualified and well-performing health workforce will be crucial for achieving universal health coverage. Countries continue to face an overall shortage of health workers in addition to imbalances in geographic distribution and skills mix. In particular, Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen have a critical shortage of health workers. Furthermore, protracted crises have led to a loss of health workers and interruptions in health professionals' education, exacerbating the gaps. The safety and security of the remaining health workforce continue to be a major concern. A rapid influx of refugees in some countries has led to increased workload and a decline in health workforce densities.



↑ *Framework for action for health workforce development*

A framework for action for health workforce development was finalized in 2017 and endorsed by the 64th session of the Regional Committee in October. The framework provides strategic guidance for countries to address health workforce challenges. A number of countries embarked on strategic planning, and analysis of the health workforce and labour market was undertaken to guide the development of the strategic plans. The Islamic Republic of Iran, Iraq, Pakistan, Somalia and the United Arab Emirates developed nursing or midwifery strategies.

In addition, case studies were conducted in the Islamic Republic of Iran, Jordan and Lebanon to understand the challenges and gaps in the primary care workforce and how to strengthen multidisciplinary teams in family practice-based primary care. A regional prototype nursing curriculum was developed to guide the process of developing nursing curricula; and curriculum review was undertaken in several countries. Finally, support was provided to Yemen to establish a B.Sc. nursing programme at the University of Aden.



↑ *Assessment measured transparency in the pharmaceutical sector in Pakistan*

With the increasing involvement of the private sector in the education and work of the health workforce, health workforce regulation is more important than ever. Strengthening governance capacities is critical; a workshop on strengthening the health workforce was held in collaboration with the World Bank and the International Monetary Fund, and support was provided for the establishment of national medical and midwifery councils in several countries.

Health workforce observatories provide mechanisms to strengthen health workforce information and evidence. In 2017, a regional meeting on health workforce observatories was held to discuss how health workforce observatories can be scaled up, introduce national health workforce accounts and agree on a set of indicators to monitor the framework for action.

In 2018, efforts will continue to scale up implementation of the framework for action with a focus on the priorities of strategic planning to ensure availability, accessibility, quality and performance of the health workforce, strengthening health workforce governance and

regulatory capacities, increasing investment in the health workforce and improving related information and evidence. Efforts will continue to tackle health workforce challenges in countries with protracted crises in order to ensure access to health care.

Essential medicines and technologies

Achieving universal health coverage will require countries to improve access to health technologies, including medicines, vaccines and medical devices. Aided by the technical support of WHO, Member States can improve access by developing national policies that promote the development of effective innovation, regulation, assessment and management programmes for health technologies within existing national health systems.

Through the programme on good governance for medicines, Member States were supported in establishing policies for implementing codes of conduct and managing conflicts of interest, increasing the public availability of information, developing membership guidelines for national committees, developing standard operating procedures for decision-making processes, establishing independent complaint mechanisms to improve protection for whistleblowers, and increasing societal engagement. An assessment report of transparency in the pharmaceutical sector in Pakistan was published in 2017. In collaboration with UNDP and the Arab Anti-Corruption and Integrity Network, specialized training on preventing corruption in the pharmaceutical sector was conducted for officials in Egypt.

Collaboration with countries continued in the implementation of WHO's global action plan

on antimicrobial resistance. Reliable national antibiotic consumption data for 2014–2016 from several countries of the Region will be published in the 2018 WHO global report on antibiotic consumption.

Surveys on national policy and regulation for traditional and complementary medicine were conducted in eight countries (Afghanistan, Jordan, Lebanon, Morocco, Oman, Somalia, Syrian Arab Republic and Tunisia). These surveys managed to identify gaps in policies, regulations and practices to be addressed by Member States. Technical support was also provided to set up policies on herbal medicine, market surveillance and vigilance systems.

Technical support was provided to the Healthcare Technology Management and Advancement centre in Lebanon to become a regional hub for innovation in health care technology. Collaboration with the centre focused on developing strategies to enhance the spirit of innovation in health technologies, investigating existing resources to promote innovation, identifying clinical gaps that need to be filled, and strengthening interdisciplinary collaboration.

Regulation of medical products – medicines, vaccines and medical devices – is a priority in the Region. Through WHO’s global benchmarking tool for national regulatory authorities, assessments of national regulatory capacity were carried out in eight countries (Afghanistan, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Pakistan, Somalia and Sudan) and resulted in the development of institutional development plans for their national regulatory authorities. Follow-up on the implementation of the plans will be conducted in the next two years. An informal assessment of the national regulatory authority was conducted in Saudi Arabia. The national

regulatory authority in Saudi Arabia is now enhancing its capacity to appropriately regulate locally manufactured vaccines.

In 2017, a regional publication on the regulation of medical devices was translated into French. Several countries are being assisted in the enhancement of their medical device regulatory functions. WHO supported the establishment of expert committees of the Intergovernmental Authority on Development to promote the harmonization of medicine regulation involving Djibouti, Somalia and Sudan and Member States from the African Region.

Technical support was provided to INASante in Tunisia and the National Institute of Health Research in the Islamic Republic of Iran to enhance their capacities to conduct health technology assessment studies. Regional experiences in promoting and facilitating the establishment of national health technology assessment units or agencies were shared as a model for African countries to follow during the proceedings of the 2017 annual meeting of health technology assessment agencies and international networks in Rome. Regional experience was also highlighted in a special issue of the *International Journal of Technology Assessment in Health Care*.

A new pharmaceutical sector country profile was piloted in Libya and Sudan. The profile provides quality information on structures, processes and outcomes of the health and pharmaceutical sectors in countries of the Region. Training was organized to enhance the management of the supply chain for medicines and medical devices in Libya.

In support of efforts to improve access to and management of assistive technologies, a rapid assessment tool was developed to collect and

analyse baseline country information. Results of the regional assessment were presented at the Global Research, Innovation, and Education in Assistive Technology (GREAT) Summit in 2017. Based on findings, a regional report is being prepared to guide the development of a regional action framework to improve access to assistive technology as an essential component of universal health coverage.

Integrated service delivery

During 2017, support provided to countries in the area of health service delivery was based on the WHO framework for integrated people-centred health services, which was adopted by the World Health Assembly in May 2016.

An online course developed in 2016 to build the capacities of general practitioners in family medicine was conducted in Egypt, Iraq, Kuwait, Saudi Arabia, United Arab Emirates and at the

United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). An advisory group of family practice experts was also established to provide strategic guidance on scaling up family practice in the Region.

An important stage towards ensuring access to health care for all is to define which programmes, services and interventions should be provided and financially covered for the population. As an initial step in the development of a generic universal health coverage priority benefit package for the Region, essential health service packages were assessed in six countries (Afghanistan, Egypt, Palestine, Saudi Arabia, Somalia and Yemen).

The critical role of the private health sector in advancing universal health coverage was highlighted by countries at the 64th session of the Regional Committee in October 2017. In response, work was initiated to develop a regional framework for action on advancing the role of the



Photo: ©WHO

↑ To strengthen service delivery for universal health coverage family physicians were trained in Iraq

private health sector in the move towards universal health coverage. Analyses of the private health sector in countries of the Region were updated in 2017 and private health sector factsheets were prepared for 18 different countries.

Technical support in the area of hospital care and management included two national capacity-building programmes on hospital care and management for public hospital managers. A model for training master trainers was developed for rolling out the programme on hospital care and management. The model will be used to replicate this programme in the Region in 2018.

Available data from the WHO emergency care system assessment collected from 12 countries shows critical organizational and implementation gaps in the Region. A new initiative was developed to strengthen the capacity of hospital managers in hospital emergency preparedness and response, with the first national training conducted in Sudan. This course will be replicated in countries in emergencies during 2018. An assessment of national policies for the hospital sector was conducted in 2017 in order to develop a regional framework for the hospital sector.

Member States were supported in different areas related to quality and safety, including in the development of national quality policies and strategies and in technical review and guidance for national health care accreditation programmes. A regional study on mapping health care accreditation programmes was conducted and the report is being finalized. At the primary care level, a framework was developed that includes a set of 34 core indicators for quality of care for countries to use in assessing, improving and monitoring the quality of care at primary health care level. Member States were also supported in

implementing the WHO maternal and newborn health framework for quality of care, and of patient safety interventions, including the launch and expansion of the Patient Safety Friendly Hospital Initiative in more countries. Other key activities included the integration of the WHO patient safety curriculum in 21 health care-related academic institutions in Oman as well as the implementation of the WHO core components of infection prevention and control in Qatar.

Health information systems

Implementation of the regional framework for health information systems and core indicators remains one of the key priorities for technical support in the Region. Key Sustainable Development Goals (SDG) indicators are incorporated in the regional core indicators list to provide countries with a unified approach for reporting health-related indicators. Intensive work with Member States in strengthening country health data and measurement systems has led to a remarkable improvement in core indicator reporting, with an average increase of 15% in indicators reported at the regional level 2014–2017. In 16 out of 22 countries, the reporting of core indicators ranges from 76% to 95%; whereas in the remaining six countries reporting ranges from 62% to 75%.

As part of efforts to enhance the capacity of countries to report on indicators that are mainly generated from population-based surveys, a consultative meeting was held in December to discuss priority national population-based surveys, recommended survey modules and national survey plans to support the generation of data for key SDG indicators and effective monitoring of progress towards universal health coverage. In 2018, the results will be adapted to



↑ **Framework for health information systems and core indicators 2017**

the context of the countries for use in national plans.

In 2017, comprehensive assessments of national health information systems were conducted in Libya and Pakistan as part of efforts to strengthen these systems. In Libya, the assessment was followed by the development of a costed national health information system strategy. A national health information system strategy was also developed in Jordan based on the results of its 2016 assessment. Three countries (Pakistan, Sudan and Syrian Arab Republic) were supported to pilot the district health information system, version 2 (DHIS2) to enhance the collection, processing, analysis and reporting of health data. A regional workshop was conducted in Jordan to build the capacity of national managers of maternal and child health programmes and health information systems in setting SDG-related targets for reproductive, maternal, newborn, child and adolescent health indicators.

Strengthening collection and improving the quality of data from civil registration and vital statistics (CRVS) systems remains a key priority in the Region. During 2017, regional activities focused on building capacity for improved coverage and quality of mortality data. The WHO automated verbal autopsy questionnaire was introduced for the first time in a workshop

for seven countries. In collaboration with Melbourne University and the Bloomberg Data for Health Initiative, a workshop was conducted to build the capacity of Member States in using ANACONDA, an electronic tool to assess the accuracy and completeness of mortality and cause-of-death data. To promote utilization of the electronic application for notification of deaths and causes of deaths (DHIS2-SMoL), a workshop for DHIS2 customization was organized for all countries in the Region. A regional orientation workshop on the International Classification of Diseases (ICD-11) was conducted in collaboration with the WHO Collaborating Centre for the WHO Family of International Classifications in Kuwait. National workshops were also conducted in four countries to build national capacity in certification of deaths and ICD-10 coding. A workshop on advanced ICD-10 coding using decision tables was conducted for the first time in the Region with the collaboration of the Bahrain Supreme Council of Health. WHO also supported workshops in several countries to evaluate progress in implementing CRVS improvement plans. During 2017, 12 countries reported mortality data using ICD-10 and one country used ICD-9.

