The Work of WHO in the Eastern Mediterranean Region

Annual Report of the Regional Director 2012

World Health Organization

Regional Office for the Eastern Mediterranean

The Work of WHO in the Eastern Mediterranean Region

Annual Report of the Regional Director 2012

Regional Office for the Eastern Mediterranean

WHO Library Cataloguing in Publication Data

World Health Organization. Regional Office for the Eastern Mediterranean
The work of WHO in the Eastern Mediterranean Region: annual report of the Regional Director 2012 / WHO Regional Office for the Eastern Mediterranean
p.
Arabic edition published in Cairo (ISBN: 978-92-9021-973-6)
(ISBN: 978-92-9021-974-3) (online)
(ISSN: 9220-1020)
French edition published in Cairo (ISBN: 978-92-9021-971-2)
(ISBN: 978-92-9021-972-9) (online)
(ISSN: 1816-2061)
1. Regional Health Planning 2. Delivery of Health Care 3. Chronic Disease - prevention & control 4. Maternal Health Services 5. Child Health Services 6. Reproductive Health 7. Communicable Disease Control 8. Nutrition Policy 9. Disaster Planning I. Title II Regional Office for the Eastern Mediterranean
(ISBN: 978-92-9021-969-9) (NLM Classification: WA 541)
(ISBN: 978-92-9021-970-5) (online)
(ISSN: 1020-9166)

© World Health Organization 2013
All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Publications of the World Health Organization can be obtained from Health Publications, Production and Dissemination World Health Organization, Regional Office for the Eastern Mediterranean, PO Box 7608, Nasr City, Cairo 11371, Egypt (tel: +202 2670 2535, fax: +202 2670 2492; email: HPD@emro.who.int). Requests for permission to reproduce, in part or in whole, or to translate publications of WHO Regional Office for the Eastern Mediterranean – whether for sale or for noncommercial distribution – should be addressed to WHO Regional Office for the Eastern Mediterranean, at the above address: email: WAP@emro.who.int.

Contents

Introduction ... 5
Strengthening health systems for universal health coverage ... 8
Promoting health across the life course ... 16
Noncommunicable diseases ... 23
Communicable diseases ... 27
Emergency preparedness and response ... 38
Implementing WHO management reforms ... 45
Conclusion ... 50
Annex 1. Organizational structure of the WHO Regional Office for the Eastern Mediterranean, June 2013 ... 54
Annex 2. Professional staff in the Eastern Mediterranean Region ... 56
Annex 3. Meetings held in the Eastern Mediterranean Region, 2012 ... 58
Annex 4. New publications issued in 2012 ... 62
Annex 5. WHO collaborating centres in the Eastern Mediterranean Region ... 64

Introduction

When I took office in February 2012, I had a vision of what might be achieved in relation to the regional health situation within the term of my office. Five years pass very quickly and so I made it a priority immediately after my election to conduct an in-depth situation analysis of health development in the Region and make a rapid assessment of the challenges, the gaps and what needed to be done, in consultation with regional stakeholders. A high-level expert meeting in March 2012 resulted in consensus on the challenges to progress in prevention and control of the principle causes of ill-health and disease burden, in health system strengthening and in maternal and child health, and on key strategic directions. These are: health systems strengthening; maternal, reproductive and child health and nutrition; noncommunicable diseases; communicable diseases; emergency preparedness and response; and WHO management and reform. Further consultations led to development of the document "Shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO"[1] which I shared with ministers of health in Geneva immediately prior to the World Health Assembly in May 2012. The broad agreement of the Member States with the content of that document empowered me with the clear mandate to proceed. Their excellent feedback gave me further guidance with regard to some of these strategic areas. In October, the WHO Regional Committee for the Eastern Mediterranean discussed the way forward and passed relevant resolutions in relation to health systems strengthening, a framework for action on noncommunicable diseases, and control of public health events of international concern through the International Health Regulations. The Committee also endorsed actions I had initiated to implement the principles of WHO reform being discussed at global level, as well as some important observations of the WHO auditors and Member States themselves.

By the end of the year, the Regional Office had also undertaken rapid assessment of progress towards Millennium Development Goals 4 and 5 in regard to maternal and child health in the 10 Member States with the highest burden of mortality in the Region. The results were presented subsequently at a high-level meeting, organized in Dubai in January 2013, on "Saving the lives of mothers and children", in order to accelerate progress towards the goals. The strengthening of health information, an area of the health system that is crucial for health planning and monitoring, was also a major area of focus. In 2012 all Member States undertook a rapid assessment of their civil registration and vital statistics systems, a major achievement in itself that will lead, by the end of 2013, to the development of national plans, a list of core indicators and a regional strategy for strengthening these systems.

[1] *Shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO.* Cairo, WHO Regional Office for the Eastern Mediterranean, 2012.

Thus, the 11 months from February to December were a busy time for WHO and for Member States. Through this groundwork we have laid the foundation for progress. However, improving health in the Region continues to face monumental challenges. For me, a priority issue is the charting of a path toward universal health coverage through prepayment schemes that work for all people. It is shocking that the Region accounts for just 1.6% of global spending on health while it accounts for 8% of the global population. Vast numbers of people in the Region have no social insurance and no easy access to health care. When they or family members need treatment, they must either go without care or must sacrifice much needed income. This is a poor state of affairs for our Region in the 21st century. But even in countries where financing of health care presents no problem, health systems suffer from important gaps that need to be addressed before access to quality health care is achieved.

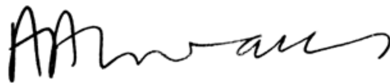
Another major issue is the impact of emergencies caused by natural disasters and political unrest on the health of affected populations, on health systems, and on socioeconomic development. In the past two years, 13 countries in the Region have experienced such emergencies, with more than 42 million people affected. Most significant, in 2012, was the rapid deterioration of the humanitarian situation in the Syrian Arab Republic, which has resulted in more than 6.8 million people in need of assistance across the entire country, as well as 4.25 million internally displaced and 1.6 million refugees in neighbouring countries.

Polio transmission persists in Afghanistan and Pakistan, threatening the global eradication programme and polio-free Member States. 2012 witnessed strengthened efforts with important achievements including a considerable reduction in the number of cases in the two countries. However, the current insecurity, the disinformation being propagated against vaccination and the recent attacks on polio health workers renders any resulting optimism null and void. This is a very serious situation that demands intensive response.

Progress in health development is increasingly supported or hindered by economic and geopolitical interests that influence the wider health and foreign policy agendas. This link has been recognized repeatedly at the United Nations General Assembly, and a number of initiatives have been started within the Organization to better prepare Member States and staff for the changed context within which health challenges need to be addressed. In this context, the Regional Office organized a seminar on global health diplomacy which provided an opportunity to bring together representatives from ministries of health and foreign affairs to discuss approaches to strengthening capacity for health diplomacy in the Region. Participants discussed the ways in which foreign policy can either hinder or help health, and the foreign policy concerns posed by emerging infectious diseases and by health issues during conflicts and in post-conflict reconstruction. This initiative is very much in its infancy and I will continue to take it forward in order to promote development of health diplomacy in the Region, including cooperation and partnerships between countries on priority health issues, such as the International Health Regulations and polio eradication, and promoting a rights-based approach in health sector response in order to enhance health equity and universal health coverage.

This annual report defines a new direction for reporting on WHO's work at regional and country

level. The following chapters focus on the strategic priorities identified as well as WHO management and reform. They identify the specific challenges that WHO will address, out of the many existing challenges, and the work that has been initiated to address these challenges. In future reports I plan to report on the progress in each of these areas, against specific benchmarks and milestones. The report does not cover the full range of WHO technical programmes but provides a snapshot of the major work being undertaken in priority areas[2].I look forward to receiving feedback on the report from Member States, partners and other stakeholders.



Ala Alwan
WHO Regional Director for the
Eastern Mediterranean

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

Strengthening health systems for universal health coverage

In 2012, the Regional Committee passed a resolution endorsing a proposed roadmap on strengthening health systems as a strategic priority, as well as necessary steps towards boosting universal coverage with quality health services at both the population and individual levels. The resolution was based on an in-depth analysis, conducted by the Regional Office in 2012, of the challenges facing health development in the Region and a review of WHO's work in supporting Member States in addressing these challenges.

Health systems in the Region face many challenges that are generally cross-cutting in nature and apply to most countries irrespective of socioeconomic and health development. Addressing these challenges is critical to the achievement of universal health coverage. Countries have been categorized into three groups based on population health outcomes, health system performance and level of health expenditure (see Table 1)[1]. Countries in groups 2 and 3 face inadequate financing and a high share of out-of pocket expenditures for health. In some low-income countries, such payments are as high as 75% of the total health expenditure. High levels of out-of-pocket payment are a major impediment to the move towards universal health coverage (Figure 1). Other challenges relating to the lack of comprehensive, people-centred, and quality health care services, ensuring adequate health workforce, improving access to essential medicines and technologies and bridging the gaps that currently exist in health information systems will also have to be addressed in the journey to universal health coverage. The need for high-level political will and commitment to move towards universal health coverage with quality population and individual health services is the predominant challenge for many countries.

[1]Group 1: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates; Group 2: Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic, Tunisia; Group 3: Afghanistan, Djibouti, Pakistan, Somalia, South Sudan, Sudan, Yemen

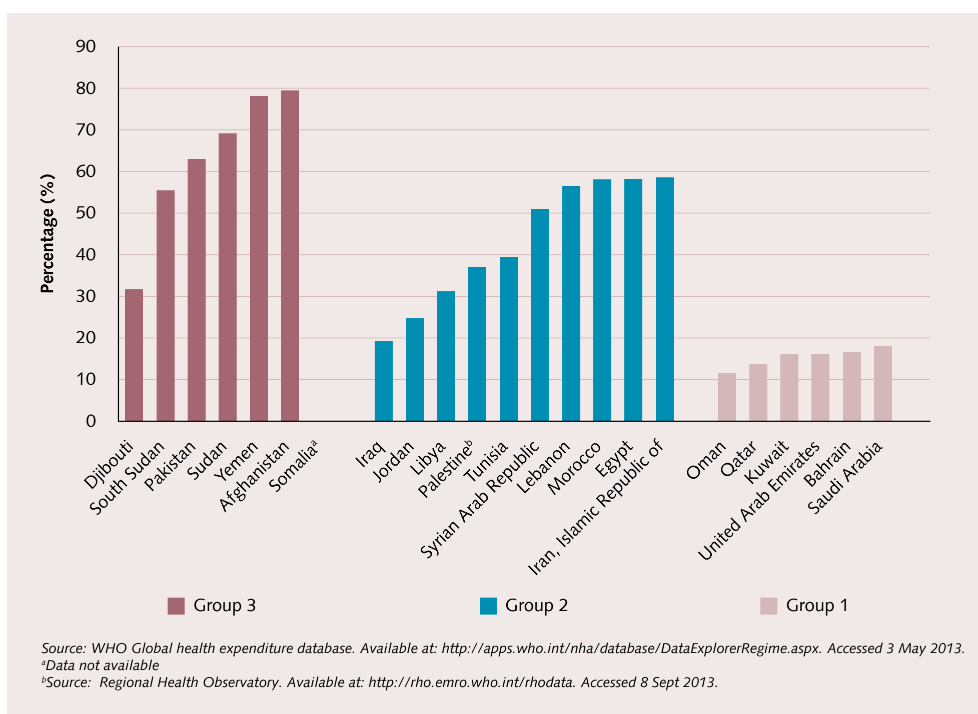
Health financing and governance

WHO's work in health financing was rejuvenated following the publication of the World Health Report 2010, which focused on reforming health financing systems to move towards universal health coverage. In 2012, requests were received from countries in all the three groups for support in this area. WHO has also focused on building the national capacities to generate the evidence needed to inform equitable, efficient and sustainable health financing policies. This included a capacity-building workshop in the new system of health accounts (SHA 2011) provided to health financing experts from 11 countries and a capacity-building exercise on the use of the new WHO tool OASIS (Organizational assessment for improving and strengthening health financing), aimed at assessing the bottlenecks undermining health financing systems performance. The Regional Office prioritized the assessment of progress towards universal health coverage in the Region. An assessment framework was developed and implementation is planned in 2013. This is intended to support Member States and WHO

Table 1.
Trends in key health outcomes in the Eastern Mediterranean Region, 1990–2010*

Health status indicator	Group 1 countries			Group 2 countries			Group 3 countries		
	1990	2000	2010	1990	2000	2010	1990	2000	2010
Life expectancy at birth (years)	72.6	74.1	75.0	69.2	71.2	73.4	52.8	56.6	60.2
Maternal mortality ratio (per 100 000 live births)	24.0	18.0	17.0	115	79	63	750	625	360
Infant mortality rate (per 1000 live births)	17.5	–	8.5	36.5	–	19	95.5	–	71.5
Under 5 mortality rate (per 1000 live births)	21.5	–	9.5	45.5	–	22	126.5	–	97
Total fertility rate	5.2	3.9	2.2	5.6	3.7	2.9	6.6	6.3	6.0

** Values are medians*
– Information not available
Source: Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. *Technical paper presented to the WHO Regional Committee for the Eastern Mediterranean, Fifty-ninth session, 2012 (available at www.emro.who.int/about-who/rc59/).*



Source: WHO Global health expenditure database. Available at: http://apps.who.int/nha/database/DataExplorerRegime.aspx. Accessed 3 May 2013.
[a]Data not available
[b]Source: Regional Health Observatory. Available at: http://rho.emro.who.int/rhodata. Accessed 8 Sept 2013.

Figure 1.
Share of out-of-pocket in total health expenditure by country group, 2011 (%)

↑ **Coverage with essential primary health care services, such as immunization, is an important aspect of universal health coverage**

in monitoring equity in health financing and progress towards social health protection.

Two events provided opportunity for Member States to share experiences in reforming health financing systems to move towards universal health coverage: a policy dialogue between ministers of finance and health on "Value for money, sustainability and accountability in the health sector", held in Tunisia for African Member States in collaboration with the African Development Bank and other development agencies; and a side session on health financing and universal health coverage, held during the 59th session of the Regional Committee. The two events have engaged countries in the current global debates around health care financing and its vital role in promoting the agenda of universal health coverage. The events were followed by a high-level seminar on health financing organized in Cairo in January 2013.

The purpose of employing the various health financing analytical tools is to generate results that can be used in national policy dialogues around the future of health financing in the specific local contexts. The Regional Office has facilitated such dialogues and focused discussions around health financing in Libya, Oman and Tunisia and provided technical support to other countries. The work to map health financing and assess where countries stand in terms of their health financing system goals and the move towards universal health coverage is progressing and has attracted the attention of a range of policy-makers.

