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## **Progress report on health issues facing populations affected by disasters and emergencies, including the International Health Regulations (2005)**

### **Introduction**

1. This report provides an update on WHO's work in relation to health emergencies from 1 June 2020 to 31 May 2021, pursuant to resolution EBSS3.R1 (2015) and decision WHA68(10) (2015). Data on outbreaks covers the calendar year of 2020.
2. The report also provides an update on progress in implementing the International Health Regulations (IHR) (2005) in the Eastern Mediterranean Region in the context of resolution EM/RC64/R.1 (2017), related to monitoring and evaluation of IHR implementation, and of resolution WHA61.2 (2008), related to annual reporting on the implementation of the Regulations by States Parties, pursuant to paragraph 1 of Article 54 of the IHR.
3. In addition, the report provides an update on the work of the IHR Regional Assessment Commission (IHR-RAC) and highlights key recommendations from the fifth meeting of the Commission for accelerating implementation of the Regulations and IHR capacities within the Region.

### **WHO's work in health emergencies**

4. The Eastern Mediterranean Region is confronted with multiple emergencies from all hazards – natural, biological, societal (including armed conflict) and technological – resulting in a high burden of morbidity and mortality. As of 31 May 2021, WHO was responding to 15 graded emergencies across the Region, including nine complex humanitarian emergencies, as well as the COVID-19 pandemic. We were also monitoring 42 public health events. WHO employs a comprehensive approach to managing health emergencies, working across all phases of the emergency management cycle: prevention, preparedness, detection, response and recovery.

### **Preparing for health emergencies**

5. Enhancing preparedness for all hazards is essential for an effective emergency response, and supporting national capacities to detect, prepare for and respond to emergencies has been the top priority for COVID-19 operations across the Region. Extensive support has been directed towards health systems development to ensure that pre-hospital services are systematically ready to manage COVID-19. Accordingly, WHO developed a technical guide and resource materials for hospital readiness and response regarding COVID-19 and an interim pre-hospital emergency medical services readiness checklist for COVID-19 to ensure minimal interruption to health services during the pandemic. Important progress in enhancing hospital preparedness was also achieved through transforming and adapting capacity-building packages into online tele-education models, such as the Hospital Emergency Preparedness and Response for Outbreak Emergencies (HEPROE) package.
6. The use of digital tools and dashboards has enhanced access to information, evidence-based decision-making and support for country preparedness. Public health emergency operations centres (PHEOC) play a crucial role in the response to public health emergencies, especially those of international concern, and must therefore have the capacity to perform core supporting functions. Great in-house efforts were dedicated towards the development of the PHEOC training package, which was piloted in Sudan and Libya and focuses on building PHEOC capacities in Member States of the Eastern Mediterranean Region and African Region. WHO has also developed and piloted the web-based public health emergency response management (PHERM) software, and successfully employed PHERM's "watch-mode" aspect to generate data on the impact of nationwide enforced measures on trends in COVID-19 cases and deaths. The signal module of this software was deployed in Jordan and Sudan.

7. Preparedness and event management at points of entry plays a pivotal role in containing and limiting public health threats. The Travel Measures Dashboard for regional points of entry captures select travel measures in real time and is entered and verified by countries to facilitate coordination and adherence to IHR (2005), Article 43. Cross-border collaboration within the Region, and with neighbouring regions, is also underway to maximize coordination in the response to COVID-19 and other public health threats. Joint surveillance and response efforts, including training on the use of WHO's mass gathering COVID-19 risk assessment tool and issuance of guidance for global Islamic observances and festivals (such as Ramadan and Eid Al Adha), offered invaluable support to Member States in their strategic preparedness.

8. To strengthen the delivery of emergency medical and health services during humanitarian crises, training drills and simulations continued as a significant tool to advance the readiness of emergency medical teams (EMTs) in 15 countries, including Lebanon and Palestine. Through the WHO EMT secretariat, three international EMTs were deployed to support the response to the port explosion in Beirut, Lebanon, in August 2020. These EMTs were later repurposed to support the response to COVID-19, while other EMTs were deployed to support the response in Djibouti, Palestine and Yemen.