Future work will focus on supporting Member States to address the remaining challenges with health information systems. In particular, countries will be supported to develop national survey plans to promote regular and focused implementation of population-based surveys. Piloting of DHIS-2 to enhance the collection, processing, analysis and reporting of health data is planned in Libya, and a comprehensive assessment of the health information system is planned in Afghanistan. The protracted emergencies in the Region and limited resources continue to affect efforts to improve health information systems, including CRVS systems. Further efforts are also



↑ Participants at the launch of the third Global Patient Safety Challenge “Medication Without Harm”

needed to improve the quality of certification of deaths using ICD-10 compliant certification forms.

Research development and innovation

WHO support focused on building the capacity of health care and academic institutions in the use of health information resources, by promoting the Hinari Access to Research for Health programme and conducting national training workshops. The *Eastern Mediterranean Health Journal* continued its regular monthly publication, including a special issue on substance use.

In the area of eHealth, a regional situation analysis was conducted on national health priorities, potential opportunities and barriers for eHealth applications. In December, the first regional workshop on the development of national eHealth strategies was conducted jointly with the International Telecommunications Union. A scaled-up smoking cessation mobile eHealth (mHealth) application was launched in Tunisia. Implementation of other evidence-based mobile eHealth applications continued in Tunisia (diabetes control) and Egypt (diabetes control, smoking cessation).

In coordination with UNESCO, a regional summit of national ethics and bioethics committees was held in Oman in April with the aim of fostering regional cooperation to address emerging issues related to bioethics.

In October, the 64th session of the Regional Committee issued a resolution calling for the establishment of regional mechanisms to support the bridging of gaps between relevant research institutions and policy-makers and the translation of research evidence into health policy statements. An expert consultation on evidence-based health policy-making, held in November, highlighted the need to support Member States to improve their institutional capacity for the conduct, governance and oversight of research, and for the use of research evidence in decision-making.

Tropical disease research projects from six countries were completed, while 10 grants for research priorities in public health in eight countries were also fulfilled. WHO continued to support capacity-building for research through regional workshops on implementation research and on good health research practices. In 2017, there were 46 WHO collaborating centres supporting WHO activities in the Region.

Promoting health across the life course

The life course approach

Promoting health and well-being across the life-course cuts across all areas of WHO's work, including the health of women before, during and after pregnancy, newborns, children, adolescents and older people. The aim is to reduce mortality and morbidity, and address the social, economic and commercial determinants of health of the population. By identifying critical stages in the life-course that influence health, opportunities for health promotion can be recognized and addressed along the continuum of care.

Reproductive, maternal, newborn, child and adolescent health

Reproductive, maternal, newborn, child and adolescent health has been recognized as a priority in the roadmap for WHO's work in the Eastern Mediterranean Region (2017–2021). It is the cornerstone of the United Nations *Global strategy for women's, children's and adolescent's health (2016–2030)* and a prerequisite for achieving the SDGs by 2030. Maternal, neonatal and child mortality levels, and meeting the need for family planning, are core indicators in monitoring the progress being made by the reproductive, maternal, newborn, child and adolescent health programmes in Member States. Unfortunately, progress remains uneven, with clear setbacks in countries affected by humanitarian crises.

In 2017, WHO maintained technical support for national strategic planning. Iraq, United Arab Emirates and Yemen launched strategic plans, good progress was made in Afghanistan, Egypt, Libya, Morocco, Pakistan and Saudi Arabia, and focused support was provided for national efforts in Syrian Arab Republic and Tunisia. In September, WHO, jointly with the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF), held the third annual intercountry meeting of maternal and child health programme managers in the Region. The 19 participating countries developed plans of action to scale up national programmes towards achieving the health related SDG targets and promoting the transfer of knowledge and expertise to Member States. The meeting released a joint statement expressing the commitment of the H6 global health partnership to the health of women, children and adolescents. The H6 partnership pulls together six United Nations agencies, related organizations and programmes to improve the health and save the lives of women and children, namely WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNFPA, UNICEF, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) and the World Bank.

In response to the specific reproductive and maternal health needs that exist in crisis situations, WHO and UNFPA held an informal consultation in August on improving the existing reproductive health emergency kits. In addition, a project to improve family planning practice in emergency situations was initiated with an assessment of practice in refugee camps in Lebanon based on WHO practice recommendations on safe and effective contraceptive use.

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To improve the quality of care for reproductive and maternal health, up-to-date WHO maternal and newborn quality of care standards and tools, including the *Standards for improving quality of maternal and newborn care in health facilities* (WHO 2016) were introduced to Member States. The Islamic Republic of Iran adapted the existing tools to their local context, providing a model for other countries in the Region. In addition, technical support was provided to Palestine and Sudan on early essential newborn care coaching, and to the Syrian Arab Republic on Integrated Management of Childhood Health (IMCI) and caring for the newborn at home in humanitarian settings.

Throughout 2017, close follow-up with countries was maintained to support the strengthening of family planning services through the implementation of evidence-based guidelines and best practices, with a focus on countries with low contraceptive prevalence rates, to assist them in developing plans of action funded by the Bill & Melinda Gates Foundation. As part of this project, a training-of-trainers course on evidence-based guidelines for strengthening family planning services was conducted for national gynaecology and obstetrics societies and midwifery associations in the Region. This resulted in plans of action to strengthen the role of the private sector in providing family planning services in countries. National training activities were also assisted, such as in Morocco and Tunisia, and WHO disseminated the publication *Medical eligibility criteria wheel for contraceptive use* (WHO 2015) to Member States to support national capacity-building activities and enhance service quality.

In October 2017, resolution EM/RC64/R.4 on the operationalization of the adolescent health

component of the *Global strategy for women's, children's and adolescents' health (2016–2030)* was endorsed at the 64th session of the Regional Committee. The resolution urged Member States to develop and/or update national adolescent health action plans using the Accelerated Action for the Health of Adolescents (AA-HA!) implementation guidance towards a comprehensive approach to the planning, monitoring and evaluating of adolescent health interventions. Ten Member States received training in the use of the guidance, with Sudan being the first country in the world to apply it in developing a country strategic plan for adolescent health and development. In addition, partnerships with concerned United Nations agencies were strengthened through the implementation, monitoring and evaluation of the *Regional framework of joint strategic actions for young people in the Arab States/Middle East and North Africa Region (2016–2017)*. Meanwhile, a regional implementation framework for newborn, child and adolescent health (2018–2025) and a regional operational field guide for child and adolescent health in humanitarian settings were developed in consultation with Member States.

The roadmap of WHO's work in the Region provides a solid platform to foster national efforts to improve reproductive, maternal, newborn, child and adolescent health using up-to-date WHO evidence-based interventions. Cross-programme proposals have been developed to support the implementation of priority areas for reproductive, maternal, newborn, child and adolescent health within the roadmap for implementation in 2018–2019. Partnerships, especially with the concerned United Nations sister agencies and key donors, resource mobilization and national capacity-building will remain critical in supporting Member States to achieve the SDGs by 2030.

Nutrition

The Region continues to suffer from a double burden of malnutrition. In 2016, the total number of stunted children under 5 years in the Region was estimated to be 20.3 million (representing 25.6% of this age group). Meanwhile, the Region is also experiencing a nutritional transition that has contributed to high rates of overweight and obesity, and is closely linked to physical inactivity and unhealthy diet. Moreover, during 2011–2016, an estimated 40% of infants under 6 months of age globally were exclusively breastfed, compared to 29% in the Region, where only Afghanistan and Palestine have exclusive breastfeeding rates over 50%, thereby meeting the global target.

In 2017, supplementation and food fortification with essential micronutrients occurred in almost all countries in the Region. Eight countries have developed nutrition surveillance systems, generating evidence for programme development. However, technical support on quality control and assurance is still needed by most Member States. The adoption of regulations implementing the International Code of Marketing of Breast-milk Substitutes has been fully achieved in six countries and partially achieved in 12.

WHO will continue to support the adoption and implementation of the UN Decade of Action on Nutrition (2016–2030) to address the double burden of malnutrition. It is working with Member States to develop a framework of action for scaling up work on nutrition and to support the development of national policies, establishment of targets, implementation of strategies and monitoring of national plans of action.

Ageing and health

In 2015, WHO published the first *World report on ageing and health*. This was followed in May 2016 by the World Health Assembly's adoption of the *Global strategy and plan of action on ageing and health*. Both reflect a new conceptual model of healthy ageing that is built around the functional ability of older people, rather than the absence of disease. In 2017, WHO continued to foster national efforts in line with the global strategy and plan of action, collaborating with countries in a global survey to monitor its implementation. The survey provided up-to-date information on country commitments to action on healthy ageing, the development of age-friendly environments, the aligning of health systems to the needs of older populations, the development of sustainable and equitable systems for providing long-term care, and monitoring and research for healthy ageing. Furthermore, WHO conducted a regional survey on active, healthy ageing and old age care, and on the age-friendly cities and age-friendly primary health care initiatives. The collected information was presented at the Seventy-first World Health Assembly in May 2018 and will be used in strengthening national programmes. Meanwhile, a regional technical guide on strengthening ageing and health services in countries is being developed.

The age-friendly cities initiative has been implemented in several cities in the Region. Sharjah has made remarkable progress in creating an age-friendly environment for its senior citizens and demonstrating a successful model for other cities, not only in the United Arab Emirates, but in other countries in the Region. Joint efforts and coordination with key partners will be vital to overcome the limited resources available to support healthy ageing programmes in countries.

Close collaboration and networking is required in strengthening national programmes to respond to the unmet health needs of older people, especially in countries in emergency situations.

Violence, injuries and disabilities, including prevention of blindness and deafness

WHO continues to play a normative technical role through its work on different aspects of road traffic injury prevention and control, which is a priority area in the roadmap of WHO's work in the Region (2017–2021). In 2017, a regional road safety report was finalized in collaboration with the Johns Hopkins Bloomberg School of Public Health, the survey for the fourth *Global road safety status report* was implemented in 19 countries, studies to estimate the cost of road traffic injuries were finalized in Egypt and Tunisia, and assessments of emergency care systems were completed in Egypt and Pakistan.

During the year, stronger collaboration and coordination was pursued with United Nations agencies in the area of gender-based violence. Multisectoral regional meetings were jointly organized on gender-based violence, female genital mutilation and essential services for women and girls subject to violence, while support was maintained to strengthen the health sector response to gender-based violence in Afghanistan and Pakistan. Meanwhile, the reports of an assessment of child maltreatment prevention readiness in regional high-income countries were finalized in collaboration with the national family safety programme of Saudi Arabia, and a regional workshop on the seven INSPIRE strategies to end violence against children was organized during the

fifth Arab regional conference on the prevention of child abuse and neglect, held in November in Dubai, United Arab Emirates.

In terms of disability, and to operationalize resolution EM/RC63/R.3 on improving access to assistive technology, a rapid assessment was done in 17 countries of the Region and a report produced to support the development of a strategic action framework. A side-event on assistive technology was also organized during the 64th session of the Regional Committee to launch the Islamabad Declaration for Improving Access to Assistive Technology.

To date, 16 Member States have developed and revised their five-year national action plans on eye health in line with the *WHO global action plan on universal eye health (2014–2019)*. In 2017, assessments were finalized of the status of eye care services in six countries, and of diabetic retinopathy and diabetes management systems in eight. WHO continued its collaboration with the International Agency for the Prevention of Blindness and hosted a regional meeting on eye health care for displaced



Photo: ©WHO Afghanistan/Sini Ramo

↑ Health care providers in Afghanistan were trained on treatment protocols to improve the health sector's response to gender-based violence

populations in December in Cairo, Egypt. An ear and hearing care situation analysis was conducted in two countries, while national plans for ear and hearing care were documented in eight. The declared political commitment in countries now needs to be translated into programmatic action and the required resources allocated. Coordination, multisectoral action, enforcement, implementation, and the evaluation of policy and legislative frameworks all need further attention.