The capacity of ministries of health in formulating and evaluating evidence-based policies and plans and in regulating the health sector is often inadequate and varies between countries. The engagement of key non-health sectors, which is essential in developing and implementing health policies as an integral part of national development plans, needs to be strengthened in almost all countries. Effective mechanisms need to be put in place for facilitating multisectoral action, based on international experience and lessons learned. The potential contribution of the private health sector to public health remains untapped. At the same time, the sector is not sufficiently regulated to ensure quality and prevent inappropriate practices. The private sector rivals the public sector in provision of primary health care services in several group 2 and 3 countries. However, its role is not well defined, its capacities poorly understood, and its practices not well monitored. Information is commonly lacking or insufficient about many of its functions, about the range of services it provides in different countries and about the financial burden to the users of these services. Based on resolution EM/RC59/R.3, a focus on the private

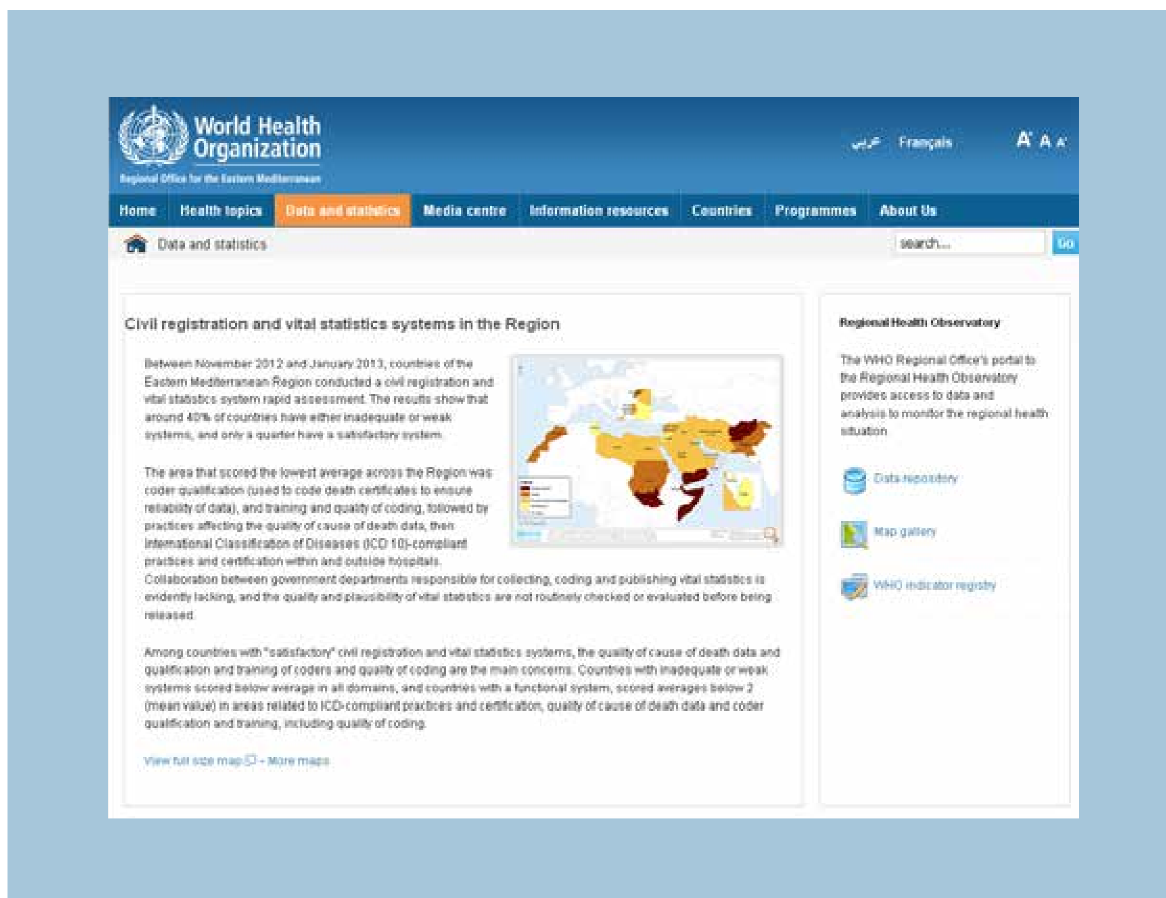
sector has been included in the programme of work of the Regional Office in 2013.

In the area of governance, a number of advisory missions were undertaken. A multi-partner mission to Pakistan made recommendations to the Government following the decision to abolish the Ministry of Health and devolve the health sector to the provinces. An in-depth review of the health system in Morocco was undertaken following the recent constitutional amendment that recognized health as a human right, and a series of missions to Libya included an in-depth review of the health system and assessment of primary health care facilities and hospitals.

The work on health policy and governance also focused on capacity-building and country support in more than half of the countries of the Region. The health system profiles of four countries were updated and profiles of another four countries are in the process of publication.

Health information systems

The health information systems are generally weak in many countries and need to be improved, especially in quality and timeliness of reporting. There are important gaps in all countries of the Region. Data collection is fragmented and often duplicated and key areas related to monitoring of



↑ **The Regional Health Observatory is directly accessible through the Regional Office web site http://www.emro.who.int**

health status, health outcomes and health system performance are either missing or poorly integrated into the national health information system. More specifically, there are major gaps in reporting of cause-specific mortality and health facility records, in conducting regular health surveys, in routine and other data collection activities and in the availability of information disaggregated by age, gender, location and/or socioeconomic status; all coupled with a scarcity of human resources trained in epidemiology and health information systems. Important variations in regional and country estimates are also observed. In discussions with Member States, coordination and strengthening collaboration in the development and reporting of estimates emerged as key priorities and will receive focus in 2013.

The strengthening of capacity in health information is also important, for decision-making and developing and evaluating policies and plans. This was emphasized by the Regional Committee in resolution EM/RC59/R.3. Civil registration and vital statistics (CRVS) received special attention in 2012. Registration of births and deaths needs strengthening in almost all countries. A rapid assessment of CRVS systems was conducted to establish a baseline of the current situation and identify gaps and priorities for improvement. The results show that almost 40% of countries have either inadequate or weak systems, and only 25% have satisfactory systems. However, overall, these systems serve only 5.3% of the population in the Region. A satisfactory level of CRVS system reflects its ability to produce data of sufficient quality to adequately cover the needs for policy- and decision-making and for monitoring the impact of interventions and development programmes. These results have paved the way for conducting a comprehensive assessment, in collaboration with relevant partners and stakeholder, as a first step in the development of country action plans for CRVS.

The Regional Office launched a Regional Health Observatory, which is directly accessible through the regional web site, to support the dissemination and use of health information. This is now the main source for country health-related information, drawing on more than 40 databases and 800 indicators collected since 1990.

WHO's work in 2013 will aim to develop technical guidance on the essential elements of health information systems, including consensus on a core list of indicators covering health risks and determinants, health outcomes (morbidity and mortality) and health system performance.

Health workforce development

Most countries need to develop a balanced, motivated, well-distributed and well-managed health workforce with the appropriate skills mix. The overall workforce density in the Region is below the global average of 4 skilled health workers per 1000 population. Eight countries (Afghanistan, Djibouti, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen) are classified as facing a crisis in human resources for health, largely due to insufficient measures to facilitate market entry, such as lack of preparation of the workforce through strategic investment in education and effective and ethical recruitment practices. Another challenge is inadequate workforce performance due to lack of adequate continuing education and training, as well as poor management practices in the public and private sectors. Policies for retention of health workers and for managing migration and attrition to

reduce wasteful loss of human resources are also lacking, despite the magnitude of the problem.

There are serious challenges to ensuring access to quality nursing education in the Region, in particular inadequate investment and the low priority given to nursing education; lack of capacity in nursing schools in terms of the availability of trainers as well as infrastructure; the need to further update nursing curricula in order to bridge the service–education gap; the limited institutional capacity to offer post-basic training programmes; and inadequate emphasis on continuous professional development programmes.

Human resources observatories in Afghanistan and Palestine were set up to support health workforce development. The Regional Office has promoted several regional tools to strengthen the capacity for workforce governance and planning, such as a guide for accreditation of health professions programmes, and tools to optimize staff workload in health facilities and to make workforce projections.

↑ Health workers are crucial to the success of universal health coverage but are in short supply in some countries

Initiatives to strengthen nursing and midwifery training included support to several countries in developing their national strategic plans. The leadership and management training programme, developed by the International Council of Nurses with WHO support, continued in several countries.

All countries are currently facing some gaps in health workforce development, mainly in the areas of production, distribution, training and continuing education, and retention, although the type and magnitude varies between countries. Addressing these gaps and developing effective and feasible strategies in these areas will require an in-depth review and analysis of existing regional and international experience and lessons learned. Health workforce development is an areas that will require greater attention in the next two years.

Integrated service delivery

Many countries are making efforts to establish effective family practice programmes as the principal vehicle for delivering primary health care and increasing access and coverage of population to health care services. Family practice is an overarching model of care delivery that contributes to moving toward universal health coverage. The challenges include the lack of adequately trained family physicians, nurses and other practitioners, maldistribution of the health workforce and insufficient engagement with hospitals to provide the necessary back-up and support.

There is a need to review international and regional experience and lessons learned based on workable models of family practice and develop guidance on feasible strategies to strengthen family practice in the Region and these areas will be the focus of attention in the coming period.

Patient safety and health system strengthening component of the global health initiatives

Support for patient safety continued with the expansion of the Patient Safety Friendly Hospital Initiative to more countries. The patient safety assessment manual was translated into Arabic and the second edition is being finalized. The patient safety multi-professional curriculum guide developed by WHO was launched; several medical schools have started to integrate it in the training curricula. Work is under way to develop a patient safety improvement toolkit that includes practical steps and needed actions for building a comprehensive patient safety improvement programme.

System-wide barriers, relating to accessibility, availability and affordability of health care, are a substantial challenge to the implementation of public health programmes, affecting the provision of services and reducing programme performance. Poor health system performance is also a constraint. In the area of health system management, a study on decentralization in 10 countries and another study on hospital management and performance assessment in 12 countries were conducted and the results shared.

Several Member States have benefited from the health system strengthening component of the global health initiatives, e.g. GAVI Alliance, Global Fund to Fight AIDS, Tuberculosis and Malaria and International Health Partnerships Plus (IHP+). Over a five-year period, funds provided by the GAVI Alliance for strengthening health systems totalled US$ 160 million and by the Global Fund US$120 million. In most countries these funds are largely channelled through national governments, with technical support provided by WHO in the development of proposals for new rounds of funding, implementation monitoring and capacity-building. Countries that have used these funds well have demonstrated good progress towards health system strengthening. However, performance varies across countries and use of the funds is sometimes caught up in extensive government procedures. Three countries have also signed the IHP+ compact. This is not a funding initiative but encourages countries and partners to agree on one national health plan. There is variation in the extent to which the countries have shown commitment to IHP+.

Many countries in the Region face complex emergencies and most health systems are not well prepared to respond to these situations and are not resilient in extended emergencies. These countries need to be supported to enhance their collaboration, coordination, planning, communications and information exchange capacities.

Essential medicines and technologies

There is insufficient access to essential technologies (medicines, vaccines, biological and medical devices) in most countries in groups 2 and 3 and irrational use is common. While almost all countries have national regulatory authorities, performance needs to be improved. Most

authorities focus on the regulation of medicines and not on the regulation of biological products, medical devices and clinical technologies including laboratories. Quality management, monitoring the private sector, and protecting public goods from commercial interests are weak and require attention.

In the area of essential technologies, six pharmaceutical country profiles were developed, national medicine policy documents were updated for two countries and five additional countries joined the good governance for medicines programme. National transparency assessment reports on vulnerability to corruption in the pharmaceutical sector were drafted for three countries and support was provided to more than 10 national regulatory authorities on good manufacturing practice inspections.

Capacity-building was supported in order to strengthen coordination between policy-makers and regulators on the proper use and evaluation of vaccines, such as diphtheria-tetanus-pertussis (DTP) and DTP-combo vaccines, as well as vaccine safety systems. Afghanistan, Sudan and Yemen received support to enhance their vaccine pharmacovigilance systems.

In the area of health technology and medical devices, missions to assess health technology infrastructure and management were conducted in several countries. In collaboration with WHO headquarters, a second wave of the global survey on medical devices was launched. Over 70% of Member States participated in this round compared to 40% in the first one. Results indicated that only 5% of the Member States of the Region have established policies and coordination units for medical devices, 29% have regulation and inventory systems and 16% have developed national procurement and maintenance guidelines. An intercountry consultation in this area of work will be organized in 2013.

Promoting health across the life course

Maternal, reproductive and child health

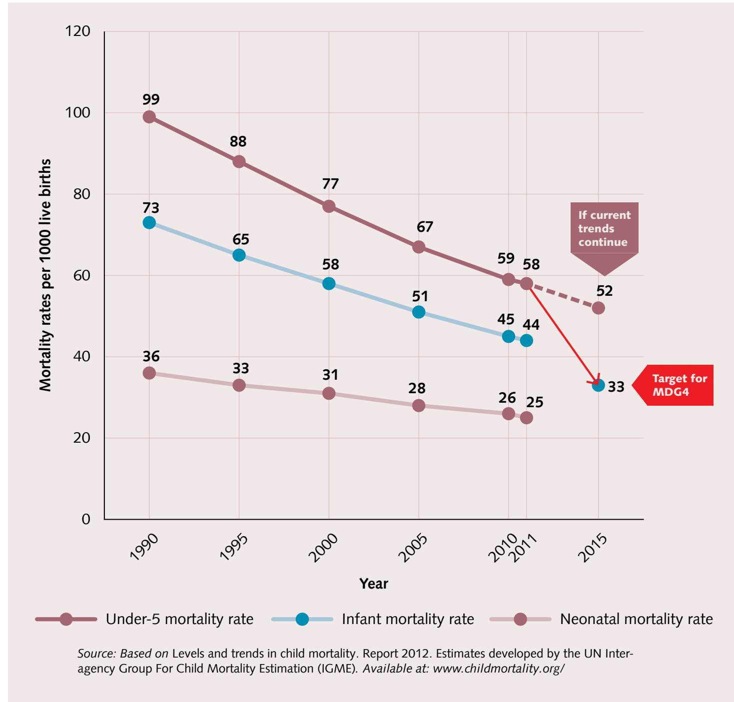
Over the past 20 years, the Region has made progress in addressing avoidable maternal and child deaths. Between 1990 and 2011, under-5 mortality declined in the Region by 41% (Figure 2). Maternal mortality declined by 42% between 1990 and 2010 (Figure 3). However, the problem remains substantial. It is estimated that 923 000 children under 5 years of age and around 39 000 women of childbearing age still die every year in the Region. Maternal and child death levels are particularly high in the poor, rural and underserved areas, among malnourished children and pregnant adolescents. While some countries have already achieved Millennium Development Goals 4 and 5, extensive efforts are still needed to accelerate the current average annual reduction rates of maternal mortality from 2.6% to 16.8% and child mortality from 2.5% to 14%, in order to achieve these goals in the Region by 2015.