9. Human health is intrinsically linked to the health of animals and the environment. Therefore, broadening the One Health approach to capitalize on current opportunities in the Region and providing countries with practical activities towards the optimal use of their resources is an important effort which aims to build national capacities. This was clearly outlined during the 6th World One Health Congress in 2020 and by the adoption of the One Health operational framework to guide countries on how to prevent and control zoonotic diseases using the One Health approach. At the organizational level, a tripartite collaboration between the WHO, Food and Agriculture Organization of the United Nations (FAO) and World Organisation for Animal Health (OIE) resulted in the development of several important tools, including the Surveillance Information Sharing tool (SIS OT) and the Joint Risk Assessment tool which was piloted in Egypt at the human–animal–environment interface.

10. The need for advanced risk communication and community engagement (RCCE) efforts to address community perceptions, behavioural patterns, rumours and misinformation has been highly evident during the COVID-19 pandemic. At the start of the outbreak, when countries of the Region were gearing up to address the newly emerging disease, materials were quickly developed by the WHO Regional Office in Arabic, English and French to help countries quickly raise awareness about how to decrease the risk of infection among different target populations. Posters were designed and distributed targeting health care workers, travellers and school children, and were widely displayed inside hospitals, points of entry and school buildings. An animated video on home care for COVID-19 patients was also produced to help explain WHO technical guidance in this area to a lay audience. Furthermore, myth-busters addressing rumours and misinformation about the disease and how it spreads were regularly prepared and posted as social media messages and expert video recordings to keep pace with the infodemic that was emerging online alongside the pandemic. And through collaboration with initiatives at WHO headquarters, WHO health alert chatbots on WhatsApp, Viber and Facebook Messenger were translated into the Region's local languages to help respond to people's questions on their social media platforms of choice. Daily messages were prepared and sent to ministers of health through WhatsApp by the Regional Director to keep them informed of the latest technical guidance, initiatives, news and scientific research coming out of WHO with regards to pandemic preparedness and response.

11. The regional RCCE Interagency Working Group (IAWG) was established in 2020 and has expanded to include over 16 United Nations agencies, international nongovernmental organizations and academic institutions to provide technical guidance, collective resources and implementation of joint initiatives. An important outcome of the collaboration within the IAWG was the publication in December 2020 of the regional guiding framework for risk communication and community engagement for the COVID-19 response in the Eastern Mediterranean Region/Middle East and North Africa by WHO, UNICEF and the International Federation of Red Cross and Red Crescent Societies (IFRC). This framework was designed to support RCCE staff and frontline responders to develop, implement and monitor an effective action plan for communicating with the public, engage with communities, and help prepare and protect individuals, families and the public's health during the early response to COVID-19.

12. The IAWG has provided invaluable support to countries through country support missions, supporting the implementation of national RCCE plans, conducting capacity-building activities, supporting national teams with media engagement, videos and messaging for both adults and children, and managing coordination with stakeholders. This RCCE collaboration augmented the use of timely data-driven planning and communication across the Region. A regional knowledge, attitude and practice (KAP) survey, undertaken in 23 countries/territories in partnership with UNICEF, helped guide and inform the response to COVID-19. It has provided valuable information on how to assess and address community fatigue and complacency, particularly as countries geared up towards the COVID-19 vaccine roll-out. A national KAP survey package to help bolster national capacities and support countries in standardizing national data collection and analysis is currently under development. The collected social and behavioural data will be consolidated under a regional dashboard and utilized across the Region to inform decision-making relevant to the COVID-19 response.

### **Detecting public health events**

13. WHO has continued to provide technical support to Member States to strengthen epidemiological surveillance and information management related to COVID-19. The surveillance pillar developed tools to collect, manage and analyse regional COVID-19 data and communicate the results of the analysis, while also providing support to countries for the strengthening of their information management capacities and guiding their response.