Health education and promotion

Insufficient physical activity is one of the 10 leading risk factors for global mortality, and the Region has a high prevalence of physical inactivity (31%) of all WHO regions. In 2014, a high-level multisectoral regional forum on the life-course approach to promoting physical activity held in Dubai, United Arab Emirates, issued a regional call to action on physical activity with a set of interventions for specific sectors. The Regional Steering Committee on Physical Activity was subsequently established to support implementation of the call to action, and a toolkit developed to guide the integration of physical activity into primary health care in countries. The next step is to pilot test the instrument in eight selected countries. In August 2017, an intercountry training of trainers workshop was organized in Cairo to support capacity-building on physical activity policies and programmes in 13 countries.

In 2017, the development of a regional strategy for oral health was initiated in coordination with the WHO Collaborating Centre for Training and Research in Dental Public Health in the Islamic Republic of Iran, and oral health guidelines developed by the WHO Regional Office for Africa were translated into Arabic for dissemination in

the Region. Also in 2017, a national health literacy capacity-building workshop was held in Sudan to support key stakeholders to understand and use health literacy in efforts to achieve the SDGs. WHO will continue to advocate for the need for health promotion in general, and physical activity and health literacy in particular, to improve the health status of the population throughout the life-course. Coordination among concerned sectors and partnerships with key stakeholders are critical elements in this.

Social determinants of health, gender, and Health in All Policies (HiAP)

In 2017, WHO continued to support the implementation of the Rio Political Declaration on Social Determinants of Health in the Region and to strengthen country capacities in adopting the HiAP approach. This included the regional adaptation, piloting and implementation of WHO global frameworks to support the integration of gender, equity and human rights in national policies and planning. In addition, close cooperation with United Nations agencies and the League of Arab States was sustained to promote health and human rights and gender in the Arab world. The Regional Office also actively participated in gender-related United Nations collective efforts and inter-agency initiatives, including with UNFPA, UN Women and the League of Arab States. Technical support has continued to foster country efforts to strengthen the health sector's role in responding to gender-based violence, including in Afghanistan and Pakistan.

A regional workshop on applying the HiAP approach to achieve the SDGs was held in Cairo, Egypt, in February, and there was regional

contribution and participation in the HiAP International Conference in Adelaide, Australia, in March, which focused on progressing the SDG agenda. At country level, in-depth assessments of the social determinants of health were conducted in Oman and United Arab Emirates; HiAP implementation training was provided in Saudi Arabia (to strengthen capacities to establish a unit in the Ministry of Health under Vision 2030 and the new health transformation plan) and United Arab Emirates; Pakistan was assisted in developing and reviewing a strategic framework for action on HiAP through an expert group meeting; and Sudan was supported in developing its road map for implementing the approach.

To support the increasing demand in the Region for support in applying the HiAP approach and addressing the social determinants of health, a mapping tool for work in the Region is being developed, along with a list of regional indicators for action on social determinants of health, a regional HiAP action framework and a regional methodology for social determinants of health assessment in countries. WHO will continue to support the implementation of the Rio Political Declaration, the effective integration of social determinants of health and gender within health programmes, the strengthening of country capacity to implement the HiAP approach, intersectoral action, and social participation to address the social determinants of health and gender.

Health and the environment

Environmental risk factors, such as air, water and soil pollution, chemical exposures, climate change and radiation, contribute to more than 100 diseases and injuries in all countries. These avoidable environmental risks cause at least 850 000 deaths annually (22% of the total burden

of diseases, or 1 in 5 of total regional deaths). A triple environmental health burden is observed through the impact of emergencies, infectious diseases and noncommunicable diseases. Indoor and outdoor air pollution alone results in 400 000 regional deaths a year (or 1 in 8 of all deaths), with about 98% of the urban populations in cities of the Region exposed to air pollutants exceeding WHO safe levels. In the Region, more than 100 million people, including 32 million children, fall ill every year from foodborne disease. Of these, an estimated 37 000 die.

In 2017, the 64th session of the Regional Committee, in resolution EM/RC64/R.3, endorsed the framework for action on climate change and health in the Eastern Mediterranean Region (2017–2021), aligned with the WHO-led strategy on health and the environment in the Arab Region (2017–2030). National plans of action to implement the regional strategy on health and environment and its related framework for action (2014–2019) have been developed and are being implemented in eight countries. Furthermore, eight Member States have begun updating their national health and climate profiles, while 82 cities in 16 countries of the Region report their air quality data through the WHO burden of disease database. Status reports on water and sanitation, including in-depth monitoring of SDG6 targets in five Member States, have also been commenced.

During the year, WHO conducted regional training on sanitation and wastewater safety planning. WHO also worked with the United Nations Economic and Social Commission for Western Asia (ESCWA) to develop a report and training kit on climate change adaptation in the health sector using integrated water resource management tools. Furthermore, support was given to the Arab Institute for Occupational Health and Safety to finalize Arabic guidelines

on occupational exposures and to translate into Arabic the WHO publication *Safe management of wastes from health-care activities*. Regional training was also held on developing national plans of action for food safety, and technical support was provided to several countries to reduce the burden of foodborne and zoonotic diseases. On chemical safety, support was given to address the health aspects of the Strategic Approach to International

Chemicals Management (SAICM) framework, the Minamata Convention on Mercury and the phasing-out of lead in paints and mercury in the health sector. Finally, a process to evaluate the *WHO Global plan of action on workers' health (2008–2017)* was initiated so that the needs and priorities of the Region are reflected in the new plan.

Noncommunicable diseases

Regional framework for action

In September 2018, the United Nations General Assembly staged the third high-level meeting on noncommunicable diseases to review progress made in implementing the 2011 Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases. According to WHO's Noncommunicable Disease Progress Monitor 2017, despite some promising trends, national progress in implementing key strategic interventions under the four areas (governance, surveillance, prevention and health care) of the regional framework for action has been limited and remains insufficient for countries to reach noncommunicable disease target 3.4 of the SDGs by 2030. Obstacles to progress in the Region include a lack of multisectoral coordination and engagement, especially of non-health sectors, weak national public health and health system capacities for prevention and control of noncommunicable diseases, and interference by industry impeding the implementation of the “best-buys” and other recommended interventions, including raising taxation on tobacco, alcohol and sugar-sweetened beverages.

Governance

During 2017, WHO continued to support countries in developing multisectoral noncommunicable disease action plans, incorporating noncommunicable diseases into national development plans and United Nations

Development Assistance Framework (UNDAF) plans, and setting up national noncommunicable disease targets. Eight out of 22 countries (36.4%) in the Region now have an operational multisectoral national policy, strategy and/or action plan that integrates noncommunicable diseases and their shared risk factors, while 16 (72.7%) have incorporated noncommunicable diseases into their national development agendas. Furthermore, building on work to mobilize and strengthen the capacity of regional civil society organizations for the prevention and control of noncommunicable diseases, WHO promoted the creation of a regional noncommunicable disease alliance.

Prevention and control of risk factors

In 2017, WHO continued to provide technical support to scale up implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) in countries. Collaboration continued with the U.S. Centers for Disease Control and Prevention (CDC) for the implementation of the Global Tobacco Surveillance System (GTSS) in countries of the Region, and with the WHO FCTC Secretariat to strengthen tobacco control. This included a regional planning workshop on the WHO FCTC 2030 initiative to strengthen WHO FCTC implementation towards achieving the SDGs, a regional meeting to support full execution of the decisions of the seventh session of the Conference of Parties (COP7), and a multisectoral workshop to promote the entry into force in the Region of the WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products. Additionally, WHO provided technical support to the League of Arab States to develop model tobacco control legislation.

Following the 2016 Gulf Cooperation Council agreement on implementing tobacco excise tax, several member countries of the Gulf Cooperation Council have started implementation, and regional training on implementing successful tobacco taxation policies was provided by WHO.

To support national tobacco control efforts, information resources were produced to highlight key findings of the *WHO report on the global tobacco epidemic 2017*, raise awareness of tobacco industry activities in countries and promote the SimSmoke tobacco control policy simulation. A resource on graphic health warnings was finalized in collaboration with the University of Waterloo, Canada.

Further collaboration with international organizations is needed for better tobacco control implementation, as is strengthening national capacity to counter tobacco industry tactics. Developing a regional action plan for tobacco control is a priority in order to move forward on tobacco control and fully meet WHO FCTC commitments.

The Region continues to experience an epidemiological and nutritional transition that is contributing to high rates of overweight and

obesity, with half of all adult women (50.1%) and more than two in five adult men (43.8%) estimated to be overweight or obese in 2014. The evolution of overweight and obesity is closely linked to physical inactivity and unhealthy diet, with the Region having a high prevalence of physical inactivity in adults (31%), and higher levels among women (37%) than men (26%).

In this context, promoting healthy diet has been identified as a key strategic and cost-effective intervention in the regional framework for action for the prevention and control of noncommunicable diseases. In 2017, the adoption of national policies to reduce population salt/sodium consumption was fully achieved in eight countries (36.4% of countries in the Region), and partially achieved in six (27.3%). Additionally, the adoption of national policies to limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply was fully achieved in 12 countries (54.5%). Furthermore, WHO's recommendations on the marketing of foods and non-alcoholic beverages to children were adopted in seven countries (31.8%) and the countries of the Gulf Cooperation Council added "sin" taxes on sweetened beverages and soft drinks (100% and 50% on energy drinks and soft drinks, respectively).



Photo: ©Ministry of Health of the United Arab Emirates

↑ In the United Arab Emirates, identifying people at risk of noncommunicable diseases, and treating them, is a priority for the health system

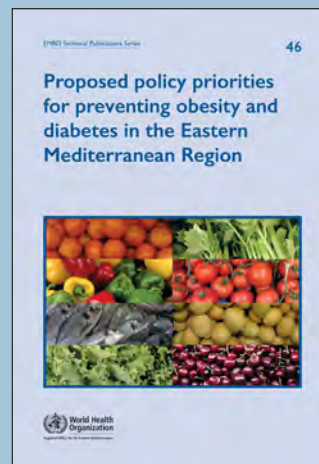
Twelve countries (54.5%) implemented at least one national public awareness and motivational communication for physical activity, including mass-media campaigns for physical activity behavioural change. This included high-income countries such as Gulf Cooperation Council countries and the Islamic Republic of Iran.

Nutrition data collection and analysis remain a challenge in the Region. Effective policy-making and accountability require effective nutrition surveillance and monitoring and evaluation systems. Developing a roadmap for action to address obesity is another priority for the Region, and has been advanced through dissemination of the recently published WHO document *Proposed policy priorities for preventing obesity and diabetes in the Eastern Mediterranean Region* (2017).

Surveillance, monitoring and evaluation

In 2017, 12 Member States set time-bound national targets for surveillance, monitoring and evaluation based on WHO guidance. Countries continued to strengthen noncommunicable disease risk factor surveillance systems by implementing the WHO STEPwise approach to noncommunicable disease surveillance (STEPS) and the Global Tobacco Surveillance System with its components, the Global Youth Tobacco Survey (GYTS), the Global Adult Tobacco Survey (GATS) and Tobacco Questions for Surveys.