In the face of the unacceptable deaths affecting these vulnerable population groups, and while maternal and child health is said to be at the heart of development, current trends indicate that insufficient priority is being given by some countries to reducing this burden. In these countries low and inequitable access to maternal and child health care services remains an issue, together with high turnover of staff and lack of an integrated national plan for maternal and child health. Political instability, inadequate financial resources to increase coverage of effective interventions and lack of quality data for evidence-based programme management are contributing to the lack of adequate progress, particularly in countries experiencing humanitarian emergencies, violent conflicts and population displacement. In response, the Regional Committee endorsed maternal and child health as a strategic priority in the Region. The strategy adopted by the Regional Office is based on three elements: a special emphasis in WHO's technical support on countries with a high burden of maternal and child mortality; focus on cost-effective, high

Photo: ©WHO/Christina Banluta

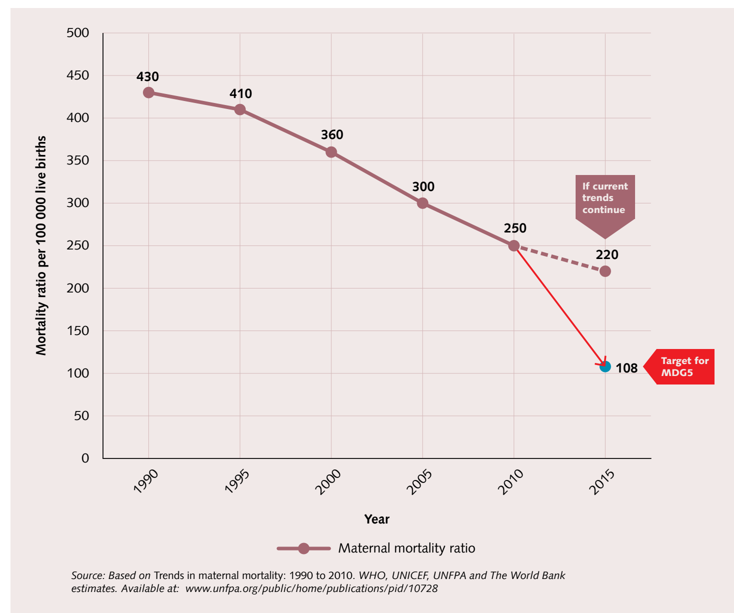
Photo: ©WHO/Murtaza Nazar

↑ Happy, healthy girls will grow into happy, healthy mothers



Source: Based on Levels and trends in child mortality. Report 2012. Estimates developed by the UN Inter-agency Group For Child Mortality Estimation (IGME). *Available at: www.childmortality.org/*

Figure 2
Under-five mortality trends, including infant and neonatal mortality, 1990–2011 and extrapolation to 2015



Source: Based on Trends in maternal mortality: 1990 to 2010. *WHO, UNICEF, UNFPA and The World Bank estimates. Available at: www.unfpa.org/public/home/publications/pid/10728*

Figure 3
Maternal mortality trend 1990–2010 and extrapolation to 2015

impact interventions in primary health care; and strengthened partnerships. The latter means both a higher level of joint work between the WHO maternal and child health programmes and other programmes, such as health systems and control of communicable diseases including immunization, as well as special efforts to strengthen coordination and joint work with other partners, in particular UNICEF, UNFPA and other non-United Nations partners. A regional expert group on maternal and child health was established in September 2012 to support the Regional Office and Member States. This was followed by an expert group meeting outlining strategic directions for maternal and child health in the Region and supporting countries in developing acceleration work plans.

Much work was done towards year end in preparation for the high-level meeting on saving the lives of mothers and children in early 2013. The elements of country work plans were discussed and outlined using evidence-based cost-effective interventions to accelerate the reduction of maternal and child mortality. A technical workshop was conducted to further analyse existing gaps and challenges while sharing information and experiences on progress made in Millennium Development Goals 4 and 5 and in policy analysis of national maternal and child health policies of 10 priority countries with a high burden of maternal and child mortality: Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Somalia, South Sudan, Sudan, and Yemen. This workshop followed a "special envoy mission" to the priority countries to advocate for and mobilize action towards greater country commitment and active engagement in developing the acceleration plans.

The Regional Office also played an active role in initiating the activities of the Commission on Information and Accountability in the 10 priority countries. A regional workshop was organized in September 2012, in which the delegations of priority country took part. The workshop was followed by support provided to seven of these countries in holding national workshops that led to developing country roadmaps to strengthen national accountability and action for improving women's and children's health.

Since counselling is a key component of improving the quality of care and its impact on public health, the Regional Office, in collaboration with UNFPA, focused on developing regional and national teams of trainers in reproductive and maternal health counselling. Coverage with the strategy for Integrated Management of Child Health (IMCI) stands at 72% of primary health care facilities across 13 countries. The Regional Office continued to support assessment of the quality of teaching and student outcomes in medical schools which have introduced IMCI into their teaching programmes. An initiative on increasing the coverage of interventions has been introduced in some countries.

The challenge for 2013 is to finalize, launch and implement the acceleration plans to intensify action in order to achieve MDGs 4 and 5 before 2015.

Nutrition

The Regional Office has provided technical support for policy development and implementation of the regional strategy and action plan on nutrition in many countries. However, operational multisectoral food and nutrition policies and plans are lacking in most countries, and coordination between agricultural and health policies is generally weak. Management of severe

malnutrition was introduced in three countries (Afghanistan, Pakistan and Yemen) through support for establishing more than 60 training and stabilization units in the main paediatric hospitals and health centres. The Regional Office, in collaboration with headquarters, supported regional capacity-building to introduce new WHO guidelines on management of severe malnutrition and to facilitate updating of relevant national protocols and action plans. The regional guidelines on wheat and maize flour fortification by vitamins and minerals were reviewed jointly with the Flour Fortification Initiative, the Global Alliance for Improved Nutrition (GAIN), Micronutrient Initiative, UNICEF and the World Food Programme to bring them into line with WHO recommendations. Advice was also given to some countries to strengthen nutrition surveillance systems.

Ageing and health of special groups

Member States generally face significant challenges relating to sustainable commitment to healthy ageing programmes, as well as gaps in the preparedness of health systems to respond to the increasing needs of ageing populations, and in the availability of well-trained health personnel with adequate expertise in this area. Still, some progress in technical collaboration with Member States was achieved in 2012.

Photo: ©WHO/Christina Banluta

↑ Artists in Sudan illustrate the World Health Day theme: Good health adds life to years

Evaluation missions visited the Islamic Republic of Iran, Jordan and Syrian Arab Republic. The findings reflected some positive progress and commitment to strengthening policies and programmes. Age-friendly cities/communities initiatives generated support in three countries (Bahrain, Jordan and Syrian Arab Republic). An update of the *Regional guide on health care of older persons for primary health care workers* was prepared, in addition to a procedural guide and a facilitator's guide. A regional electronic tool was designed to collect data on ageing and health. Several countries developed and updated their national strategies on active, healthy ageing and old age care. Saudi Arabia developed a national strategy document as well as updated guidelines on health care of older persons and Oman pioneered the design of a unique elderly care service programme.

Violence, injuries and disabilities

In 2012, WHO designated injury prevention as a priority programme in the Region, with specific focus on road traffic injuries and trauma care. A regional five-year plan (2012–2016) to reduce road traffic injuries was developed in collaboration with regional and international experts. The baseline for the *Global status report on road safety 2013* was established by 19 countries. National road safety activities were documented in 13 countries using a regional tool, and regional capacity-building workshops were conducted in 16 countries for public health professionals in violence and injury prevention and injury epidemiology. Injury prevention was integrated into the public health, emergency medicine and nursing curricula. The regional framework

Photo: ©Mohammed Abdel Ghani

↑ **Persons with disabilities have the right to the highest attainable standard of health without discrimination on the basis of disability (Convention on the Rights of Persons with Disabilities, Article 25)**

for child and adolescent injury prevention was finalized and a child injury prevention module was included in the regional training package for community representatives and health volunteers.

The *World report on disability* was launched in Sudan with subsequent multisectoral training on coordinated implementation of the national disability strategy. Training on reporting on implementation of the Convention on the Rights of Persons with Disabilities was conducted in collaboration with the League of Arab States and other partners. In addition, a rapid assessment of rehabilitation services with special focus on assistive devices and prosthetics and orthotics was undertaken in Egypt and Tunisia.

Health promotion and education

In the area of health promotion, the Regional Office developed a tool to facilitate the development of national plans of action and involvement of multiple sectors. As part of WHO's work on the International Health Regulations, the Regional Office, in collaboration with WHO headquarters and Indiana University, conducted a mapping of existing capacities in the area of risk communication during a health crisis and a draft framework on risk communications during a health crisis. The framework was developed to clarify the different core communication "nodes" that intervene during emergencies, and the needed coordination.

In collaboration with the Centers for Disease Control and Prevention, Atlanta and WHO headquarters, the Global School Health Survey was expanded to Iraq, Qatar and Sudan.

Photo: ©WHO Jordan

↑ **A volunteer distributes information on road safety in a campaign in Jordan to mark United Nations Global Road Safety Week**

In the area of oral health, the Regional Office conducted an expert meeting to finalize a regional strategy on oral health promotion and a core set of oral health promotion indicators.

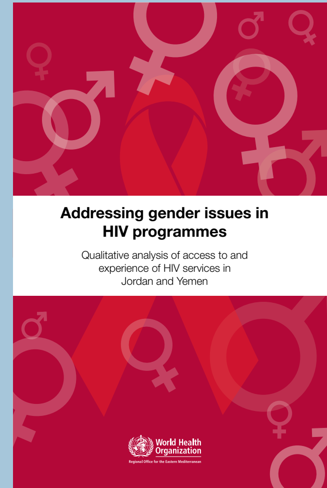
Social determinants of health and gender

WHO provided technical support to some countries in developing a plan and a set of actions on social determinants of health. A regional strategic plan to operationalize the Rio Political Declaration on Social Determinants of Health was developed and discussed in an intercountry workshop.

The healthy city programme expanded throughout the Region with implementation of the Urban Health Equity Assessment and Response Tool to identify health equity gaps and define policy responses. The Regional Office supported the Ministry of Health of Sudan in developing and

field testing a training manual on managing disaster risks in communities for mobilizing community action and response in disaster risk reduction. A Regional Healthy City Network web site was launched in January 2012 to enable mayors and governors to register their cities and exchange their innovations and experiences.

Capacity-building was supported in Afghanistan, Iraq, Palestine, and Pakistan to support gender mainstreaming in public health and on health sector management and response to gender-based violence.



↑ *Recent publication on gender and health*

↑ The Regional Healthy City Network site enables mayors and governors to register their cities and exchange experience http://applications.emro.who.int/hcn/

Noncommunicable diseases

2012 marked a turning point for advancing the agenda of noncommunicable diseases in the Region with the designation of prevention and control of these diseases as one of the five strategic priorities for the Regional Office for the next five years. This prioritization stems from recognition of the profound health, health system and development burden of these diseases in the Region and builds on a clear vision, and corresponding strategic directions, to which Member States agreed in the Political Declaration of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases, in September 2011.

Recognizing and building on the existing work of WHO and Member States in this area, the focus in 2012 was on raising the profile of noncommunicable diseases in the health and development agenda, developing a regional roadmap for action and initiating work in priority areas, as well as creating the necessary structures at the Regional Office to support regional action. However, serious challenges impede regional progress in implementing the commitments made by Member States in the United Nations Political Declaration. At the level of governance and policy, high-level political will and commitment are lacking or inadequate in many countries. Where such commitment exists, measures to translate it into concrete action are often insufficient. Multisectoral action, a prerequisite for effective prevention of noncommunicable disease, is weak in most countries.

The lack of engagement of non-health sectors hinders implementation of key cost-effective, high impact interventions, or "best buys", such as the six proven tobacco control measures, salt reduction, and awareness campaigns on diet and physical activity. Member States of the Region have generally been slow in implementing the the WHO Framework Convention on Tobacco Control (FCTC) and its MPOWER measures. This has resulted in continued high rates of tobacco use. There are still two countries in the Region (Morocco and Somalia) that have not yet ratified the WHO FCTC and the damage to public health caused by promoting tobacco use by the industry is unfortunately unopposed in many countries. Similarly, while there is high consumption of salt, saturated fatty acids and *trans*-fatty acids, coordinated action on nutrition, especially through multisectoral policies of wide population impact, has been lacking. Capacity to monitor noncommunicable diseases is generally weak and surveillance systems need to be strengthened and institutionalized in all countries. Experience in integrating health care for common noncommunicable diseases, such as diabetes and cardiovascular diseases, into primary health care is accumulating but major gaps exist, reflecting broader health system challenges.

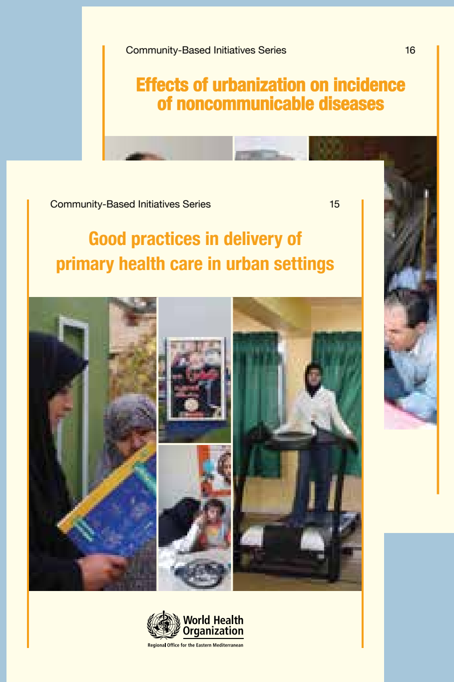
These challenges notwithstanding, WHO and Member States have worked together to move the agenda for the prevention and control of noncommunicable diseases forward. Several milestones exemplify the progress that has been accomplished towards scaling up action but also highlight the demands that still lie ahead. A key milestone was the endorsement by the Regional Committee of a regional 'Framework for action' to scale up the implementation of the United Nations Political Declaration (resolution EM/RC59/R.2). The framework outlines the key

interventions in four priority areas: governance; prevention and reduction of risk factors; surveillance, monitoring and evaluation; and health care. A series of consultations and regional meetings were important in paving the way for the resolution. The International Conference on Healthy Lifestyles and Noncommunicable Diseases in the Arab World and the Middle East, organized by the Regional Office in collaboration with the Government of Saudi Arabia in September 2012 in Riyadh, Saudi Arabia, was the first major regional response to the United Nations Political Declaration. Another milestone was the establishment in the Regional Office of a new Department of Noncommunicable Diseases and Mental Health with a clear mandate for scaling up regional action in these areas.

Important progress has been made in the four strategic areas of the framework. In the area of governance and policy development, the Regional Office is actively working with countries to establish multisectoral national plans during 2013, develop national capacity and monitor progress. Two regional consultations were conducted to develop the input to the Global Action Plan on the Prevention and Control of Noncommunicable Diseases 2013–2020, and the associated Global Monitoring Framework, for adoption by the World Health Assembly in May 2013. Collaboration has been initiated with the international Disease Control Priorities Network to promote research and build regional capacity in cost–effectiveness analysis for policy-making in the area of noncommunicable diseases. Work will continue in 2013 to develop a core of regional trainers in various aspects of disease-control priority-setting processes for noncommunicable disease interventions.

With regard to prevention, the focus has been on addressing the shared risk factors for the four main groups of noncommunicable diseases. Nutrition-related risk factors, such as salt and fat intake and tobacco use, are being targeted for priority action. Development of food-based dietary guidelines has been expanded to include Afghanistan, Egypt, Lebanon and Oman. A pilot project to build regional capacity in nutrition profiling, part of a global initiative, has been implemented jointly with the United Arab Emirates University. A seminal intercountry workshop conducted in November 2012 on effective population-wide approaches to salt reduction has led to initiation of salt reduction measures at the national level in Kuwait. This experience, which can potentially have important impact on population health if sustained and further developed, is being expanded regionally in 2013.

With regard to tobacco control, the Regional Office has continued to prioritize the implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC), and the associated MPOWER measures. A promising development in 2012 was the adoption by four Member States of new tobacco control legislation, with maximized measures. Development of leadership and capacity for tobacco control action received important attention. The Global Leadership Course in Tobacco Control was held for the first time in the Region, in partnership with Johns Hopkins University. A regional workshop for the FCTC parties enhanced their capacity for participation in the fifth session of the FCTC Conference of the Parties (COP5). Capacity-building was also supported in other areas: taxation and pricing of tobacco products for member states of the Gulf Cooperation Council (GCC), implementation of Article 5.3 of the WHO FCTC on tobacco industry interference,



↑ ***Recent publications on community-based initiatives***

↑ ***Recent publications on tobacco control***

tobacco cessation, implementation of tobacco-free public places and of pictorial health warnings and banning of all forms of tobacco advertising, sponsorship and promotion.

In the area of surveillance and monitoring, more countries have completed the STEPS survey bringing the total number of Member States that have conducted the survey and published the corresponding reports to 18. The Regional Office has provided support to GCC member states to develop national targets and indicators in line with the global monitoring framework, which will continue in 2013, and to all Member States to implement the Global Tobacco Surveillance System (GTSS), analyse the data, finalize country reports and develop dissemination plans. The Regional Office is also supporting the development and implementation of priority global surveys such as the Global Youth Tobacco Survey and the Global Adult Tobacco Survey, in cooperation with international partners. The regional portion of the Fourth Global Tobacco Control Report was completed. The report will be published in 2013.