14. More than 8000 signals related to COVID-19 were captured between 1 June 2020 and 31 May 2021. Several valuable tools have been developed and adopted to assist with signal detection, including Epidemic Intelligence from Open Sources (EIOS), the media scanning tool developed by WHO, and Sprinklr and Epitwitter, tools that capture information on social media in general and on Twitter in particular, respectively. EIOS was deployed in Afghanistan, Lebanon, Sudan, Syrian Arab Republic and Tunisia to improve detection capacity.

15. Several electronic data management and visualization platforms were developed or improved to report on the COVID-19 situation in countries of the Region, including a regional COVID-19 dashboard, Rt dashboard, public health and social measures dashboard and country-specific platforms, or to support regional activities, such as vaccination and monitoring and evaluation. An online signal module developed by the Regional Office was used to manage the signals. It was complemented by a well-structured and secure regional data system, using the DHIS2 platform to manage regional data and data analysis tools to automatically produce graphs, tables, maps and communication material.

16. Existing indicators to monitor the weekly evolution of the pandemic were improved and new ones were built. The COVID-19 monitoring and evaluation framework to monitor response activities at country level was updated to align with the Strategic Preparedness and Response Plan 2021 (SPRP 2021), and a user-friendly data collection tool and training toolkit were developed. Training was delivered to eight countries, and Pakistan was supported to develop a national monitoring and evaluation framework.

17. Daily, weekly and monthly products to communicate the epidemiological situation were designed and improved. This included over 700 daily updates, more than 350 daily, 25 weekly and 6 monthly WhatsApp posts, and 10 epidemiological updates included in biweekly situation reports. WHO also produced and updated thematic maps that visualized various COVID-19 data analyses, including on the evolution of numbers of cases and deaths at national and subnational levels, and on the distribution of SARS-CoV-2 variants.

18. The EMFLU regional platform for sharing epidemiological and virological data on influenza has been updated to collect and manage weekly aggregate forms in addition to case report forms. As of 30 May 2021, the EMFLU database had stored a total of 2.76 million COVID-19 reports from 16 countries. More than 200 presentations of the epidemiological situation, including 64 to partners, were made.

19. WHO improved its modelling capacities and undertook 24 rounds of modelling analysis for COVID-19 to forecast numbers of cases, deaths and hospitalizations, and guide decisions on the application of public health and social measures, in Afghanistan, Egypt, Jordan, Lebanon, Pakistan, Palestine, Syrian Arab Republic, Tunisia and Yemen.

20. Epidemiologists were deployed for surveillance support to Afghanistan, Libya, Morocco, Pakistan and Sudan. Assessments of event-based surveillance were conducted in Afghanistan, Libya and Sudan and were

followed by the development of event-based surveillance national guidelines in Afghanistan. WHO's surveillance pillar contributed to field missions in Afghanistan, Jordan, Lebanon, Libya, Pakistan, Sudan, Syrian Arab Republic and Tunisia.

21. Regional contact tracing strategies were initiated, and contact tracing activities supported, in Afghanistan, Jordan, Lebanon and Tunisia. Training on Go Data, the electronic contact tracing tool, was conducted in Egypt, Libya, and Syrian Arab Republic.

22. Innovative technologies were identified to improve the detection of public health events. Through the EIOS platform, WHO started using tools to capture information on social media. Between 1 June 2020 and 31 May 2021, almost 2000 pieces of information were captured through media scanning, including 200 from social media; a total of 69 signals were captured, and 20 new events were monitored; 10 rapid risk assessments and public health situation analyses were conducted for HIV in Pakistan, malaria in Djibouti and Pakistan, the port explosion in Lebanon, floods and intercommunity violence in Sudan, escalation of violence in the occupied Palestinian territory, and complex emergencies in Afghanistan; and six updates were posted on the IHR Event Information Site, five Disease Outbreak News newsletters were published on the Regional Office website, and 253 daily bulletins of signals and events and 50 weekly summary of events were disseminated.