Morocco and Oman were able to complete data collection for national-level STEPS, with Oman integrating the GATS questionnaire into its national STEPS survey successfully, while Egypt, Lebanon and Sudan completed data analysis for their national-level STEPS surveys. Qatar and Somalia made progress in the development



↑ *Technical guidance on preventing obesity and diabetes*

of a protocol for national-level STEPS implementation in early 2018, while United Arab Emirates integrated its national-level STEPS questionnaire into the World Health Survey and embarked on the data collection phase.

Pakistan, under a donor funding mechanism, was selected to implement the GATS repeat survey in 2018, while Saudi Arabia continued its work on GATS implementation, and the Islamic Republic of Iran, Kuwait, Morocco, Oman, Palestine and Tunisia completed the data analysis for their GYTS repeat surveys. In collaboration with the International Agency for Research on Cancer (IARC), Jordan, Syrian Arab Republic and United Arab Emirates received training on CanReg5 software, an open source tool to input, store, check and analyse cancer registry data following international standards (ICD-10).

All countries in the Region successfully completed the noncommunicable disease country capacity survey for 2017. The survey is a periodic assessment of national capacity for the prevention and control of noncommunicable diseases, and is designed to monitor progress towards implementation of the United Nations



↑ *Technical guidance on detecting cancers early*

Political Declaration and the regional framework for action on the prevention and control of noncommunicable diseases. The survey covers: health system infrastructure; funding; policies, plans and strategies; surveillance; primary health care; and partnerships and multilateral collaboration. The information collected will be used to assess country progress at the United Nations General Assembly and the World Health Assembly in 2018. Updated regional status and country profiles based on country capacity survey results for 2017 were developed to assist countries in identifying gaps, challenges and the way forward.

Health care

In 2017, in line with the SDGs and universal health coverage agenda, WHO scaled up its support to countries in the Region in reorienting health services for better management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors, with a focus on primary health care, including in crises and emergencies. In particular, support was provided for the development and implementation of national cancer control programmes. A milestone

was reached in October with the endorsement by the 64th session of the Regional Committee of a regional framework for action on cancer prevention and control.

Guidance and country support was also given for the management of noncommunicable disease care in crises and emergencies. A notable achievement was the deployment in the Syrian Arab Republic of a new WHO emergency kit for the management of noncommunicable diseases during emergencies. The emergency health kit includes medical equipment and 22 essential medicines for chronic diseases such as hypertension, cardiac diseases, diabetes, chronic respiratory diseases, and selected mental health and neurological conditions. The kit also includes noncommunicable disease management protocols for health care workers, based on WHO standards. The new kit will now be available in the WHO catalogue for all countries in need. Expansion of its deployment is expected soon in other countries facing emergencies, such as Iraq and Yemen.

Mental health

Following the endorsement by the Regional Committee in 2015 of the regional framework to scale up action on mental health, the area of mental health and substance abuse is beginning to gain traction. In order to monitor and report on global and regional targets, data were collected and compiled using the Mental Health Atlas questionnaire. Since 2015, a regional course in leadership in mental health has been developed and hosted annually by the American University in Cairo to strengthen institutional capacity in countries.

To bridge the treatment gap for mental health problems through integration within primary

health care, the WHO Mental Health Gap Action Programme (mhGAP) was initiated or scaled up in many countries in 2017, including Afghanistan, Egypt, Iraq, Jordan, Lebanon, Libya, Pakistan, Palestine, Somalia, Syrian Arab Republic and Tunisia. WHO support was provided to the Islamic Republic of Iran to review the national programme for suicide prevention, to Afghanistan and Tunisia in developing suicide prevention programmes, to Oman, Qatar and United Arab Emirates to develop their national autism plans, to Qatar and Tunisia for the development of dementia plans, and to Afghanistan, Lebanon and Sudan to review and draft mental health legislation and regulations. To promote mental health and prevent mental disorders, a school mental health package was developed that is being piloted in Egypt, Islamic Republic of Iran, Jordan, Pakistan and United Arab Emirates, and is being used in other WHO regions.

During 2017, technical support continued to be provided to strengthen mental health and psychosocial support for populations in Iraq,

Libya and Yemen, and those affected by the Syrian crisis, in coordination and collaboration with United Nations agencies, nongovernmental organizations, national stakeholders and academic institutions, with a focus on needs assessment, capacity-building and enhancing access to services. This led to the development of a regional mental health and psychosocial support capacity-building course, piloted in Saudi Arabia, the development of a curriculum for enhancing the capacity of general nurses for provision of mental health care, piloted in the Syrian Arab Republic, and the field testing of a psychosocial intervention package to be delivered through non-specialized health workers in emergencies, including the piloting of an electronic version in Egypt, Jordan, Lebanon and Syrian Arab Republic.

In collaboration with the United Nations Office on Drugs and Crime (UNODC), technical support was provided to set up opium substitution treatment services in Egypt, Kuwait and Palestine, expand services in Lebanon, Morocco and United Arab Emirates, and review national



↑ World Health Day 2017

strategies in Iraq and Jordan. Furthermore, the annual regional capacity-building workshop for mid-level managers on substance use policy development and service delivery was held and WHO is continuing to contribute to the field trials of different versions of chapter 6 of the International Classification of Disease, Eleventh Revision (ICD-11) and treatment and prevention standards for substance use disorders.

Despite this progress, challenges remain, with mental health continuing to have a low political and public health profile. The stigma attached to mental health leads to discrimination in resource

allocation and service development, delivery and utilization, with institutional care remaining the dominant model of care in most countries, thereby compounding under-resourcing with inefficiency. To overcome these challenges, WHO will continue to strengthen its collaboration with regional and global partners to implement the provisions of the regional framework to scale up action on mental health and enhance public mental health literacy through the development of a mental health literacy package and targeted campaigns, building on the momentum generated by the World Health Day 2017 *Depression: let's talk* campaign.

Communicable diseases

Poliomyelitis eradication

There has been excellent global progress towards stopping wild poliovirus transmission in 2017; just 22 cases of the only remaining serotype of wild poliovirus type 1 (WPV1) were reported from two endemic countries, namely Afghanistan and Pakistan (14 cases and 8 cases, respectively), the lowest number of polio cases ever reported since the start of the Global Polio Eradication Initiative in 1988. However, although case numbers are down, WPV1 is still being isolated in 2017 in wide geographical areas in both Afghanistan and Pakistan.

The onset of the last polio case in the world due to wild poliovirus type 2 was in 1999, and the date of onset of the most recent case due to wild poliovirus type 3 was in November 2012. The eradication of wild poliovirus type 2 was certified in September 2015 by the Global Certification Commission.

Seventy-four cases of circulating vaccine-derived poliovirus type 2 (cVDPV2) were confirmed in 2017 in north-east Syrian Arab Republic (Deir Ez-Zor, Raqqa and Homs). The first case detected had onset on 3 March, and the date of onset of the most recent case was 21 September 2017.

During the fifteenth meeting of the IHR Emergency Committee regarding the international spread of polio on 14 November 2017, the committee considered the risk of international spread of poliovirus to remain a Public Health Emergency of International



Photo: ©WHO Afghanistan/Sini Ramo

↑ Polio vaccination teams at border crossing points with Pakistan and Islamic Republic of Iran vaccinate children in Afghanistan

Concern (PHEIC) and extended the revised temporary recommendations for a further three months. Afghanistan and Pakistan fall under states infected with WPV1, with potential risk of international spread, while Syrian Arab Republic falls under states infected with cVDPV2 with potential risk of international spread.

Despite the tremendous progress globally and in the Region, as long as wild poliovirus (WPV) is circulating anywhere, risks remain. The risk of importation of WPV1 or the emergence of circulating vaccine-derived polioviruses (cVDPV) remains high due to ongoing transmission of poliovirus in endemic foci in Afghanistan and Pakistan, as well as complex emergency situations in several countries of the Region that have resulted in extensive population movements, inaccessibility, and deteriorating routine immunization coverage in several areas. In addition, there was a global supply shortage of inactivated polio vaccine (IPV) in 2016 and 2017.

Afghanistan and Pakistan have developed robust national emergency action plans to stop polio transmission in 2018. Pakistan progressed very well in 2017, reducing the number of polio cases

by 60% from 20 cases in 2016 to 8 cases in 2017, while the number of cases slightly increased in Afghanistan from 13 cases in 2016 to 14 cases in 2017, with 10 cases (71%) reported from the conflict and access-affected southern region of the country.

Response activities to contain the outbreak of cVDPV2 in the north-east of the Syrian Arab Republic have been implemented in a situation that is extremely difficult operationally. The response is paying dividends, as reflected by the decline in transmission, with no new cases detected since 21 September 2017. Response activities are continuing to ensure that the outbreak has been contained.

Surveillance performance indicators in all countries of the Region except one have been maintained at and above certification standards in 2017. Moreover, environmental surveillance has been expanded to include Islamic Republic of Iran, Jordan, Lebanon, Pakistan, Somalia and Syrian Arab Republic, in addition to Afghanistan and Egypt, where the system has been established for some years. Environmental surveillance will

be further expanded in 2018 to Iraq, Sudan and Yemen.

National preparedness and response plans in all polio-free countries in the Region except Palestine and Yemen were tested and updated in simulation exercises conducted in 2016 and 2017 to mitigate the risk of importation of WPV and/or the emergence of VDPVs, and to ensure an effective response should it occur. However, the only way to completely eliminate the risk of importation of wild poliovirus is by stopping polio transmission in Afghanistan and Pakistan. The risk of VDPVs emerging, particularly in conflict-affected countries with a significant number of children inaccessible to immunization services, remains.

The countries of the Region successfully implemented the switch from trivalent to bivalent oral polio vaccine in April 2016. It is imperative that all the countries of the Region complete Phase I containment requirements and start Phase II poliovirus type 2 containment as an integral part of implementation of the Global Action Plan III (GAP III) for poliovirus containment and a prerequisite for certification of polio eradication.

Somalia and Sudan have conducted polio asset mapping in 2017 as part of the post-eradication transition process to determine what polio functions will be integrated into other existing initiatives, and what functions may be prioritized or phased out. Both countries are planning to complete their transition plans by May 2018. The other two transition priority countries in the Region, Afghanistan and Pakistan, are still endemic and will develop their transition plans within a year of stopping transmission.

In the low transmission season of 2018, the Region and the world have the best ever opportunity



Photo: ©WHO Afghanistan/Sini Ramo

↑ Children in Afghanistan are immunized against polio during a national immunization day

to stop poliovirus transmission. To achieve this historic goal, the Region must continue to address ongoing wild poliovirus transmission in the remaining endemic foci in Afghanistan and Pakistan, reach inaccessible children in Afghanistan, Iraq, Pakistan, Somalia and Syrian Arab Republic, and maintain population immunity, even in emergency countries and among displaced populations, while maintaining vigilance and the capacity to detect and respond to any new introduction or outbreak due to WPV or cVDPV.

A key priority for 2018 is to stop WPV transmission in Afghanistan and Pakistan by supporting implementation of national emergency action plans through technical, financial and logistical support. Another priority will be to continue support to the Syrian Arab Republic to ensure that the outbreak of cVDPV2 is completely contained and transmission has been interrupted. Enhancing preparedness and response capacity in all countries will continue, with a strong focus on improving surveillance systems to ensure early detection and effective response to any introduction of poliovirus, and supporting countries in containment and preparation for certification of polio eradication.