In the area of health care, the Regional Office provided technical support for adapting and implementing the WHO package of essential interventions for noncommunicable diseases in primary health care to three countries (Kuwait, Sudan and United Arab Emirates), raising to six the total number of countries with trained staff and integrated protocols for the screening and management of noncommunicable diseases in primary health care.

The challenge for 2013 is for Member States to strengthen their commitment and accord a higher priority to addressing the alarming rise in the magnitude of noncommunicable diseases and to

translate that commitment into concrete action in implementing the framework for action adopted during the fifty-ninth session of the Regional Committee

Mental health

Mental, neurological and substance use disorders account for more than 11% of disability-adjusted life years lost and 27% of the years lived with disability in the Region. Conflict and complex humanitarian emergencies, with attendant displacement of populations and diminution of social support, add significantly to this burden. Stigma and discrimination, lack of political commitment, limited financial and human resources, and the low public health profile of mental illness have contributed to a huge treatment gap for mental disorders. More than three quarters of people with serious mental disorders in low and middle-income countries of the Region and up to half in high-income countries have no access to basic treatment.

To address these challenges, the Regional Office has responded through a multipronged approach guided by the regional strategy for mental health and substance abuse. During 2012 the Regional Office contributed to the development of the comprehensive mental health action plan 2013–2020, for adoption by the World Health Assembly in May 2013, to ensure regional relevance and buy-in from Member States. The Mental Health Gap Action Programme (mhGAP) has been launched in Afghanistan, Egypt, Iraq, Jordan, Libya, Oman, Pakistan, Somalia and Sudan. The Regional Office contributed to the *Mental health atlas 2011* and the *Atlas on substance use* with the aim of building the evidence base for action in the Region. Technical support was provided to update national policies and legislation in Afghanistan, Djibouti, Islamic Republic of Iran, Oman, Qatar, Somalia, and Sudan.

Communicable diseases

Communicable diseases are estimated to be responsible for around one third of all deaths and one third of all illnesses in the Region. Despite successes in eliminating and eradicating some of these diseases in some countries, the Region continues to suffer from a significant burden of communicable diseases which hampers socioeconomic development. The importance of communicable disease control has increased in recent years due to increased travel, trade, migration and emergence of new infections. In addition to the chronic challenges of weak health systems, inadequate commitment and financing for communicable disease control have resulted in delay to achievement of regional targets. Several countries are facing political instability, social unrest, ongoing conflict and insecurity, all of which have an impact on control of communicable diseases. In this section, we address four thematic areas: poliomyelitis eradication; HIV, tuberculosis, malaria and tropical diseases; immunization and vaccines; and health security and regulations.

Poliomyelitis eradication

The poliomyelitis eradication programme is a high priority initiative that is directly supervised by the Regional Director. All countries of the Region are free from polio except Afghanistan and Pakistan where poliovirus circulation has never been stopped. The remaining identified reservoirs of poliovirus in Pakistan are the Quetta block (Pishin, Kilabdella and Quetta) in Baluchistan, Gadap Town in Karachi and Khyber Agency in the Federally Administered Tribal Areas (FATA), while in Afghanistan, Kandahar and Helmand provinces in the southern region are the main reservoirs. Persistent transmission in Pakistan and Afghanistan has held back global polio

Photo: ©Press Information Department/Government of Pakistan

↑ The Regional Director met with the President of Pakistan to discuss the progress towards polio eradication

eradication, and is a threat to polio-free countries. Somalia and Yemen are considered at high risk because insecurity has led to low population immunity resulting in the circulation of vaccine-derived polioviruses. Djibouti, South Sudan and the Syrian Arab Republic are all being kept under close surveillance.

2012 witnessed major achievements. Pakistan reported 58 polio cases in 2012 compared to 198 in 2011 while Afghanistan reported 37 cases compared to 80 in 2011. Pakistan developed and implemented an augmented national emergency action plan, addressing the various challenges, including consistent government oversight, ownership and accountability at each administrative level. Significant efforts and initiatives were made by the programme, particularly the adequate and appropriate use of bivalent oral polio vaccine, introduction of short-interval additional doses, the development of comprehensive sub-district plans, introduction of a surge of support staff by WHO and UNICEF at the implementation level, improvements in the monitoring system through the use of lot quality assurance sampling and maintenance of a very sensitive surveillance system supported by a well-functioning regional reference laboratory. The Government of Afghanistan also developed a national emergency action plan which includes improving management and accountability, reducing inaccessibility, increasing community demand and strengthening routine immunization. Permanent polio vaccination teams and district immunization management teams were put in place in poorly performing districts to improve routine immunization services in 28 districts. Strong cross-border coordination is needed between both countries in order to: map children who have been missed and identify why they are being missed; reach and vaccinate each and every child across the border; and ensure continuous communication at the operational level and between the two governments. A management and

Photo: ©WHO Regional Office for the Eastern Mediterranean

↑ Early in 2013 the Grand Imam of Al Azhar received Muslim scholars to discuss the rights of children to vaccination against polio and other killer diseases

accountability framework has been introduced in the high-risk districts of both Member States.

However, the programme in Pakistan is facing several new challenges, including a ban on vaccination in North and South Waziristan, and resistance from the militant factions in Karachi, Khyber Pakhtunkhwa and parts of the Federally Administered Tribal Areas (FATA). Efforts are needed to de-link the programme from the disinformation being propagated around it and to present a neutral interface. In Afghanistan, conflict and inaccessibility hamper progress. These challenges are currently being addressed by strengthening the communications component of the programme, establishment of the Islamic Advisory Group and strengthening regional ownership of the polio programme. No country is completely immune from reintroduction of polio if transmission remains in Pakistan and Afghanistan. Support from other countries of the Region is critical to success. The Regional Committee pledged to unite for a polio-free Region and one of the challenges for 2013 is to translate that pledge into concrete action.

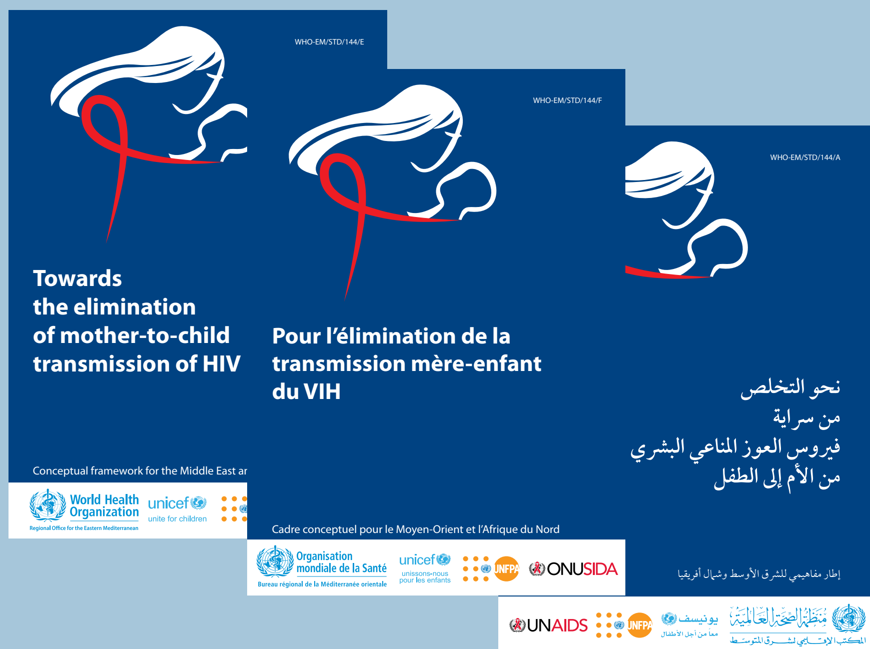
Somalia remains at high risk of a wild poliovirus outbreak due to the large pool of inaccessible and unvaccinated children if importation were to occur. The major challenge is reaching and vaccinating an estimated 800 000 target children in inaccessible areas due to insecurity. The vaccine-derived poliovirus (cVDPV) outbreak in Yemen is indicative of the large population immunity gap which resulted from chronic low routine immunization coverage and lack of high-quality supplementary immunization activities. In response to the outbreak, Yemen conducted three national immunization days and one subnational immunization day. Oral polio vaccine (OPV) was also added to a measles catch-up campaign.

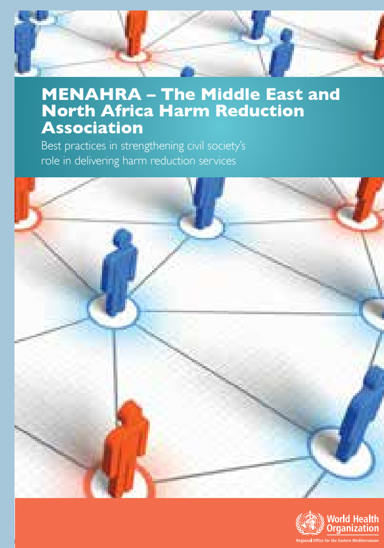
Ten polio-free countries at risk of importation (Djibouti, Egypt, Iraq, Islamic Republic of Iran, Jordan, Libya, Saudi Arabia, Sudan, South Sudan and Syrian Arab Republic) conducted subnational immunization days with a focus on geographic areas with high-risk populations and low routine immunization coverage, in an effort to boost population immunity of high-risk groups. Other vaccination opportunities, such as measles campaigns and Child Health Days, were used to deliver additional doses of oral polio vaccine (OPV) to help boost population immunity.

Key acute flaccid paralysis (AFP) surveillance indicators (i.e. non-polio AFP rate and percentage of adequate stools) at the national level are reaching international certification standards. However, at the subnational level, there are gaps, which are more significant for the countries that have been polio-free for many years. All the countries of the Region have maintained the expected non-polio AFP rate per 100 000 children under the age of 15 years except for Morocco, which is close to the expected rate. The percentage of AFP cases with adequate stool collection is above the target of 80%, except in Djibouti, Lebanon and Tunisia.

HIV, tuberculosis, malaria and tropical diseases

The HIV epidemic has continued to spread fast through the Region. The latest estimates show that approximately 560 000 people are living with HIV in the Region. Although the overall prevalence in the general population is still low, the proportion of newly infected people among all people living with HIV is the highest globally. AIDS-related deaths have almost doubled in the past decade among both adults and children, reaching a total of 38 400 in 2011. HIV treatment coverage is only 13%, the lowest among WHO regions.





↑ ***Recent publications on HIV/AIDS***

Lack of political commitment, inadequate access to health services for populations at higher risk, high stigma and discrimination, and weaknesses of health systems continue to challenge effective control and delivery of care.

WHO focused its support to Member States on the development of HIV testing and treatment guidelines and capacity-building in service delivery. Guidance was provided on service-delivery to populations at higher risk that are difficult to reach with conventional health services and countries were supported to develop novel service-delivery approaches, including through community-based organizations. Collaboration with the regional knowledge hub on HIV surveillance in the Islamic Republic of Iran was maintained to strengthen the institution's role as a regional resource and training centre.

Concerned about the lack of progress in preventing mother-to-child transmission of HIV in the Region, WHO in partnership with UNICEF, UNFPA and UNAIDS launched a regional initiative to eliminate mother-to-child transmission of HIV (eMTCT). The initiative adopts the overall global goals of reducing the number of new HIV infections among children by 90% by 2015, and reducing the number of AIDS-related maternal deaths by 50%, also by 2015. It promotes a comprehensive approach including preventing unintended pregnancies among women living with HIV; preventing transmission of HIV from HIV-infected pregnant women to their children; and providing treatment, care and support to mothers, children and families living with HIV.

In 2011[1], 11 countries achieved a tuberculosis case detection rate of 70%, 13 achieved 85%

[1]For tuberculosis case detection, WHO receives data a year later, thus case detection data relate to 2011 and treatment outcome data to 2012.

treatment success rate and 12 developed national strategic plans for 2011–2015. The laboratory network was expanded, especially for culture and drug susceptibility testing. Technical support was extended in drug management and promotion of prequalification of pharmaceutical companies. The electronic nominal recording and reporting system (ENRS) is now being used in five countries and the web-based surveillance system (WEB TBS) was introduced in several countries. Eleven countries received support in conducting surveys to assess the burden of drug-resistant tuberculosis. Review missions were conducted in five countries. Several countries received technical support in conducting surveys and studies to estimate the extent of underreporting of tuberculosis cases and burden.

An estimated 46% of the population was living in areas at risk of local malaria transmission in 2011. Countries reported a total of 6 789 460 malaria cases (see Tables 2 and 3), of which only 16.8% were confirmed parasitologically and the rest were treated based on clinical diagnosis. Six countries accounted for more than 99.5% of the confirmed cases in 2011 (Afghanistan, Pakistan, Somalia, South Sudan, Sudan and Yemen). According to 2010 data, the number of estimated malaria deaths was 15 000. Malaria control and elimination still face several challenges. Access to facilities for parasitological diagnosis in countries with a high burden of malaria is limited and the quality is poor. Resistance to anti-malarial drugs is growing in *P. falciparum* endemic countries. Malaria surveillance, monitoring and evaluation are weak and the compliance of private providers with national treatment guidelines is low. Insecurity, climate change and natural disasters are additional challenges for malaria control; for example the malaria situation in Pakistan has worsened since the heavy floods in 2010. Malaria-free countries also face the challenge of increasing imported malaria resulting from huge population movements, both legal and illegal.

Among the achievements made, Iraq was included among the non-malaria-endemic countries after three years with no reported local transmission. The Islamic Republic of Iran and Saudi Arabia achieved targets of more than 80% coverage of malaria control and elimination interventions. Other countries showed good progress in coverage

Table 2.
Reported malaria cases in countries with high malaria burden

Country	2010		2011		2012	
	Total reported cases	Total Confirmed	Total reported cases	Total Confirmed	Total reported cases	Total Confirmed
Afghanistan	392 463	69 397	482 748	77 549	391 365	54 840
Djibouti	3 962	1 019	624	NA	NA	NA
Pakistan	4 281 356	240 591	334 589[a]	334 589	289 759[a]	289 759
Somalia	24 553	24 553	41 167	3 351	NA	NA
South Sudan	900 283	900 283	795 784	112 024	1 198 358	NA
Sudan	1 465 496	720 557	1 246 833	506 806	NA	NA
Yemen	198 963	106 697	142 147	90 410	153 981	105 066

NA: not available
[a]*Confirmed cases only*

Table 3. Parasitologically-confirmed cases in countries with no or sporadic transmission and countries with low malaria endemicity

Country	2010		2011		2012	
	Total reported cases	Autochthonous	Total reported cases	Autochthonous	Total reported cases	Autochthonous
Bahrain	90	0	186	0	NA	NA
Egypt	85	0	116	0	206	0
Iraq	7	0	11	0	NA	NA
Iran, Islamic Republic of	3 031	1 847	3 239	1 710	NA	532
Jordan	61	2	58	0	117	0
Kuwait	343	0	476	0	NA	NA
Lebanon	NA	NA	NA	NA	115	0
Libya	NA	NA	NA	NA	88	0
Morocco	218	0	312	0	359	0
Oman	1 193	24	1 531	13	NA	NA
Palestine	NA	NA	NA	NA	NA	NA
Qatar	440	0	673	0	NA	NA
Saudi Arabia	1 941	29	2 788	69	3 406	83
Syrian Arab Republic	23	0	48	0	42	0
Tunisia	72	0	67	0	79	0
United Arab Emirates	3 264	0	5 242	0	5 165	0

NA: not available

with malaria interventions such as long-lasting insecticidal nets (LLINs), but have yet to achieve the target of more than 80%. By the end of 2012, the operational coverage of LLINs in Sudan had increased to more than 50%. In Afghanistan, the proportion of households with at least one LLIN increased from 9.9% in 2009 to 43.4% in 2011. In the same period, the proportion of children under 5 years of age who slept under LLINs the night before the survey increased from 2% to 32%. WHO continued to support capacity-building of national programmes through regional trainings on malaria planning and management, microscopy and quality assurance,

Photo: ©WHO/Hoda Atta

↑ Water wells, essential for daily living needs in many parts of the Region, also provide potential breeding sites for the mosquitoes that transmit malaria

using polymerase chain reaction (PCR), and elimination. Djibouti finalized a programme review, while the Islamic Republic of Iran, South Sudan, Sudan and Yemen are at different stages of such a review. Programme reviews were also supported in Oman, Qatar and Saudi Arabia. With technical support from WHO at the country and regional level, countries succeeded in signing agreements for extending Global Fund grants.