23. The development of a regional integrated disease surveillance strategy was initiated after a mapping of regional surveillance activities and a literature review were undertaken.

24. The health cluster response monitoring framework was developed, and data for 2019 and 2020 collected.

25. The Health Resources and Services Availability Mapping System (HeRAMS) was rolled out in Pakistan (Baluchistan) and Somalia. A video for the advocacy of HeRAMS in Yemen was developed.

26. WHO conducted several training sessions on various information management-related topics, including a three-day course on the "R" software for 21 participants in Beirut, Lebanon.

### **Managing epidemics and pandemics**

27. The Eastern Mediterranean Region continues to confront serious public health threats from emerging and re-emerging infectious disease outbreaks and other public health emergencies. The complex humanitarian emergencies and protracted conflicts in several countries in the Region further damage already fragile health systems, making the control and prevention of emerging infectious diseases extremely challenging. The WHO Regional Office provides Member States with strategic, operational and technical support to detect, investigate and respond to emerging and high-threat pathogens, and to prevent their international spread. Although national core capacities for preparedness continue to progress, many countries in the Region remain vulnerable to emerging infectious disease threats.

28. In 2020, seven out of 22 countries/territories in the Region experienced 14 major outbreaks due to 10 diseases (excluding COVID-19) with the potential for international spread. The outbreaks that were detected, investigated and rapidly responded to include poliomyelitis in Afghanistan and Pakistan, chikungunya in Somalia and Sudan, cholera in Somalia and Yemen, dengue fever in Pakistan and Yemen, diphtheria in Sudan and Yemen, Crimean-Congo haemorrhagic fever in Afghanistan, chickenpox (varicella) and extensively drug-resistant typhoid fever in Pakistan, Middle East respiratory syndrome (MERS) in Saudi Arabia and United Arab Emirates, and viral haemorrhagic fever in Sudan. In total, there were 241 190 cases and 302 deaths from these outbreaks in seven countries. The likelihood of the emergence and rapid transmission of highly pathogenic avian influenza or other novel influenza virus among humans has increased in recent years in the Region, as some countries have reported avian influenza outbreaks in poultry or wild birds.

29. WHO has continued to produce and make available to Member States strategies, technical guidelines, epidemiological reports and other information products on the emerging infectious diseases affecting the Region. In October 2020, the Regional Committee endorsed the regional strategic framework for the prevention and control of emerging and epidemic-prone diseases (in resolution EM/RC67/R.1), and several countries have already begun implementation of its recommendations. Other technical documents developed include the updated regional cholera strategic framework, a regional report highlighting outbreaks in the past 10 years, a manual for

estimating the burden of acute communicable diseases and syndromes in settlements of displaced populations, risk communication materials for emerging infectious diseases, an updated Early Warning Alert and Response Network (EWARN) evaluation protocol with benchmarks, EWARN transition and exit strategy guidance and a training package for EWARN field implementation. Training packages for EWARN implementation, rapid response team operations and ICU/critical care for severe acute respiratory infections were developed and shared with countries in the Region. Other information reports produced and disseminated include 52 weekly epidemiological monitoring bulletins, weekly and monthly regional and country-specific cholera, influenza, MERS-CoV and COVID-19 reports, and the 2019 annual regional outbreaks report. All technical materials were regularly posted on the Regional Office website or disseminated through other networks.

30. Enhancing early warning alert and response surveillance for countries experiencing complex emergencies or with underperforming infectious disease surveillance systems remains a key priority for the Region. WHO provided technical support to strengthen, upgrade and expand EWARN surveillance systems in Libya and Yemen, which aided these countries to timely detect disease outbreaks, understand the risk of transmission of epidemic threats, and track the trend of morbidity and mortality among displaced and crisis-affected populations. Technical missions were deployed to Libya to assess the effectiveness and usefulness of EWARN to detect, confirm and respond to priority diseases. The annual subregional EWARN workshop focused on transitioning EWARN systems in emergency situations to routine or national surveillance systems, with the participation of ministry of health and WHO country office representatives from Afghanistan, Iraq, Libya, Somalia, Sudan, Syrian Arab Republic and Yemen, all of whom also contributed to the development of a transition roadmap.