Photo: ©WHO

↑ Dr Rik Peepkorn, WHO Representative in Afghanistan, addresses a meeting of the Technical Advisory Group on polio eradication

Effectively utilizing polio assets, infrastructures and lessons learned to improve routine immunization and other key public health interventions by developing robust transition plans in priority countries (Afghanistan, Iraq, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen) is another key area of focus. To this end, support will be provided to polio transition priority countries to develop country-specific transition plans to sustain polio-free status after certification of polio eradication, benefit other public health interventions and learn lessons from polio eradication.

Technical support to countries will include regular review of programmes in Pakistan, Afghanistan and the Horn of Africa through Technical Advisory Group meetings to analyse progress and advise governments on the most effective technical interventions. It will also involve conducting regular risk analysis (quarterly for at-risk countries and twice a year for other countries) to identify risks and develop specific mitigation strategies. Additionally, building the capacity of polio-free countries to respond to polio emergencies will be done through training on polio outbreak standard operating procedures and



Photo: ©WHO Afghanistan/Simi Ramo

↑ A child in Afghanistan receives oral polio vaccine

conducting simulation exercises to field test and update national preparedness and response plans. Annual review of the certification requirements of the polio-free countries will continue to be done by the Regional Certification Committee.

HIV, viral hepatitis, tuberculosis, malaria and tropical diseases

Despite the low prevalence of HIV in the Region, the increase in the number of new cases remains a concern. The number of people living with HIV (PLHIV) in the Region increased from 340 000 in 2016 to 350 000 by the end of 2017. Ninety-five per cent of this increase occurred in key populations at risk of HIV. Furthermore, only 30% of PLHIV have been diagnosed, indicating that limited access to HIV testing is the main impediment to access to care and treatment.

In response, WHO organized a consultation in July 2017 in Beirut, Lebanon, on accelerating access to the continuum of HIV diagnosis, care and treatment, with a focus on HIV testing. Moreover, World AIDS Day 2017 advocacy activities focused on promoting HIV testing. WHO also provided support to the Islamic Republic of Iran and Pakistan to improve testing efficiency and linkage to care for those diagnosed HIV positive.

As a result of adopting the “Treat all” approach, the treatment coverage rate improved by 12.5% compared to 2016 and the number of PLHIV receiving antiretroviral therapy (ART) reached 64 900 by the end of 2017. Still, the overall coverage of ART in the Region did not exceed 18%. Developing model programmes that can be replicated to increase HIV diagnosis and

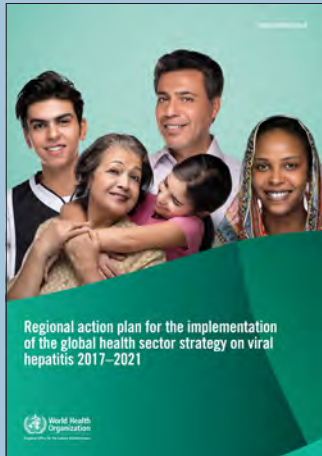
treatment coverage will be the focus of future WHO support in the Region.

Viral hepatitis remains a significant cause of mortality in the Region, with 80% of those infected with viral hepatitis C residing in Egypt and Pakistan. The majority of new infections are caused by weak injection safety and infection prevention and control measures in health services, followed by injecting drug use. Regional coverage of hepatitis B vaccine birth dose immunization increased from 22% in 2016 to 34% in 2017. Egypt continues to be a global success story in hepatitis C treatment. Over five million tests were conducted between October 2016 and December 2017, and 1.5 million cases were treated for the infection. Strong political commitment has also been demonstrated for the implementation of the first hepatitis strategic framework developed in Pakistan. Moreover, both Egypt and Pakistan have succeeded in reducing the price of direct acting antivirals to less than 0.1% of its global price, enabling rapid scale-up of treatment. Also in 2017, Morocco developed its national hepatitis strategy and initiated the first epidemiological survey of hepatitis B and C prevalence in the country.

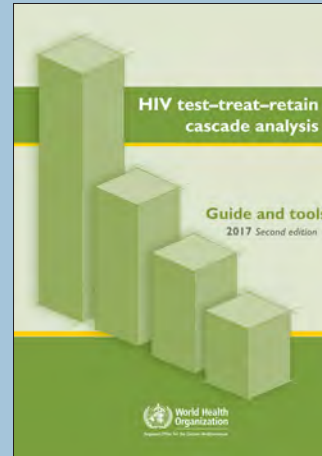


Photo: ©WHO

↑ Former Minister for National Health Services Regulation and Coordination Mrs Saira Afzal Tarar signs Pakistan Declaration to eliminate hepatitis by 2030



↑ *Regional action plan for the implementation of the global health sector strategy on viral hepatitis 2017–2021*



↑ *Second edition of the HIV test-treat-retain cascade analysis*

Future support will focus on the development of national strategic plans, testing and treatment guidelines, and developing and rolling-out surveillance, monitoring and evaluation systems.

During 2016, a total of 527 693 tuberculosis cases (all forms) were notified in the Region. Despite a slight improvement in the tuberculosis case detection rate (currently referred to as the treatment coverage rate), it is still far below the global target of 90%. Eight countries in the Region (Afghanistan, Egypt, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen) are responsible for around 97% of missed tuberculosis cases. The treatment success rate reached 91% for the new and relapsed patient cohort of 2015, and slow but steady improvement has been seen in the detection and management of multidrug-resistant tuberculosis (MDR-TB) cases. Of 21 000 estimated MDR-TB cases, 4713 cases were detected and 4073 started treatment in 2016. The destruction of health systems, huge population movements and worsening of the security situation have all severely impacted the implementation of tuberculosis control strategies in countries experiencing complex emergencies.

The regional End TB action plan 2016–2020 was endorsed by the Regional Committee in October 2017. Also in 2017, support was provided to update tuberculosis strategic plans, guidelines and standard operating procedures in Afghanistan, Iraq and Pakistan, in line with the regional action plan and WHO's End TB Strategy. New updates in both diagnosis and treatment for MDR-TB and tuberculosis in children were widely distributed through the support of the regional Green Light Committee, and capacity-building in tuberculosis diagnosis was conducted for staff from 10 countries, and in rifampicin resistance/MDR-TB management for staff from 20 countries (over the period 2016–2017). In addition, a tuberculosis and MDR-TB laboratory task force was established to strengthen the tuberculosis laboratory network in the Region. In November, 14 countries of the Region participated in the first WHO Global Ministerial Conference on Ending TB in Moscow. WHO will continue work with countries to promote the establishment of a comprehensive package to increase tuberculosis case detection, including tuberculosis diagnosis and treatment services for countries with refugee or internally displaced populations.

The reported number of confirmed malaria cases in the Region was 1.36 million in 2017, 65% of which were reported from Pakistan and Sudan, with 1626 deaths reported due to malaria. However, 14 countries in the Region are free from indigenous malaria transmission, the Islamic Republic of Iran and Saudi Arabia are at the stage of malaria elimination, and Egypt has reported zero local cases for the three years required to be eligible for certification of malaria-free status. During 2017, the proportion of suspected cases tested for malaria in six high-burden countries was 81%. Coverage of the main interventions in endemic countries is increasing, but is yet to achieve the target of universal coverage. The reported operational coverage of nets for at-risk populations in Afghanistan, Pakistan, Sudan and Yemen was 70%, 21%, 78% and 51%, respectively. The quality and coverage of the malaria surveillance system increased in Pakistan, Somalia and Sudan, following adoption of DHIS2.

In 2017, technical support was provided for the development of national strategies for malaria

control and elimination and for capacity-building in Afghanistan, Somalia and Yemen. Support was also given to the Malaria Indicators Survey in Somalia, for monitoring drug and insecticide resistance in Afghanistan and Pakistan, for an external competency assessment for malaria microscopy, and for resource mobilization in high-burden countries. Protracted emergencies in many malaria-endemic countries in the Region is the main challenge for implementation of malaria control interventions. Outbreaks of other vector-borne diseases (chikungunya and dengue) in malaria-endemic countries puts further strain on the limited human and financial resources. In the upcoming period, WHO will focus on developing an integrated strategy for continuation of malaria and other vector-borne disease interventions, particularly in countries experiencing complex emergencies. The involvement of other sectors beyond health will be key in future planning.

Significant progress in the fight against neglected tropical diseases was achieved in the Region in 2017. The control and elimination of neglected tropical diseases is now considered to be a major



Photo: ©WHO

↑ High-level Ministerial Conference on ending TB in Moscow

Table 1
Parasitologically-confirmed cases in countries with no or sporadic transmission and countries with low malaria endemicity

Country	2015		2016		2017	
	Total reported cases	Autochthonous	Total reported cases	Autochthonous	Total reported cases	Autochthonous
Bahrain	87	0	106	0	133	0
Egypt	291	0	233	0	305	0
Iran (Islamic Republic of)	799	187	705	94	939	74
Iraq	2	0	5	0	9	0
Jordan	59	0	51	0	44	0
Kuwait	309	0	390	0	419	0
Lebanon	125	0	134	0	152	0
Libya	324	2	370	2	397	NA
Morocco	510	0	409	0	586	0
Palestine	2	0	1	0	1	0
Oman	822	4	807	3	1078	18
Qatar	445	0	493	0	444	0
Saudi Arabia	2620	83	5382	272	3151	177
Syrian Arab Republic	12	0	12	0	25	0
Tunisia	88	0	99	0	120	0
United Arab Emirates	3685	0	3849	0	4013	0

NA: not available

Table 2
Reported malaria cases in countries with high malaria burden

Country	2015		2016		2017	
	Total reported cases	Total confirmed	Total reported cases	Total confirmed	Total reported cases	Total confirmed
Afghanistan	350 044	103 377	392 551	190 161	320 045	161 778
Djibouti	9557	9557	13 804	13 804	14 671	14 671
Pakistan	3 776 244	202 013	2 115 941	318 449	2 190 418	350 467
Somalia	39 169	20 953	58 021	35 628	37 156	35 138
Sudan	1 102 186	586 827	974 571	566 015	1 368 589	720 879
Yemen	104 831	76 259	144 628	98 701	114 004	84 677



Photo: ©WHO

↑ Officials of Egypt's Ministry of Health and Population talk to local people during surveillance phase of lymphatic filariasis elimination programme

contributor to achieving universal health coverage, and four of them have been included among the priority areas in the roadmap of WHO's work in the Eastern Mediterranean Region (2017–2021). Links were established or strengthened with significant partners to reinforce support to neglected tropical disease activities in the Region. Moreover, the Expanded Special Project for Elimination of Neglected Tropical Diseases has now been extended to the Region and the Reaching the Last Mile Fund, sponsored by the Crown Prince of Abu Dhabi, was launched in November to mobilize partnerships to eliminate and eradicate preventable deadly diseases that hinder the health and economic prospects of the world's poorest people.