Several activities were carried out to address vector-borne diseases in the Region. WHO focused its support on the implementation of the regional *Framework for action on the sound management of public health pesticides*, on demonstration studies for sustainable alternatives to DDT and on strengthening national vector control capabilities in Member States. Joint work was carried out with countries to develop a regional database on insecticide resistance. A regional consultation on insecticide resistance management was conducted and participating countries agreed to incorporate an insecticide resistance management component into the national integrated vector management strategies and continue to strengthen entomological surveillance.

With regard to neglected tropical diseases, human African trypanosomiasis remains a challenge in South Sudan. The decline achieved in the number of cases over recent years, and the consequently higher proportional cost of treatment per patient, is now making it difficult to get partners involved in control activities. Accessibility during the rainy season represents a major issue for several tropical disease programmes in South Sudan and Sudan.

A 50% reduction was observed in the number of cases of guinea-worm disease in South Sudan in 2012 compared to 2011 and only 179 villages remain endemic. The lymphatic filariasis elimination programmes in Egypt and Yemen completed the elimination phase and capacity was built to assess transmission for elimination verification. Onchocerciasis was certified as having been eliminated from Abu Hamad, the largest endemic focus in Sudan. Praziquantel distribution in the three schistosomiasis-endemic countries (Yemen, Sudan and Somalia) increased by 70% despite the challenge of insecurity. The enhanced global strategy 2011–15 for leprosy elimination and its operational guidelines were translated into Arabic and the strategy is being implemented. The rapid diagnostic field test for visceral leishmaniasis is now widely available and has shortened the treatment from 30 to 15 days.

↑ ***Recent publication on vector control***

Immunization and vaccines

Immunization programmes in the Region are confronted by several challenges. The progress towards coverage targets continues to be affected by the security situation, particularly in Afghanistan, Pakistan, Syrian Arab Republic and Yemen. The global shortage of DTP and DTP-HepB and pentavalent vaccine also affected Egypt, Islamic Republic of Iran and Libya. Inadequate managerial capacity and commitment

to routine immunization remained visible challenges in some countries in 2012. High-level support to routine immunization, especially in Afghanistan and Pakistan, is urgently needed. Inadequate financial resources, particularly for implementation of measles and tetanus supplementary immunization, introduction of new vaccines in middle-income countries and co-financing in GAVI eligible countries, and implementation of activities pertaining to improvement of vaccination coverage in countries with low coverage continued to be issues of concern. Allocation of government resources and the support of partners are needed to scale up the response against vaccine-preventable diseases. In this regard the Decade of Vaccines and the Global Vaccine Action Plan represent opportunities for resource mobilization which countries can make use of.

Technical support was extended to countries in a number of areas including: assessment of the different areas of the Expanded Programme on Immunization (EPI) and development of plans for improvement; ensuring an adequate logistics system; introduction of new vaccines; development of applications for support from the GAVI Alliance; strengthening surveillance; and monitoring and evaluation of EPI. Although vaccination coverage data for 2012 are not available yet, preliminary reports indicate that 15 countries in the Region continued to achieve the target of 90% routine vaccination coverage while Djibouti was close to achieving the target. Egypt and Tunisia were able to maintain high routine vaccination coverage above 95%, despite the challenges, and Somalia and South Sudan also saw an increase in coverage. However, the situation in the Syrian Arab Republic is alarming and vaccination coverage has dropped significantly. The third regional vaccination week was successfully implemented in April 2012 with the theme "reaching every community".

Nine countries reported very low incidence of measles (<5 per million population) and are close to achieving measles elimination (Figure 4). Regarding implementation of the regional measles elimination strategy, fourteen countries achieved above 95% coverage with the first dose of measles-containing vaccine (MCV1) and a second dose (MCV2) is now being implemented in 21 countries following its introduction in Sudan and Djibouti. As for surveillance, all countries have implemented measles case-based laboratory surveillance either nationwide (20 countries) or as sentinel surveillance (Djibouti, Somalia and South Sudan). Local measles genotypes, which are necessary for validating measles elimination, were identified in 22 countries.

Introduction of new life-saving vaccines made further progress in 2012. Hib vaccine is now in use in 20 countries and is expected to be introduced in the remaining countries soon. Pneumococcal conjugate vaccine is now in use in 11 countries and rotavirus vaccine in 7 countries. The first phase of a meningococcal A conjugate vaccine campaign in Sudan was implemented. Pneumococcal and rotavirus vaccines are expected to be introduced soon in more countries thanks to the support of the GAVI Alliance. The main challenge facing new vaccines introduction is the unaffordability of the new vaccines for middle-income countries. WHO is working to enhance new vaccines introduction, particularly in middle-income countries through establishing a regional pooled vaccine procurement system, advocacy for allocation of more national resources and strengthening evidence-based decision-making

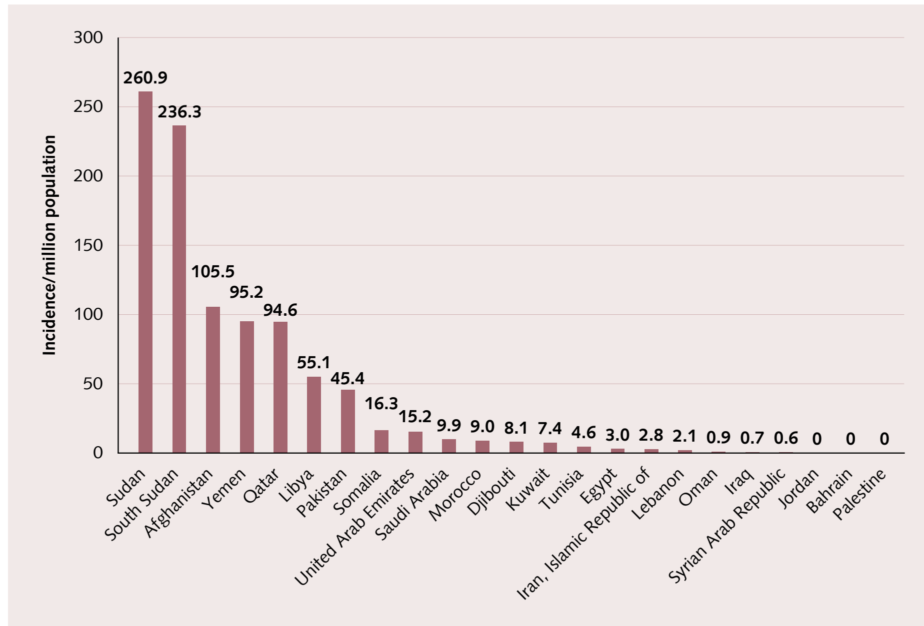


Figure 4
Incidence rate per million population of confirmed measles cases, 2012

and national immunization technical advisory groups.

Health security and regulations

In 2012, there was an unprecedented rise in the incidence of emerging and re-emerging communicable diseases, posing constant threats to regional health security. Outbreaks occurred periodically throughout the year affecting a large number of countries and causing some of the worst human misery ever seen in the Region. The outbreaks included avian influenza A (H5N1) in Egypt, cholera in Iraq and Somalia, Crimean-Congo haemorrhagic fever in Afghanistan and Pakistan, diphtheria in Sudan, measles in Afghanistan, Pakistan and Somalia, nodding syndrome and hepatitis E in South Sudan, yellow fever in Sudan, West Nile virus infection in Tunisia and the influenza outbreak seen towards the end of the year in Palestine and Yemen caused by influenza A (H1N1). The emergence of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) in Jordan, Qatar and Saudi Arabia with a high case fatality rate, on top of these outbreaks, was a stark reminder of the increase in epidemic-prone emerging diseases in the Region. While the looming threat of a pandemic from avian influenza still persists in the Region, the appearance of MERS-CoV in humans greatly underscored the vulnerability of the Region to the threat of emerging diseases. The ongoing conflicts and chronic humanitarian emergencies prevailing in many countries and resulting in large numbers of displaced populations are among the major risk factors for the spread of new diseases.

Early detection and rapid response to contain epidemic threats from emerging diseases remain the biggest challenge. WHO has continued to provide strategic technical support to countries to develop, strengthen and maintain adequate

Photo: ©WHO/Christina Banluta

Photo: ©WHO/Christina Banluta

↑ **In response to the yellow fever outbreak in parts of Sudan, more than 3.2 million people were vaccinated and a national yellow fever risk assessment was conducted**

surveillance and response capacity to detect assess and respond to public health events of both national and international concern. As part of the ongoing efforts to improve the Region's collective preparedness and response capacities, WHO invested in improving sub-regional and local capacities for epidemic intelligence and risk assessment for informed public health actions to contain epidemic threats. Pakistan received support in organizing an international conference on dengue fever which led to recommendations on surveillance, detection, management, vector control, behavioural interventions and emergency response in outbreaks.

WHO coordinated with its Global Outbreak Alert and Response Network (GOARN) partner institutions and WHO collaborating centres for the deployment of experts and laboratory resources for outbreak response and containment operations in a number of countries at risk of international spread of epidemics where the national outbreak response operations are not adequate to contain the threats of international spread given the size and magnitude of these outbreaks. These included yellow fever in Sudan, nodding syndrome in South Sudan, Middle East respiratory syndrome coronavirus (MERS-CoV) in Jordan, Qatar and Saudi Arabia and severe influenza in Palestine. In order to further strengthen the infection prevention and control programme in the Region, consultations were held to develop tools for surveillance of health-care associated infections and guidelines for preventing infections associated with health care from acute viral haemorrhagic fevers.

The International Health Regulations 2005 (IHR) are an international legal agreement binding on all WHO Member States. All State Parties in the Region, except the Islamic Republic of Iran, fell short of the implementation goals for June 2012. Requests for a 2-year extension supported by plans of implementation were submitted by 17 Member States. Three (Libya, Pakistan and United Arab Emirates) submitted only requests for extension and one country (Somalia) has not complied with the extension requirements. Countries have faced a number of challenges during the implementation of regulations. These include: lack of supportive public health laws and other legal and administrative instruments; insufficient coordination among the different stakeholders at country level and with neighbouring countries;

high turnover of qualified personnel; and insufficient financial capacity to cover planned activities.

There was marked progress in developing and sustaining several of the requirements for implementation of the regulations in the Region, with regional implementation of the requirements estimated at 67%, based on data collected through the 2011 monitoring questionnaire. However, many requirements remain a challenge and need further work. These include: implementing the new legislation and national policies put in place to facilitate the implementation of the regulations; testing existing coordination mechanisms among the different stakeholders; evaluating the early warning function of the indicator-based surveillance; establishing event-based surveillance; and strengthening cross-border surveillance. Furthermore, programmes for protecting health care workers and monitoring systems for antimicrobial resistance need to be established. National preparedness and response plans need to be tested. Many requirements in the general obligations, as well as effective surveillance and response at points of entry also need to be fulfilled. Meeting the requirements for detecting and responding to foodborne disease and food contamination and in detecting and responding to chemical and radionuclear emergencies are other areas that need to be considered. Effective communications, coordination and collaboration among different sectors and enhancement of human resources are vital to efficient application of the regulations.

Emergency preparedness and response

The Eastern Mediterranean Region has a high risk for natural hazards such as earthquakes (Islamic Republic of Iran), floods (Pakistan) and drought (which has resulted in famine in Djibouti, Somalia and South Sudan since 2011 and is expected to re-emerge in 2013). Political instability and civil conflict in countries such as South Sudan, Sudan, Syrian Arab Republic and Yemen have resulted in millions of people in need of emergency and basic health services, especially the most vulnerable populations, such as women, children and the elderly. More than 50% of the world's refugees originate from the Eastern Mediterranean Region. In light of the increasing number and magnitude of emergencies in the Region, in March 2012 the Regional Director identified the area of emergency preparedness and response as one of five priority areas with the goal of increasing the resilience of countries to emergencies, disasters and other crises, and subsequently ensuring effective public health response to risks and threats. A new set of strategic priorities was defined to outline the way forward, including offering support to countries in developing clear policies and legislation based on an all hazard and 'whole health' approach, and paying special attention to safeguarding health facilities and the health workforce in times of emergency.

In all countries facing emergencies, there was a highlighted need in 2012 to ensure that health services for vulnerable populations, especially

↑ Health facilities often function under severe constraints during emergencies, such as in this hospital in the Syrian Arab Republic where a nurse uses the light from a mobile phone to check on a newborn baby during a power cut

women and children in the most affected areas, were made available. Priorities included the provision of obstetric and gynaecological health services, as well as vaccinations for children below the age of 5 years. In countries with on-going conflict and violence, mental health services were largely unavailable due to a lack of qualified health staff. Increasing numbers of refugees and internally displaced persons in countries such as South Sudan, Syrian Arab Republic and neighbouring countries, Sudan and Yemen highlighted the need for effective disease monitoring and response systems for the prompt control of communicable disease outbreaks. In both acute crises and protracted emergencies, the burden of noncommunicable disease also came to the fore as patients lost access to essential drugs and life-saving treatment.

Reform in WHO's work in emergencies, specifically the Emergency Response Framework, stressed the need for strengthening country office capacity to prepare for and respond to crises. To ensure a more rapid response, an emergency surge roster was developed with identified expertise on standby. Additionally, the process of establishing a regional WHO hub for medicines and medical supplies and equipment was initiated. On a regional level, medicines, medical supplies, logistics, and office and laboratory equipment worth almost US$ 120 million were provided to six countries facing emergency (Afghanistan, Libya, Pakistan, Somalia, Sudan and Syrian Arab Republic), amounting to almost 40% of WHO procurement on a global level.

Despite an increase in the funding of health activities in emergencies, only 38% of the Region's health funding requirements was met in 2012. The health sector continues to be severely underfunded, emphasizing the need for a more coordinated approach by traditional and non-traditional partners to address the health needs of affected populations in the Region.

Photo: ©WHO/Abdul Malik

↑ Emergency supplies are checked following arrival in Afghanistan

An evolving leadership role in health emergencies

In all countries experiencing emergencies, WHO supported health authorities to lead a coordinated and effective health sector response together with the national and international community, in order to save lives and minimize adverse health effects, with specific attention to vulnerable populations. One of the main challenges was lack of accessibility and humanitarian space. The delivery of health services to affected populations in Palestine, South Sudan and Syrian Arab Republic was impeded by the limited access by health humanitarian partners and by health care workers to their place of work due to insecurity. Twenty-three months into the crisis in the Syrian Arab Republic, for example, 70% of health workers in heavily affected areas reported difficulties in accessing their workplace.

Similar challenges associated with inaccessibility and insecurity that impeded the delivery of emergency and basic health services were faced in Afghanistan, Somalia, South Sudan and Yemen.