31. The establishment and improvement of rapid response team capacity in countries to respond to outbreaks and other public health risks quickly and effectively is one of the requirements of the IHR core capacities. WHO supported efforts to enhance and expand capacities for outbreak investigation, verification and response to public health threats through the training and operationalization of national and subnational rapid response teams in six countries of the Region. All the trained national and subnational rapid response teams have actively supported and contributed to investigation and response activities for COVID-19, cholera, measles and other disease-specific outbreaks detected across the Region. National rapid response teams from the Region took part in a global virtual training series, focusing on COVID-19 contact tracing, risk communication and community engagement and data management, with 500 participants from 20 countries participating. WHO has developed assessment techniques using key performance indicators to measure the performance and operations of rapid response teams in order to track progress and identify gaps.

32. Successful technical surge deployments were made of an integrated vector management specialist to Sudan to support the prevention and control of vector-borne diseases; of three epidemiologists to Yemen on an emergency basis to strengthen EWARN surveillance and assist with the COVID-19 response; of an epidemiologist to Syrian Arab Republic to support epidemiological and laboratory surveillance of COVID-19; and of a laboratory expert from the Chinese Center for Disease Control and Prevention (China CDC) to the WHO Regional Office to support COVID-19 laboratory activities identified through the Global Outbreak Alert and Response Network (GOARN). Through GOARN, experts were also deployed as part of country support missions for the COVID-19 response in Afghanistan, Iran (Islamic Republic of), Iraq, Lebanon and Sudan, as well as to the Regional Office.

33. Through the mechanism of the Pandemic Influenza Preparedness (PIP) Framework Partnership Contribution, WHO directly supported countries in the Region in improving and sustaining existing surveillance and response capacities for influenza and other respiratory infections; sustaining and enhancing laboratory capacities of national influenza centres and influenza laboratories; determining the seasonality and risk factors of seasonal influenza and better understanding influenza epidemiology and disease burden for influenza-associated illness; and advocating for seasonal influenza vaccine policies that will promote the introduction and increased use of influenza vaccines in high-risk groups within the Region. The percentage of countries reporting influenza data to EMFLU and FluNet increased from 83% in 2017 to 94% in 2019, but this dropped to 58% in 2020 due to the COVID-19 pandemic. The number of countries sharing influenza viruses/clinical specimens with WHO collaborating centres also declined during the pandemic, as only 11 countries shared influenza viruses/clinical specimens in 2020 for influenza vaccine strain selection. However, despite the challenges, many countries in the Region have gradually reactivated their influenza sentinel surveillance activities and increased the number of specimens collected and tested for influenza and SARS-

CoV-2. Accordingly, epidemiological and virological influenza data reporting has been gradually increasing across the Region during 2021.

34. Through its expertise in laboratory diagnostics of high-threat pathogens, WHO supported countries to enhance their capacities in detecting and identifying seasonal, zoonotic and pandemic influenza viruses as well as other emerging respiratory pathogens, and to improve their diagnostic capacities for vector-borne, waterborne and diarrhoeal diseases. WHO also supported the deployment of laboratory specialists to improve or establish in-country or international laboratory referral pathways for high-threat pathogens in low-income countries. Shipment of samples from country-based laboratories to international or regional reference laboratories was facilitated by WHO through a robust sample transportation system.