The elimination of lymphatic filariasis as a public health problem was validated in Egypt, Yemen progressed in the finalization of its validation dossier and Sudan scaled up mass drug administration. Interruption of transmission of onchocerciasis was definitely confirmed in the second focus in Sudan, while planning and resource mobilization towards elimination was done in Yemen. With regard to schistosomiasis, surveys

to demonstrate interruption of transmission were carried out in Iraq, the Islamic Republic of Iran and Oman, while Egypt started implementation of its elimination plan; and mass treatment with praziquantel was carried out in Somalia, Sudan and Yemen. Treatment of school-age children for soil-transmitted helminthiasis was implemented in Afghanistan, Egypt, Iraq, Somalia, Sudan, Syrian Arab Republic and Yemen, as well as in the five fields of operation of UNRWA, namely Jordan, Lebanon, Syrian Arab Republic, and the West Bank and Gaza Strip. WHO provided technical, and in some cases financial, support and donated the medicine. In Pakistan, soil-transmitted helminthiasis mapping was completed in preparation for the commencement of mass treatment. Implementation of the SAFE strategy for trachoma progressed regionally, notably in Sudan, while mapping was completed in Somalia. A regional trachoma action plan was developed in collaboration with the Eastern Mediterranean Region Alliance for Trachoma Control.



Photo: ©WHO

↑ A young girl undergoes ophthalmologic examination for trachoma in Islamic Republic of Iran

Progress was made in Sudan to strengthen surveillance and awareness of dracunculiasis (commonly known as Guinea worm disease), and the country submitted its eradication dossier in preparation for the planned visit of the international certification team in 2018. Implementation of leprosy elimination activities and the reporting of yearly statistics progressed, especially in the remaining high-burden countries: Afghanistan, Egypt, Pakistan, Somalia, Sudan and Yemen. Notably, intensification of case-finding in Somalia resulted in detection of over 1000 new cases in 2017. With regard to cases of cutaneous leishmaniasis, the Region shoulders 74% of the global burden, with 119 608 cases detected in 2016. Significant improvements were made in case-detection, access to diagnosis and treatment, and reporting of both cutaneous and visceral leishmaniasis in Afghanistan, Pakistan, Syrian Arab Republic, Somalia and Sudan. Priority actions for controlling mycetoma were taken in line with resolution WHA69.21 of the Sixty-ninth World Health Assembly in 2016 on addressing the burden of mycetoma.

Immunization and vaccines

Despite the challenging situation, the Region is managing to maintain immunization coverage at 80%. The regional average of diphtheria-tetanus-pertussis (DTP3) vaccine coverage increased from 80% in 2016 to 81 in 2017, while 14 countries maintained the target of $\geq 90\%$ DTP3 vaccination coverage. However, although DTP3 coverage in the Syrian Arab Republic increased slightly from 42% in 2016 to 48% in 2017, an estimated 3.7 million children missed DTP3 immunization in 2016, 94% of whom were in countries experiencing emergencies, namely Afghanistan, Iraq, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen. Ten countries achieved



Photo: ©WHO

↑ Children from communities of internally displaced persons in Somalia were targeted by a preventative measles vaccination campaign

$\geq 95\%$ coverage with the first dose of measles-containing vaccine (MCV1) and two countries achieved 94% in 2017, compared to 12 countries in 2016, and 21 countries provided the routine second dose of measles-containing vaccine. Measles case-based laboratory surveillance is implemented in all countries, and seven countries are close to achieving the measles elimination target. A regional verification commission for measles and rubella elimination was established, and verification of elimination in two countries is planned for 2018. Moreover, except for Egypt, the introduction of inactivated polio vaccine is almost completed.

During 2017, WHO held intercountry immunization meetings in Oman, which provided countries with updates and an opportunity to meet with partners and the Regional Technical Advisory Group on Immunization. WHO also supported countries such as Iraq, Syrian Arab Republic and Yemen to develop and implement outreach immunization activities, including for the control of a diphtheria outbreak in Yemen

and nationwide measles/rubella supplementary immunization activities (SIAs) in Libya. It supported periodic immunization reviews in Iraq and mobilized the Gavi Alliance to fund supplementary measles immunization in Afghanistan, Pakistan, Somalia and Yemen. Support was also provided to assess data quality in Pakistan, including the development of a data quality improvement plan. The regional network for measles/rubella case-based surveillance and regional surveillance network for bacterial meningitis, bacterial pneumonia and rotavirus were further strengthened to include the provision of laboratory supplies, capacity-building activities, coordinating the external laboratory quality control system, and monitoring and evaluation.

The security situation in many countries in the Region in 2017 caused the delay or cancellation of planned immunization activities and the delivery of vaccines. This was exacerbated by limited awareness of elimination and control goals, insufficient commitment to routine

immunization programmes, and a lack of adequate and sustainable funding, with a total reliance on donor funding in some countries.

Priority WHO support to countries for 2018 will include support for the preparation and implementation of district microplans, comprehensive immunization reviews, and the updating of comprehensive multi-year strategic plans for immunization and plans of action. Ensuring adequate preparation for, and implementation of, measles SIAs in five countries, developing national capacity for documentation of measles/rubella elimination, and verification of elimination in the countries that are ready will also be priorities. WHO will likewise seek to establish a regional verification commission for hepatitis B and support verification that the control target has been achieved in ready countries. During 2018, WHO will continue to work on raising the visibility of immunization targets and mobilizing national and partner commitment to achieving them.



Photo: ©WHO

↑ A nationwide measles immunization campaign was conducted in Somalia targeting 4.4 million children aged from six months to 10 years

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In 2017, assessments of the regulatory capacity of Afghanistan, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Pakistan, Somalia and Sudan were carried out using the WHO national regulatory authorities global benchmarking tool. These resulted in the development of institutional development plans for the national regulatory authorities. Follow-up on the implementation of these plans will be conducted over the next two years. An informal national regulatory authority assessment was also conducted in Saudi Arabia.

Also during 2017, technical support in the area of vaccine safety was provided to Pakistan, Syrian Arab Republic and Yemen to address gaps in adverse events following immunization (AEFI) investigation and causality assessments. The capacity-building of regulators in vaccine-producing countries (Egypt, Islamic Republic of Iran and Saudi Arabia) and countries supported by the Pandemic Influenza Preparedness (PIP) framework (Pakistan and Sudan) was also undertaken through WHO's Global Learning Opportunities for Vaccine Quality initiative.

With the closure in 2016 of the Global Action Plan for Influenza Vaccines (GAP) which sought to address the challenges to sustainable influenza vaccine production and uptake in developing countries, WHO has developed an assessment tool to evaluate the sustainability of influenza vaccination in influenza pandemic preparedness plans. The assessment tool was adapted and piloted in Morocco in 2017.

Antimicrobial resistance

In view of the global importance of antimicrobial resistance, the 64th session of the Regional Committee adopted resolution EM/RC64/R.5 on antimicrobial resistance in October 2017.

The resolution urges countries in the Region to develop and endorse national action plans for antimicrobial resistance, establish a multisectoral high-level coordinating structure to oversee their implementation, enforce policies to prevent the purchase of antimicrobials without prescription, and establish national antimicrobial resistance surveillance systems and infection prevention and control programmes. As of December 2017, 10 countries had developed antimicrobial resistance national action plans, of which two had been officially submitted to WHO. The plans involve the engagement of multiple sectors, including the animal, agricultural and food production sectors.

A series of training workshops were held in 2017 to improve the capacities of national focal points on the implementation of the global antimicrobial resistance surveillance system (GLASS) and on the use of the WHONET software programme for antimicrobial resistance data entry, analysis, aggregation and reporting to the GLASS platform. As a result, 11 countries have enrolled in the GLASS platform, of which nine submitted antimicrobial resistance data that were published in the GLASS report published in January 2018. Moreover, national teams from eight countries were trained in WHO methodology to collect national antibiotic consumption data. As a result, antibiotic consumption data from Islamic Republic of Iran, Jordan and Sudan have been submitted and will be included in a global antibiotic consumption report. In addition, the status of infection prevention and control programmes was assessed in eight countries, and strategic plans developed to enhance or create national and facility-level programmes.

Also in 2017, the WHO tailoring antimicrobial resistance programmes (TAP) guide, a protocol for behaviour change on antimicrobial resistance,

was developed in collaboration with experts from different countries of the Region. It is to be piloted in Egypt, Qatar and Sudan during 2018. Technical support was also provided to set up internal laboratory quality control systems for three countries (Iraq, Jordan and Sudan) by arranging shipment of quality control strains for antimicrobial resistance pathogens. WHO celebrated World Antibiotic Awareness Week 2017 (13–19 November) with a Cairo-based event involving the Food and Agriculture Organization of the United Nations (FAO), the media and experts in infection prevention and control, surveillance and research. Regional communication materials were developed and a regional media competition launched to encourage the media to write about antimicrobial resistance and antibiotic usage in the Region. Furthermore, a variety of advocacy and awareness-raising activities took place in 11 countries to celebrate the Week.

Looking forward, the main challenges facing the proper implementation of antimicrobial resistance strategies in the Region are a lack of national financial and human resources to support antimicrobial resistance and infection prevention and control programmes, limitations in the capacities of microbiology laboratories, and the fragmentation of antimicrobial resistance/infection prevention and control programmes at country level. WHO will continue providing the necessary technical support to Member States to raise their capacities in developing national action plans for addressing antimicrobial resistance, establishing effective national and facility-level infection prevention and control programmes and developing and implementing national antimicrobial resistance surveillance programmes. WHO will also support countries in implementing relevant advocacy, awareness and educational programmes to promote behaviour change.

Public health laboratories

In 2017, in line with the strategic framework for strengthening health laboratory services (2016–2020), five countries (Afghanistan, Iraq, Morocco, Pakistan and Saudi Arabia) received focused guidance and support for the establishment of a national laboratory working group and development of national laboratory policies and strategic plans. Additionally, the management and governance of laboratory systems and individual laboratories were strengthened through training and mentorship of 84 senior staff in three countries (Afghanistan, Jordan and Sudan). In Sudan, the curriculum for medical laboratory science was reviewed and updated to support laboratory workforce development.

During 2017, WHO also supported the monitoring and evaluation of laboratory performance and quality in 20 countries. This included coordinating external quality assessment programmes and training activities, which resulted in certification of 53 staff as assessors of health laboratories. Biosafety and biosecurity were identified by the International Health Regulations (IHR 2005) JEE as requiring major improvements in the Region. Nine countries were supported in establishing a core of qualified national biosafety officers and trainers. They now provide national and provincial biosafety and biosecurity training and the maintenance and servicing of biosafety cabinets. Furthermore, to improve specimen referral by air, 118 staff were certified as shippers of infectious substances.

Laboratories continue to play a cross-cutting role and have contributed to various technical areas such as the establishment of antimicrobial resistance surveillance, provision of reagents and kits for diagnosis of priority infections, and provision of technical support during emergencies.

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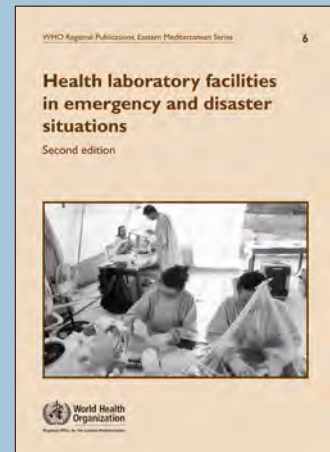
A second edition of WHO's *Health laboratory facilities in emergency and disaster situations* was published in 2017.

Blood safety

In 2017, WHO provided guidance to countries for the implementation of the regional strategic framework for blood safety and availability (2016–2025), with a focus on strengthening blood regulatory systems, improving blood donor management, strengthening haemovigilance systems and meeting the increased demand for blood transfusion during humanitarian emergencies. To strengthen national blood regulatory systems, the blood legislation of nine countries was reviewed and technical support provided to update legislation for the effective management of blood and blood products as essential medicines. In addition, recognizing the differences in blood legislation among countries, and to facilitate the harmonization of legislation across the Region and the implementation of WHO recommendations, WHO is providing technical support in updating their blood legislation.