The delivery of basic and emergency health care services was also impeded as an indirect result of economic sanctions on countries such as Islamic Republic of Iran, Libya and Syrian Arab Republic. For example, pharmaceutical plants in the Syrian Arab Republic that had previously produced almost 90% of the country's medicines were forced to halt production due to the combined effects of economic sanctions, fuel shortages and damage to infrastructure. Consequently, health facilities received insufficient supplies from the central authorities due to critical shortages in life-saving essential medicines.

To ensure that urgently needed medicines and medical supplies were available, WHO worked with governments and partners to broker the procurement and provision of supplies. Examples of these partnerships included those with the League of Arab States for the provision of medicines and medical supplies to Syrian Arab Republic and Yemen, and with local authorities and the Organization of Islamic Cooperation to coordinate access of the population to health services in Somalia.

In countries such as Afghanistan, Libya, Pakistan and Syrian Arab Republic, where health care workers and health facilities were intentionally targeted or indirectly affected, WHO condemned the attacks in the regional and international media and through advocacy campaigns, referring to World Health Assembly resolutions and human rights laws prohibiting the targeting of health staff in times of conflict.

Saving lives and meeting health needs

Incapacitated health systems in countries experiencing emergencies often result in vulnerable populations having little or no access to health care services. In the Syrian Arab Republic, more than 50% of public hospitals had been damaged or destroyed as a result of the conflict as of December 2012. To ensure the continuity of health care services, WHO partnered with 13 local nongovernmental organizations to ensure the provision of treatment, medicines and medical supplies. By the end of 2012, WHO had provided medicines and medical supplies for 1.2 million treatments, and more than 195 000 blood safety kits to the national blood bank, trauma surgery and emergency care supplies, intravenous nutrition fluid and intravenous supply sets to hospitals in affected areas.

Vulnerable populations in Afghanistan and Somalia, especially women and children, were reached through field hospitals and mobile clinics. In Somalia, children and women of childbearing age in remote communities and underserved areas were reached thorough health interventions on Child Health Days, in partnership with the national authorities and UNICEF. Nationwide emergency vaccination campaigns were conducted with health partners in Afghanistan, South Sudan and Sudan, as well as in Syrian Arab Republic where WHO and UNICEF supported the Ministry of Health in measles and polio vaccination campaigns for 2 million and 2.5 million children under 5 years of age, respectively. WHO provided vaccines, paracetamol and multivitamin syrups, as well as ensured capacity-building for national staff to implement the campaign effectively and efficiently.

↑ **Emergency response can involve extraordinary effort, as here in eastern Sudan where WHO staff and volunteers carry boxes of medicines and supplies across a flooded area to reach a health facility**

In order to detect, and provide a timely and effective response to confirmed outbreaks, ministries of health strengthened the Early Warning Alert and Response (EWAR) systems in six countries (Afghanistan, Iraq, Jordan, Pakistan, Somalia and Sudan). These systems allowed WHO and partners to detect and manage outbreaks of cholera in southern and central Somalia, yellow fever in Sudan, acute watery diarrhoea in South Sudan, cholera in Iraq and tuberculosis among Syrian refugees in Jordan. As a result of the deteriorating heath situation in the Syrian Arab Republic, WHO established an early warning and response system and provided training to national surveillance focal points from around the country. Data collection began in September 2012 and enabled WHO and national authorities to monitor and control reported cases of hepatitis A, typhoid and leishmaniasis.

Incapacitated health systems and shortages in medicines also increase the burden of noncommunicable diseases as populations are no longer able to get regular treatment or access to essential, life-saving medicines. This has highlighted the need to update national lists of urgently required essential medicines in emergency countries based on disease profiles, current gaps and critical needs, with the Syrian Arab Republic identified as a priority country in early 2013.

Ensuring the collection and dissemination of health information in emergencies

One of the biggest challenges faced during emergencies is obtaining timely information on the health system so that health risks, needs and gaps can be accurately assessed. This challenge can be further aggravated during complex emergencies where access to this information is hindered. To ensure an efficient approach in managing

health information, WHO worked with national authorities and health partners to establish emergency health information management systems and coordinated the collection, analysis and dissemination of essential information.

In the Syrian Arab Republic, WHO participated in two interagency assessment missions and conducted rapid assessments of public health facilities in all governorates to determine accessibility and functionality. In the neighbouring countries of Iraq, Jordan and Lebanon, nutrition assessments were conducted among Syrian refugees living in both the refugee camps and within the host communities. Nutrition assessments were also conducted in Afghanistan, Pakistan and Yemen to ensure capacity-building for response to severe and acute malnutrition.

In Pakistan, the Health Resources Availability Mapping System (HeRAMs) was integrated into the national health system to ensure good practice in the mapping of health resources and services availability in emergencies and to strengthen informed based decision-making by the Health Cluster. Inter-agency partnerships were also strengthened through WHO support of the assessment of 65 UNHCR-administered health facilities.

Strengthening country office capacity

Natural disasters and political unrest can occur at any time and are often difficult to predict. In order for WHO's country offices to efficiently support country response operations, the deployment of health experts and procurement of medicines during emergencies must be as rapid and streamlined as possible. Challenges encountered at the onset of emergencies include the need to be able to identify and deploy qualified expertise rapidly and the lengthy procurement procedures within WHO for medicines and medical supplies.

To address these challenges, a regional emergency roster of public health experts was developed to enable WHO to respond in a more timely and effective manner to emergencies in the Region, with a number of public health experts identified and on standby. Negotiations were initiated in December 2012 with the United Arab Emirates Government to establish a dedicated hub for WHO in Dubai's Humanitarian City. This hub will ensure that standard medical kits and supplies are stockpiled for more rapid deployment as needed in emergencies, and streamline the procurement process for WHO's health relief operations in the Region and around the world. The standard operating procedures, developed in 2010 to streamline WHO's work in emergencies, continued to be adhered to in addressing these challenges.

Emergency risk management

The growing number of large-scale emergencies enhanced the momentum of engaging Member States in multisectoral emergency risk management in the Region. It also highlighted the need to strengthen the emergency preparedness and response capacity of health systems, including the coordination among national and private sector partners.

Advocacy continued throughout 2012 in order to ensure that health is one of the priorities addressed in the global, regional and national development and disaster risk management agendas, in partnership with UNISDR, League of Arab States and UNDP. As a result, health has been underscored as one of the priority areas in

Photo: ©WHO/KPK Pakistan

↑ WHO staff conduct water quality monitoring during the 2012 floods in Pakistan

the policy guidance for disaster risk reduction for Arab, African and Asian Member States, developed by all key partners. WHO was invited to participate in the First Arab Conference on Disaster Risk Reduction in 2013, where the regional disaster risk reduction platform was planned to be launched. A side meeting on multisectoral health is planned to be held during the conference for representatives/delegates of participating Member States.

Recognizing that incapacitated health systems impede national ability to respond to emergencies in a timely and efficient manner, emergency risk management was one of the areas highlighted for action within the context of the regional strategic priorities endorsed by the Regional Committee. This has spearheaded the impetus towards building national capacity with an all-hazard risk management approach incorporating the International Health Regulations (2005). As a result, the regulations have been included in national and regional training curricula for public health emergency management. To meet the challenges, even countries with protracted emergencies (Afghanistan, Pakistan and Sudan) are developing capacity in managing crises in a more institutional manner. This has also become evident in Islamic Republic of Iran, Oman and Pakistan, which are managing acute emergencies at the national level with minimal external support.

So far, seven countries (Afghanistan, Bahrain, Islamic Republic of Iran, Oman, Pakistan, Qatar and Sudan) are on track to institutionalize emergency risk management within the health sector. In light of this, preparation was undertaken to launch comprehensive risk assessment in Qatar and Sudan in the coming year. While establishing emergency risk management programmes remains a priority, simultaneous training in the areas of hospital preparedness, public health emergency management and disaster risk reduction also remain in focus in many countries. Recognizing that the safety of health facilities and health workforce is of utmost importance in the response to any public health emergency, several countries, including Bahrain, Islamic Republic of Iran, Lebanon, Oman and Sudan, are continuing to implement the hospital safety programme. WHO also worked with partners to develop a training programme on hospital preparedness in conflict situations.

To harmonize the national capacity-building activities from an all hazard approach at WHO, preparedness activities for emergencies, including epidemic and pandemic preparedness

and core capacities for implementation of the International Health Regulations, were merged into one technical body ensuring optimum use of resources within the framework of health security and regulations under the auspices of of the Department of Communicable Disease Control. This was done in alignment of 2014–2015 biennium planning priorities.

Scaling up emergency response in the Region

With the deterioration of the situation inside the Syrian Arab Republic and the increasing scale and complexity of health issues and response in the neighbouring countries, the emergency was designated Grade 3 by WHO in December 2012 – the first time a Grade 3 was announced in the history of the Organization. As outlined in WHO's Emergency Response Framework, a Grade 3 emergency called for the establishment of an emergency support team (EmST) to provide a consolidated, dedicated response to the crisis at the regional level by reinforcing WHO's four critical functions: 1) coordination; 2) information; 3) technical expertise; and 4) core services. Plans for the immediate establishment of the EmST were finalized in December 2012 in a meeting in Beirut attended by senior representatives from all three levels of the Organization.

In addition to consolidating WHO's response on a regional level to the Syrian crisis, the establishing of the EmST also reinforced the one-WHO model as other regions expressed their support. Despite its own financial limitations, the Regional Office for Africa donated US$ 100 000 to support EmST operations while WHO headquarters and the Regional Office for Europe deployed technical expertise as part of the emergency team.

Implementing WHO management reforms

The Regional Director made clear his commitment to dynamic, effective and transparent management, to building a coordinated one-WHO response to global and regional health challenges, and to intersectoral approaches to major public health issues. A number of challenges and priorities were identified for action to enhance management processes, efficiency and transparency.

Programmes and priority-setting

Regional strategic directions: based on the in depth analysis of the challenges facing health development in the Region, five technical areas were identified in which WHO's capacity will be increased and technical support to Member States Strengthened, including: health system strengthening; maternal, reproductive and child health and nutrition; noncommunicable diseases; communicable diseases; and emergency preparedness and response. These priorities are consistent with the priorities recommended subsequently by the Executive Board, and endorsed by Member States, for the draft Twelfth General Programme of Work for 2014–2019.

Specific needs of Member States: While there have been advances in the field of health in a number of Member States in recent years, wide disparities remain between and within countries in regard to specific health challenges. Countries also differ widely in population health outcomes, health system performance and level of health expenditure. This means that strategies must be tailored to the needs of countries at both the regional and country levels. This will allow for more targeted technical cooperation and the establishment of networks between countries with similar challenges and experiences.

Technical support to Member States: Strengthening the technical competence of WHO and expanding the capacity to deliver first-class technical support is a key priority of the reform process. Current capacity has been reviewed and adjustments to existing practices are currently under development. Technical departments have already initiated the establishment of rosters of well qualified experts in each key technical area who are selected and retained in advance for deployment to Member States as and when required. The outcome of technical support to Member States will be evaluated regularly and jointly by WHO and the recipient Ministry of Health.

Programming, results framework and standardized planning: The twelfth general programme of work and the programme budget 2014–15 established the programming and results framework, which will be used as the basis for planning and performance monitoring. This was built around six categories that replaced the current 13 strategic objectives: 1) communicable diseases; 2) noncommunicable diseases; 3) promoting health throughout the life-course; 4) health systems; 5) prepardness, surveillance and response; 6) corporate services and enabling functions. After a clear priority setting at country level, planning will essentially address country priorities as well as normative work, taking into consideration regional and global resolutions and recommendations from other advisory bodies

such as the Technical Advisory Committee (TAC) that replaced the Regional Consultative Committee (RCC). The Regional Office has adopted an important principle which is to reduce the fragmentation of plans and focus action on fewer programme areas and deliverables.

Country cooperation strategy documents: The process of development of country cooperation strategy (CCS) documents involves extensive consultations across the Secretariat, with the country's government, and with bilateral and multilateral agencies, civil society, academic institutions, collaborating centres and the private sector. However, there are currently significant gaps in the way the CCS is developed, and the quality of the process and of the outcome varies from one country to another. An in-depth analysis of the current experience is being conducted, and updated guidance on the CCS process, reflecting the importance of the document as an essential tool for the implementation of WHO reform, will be developed.

Within the same spirit the Joint Programme Review and Planning Mission (JPRM) process is also being reviewed for streamlining and refocusing the country programmes on key priorities. A new approach will be implemented for the biennium 2014–2015 taking into consideration the new programme budget structure, the recommendation of the Regional Committee, as well the regional vision and global categories mentioned above.

Decentralization of services: To ensure that services provided at country level are optimal, activities within the Regional Office that are of similar nature have been grouped, with the aim of considering their eventual relocation to more cost-effective locations. One example of this approach is the consolidation of all environmental health projects and activities within the Regional Centre for Environmental Health Activities in Amman, Jordan.

Governance

WHO's reform programme seeks to attract more active engagement and more informed participation by all Member States in governance processes, and to rebalance the way in which Member States exercise their role as informed and active participants in the work of the governing bodies. Based on guidance from Member States in January 2012, work in the area of governance focuses on four main priorities: a) more rational scheduling, alignment and harmonization of governance processes; b) strengthened oversight; c) greater strategic decision-making by governing bodies; and d) more effective engagement with other stakeholders. The reform addresses the need for improved linkages between regional committees and global governing bodies, as well as standardizing the practices of the six regional committees. Initiatives have included:

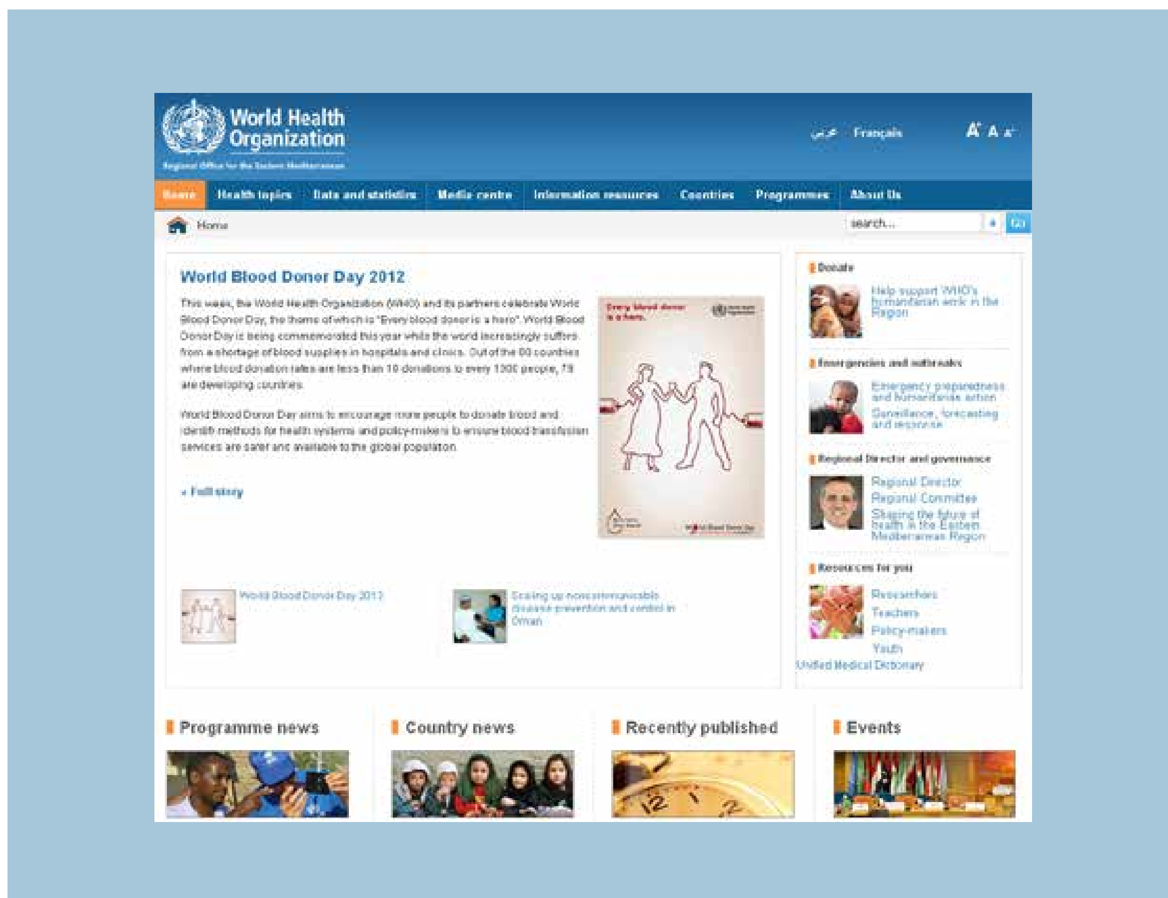
- high-level meetings for Member States' representatives and permanent missions in Geneva prior to each major meeting of the WHO governing bodies (World Health Assembly, Executive Board);
- concise and timely briefings to representatives to global governing bodies' meetings to facilitate health policy decision-making processes;
- video and teleconferences with representatives on important issues of concern to Member States whenever the situation warrants it;
- revised rules of procedure of the Regional Committee to ensure alignment with best practice in the Organization;

- a regional Technical Advisory Committee to provide advice to the Regional Director on matters relating to strengthening technical cooperation among and between Member States of the Region, providing support in evaluating programmes and assisting with resource mobilization, with a planned meeting in April of each year.