The demand for blood and blood products continues to increase in countries affected

by humanitarian emergencies. Five countries (Afghanistan, Iraq, Libya, Syrian Arab Republic and Yemen) were supported to integrate blood transfusion services within their overall national emergency preparedness and response efforts, and to address the safety and availability of blood transfusion during humanitarian emergencies. WHO will continue to provide comprehensive guidance and support for implementation of the regional strategic framework, with a focus on the key priority interventions outlined in the framework.



↑ *Technical guidance on provision of basic laboratory services in various types of emergencies*

WHO Health Emergency Programme

Introduction

As host to some of the world's biggest emergencies, the Eastern Mediterranean Region carries the largest burden of people in need of aid, with more than 76 million people directly or indirectly affected by conflict, environmental threats and natural disasters.

In 2017, the Syrian Arab Republic entered its seventh year of conflict, with the humanitarian situation of people living in besieged areas becoming increasingly dire. More than two years of conflict in Yemen led to the world's largest food crisis, the world's largest cholera epidemic, a rapidly expanding diphtheria outbreak and the near collapse of the health system. In Iraq, a military offensive aiming at liberating Mosul led to the displacement of almost one million people. Somalia faced a triple threat of drought, impending famine and disease outbreaks. Afghanistan, Libya

and Palestine struggled to provide health care services in insecure and under-resourced settings.

WHO responded to 10 graded emergencies in the Region during 2017, including four Grade 3 major emergencies in Iraq, Somalia, Syrian Arab Republic and Yemen. Somalia was classified by WHO as a Grade 3 emergency in May 2017, requiring a scaled-up Organization-wide response. As part of WHO's Whole-of-Syria response, the Gaziantep hub in Turkey was assigned to work within the Grade 3 Syria crisis to expedite the provision of health care cross-border from Turkey to people in northern Syria. The dengue



↑ A young child recovers from severe acute malnutrition in a WHO-supported therapeutic feeding centre in Al-Thawra Hospital in Al-Hudaydah, Yemen



↑ Fifteen fully equipped ambulances were airlifted into Iraq to meet the demand for referral services in west Mosul



↑ WHO and partners scaled up efforts to minimize spread of acute watery diarrhoea/cholera

fever outbreak in Pakistan was assigned a Grade 1 emergency from July 2017 to January 2018. Other graded emergency countries included Afghanistan, Libya, Pakistan and Palestine.

Health security threats in the Region continued to place populations at increased risk. In 2017, outbreaks of cholera were reported from Somalia and Yemen, while dengue and other epidemic arboviruses such as chikungunya were reported from Pakistan, Somalia and Sudan. Oman, Qatar and the United Arab Emirates continued to report transmission of Middle East Respiratory Syndrome (MERS) coronavirus sporadically, while Lebanon reported one imported MERS case and Saudi Arabia reported eight small hospital outbreaks of MERS. Avian influenza among humans was reported in Egypt, although the numbers were low compared to numbers reported in 2014–2015. Crimean–Congo haemorrhagic fever was reported in Afghanistan and Pakistan, and the United Arab Emirates reported travel-

associated Legionnaire’s disease during the first quarter of 2017. A number of countries, notably Afghanistan, Pakistan, Palestine and Tunisia, also reported a high number of seasonal influenza cases. At least eight countries in the Region (Djibouti, Egypt, Oman, Pakistan, Saudi Arabia, Somalia, Sudan and Yemen) fall within Category 4 of WHO’s new country classification for Zika virus, meaning that these countries have established competent vectors without any documented past or current transmission.

WHO’s response

The constraints on the health sector response in major emergencies in the Region included insecurity and limited humanitarian access to people in need, limited capacities of national health systems and partners, shortages of health personnel, bureaucratic constraints and insufficient funding. In a number of countries, the operating environment remained volatile with



Photo: ©WHO

↑ WHO conducts field visit to Eastern Aleppo

frequent attacks on health care. Out of a total of 212 attacks on health care recorded by WHO globally in the first three quarters of 2017, 170 (80%) occurred in the Eastern Mediterranean Region, with a significant majority of all attacks occurring in the Syrian Arab Republic. Despite the neutrality of health, political developments in a number of countries resulted in restrictions on access and increasing violence, impeding WHO's ability to reach people in need. An escalation of clashes in Yemen in December 2017 forced WHO and many partners to scale back their operations in the country. The operational challenges faced by WHO in emergency countries included limited availability of skilled public health expertise for surge deployment. This highlighted gaps in the existing emergency rosters and the need for improved systems to identify, train and retain a larger pool of more skilled public health experts who are ready for immediate deployment when needed.

Despite these challenges, within 72 hours of both the deadly blasts in Somalia in October and the earthquake at the border between the Islamic Republic of Iran and Iraq in December, supplies



Photo: ©WHO

↑ A WHO team assesses the damage caused to health facilities in Aleppo

were delivered from WHO's hub in Dubai to national health authorities using regional funds. In 2017, WHO's logistics hub in Dubai delivered a total of 85 shipments of medicines and medical supplies (weighing 791 tonnes) to 20 countries in the Region and beyond. In Iraq, Somalia, Syrian Arab Republic and Yemen, these supplies successfully reached more than 23.5 million beneficiaries. As needs for life-saving medicines and medical supplies in emergency countries increased, international suppliers were unable to keep up with growing demands by WHO. This highlighted the need to increase the number of regional wholesale suppliers. In line with this, WHO is expanding the role of its logistics hub in Dubai to an operational role that is better equipped to fill ongoing and increasing needs through a more streamlined and expedited process. A strategic assessment of estimated health supplies by all priority emergency countries will be conducted, and the supplies procured and pre-positioned in the hub for dispatching as needed. This will ensure that urgently needed health supplies reach their destination in a period of weeks rather than months.



Photo: ©WHO

↑ Trauma care medicines and surgical supplies were dispatched from WHO's regional operations hub in Dubai to Somalia to support the provision of surgical care to patients injured in the attacks in Mogadishu

In accordance with the principles of the revised Emergency Response Framework (ERF), WHO activated the Incident Management System in all Grade 3 countries in the Region to fulfil its six



Photo: ©WHO

↑ A child receives oral cholera vaccine in Somalia during successful immunization campaign to contain the outbreak



Photo: ©WHO

↑ WHO scaled up efforts to respond to the urgent health needs of people displaced from Raqqa as a result of conflict

critical functions. This involved the deployment of an Incident Manager, a public health officer and an information management officer to support ongoing response activities on the ground and scale up WHO's operational and technical support to address the immediate health needs and risks facing populations. Also in line with the implementation of the ERF, in November 2017 WHO began development of a regional roadmap, a strategic handbook and emergency operation plans for the activation of a regional emergency operations centre (EOC). In November and December 2017, the EOC was activated to coordinate the response to acute watery diarrhoea/ cholera outbreaks in Somalia, Sudan and Yemen, and the earthquake at the Iranian/Iraqi border.

WHO led or jointly led health sector coordination in eight countries in the Region where the health cluster has been activated. Health cluster achievements in 2017 included preventing the collapse of the health system and closure of 14 public hospitals and 18 nongovernmental organization hospitals in Gaza by providing essential fuel to run back-up generators during the 20-hour power cuts. In Iraq, the cluster operationalized the trauma referral pathway and

was instrumental in saving the lives of 24 000 severely injured people, and health cluster partners immunized 99% of target children in newly accessible areas. In Yemen, health partners were able to reach 6 million people with life-saving health services and supported the collapsing health system through the provision of essential medicines, incentives to health workers, operational costs and rehabilitation to keep more than 2500 health facilities running. In Pakistan, health partners conducted a vulnerability assessment for the Federally Administered Tribal Areas (FATA), and the findings were used to develop a transition plan for 2018–2020 which serves as the basis for FATA transition from emergency to development. In the Syrian Arab Republic, health cluster partners supported 14.4 million medical procedures and provided 8.6 million treatment courses.

The Emergency Medical Team (EMT) initiative was launched in the Region in September 2017 with the goal of establishing a cadre of skilled national multidisciplinary medical teams to act as first responders when emergency strikes. The regional EMT strategy was created with a three-pronged approach: scaling up national

EMT capacity in country; deploying national EMTs from one country in the Region to another as needed; and establishing a dedicated EMT coordination cell in national emergency operations centres. Each country decides how many teams and what types of teams they want. Countries also decide what teams to establish for deployment to other countries. Once these international teams comply with WHO standards they become part of the regional EMT system. From September to December 2017, trauma experts from the Regional Office worked with 15 countries to initiate the process, and conducted meetings with the ministries of health of Egypt, Islamic Republic of Iran, Jordan, Oman, Palestine and Qatar to provide an overview of the initiative. In the Islamic Republic of Iran, a two-day workshop on the EMT initiative was conducted with all stakeholders to create a national EMT taskforce to oversee the creation of a national multidisciplinary EMT.

In 2017, WHO's work in the area of emergencies was 80% funded on average, through support from a number of key donors. These included the United States Agency for International Development (USAID), United States Department of State, European Commission's Humanitarian Aid and Civil Protection Department (ECHO), Germany, United Nations Office for the Coordination of Humanitarian Affairs (OCHA), Japan, Republic of Korea, United Nations Central Emergency Response Fund (CERF), United Kingdom, Norway, Qatar, Kuwait, World Bank, Saudi Arabia, United Arab Emirates, Oman, China, Italy, France, Canada, Algeria and Lithuania. However, while some countries received substantial support from donors in 2017, other countries facing forgotten emergencies, where health needs are just as critical, remained significantly underfunded, including

Somalia, Sudan and refugee-hosting countries. The emergency in the Syrian Arab Republic was also underfunded in 2017. Since the activation of the Regional Solidarity Fund in January 2016, country donations to the Fund have been limited, and WHO still depends on internal funding for its immediate emergency response needs. In 2017, WHO allocated US\$ 1.6 million of internal funding to support emergency response activities in Iraq, Somalia, Syrian Arab Republic and Yemen. Activities supported included cholera response, health services for internally displaced persons and immunization campaigns.

To strengthen the funding base for its activities, WHO will enhance engagement and dialogue with existing partners and new partners in order to mobilize resources for emergency response, aiming to increase by half the total contributions for health emergencies, including for under-resourced countries. To that end, it will strengthen institutional dialogue and presence across the Region and establish regional partnerships promoting multi-year funding, so that it is able to serve the longer-term needs for investment in under-funded countries and complex emergencies. This includes developing new partnerships and new models of funding.

Efforts will also continue to scale up response and early recovery by setting up incident management systems and emergency operating centres, promoting the use of country business models, expanding the Dubai logistics hub and strengthening coordination through health clusters.