Management

Stronger technical, normative and policy support for all Member States is a key area in WHO reform. The area of management aims to achieve six main objectives: a) effective technical and policy support for all Member States; b) staffing matched to needs at all levels; c) a financing mechanism that respects agreed priorities; d) effective systems for accountability and risk management; e) a culture of evaluation; and f) strategic communications. In this area, the secretariat embarked on the following initiatives.

Realignment of the Regional Office structure: Two new departments were created within the Regional Office – Information, Evidence and Research and Noncommunicable Diseases and Mental Health – to meet the health challenges



↑ The Regional Office launched a new web site in June 2012 aimed at providing fast, effective communication and information for Member States www.emro.who.int/

facing the Region, ensure focus is placed on key programme areas, and improve synergies across programmatic areas. The units concerned with communications, partnerships and resource mobilization were consolidated for greater coherence and efficiency. A new strategy for this important area is being developed in collaboration with key stakeholders, and in consultation with headquarters and other regional offices. This realignment of structure with current needs will lead to a more streamlined distribution of the workforce.

Resource mobilization: WHO is actively taking part in global efforts to secure increased feasibility and predictability of financing, with a focus on regional donors and partners. Mobilization of resources from within the Region is minimal compared with other WHO regions. There is currently no operational resource mobilization strategy. The unit responsible for resource mobilization has been strengthened and a comprehensive resource mobilization plan will be developed in 2013.

WHO in the Region is committed to building stronger and more effective engagement with regional stakeholders, nongovernmental organizations, academia and the private sector, including the Organization of the Islamic Conference, Islamic Development Bank, African Development Bank, Gulf Cooperation Council, League of Arab States, and United Nations regional bodies. Emphasis will also be placed on coordination with global health initiatives and with development partners at the country level. Initial steps have been undertaken by the Regional Office in this direction in the past few months.

Strengthening country offices: Reports by internal and external auditors, as well as clear observations from Member States have shown the need for increased support to countries through more efficient managerial processes and improvements in the way challenges are addressed in the operating environment. Specific gaps have been identified in leadership, in quality of technical support provided to countries, and in the linkage between the CCS and operational planning. Other significant challenges concern financing, monitoring and the maintaining of an adequate control environment. The planning process and tools that guide WHO's technical activities in Member States need to be more efficient and effective, and should aim to ensure that there is a clear connection between the needs of Member States, the CCS, and the funding and activities planned by WHO in a given budgetary cycle.

Staffing: Staff selection methods are being revised through the implementation of a recruitment process based on generic, rather than customized, post descriptions. This is intended to lead to a more transparent and efficient recruitment process. Improvements in staff development activities are intended to strengthen country offices and will prepare national staff to be more competitive when applying for international positions in the Organization. The rotation of staff between country offices and the Regional Office has been initiated and will address the deteriorating effect of staff remaining in one duty station for too long. Performance management has been assigned a higher priority and will be closely linked to staff development to ensure that WHO staff meet the expectations set by Member States.

Evaluation: Internal control mechanisms have been strengthened through the introduction of quality assurance processes and a regional compliance function. An independent evaluation

of key programmes has been initiated and financial and management reviews of key offices have been launched to complement routine internal and external audits. A risk management framework has been introduced with input from country offices and programmes across the Region to allow for the identification of strategic and operational risks and mitigation measures. A compliance committee has been established to enhance the Organization's control environment and to mitigate the determined risks. Compliance reviews were conducted on some critical areas such as agreements for performance of work and travel. The level of compliance with the established travel policies has improved and further improvement is expected by the end of 2014.

Conclusion

2012 was an opportunity for Member States and WHO to agree on the key challenges facing health development in the Region. In-depth and objective assessment of the health situation in countries indicated clear priorities for technical collaboration with WHO which were endorsed by the Regional Committee. The current challenges facing health systems strengthening, maternal and child health, prevention and control of noncommunicable diseases and the unfinished agenda in communicable diseases, emergency preparedness and response, and WHO reform have been described in this report. I have also set forth the strategic action that WHO and Member States undertook together in 2012 to address some of these challenges, within the context of their joint programmes.

We are constantly building on the evidence, experience and valuable work undertaken in previous decades. In the past two years, very clear roadmaps have been agreed at global level on how to tackle key health priorities, and governments, donors and partners have indicated their commitment to following these roadmaps, whether at the United Nations General Assembly, the World Health Assembly or other international forums. Baselines and targets against which to measure our progress have been set out in the various technical documents presented to the Regional Committee, and in the individual country plans that have been or are being developed in each area. The challenge for Member States is to initiate concrete action to implement these roadmaps and meet the various global commitments. The challenge for us in WHO is to strengthen our efforts in order to provide enhanced technical support to countries.

In the area of health systems strengthening, the focus will be on health sector leadership and governance, development and implementation of a road map for universal health coverage, and ensuring a well balanced health workforce, access to essential medicines and technologies, and an integrated network of primary health care facilities. The health system must be supported and backed up by a robust health information system that includes civil registration and vital statistics and specific emphasis will be placed on promoting development of these. Mechanisms for multisectoral collaboration must also be strengthened to support the efforts of the health sector in all areas, including the private sector.

Within the context of promoting health across the life course, the priority will be to accelerate action to achieve Millennium Development Goals 4 and 5. This will mean developing and implementing national plans to reduce child and maternal mortality in the 10 countries with the highest burden and mobilizing resources to support implementation of such plans. These plans will need to scale up implementation of cost-effective interventions, prioritize the underserved geographical areas and address inequities in the response to maternal and child health needs, whether within the health system or in collaboration with other sectors. Increased attention also needs to be given to injury prevention, particularly among children and on the roads.

The momentum generated on behalf of the growing burden of noncommunicable diseases must be followed up through implementation of the *Regional framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases*, covering the areas of governance, prevention and reduction of risk

factors, surveillance, and health care. Partnerships and integration of noncommunicable diseases into primary health care must also be strengthened. Action to implement the WHO Framework Convention on Tobacco Control needs to stepped up, and much greater attention needs to be given to diet and physical activity. With regard to communicable diseases, the immediate focus will be on supporting achievement of the disease-related Millennium Development Goals. Disease surveillance systems must be integrated and investment in immunization programmes needs to be increased. The polio eradication programme must be a priority for all countries. The recent outbreak in Somalia and the detection of the poliovirus in environmental samples in countries that have been polio-free for many years leaves no room for complacency. Intensive and strengthened work will be required in Afghanistan and Pakistan to maintain the progress in 2012, and in polio-free countries to maintain high population immunity, certification standard AFP surveillance, and capability to detect any importation. Tuberculosis and malaria require continued emphasis to improve case detection, through developing public–private partnerships, improvement of laboratory capacity and strengthening surveillance. Access to antiretroviral therapy (ARV) and other HIV services, particularly for high-risk populations, as well as action to eliminate mother-to-child transmission of HIV, must be stepped up. Implementation of the International Health Regulations on time is also a priority and emphasis will continue to be placed on building the necessary national core capacities in surveillance, response, laboratory support and human resources.

The ongoing conflicts and chronic humanitarian emergencies prevailing in many countries in the Region and resulting in large numbers of displaced populations are major risk factors for long-term health and health system development. The strategic priorities in emergency preparedness and response are to develop clear policies and legislation based on an all hazard and 'whole health' approach, with special attention to safeguarding health facilities and the health workforce in times of emergency. Despite an increase in the funding of health activities in emergencies, only 38% of the Region's requirements were met in 2012. The health sector continues to be severely underfunded, emphasizing the need for a more coordinated approach by traditional and non-traditional partners to address the health needs of affected populations in the Region.

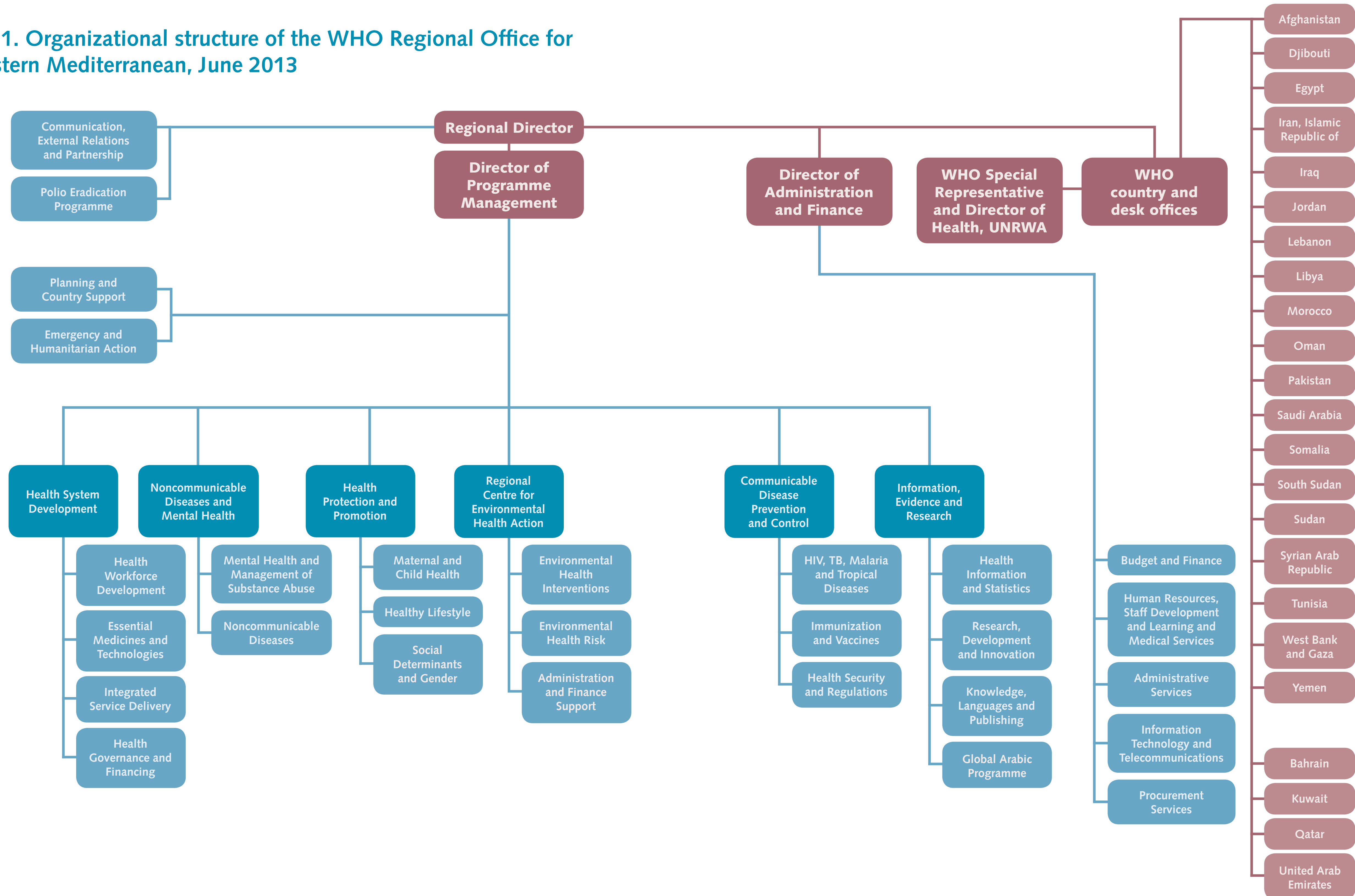
What is most striking is that none of this action can be viewed in isolation. The identification of strategic priorities should not imply that these can be addressed separately from each other. Thus, health system strengthening is as essential to the achievement of the Millennium Development Goals, and to sustaining these gains after 2015, as it is to the prevention and control of noncommunicable diseases. Emergency preparedness, disease surveillance and reporting, and an integrated multisectoral approach to tackling noncommunicable diseases are all complementary within the context the of national health development.

The WHO reform process will help WHO to strengthen its technical support to Member States, in quality and timeliness, both at regional and country level. In turn, this will support increased coordination and complementarity between the national programmes so that actions taken in one area of WHO's cooperation with countries enhance the outcomes of actions taken in another area. Management reforms will support the improvement of transparency and accountability,

so that Member States can be sure that their contributions to WHO are used cost-effectively, efficiently and appropriately. Health diplomacy will have an increasingly important role to play in shaping the global and regional health agenda, and I hope that Member States of the Region will continue to increase their participation in the work of the World Health Assembly and Executive Board.

The Regional Committee has endorsed a challenging but clearly defined agenda for WHO and the Member States in the next four years. Milestones against which to measure our progress have been established. WHO will continue to do its best to improve its collaboration with and support to countries. Likewise, I very much hope that Member States will do their part to follow through on the action plans to which they have committed. Together we have much to achieve.