Emerging infectious diseases

The likelihood of the emergence and rapid transmission of high-threat pathogen diseases

has increased in the Region due to the acute, protracted humanitarian emergencies affecting many countries directly or indirectly, which have led to high numbers of internally displaced persons and refugees living in overcrowded, overburdened spaces, with little or no access to basic health care services and environmental infrastructure. Other risk factors include rapid urbanization, climate change, weak surveillance, limited laboratory diagnostic capacity and increased human–animal interaction. Meanwhile, challenges persist for efforts to prevent and control emerging and epidemic-prone diseases in the Region, including knowledge gaps regarding the risk factors for transmission and disease epidemiology for a number of emerging and epidemic-prone infections that are commonly prevalent in the Region, weakened or fragmented disease surveillance systems for early detection of health threats, and limited laboratory diagnostic capacities owing to fragile health systems in crisis-affected countries. These challenges arise as a result of insufficient investment in disease surveillance and response activities, and the absence of a cohesive and inclusive country-focused strategy for the prevention, containment and control of emerging and epidemic-prone diseases.

In 2017, a number of outbreaks of emerging infectious disease were successfully contained, including cases of dengue fever in Pakistan, cholera in Somalia, travel-associated Legionnaire's disease in the United Arab Emirates, acute watery diarrhoea in Sudan, and a small number of hospital outbreaks of MERS in Saudi Arabia. This was possible due to rapid field investigation and deployment of surge staff from the Regional Office, the involvement of Global Outbreak Alert and Response network (GOARN) partners to provide support to the operational response, and by guiding and advising the affected countries in

implementing rapid public health containment measures.

The WHO Emerging and Dangerous Pathogens Laboratory Network was established in 2017 to develop high-security laboratories for the timely detection, management and containment of outbreaks from novel, emerging and dangerous pathogens. The Network has already conducted laboratory training in the detection and diagnosis of emerging diseases. Also in 2017, surveillance systems in the Islamic Republic of Iran, Palestine, Saudi Arabia, Somalia, Sudan, the Syrian Arab Republic and the United Arab Emirates were enhanced for emerging diseases, and early warning systems set up for detection of health threats. Additionally, in line with resolution EM/RC62/R.1, a sentinel surveillance system for severe acute respiratory infections (SARI) was established and operationalized in 19 out of 22 countries, enhancing their capacity for detection and mitigation of threats from MERS coronavirus, avian influenza A (H5N1) and other similar novel respiratory viruses. The Eastern Mediterranean Flu Network, a regional database for influenza data sharing, was expanded to receive SARI surveillance data from 13 of 19 countries in the Region with functioning



Photo: ©WHO

↑ WHO team assesses laboratory detection capacity for dengue fever in a hospital in Pakistan



Photo: ©WHO

↑ WHO worked closely with the Ministry of Health of Saudi Arabia during the hajj to oversee, guide and advise on appropriate public health preparedness measures

influenza surveillance. In addition, a technical advisory group was established to identify priority research initiatives on MERS in the Region to address critical knowledge gaps and contribute to improving the public health response to MERS. WHO also organized the first-ever scientific conference on acute respiratory infections to review progress in influenza surveillance and showcase new knowledge gained in surveillance for detection of influenza and other emerging respiratory viruses in the Region. During 2017, WHO also oversaw the implementation of public health preparedness, readiness and mitigation measures in Saudi Arabia during the hajj 2017 (1438 H), as required by the IHR. Risk-mapping for current and future distribution of *Aedes* mosquito vectors was completed as part of the regional plan to identify potential Zika hotspots, and to enhance preparedness and readiness measures for prevention, detection and early response to Zika virus infections. Operational strategies for strengthening cholera preparedness and other control measures were harmonized for rapid implementation in affected countries and at-risk countries, following a consultative meeting held in mid-2017 in Beirut, Lebanon. Currently, evidence on burden and risk factors for emerging disease health threats, and on best practices for



Photo: ©WHO

↑ Zika diagnostic training in Amman, Jordan, to enhance preparedness and readiness measures for prevention, detection and early response to Zika virus infections

control interventions, is being accumulated through a systematic review.

Going forward, WHO will strengthen the prevention and control of emerging and epidemic-prone diseases by helping countries forecast, detect and assess the risk of health events and mount rapid responses to outbreaks, mapping hotspots and building effective surveillance systems, and conducting risk assessments in high-risk countries as a basis for plans for preparedness and response.

Preparedness

In 2017, support was provided to Egypt, Iraq, Jordan and Pakistan to conduct risk assessments and develop their all-hazards preparedness and response plans. The regional roster of experts was augmented in conducting a regional public health emergency pre-deployment course for national counterparts and WHO country office staff. In addition, supporting the International Committee of the Red Cross to conduct a regional course on health emergency for large populations provided an additional opportunity to effectively train more staff from the Region. A hospital emergency course was conducted in Bahrain, Libya and Sudan as part of series to be repeated across the Region.

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In addition, the Regional Office participated in the first global face-to-face meeting of the WHO operational readiness task force.

An expert two-day consultation was held with the purpose of bringing international and national stakeholders together to discuss the health of migrants and displaced populations. An analysis of health impacts on internally displaced persons, refugees, migrants and returnees in the Region was presented, and a proposed regional plan of action was discussed.

As part of implementation of Regional Committee resolutions EM/RC62/R.3 of 2015 and EM/RC63/R.1 of 2016, the Regional Office continued to support additional voluntary JEEs. In 2017, support was given to Kuwait, Oman, Saudi Arabia and United Arab Emirates. WHO has consistently liaised with the remaining countries and provided training for several of them to commence self-assessment in order to undergo JEE. Regional guidance on conducting JEEs in crisis countries was developed and training workshops were additionally provided for Libya, Iraq, Syrian Arab Republic and Yemen. The training was a unique opportunity for participants to share experiences and return to their countries as advocates for the process.

As JEE completion is only the first step, the focus has shifted towards assisting countries in developing and costing their national action plans for health security post-JEE. Utilizing JEE results, as well as other assessments and results from the IHR monitoring and evaluation framework, the plans incorporate a multisectoral approach to strengthening national health security under IHR. In 2017, national workshops were convened in Jordan and Saudi Arabia involving all relevant IHR-bound sectors. The workshops identified priority actions across the 19 technical areas of the

JEE. WHO also provided technical support to Afghanistan and Sudan to develop their national action plans for health security.

Under the IHR monitoring and evaluation framework, WHO has provided technical support to countries in implementing their IHR capacities. Egypt, Iraq and Pakistan held diverse exercises from “table-top” to full-scale simulations in order to test and improve implementation of their national capacities. An after-action review to critically review outbreak response for systematic gaps was held in Morocco (brucellosis), with additional reviews planned for outbreaks in Pakistan (dengue) and Sudan (acute watery diarrhoea). The Region convened its sixth stakeholder meeting to review IHR implementation in December 2017, bringing together diverse national sectors and technical partners. This year the scope was expanded to global participation in light of the IHR’s tenth anniversary. Two national bridging workshops, effectively bringing together the JEE process and World Organisation for Animal Health (OIE) tool for evaluating the performance of veterinary services, were held in Jordan and Morocco to improve collaboration between the human and animal health sectors and identify and plan joint activities for inclusion within national action plans for health security.

WHO will continue to support countries to meet the requirements of the IHR by building and sustaining their capacities in all-hazards surveillance and response and providing support in monitoring their compliance with the IHR, developing national action plans for health security, building capacity of their IHR focal points, mobilizing resources, fostering coordination and dialogue with partners, and getting support from other countries.

Implementing WHO management reforms

Programmes and priority-setting

The final phases of development of the Programme Budget 2018–2019 were completed through bottom-up planning in close coordination with Member States, and the 2017 operational planning exercise was conducted based on the priorities identified. The joint planning exercise concluded with face-to-face meetings in Cairo to ensure more harmonized plans, clearer roles and responsibilities for the two levels of WHO and the incorporation of a risk management approach.

Operational planning for the 2018–2019 biennium was also guided by the *Roadmap of WHO's Work in the Eastern Mediterranean Region 2017–2021* as a five-year strategic plan for WHO in the Region. The roadmap translates global and regional commitments, including the 2030 Agenda for Sustainable Development and the WHO reform agenda, into a set of strategic actions to guide WHO's work with Member States in the Region. In the context of the Sustainable Development Agenda, the Regional Office launched an initiative to strengthen cross-cutting work at the regional level by encouraging new avenues for technical collaboration. Lessons learned from the regional approach will be incorporated at country level during the next planning cycle to encourage the intersectoral collaboration needed to achieve the health-related targets of the SDGs.

In 2017, more authority was given to heads of budget centres for the management of corporate flexible funding for priority activities in order to allow for the timely utilization of such funds, particularly in country offices. Review at the end of the biennium showed that 77% of expected outputs had been fully achieved, and the Region's contributions were incorporated in the Organization-wide results reported to Member States. In keeping with corporate commitments to focus on countries and increase overall organizational transparency, key information on country achievements and on budgetary and financial matters was made available online through the WHO programme budget portal. Tools to support monitoring and decision-making included the addition of new dashboards aimed at monitoring budget and fund utilization, technical progress and a number of key compliance indicators.

The Region actively contributed to the development of the Thirteenth General Programme of Work and its planning and budgeting framework, including major contributions to improve related prioritization and planning processes.

Governance

High-level meetings of ministers and representatives of Member States and permanent missions in Geneva continued to be held prior to the World Health Assembly and Executive Board. These meetings provide an excellent opportunity to review with ministers of health and senior government officials the progress in addressing key priorities since the previous meetings. They have also had a positive impact in strengthening the engagement of Member States in global

discussions on health and WHO reform. Daily briefings during the Executive Board meeting and the World Health Assembly provided additional opportunities for Member States from the Region to interact and agree on common positions that affect the Region.

At its 64th session, held in Islamabad in October 2017, 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.

Management

The Regional Office continued to develop essential instruments to enhance the WHO reform process with a special emphasis on managerial reform, working closely with the other levels of the Organization to achieve the goals listed in the Twelfth 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.

Managerial actions associated with the reform process taken by the Regional Director with respect to staff mobility and rotation, performance management and human resource planning and

management continued. Accountability and controls remained at the heart of improvement efforts, focusing on the compliance areas that were mentioned repeatedly in preceding years' internal and external audit observations: direct financial cooperation, direct implementation, imprest purchase orders, asset inventories and non-staff contractual arrangements. The use of monthly compliance dashboards throughout the year has increased the awareness and capacity of staff across the Region with regard to key administrative issues. Activities aimed at managing financial and administrative risks effectively, improving the internal control framework, reducing audit observations to a minimum and closing outstanding audit observations in a timely manner. In 2017, all audits resulted in satisfactory or partially satisfactory ratings, showing continued improvement in controls and a deep commitment to zero tolerance of non-compliance across the Region.

WHO will continue to address key challenges including the need for: capacity-building to help Member States remain 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; and continuing improvement in accountability and control, as embedded in the regulatory frameworks.

Conclusion

This report has highlighted the huge scope and range of WHO's activities in the Region. That reach and ambition will not diminish in future, but there are going to be important changes in the way we work.

In 2018, after extensive consultation, the World Health Assembly adopted the thirteenth General Programme of Work (GPW 13), setting WHO's strategic aims until at least 2023. GPW 13 outlines three strategic priorities linked to the 2030 Agenda for Sustainable Development with a view to maximizing WHO's impact on public health in different countries.

Work is already underway on how best to translate that global work programme into the very particular context of the Eastern Mediterranean Region. The Regional Office is undertaking comprehensive dialogue with each country to identify its public health priorities and how best we can support them, and at the 65th session of the Regional Committee in October 2018, Member States will together consider a series of reports and recommendations on implementing GPW 13 in the Region.

We look forward to working with our Member States and partners to make an even bigger impact on public health in the coming years.

**Promote health, keep the world safe,
serve the vulnerable**



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