Annex 1. Organizational structure of the WHO Regional Office for the Eastern Mediterranean, June 2013



Annex 2. Professional staff in the Eastern Mediterranean Region

a) By number and nationality as at 31 December 2012

Nationality	Regional/Intercountry	Country	Total
Egypt	18	5	23
United States of America	7	4	11
Pakistan	6	10	16
Iran, Islamic Republic of	5	–	5
Tunisia	5	4	9
United Kingdom	5	2	7
Canada	4	1	5
Syrian Arab Republic	4	1	5
Jordan	3	2	5
Somalia	3	–	3
Sudan	3	5	8
Bahrain	2	–	2
Bangladesh	2	1	3
Denmark	2	–	2
Italy	2	2	4
Lebanon	2	4	6
Morocco	2	1	3
Trinidad and Tobago	2	1	3
Yemen	2	2	4
Belgium	1	1	2
Djibouti	1	–	1
Germany	1	3	4
Finland	1	–	1
France	1	2	3
Iraq	1	2	3
Netherlands	1	2	3
New Zealand	1	–	1
Philippines	1	–	1
Republic of Moldova	1	–	1
Russian Federation	1	1	2
Saudi Arabia	1	1	2
Seychelles	1	–	1
Spain	1	–	1
South Sudan	1	–	1
Sweden	1	–	1
Switzerland	1	1	2
Afghanistan	–	3	3
Algeria	–	1	1
Azerbaijan	–	1	1
Eritrea	–	1	1
Ethiopia	–	2	2
Georgia	–	1	1
Japan	–	1	1
Kenya	–	2	2
Libya	–	1	1

Nationality	Regional/Intercountry	Country	Total
Nigeria	–	1	1
Norway	–	1	1
Romania	–	1	1
Uganda	–	2	2
Total	96	76	172

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

b) From Member States, by number and nationality as at 31 December 2012

Country	Global recruitment priority list[1]	Global range[2]	Total in WHO	Of which in the Eastern Mediterranean Region
Egypt	C	003-012	30	23
Pakistan	C	005-014	26	16
Iran, Islamic Republic of	C	004-012	16	5
Jordan	C	001-008	13	5
Lebanon	C	001-008	13	6
Sudan	C	001-010	13	8
Tunisia	C	001-008	11	9
Morocco	B1	001-010	7	3
Iraq	B1	002-009	5	3
Somalia	B2	001-008	5	3
Syrian Arab Republic	B1	001-008	5	5
Afghanistan	B1	001-008	4	3
Yemen	B1	001-008	4	4
Saudi Arabia	A	005-011	3	3
Bahrain	B1	001-007	2	2
Djibouti	B1	001-007	2	1
Libya	B1	001-008	1	1
South Sudan	A		1	1
Kuwait	A	001-008	–	–
Oman	A	001-008	–	–
Qatar	A	001-007	–	–
United Arab Emirates	A	002-008	–	–
Total of regional nationalities			161	101
Total of other nationalities			1993	71
Grand total			2154	172

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

[1]A Countries from which recruitment of professional posts is to be encouraged as a first ranking priority

B1 Countries from which recruitment of professional posts is to be encouraged as a second ranking priority

B2 Countries from which recruitment for professional posts is permissible

C Countries from which recruitment for professional posts is restricted

[2]Current range of recruitment permitted based on assessed contribution

Annex 3. Meetings held in the Eastern Mediterranean Region, 2012

Meeting title, location and date
Intercountry training workshop on surveillance of measles and other vaccine preventable diseases and monitoring evaluation on national immunization programmes, Sharm El Sheikh, Egypt, 13–18 January 2012
First coordination meeting on the regional comparative breast cancer research programme, Sharm El Sheikh, Egypt, 21–22 January 2012
Regional workshop on tobacco control and trade, Cairo, Egypt, 29–31 January 2012
WHO Flour Fortification Initiative joint harmonization workshop for wheat and maize flour fortification, Amman, Jordan, 20–22 February 2012
Meeting of technical working group on the elimination of mother-to-child transmission of HIV in the Region, Cairo, Egypt, 27–28 February 2012
High-level expert meeting on health priorities in the Eastern Mediterranean Region, Cairo, Egypt, 1–2 March 2012
Technical consultation on the Arabic regional package on the infant and young child feeding component of IMCI, Aswan, Egypt, 11–15 March 2012
Regional conference for the launch of the patient safety curriculum guide, Muscat, Oman, 11–12 March 2012
Consultation on evaluating policies and strategies for tuberculosis control in complex emergencies, Sharm El Sheikh, Egypt, 12–14 March 2012
Eleventh meeting of the regional programme review group (RPRG) on lymphatic filariasis elimination, Cairo, Egypt, 20–21 March 2012
Meeting of the Technical Advisory Group on Polio Eradication for Pakistan, Islamabad, Pakistan, 21–22 March 2012
Consultation on health information system platform, Cairo, Egypt, 26–27 March 2012
Intercountry meeting on strengthening surveillance and response capacities under the International Health Regulations, Beirut, Lebanon, 26–28 March 2012
Intercountry laboratory training workshop on measles and rubella virus detection, sequence and sequence analysis , Tunis, Tunisia, 2–7 April 2012
Twenty-sixth meeting the Regional Commission for Certification of Poliomyelitis Eradication, Dubai, United Arab Emirates, 3–5 April 2012
Consultation for analysing and reporting the results of TB drug resistance surveys, Cairo, Egypt, 23–26 April 2012
Programme managers' review meeting on cutaneous leishmaniasis control in the Region, Cairo, Egypt, 30 April–2 May 2012
Subregional meeting on tobacco control taxes, Cairo, Egypt, 1–3 May 2012
Meeting of the Technical Advisory Group on Poliomyelitis Eradication for Afghanistan, Kabul, Afghanistan, 6–7 May 2012
Seminar on global health diplomacy, Cairo, Egypt, 6–7 May 2012
High-level consultation on health system strengthening for members of the Iraqi parliamentary committee on health and environment, Cairo, Egypt, 9–10 May 2012
Regional consultation on suicide and attempted suicide, Cairo, Egypt, 14–16 May 2012
Consultation to develop tools for calculating the burden of influenza in the Region, Cairo, Egypt, 15–17 May 2012

Annex 3. Meetings held in the Eastern Mediterranean Region, 2012 *(continued)*

Meeting title, location and date
Second regional consultation on strengthening the coordination between national regulatory authorities and National Immunization Technical Advisory Groups, Sharm El Sheikh, Egypt, 5–6 June 2012
Intercountry workshop for MDR-TB community management, palliative care, stigma, ethical considerations and pharmacovigilance, Cairo, Egypt, 10–14 June 2012
Subregional workshop on environmental health in health care facilities with special focus on health care waste, Amman, Jordan, 12–14 June 2012
Consultation to develop guidelines and tools for surveillance of health care-associated infection, Cairo, Egypt, 18–19 June 2012
Good governance for medicines programme: intercountry training on transparency assessment, Amman, Jordan, 17–19 June 2012
Intercountry meeting to build capacity on the new system of health accounts 2011, Doha, Qatar, 17–29 June 2012
Consultation to develop guidelines for infection prevention and control in health care facilities for viral haemorrhagic fevers, Cairo, Egypt, 20–21 June 2012
Consultation on health systems strengthening in countries of the Eastern Mediterranean Region, Cairo, Egypt, 20–21 June 2012
Second intercountry training workshop on reproductive health counselling, Amman, Jordan, 24–28 June 2012
Regional consultation on the development of an updated global action plan for the prevention and control of noncommunicable diseases (2013–2020), Cairo, Egypt, 30 June–2 July 2012
Consultative meeting to provide regional input into the Global Action Plan for Mental Health, Cairo, Egypt, 2–4 July 2012
Subregional meeting on building legislation capacities as per the requirements of IHR - Group A, Marrakech, Morocco, 2–4 July 2012
Subregional meeting on building laboratory capacities as per the requirements of IHR - Group A, Marrakech, Morocco, 5–6 July 2012
Twenty-sixth meeting of the Regional Director with WHO Representatives and Regional Office Staff, Cairo, Egypt, 8–10 July 2012
Fifth meeting of the regional Scientific and Technical Advisory Committee of the WHO/EMRO/UNEP/GEF-supported project, Cairo, Egypt, 10–12 July 2012
Capacity building workshop on mapping health care financing and assessing social health protection, Cairo, Egypt, 16–18 July 2012
Consultation on health information systems and the global burden of disease, Amman, Jordan, 17–18 July 2012
Consultation to identify key issues in implementation of IDSR strategies in the Region, Cairo, Egypt, 23–25 July 2012
E-Health task force meeting, Cairo, Egypt, 6–8 August 2012
Intercountry meeting on regional tools for calculating the burden of influenza, Marrakech, Morocco, 27–29 August 2012
Training workshop on the transmission assessment survey, Cairo, Egypt, 28–30 August 2012
Consultation on determining the feasibility of introduction of seasonal influenza vaccines and developing a regional plan, Marrakech, Morocco, 30 August–1 September 2012
Intercountry workshop on the development of an accountability framework, Cairo, Egypt, 2–4 September 2012
Intercountry workshop on promoting urban health equity and response, Cairo, Egypt, 2–4 September 2012

Annex 3. Meetings held in the Eastern Mediterranean Region, 2012 *(continued)*

Meeting title, location and date
Subregional meeting on building legislation capacities as per requirements of IHR - Group B, Cairo, 9–11 September 2012
Subregional meeting on building laboratory capacities as per requirements of IHR - Group B, Cairo, 12–13 September 2012
Twenty-seventh intercountry meeting of national managers of the Expanded Programme on Immunization, Sharm El Sheikh, Egypt, 16–19 September 2012
Training workshop on management of severe malnutrition and nutrition surveillance, Pakistan, 17–22 September 2012
Regional consultation of focal points for risk communication, Hammamat, Tunisia, 18–20 September 2012
Consultation to promote infection prevention and control standards in the Region, Cairo, Egypt, 20 September 2012
Intercountry meeting on measles/rubella elimination, Sharm El Sheikh, Egypt, 22–25 September 2012
Intercountry meeting on implementation of FCTC guidelines on treating tobacco dependence, Cairo, Egypt, 23–25 September 2012
Subregional training on nutrition surveillance, Islamabad, Pakistan, 24–28 September 2012
Regional meeting on strengthening the national regulatory authority capacities for regulation of DTP and DTP combo vaccines, Sharm El Sheikh, Egypt, 24–29 September 2012
Subregional meeting on HIV among key populations at increased risk of sexual transmission of HIV, Cairo, Egypt, 25–27 September 2012
Regional consultation on insecticide resistance management, Casablanca, Morocco, 25–27 September 2012
Regional consultation on a comprehensive global monitoring framework and set of voluntary global targets for the prevention and control of noncommunicable diseases, Cairo, Egypt, 30 September 2012
Fifty-ninth Session of the WHO Regional Committee for the Eastern Mediterranean, Cairo, Egypt, 1–4 October 2012
Subregional training workshop on early recognition , detection and response to respiratory outbreaks for the rapid response team, Cairo, Egypt, 14–17 October 2012
Meeting on validating the process and results of the Pakistan tuberculosis disease prevalence survey, Cairo, Egypt, 16–18 October 2012
Meeting on outbreak alert and response network in the Eastern Mediterranean Region, Casablanca, Morocco, 21–23 October 2012
Programme managers' meeting on leprosy elimination, Cairo, Egypt, 4–6 November 2012
Regional consultation on the development of a Masters programme in mental health policy and services, Cairo, Egypt, 5–6 November 2012
Technical consultation to finalize the regional strategy on oral health promotion, Shiraz, Islamic Republic of Iran, 12–14 November 2012
Regional stakeholders' meeting to map out the needs for implementing the IHR core capacities, Rabat, Morocco, 12–15 November 2012
First regional meeting on strengthening pharmacovigilance of vaccines, Cairo, Egypt, 14–15 November 2012
Nineteenth meeting of the Eastern Mediterranean Regional Working Group on the Global Alliance for Vaccines and Immunization, Cairo, Egypt, 15–16 November 2012
Subregional training workshop on laboratory quality management, Cairo, Egypt, 19–22 November 2012

Annex 3. Meetings held in the Eastern Mediterranean Region, 2012 *(concluded)*

Meeting title, location and date
Expert consultation on environmental health strategy in the Mediterranean Region, Amman, Jordan, 25–26 November 2012
Meeting of the Technical Advisory Group on Poliomyelitis Eradication for Afghanistan, Kabul, Afghanistan, 26–28 November 2012
Global leadership course on tobacco control, Cairo, Egypt, 26–30 November 2012
Consultation on developing salt and fat reduction strategy in the Eastern Mediterranean Region, Cairo, Egypt, 28–29 November 2012
Training for Good Manufacturing Practices inspectors on GMP compliance of candidate manufacturers to the WHO prequalification programme for medicines, Salala, Oman, 2–6 December 2012
Fifteenth meeting of national tuberculosis programme managers, Cairo, Egypt, 9–12 December 2012
Training workshop on vaccine safety tools and methods, Cairo, Egypt, 11–12 December 2012
Regional workshop for training of trainers on the WHO Quality Rights Toolkit, Cairo, Egypt, 12–14 December 2012
Subregional workshop for estimating burden of disease associated with influenza, Sharm El Sheikh, Egypt, 12–13 December 2012
Intercountry meeting of the Eastern Mediterranean Acute Respiratory Infection Surveillance network, Sharm El Sheikh, Egypt, 12–13 December 2012
Capacity-building workshop: introduction to economic evaluation with special application to noncommunicable diseases, Cairo, Egypt, 16–18 December 2012
Arab report on disability: first stakeholders' meeting, Cairo, Egypt, 26 December 2012

Annex 4. New publications issued in 2012

Title	Originator
Publications	
Addressing gender issues in HIV programmes. Qualitative analysis of access to and experience of HIV services in Jordan and Yemen Language: English	Regional Office
MENAHRA-The Middle East and North Africa Harm Reduction Association. Best practices in strengthening civil society's role in delivering harm reduction services Language: English	Regional Office
Regional strategy on mental health and substance abuse Language: English	Regional Office
Health of displaced Iraqis in Egypt, Jordan, Lebanon and the Syrian Arab Republic 2011 (Summary) Language: English	Regional Office
Communicable diseases in the Eastern Mediterranean Region. Prevention and control 2010–2011 Language: English	Regional Office
Training manual for community based initiatives: a practical tool for trainers and trainees Language: Arabic	Regional Office
Good practices in delivery of primary health care in urban settings Community-Based Initiatives Series 15 Language: English	Regional Office
Effects of urbanization on incidence of noncommunicable diseases Community-Based Initiatives Series 16 Language: English	Regional Office
Towards age-friendly primary health care Language: Arabic	Headquarters
Demographic, social and health indicators in the Eastern Mediterranean Region 2012 Language: English	Regional Office
The work of WHO in the Eastern Mediterranean Region. Annual report of the Regional Director 2011 Languages: Arabic/English/French	Regional Office
Exposure to second-hand smoke in selected public places in the WHO Eastern Mediterranean Region. Report of a pilot study Language: English	Regional Office
Elimination of schistosomiasis in Morocco. A reality and a success of three decades of struggle Language: French	Regional Office
Framework for action on the sound management of public health pesticides in the Eastern Mediterranean Region 2012–2016 Languages: English/Arabic/French	Regional Office
Pharmaceutical situation assessment – Level 2 health facilities survey. Syrian Arab Republic Language: English	Regional Office
Training manual for the healthy city programme Language: Arabic	Regional Office

Annex 4. New publications issued in 2012 *(concluded)*

Title	Originator
Publications	
Towards the elimination of mother-to-child transmission of HIV Languages: English/Arabic/French	Regional Office
Shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO Languages: English/Arabic/French	Regional Office
Developing and improving national toll-free tobacco quit-line services Language: Arabic	Headquarters
Tobacco-free cities for smoke-free air: a case study in Mecca and Medina Language: Arabic	Headquarters
Smoke-free movies: From evidence to action Language: Arabic	Headquarters
Fact sheets	
Integration of tobacco cessation efforts into primary health care in the Eastern Mediterranean Region Language: English	Regional Office
Tobacco industry tactics and plans to undermine tobacco control efforts Language: English/Arabic/French	Regional Office
Clearing the air: measuring second-hand smoke in Bahrain Djibouti Egypt Islamic Republic of Iran Iraq Jordan Lebanon Oman Pakistan Sudan Yemen	Regional Office
Periodicals	
CBI Newsletter Vol. 7 Issue 1–Issue 2 Language: Arabic/English/French	Regional Office
Eastern Mediterranean Health Journal, Vol.18 No.1–No.12 Language: English/Arabic/French	Regional Office
IMEMR current contents Vol. 10 No.1–No.3 Language: English	Regional Office

Annex 5. WHO collaborating centres in the Eastern Mediterranean Region

as at July 2013

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

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

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

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

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

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

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