35. WHO supported and advocated for countries in the Region to utilize and leverage their existing molecular testing and sequencing capacities for seasonal influenza and MERS-CoV for use for SARS-CoV-2, in order to save time and resources. At the same time, the molecular testing capacity across the Region has been strengthened and expanded from 19 national influenza centres and other national influenza laboratories with reverse transcription-polymerase chain reaction (RT-PCR) capacity to more than 600 public health laboratories at the subnational level, in addition to private and university laboratories. As new variants of SARS-CoV-2 emerge, it becomes important to establish and enhance genome sequencing surveillance capability in the Region to detect, identify and monitor circulating SARS-CoV-2 variants. As of 30 May 2021, 14 out of 22 countries/territories in the Region had developed genome sequencing capacity to detect and monitor new variants, while WHO has facilitated the shipment of samples from those without genome sequencing capacity to two regional reference laboratories in Oman and United Arab Emirates and other international reference laboratories. WHO has continued to advocate for the utilization of existing sequencing capacity in the private sector and academic institutions to complement government efforts to expand sequencing capacity. WHO has continued to provide support to countries in reactivating and sustaining influenza and MERS-CoV surveillance, as well as conducting a serological investigation on MERS-CoV transmission within high-risk populations in two countries.

36. WHO supported and facilitated the annual WHO External Quality Assurance Project (EQAP) assessment for detecting influenza and SARS-CoV-2 viruses by RT-PCR, with the aim of improving laboratory detection capacity and performance in the Region. The results of the assessment provide an opportunity to assess laboratory performance against international quality standards and will assist WHO to identify capacity gaps in Member States and the technical support and resources required to address these gaps. In 2020, all 27 national and 249 subnational laboratories in the Region participated in the EQAP assessment for detection of SARS-CoV-2 using routine molecular testing, and 95% of them achieved an overall score above 90%. WHO and partners conducted laboratory technical training to address capacity gaps and enhance knowledge and skills among laboratory technical staff on the detection and diagnosis of emerging infectious diseases, with over 200 laboratory personnel from 22 countries/territories trained in 2020.

37. WHO continued to support countries in the Region to strengthen clinical management capacity for diseases caused by high-threat pathogens, including COVID-19, MERS, influenza and haemorrhagic fever, among others. Surge support to meet the urgent demand for strengthening case management of COVID-19 was provided to countries in the Region through short training courses and a knowledge-sharing network to build sufficient capacity in COVID-19 case management among health care workers. Demand-led training, including an introductory critical care/ICU management training course (lasting between a few days and two months) and an online session, were conducted by WHO technical staff both in-person and virtually for Afghanistan, Iraq, Jordan, Lebanon, Pakistan, Palestine, Somalia and Yemen. In response to surge demand for the use of medical oxygen and oxygen delivery devices for COVID-19 patients, WHO also developed a training course on their safe use. A regional webinar session was conducted twice with the participation of many health care workers and health authorities from across the Region. WHO also developed a fire and oxygen risk assessment tool to be adopted by health facilities in resource limited settings, and conducted training sessions for Iraq after a series of oxygen-related fire incidents. In addition to these training sessions, technical missions were conducted by Regional Office staff to assess and monitor clinical management practices, and to support countries to develop and adapt ICU standard operating procedures to local contexts. Support was also provided for timely procurement to address identified shortages, including of biomedical/ICU equipment, supplies and training tools. As of 31 May, over 20 000 health care workers had been trained on case management of COVID-19 patients in 10 countries/territories in the Region.

38. WHO supported 16 countries in the Region to optimize the procurement of medical oxygen, treatment drugs, biomedical supplies and equipment to fill gaps in local health care settings in collaboration with the United Nations COVID-19 supply chain system. The Regional Office held regional webinars on a biomedical forecasting tool and the use of oxygen and biomedical equipment, and the mapping of regional oxygen capacity is underway to support proactive and sustainable oxygen supply in resource-limited settings.

39. WHO supported 10 countries (Bahrain, Egypt, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan and Saudi Arabia) in the Region to join the global Solidarity trial for therapeutics and other clinical research to help find an effective treatment for COVID-19, while several countries contributed to the WHO Global Clinical Platform for COVID-19 to share patient data (Jordan has been the main contributor). Other ongoing regional clinical research projects include a medication error study in the context of COVID-19 and a regional ICU human resources capacity assessment study.

40. WHO continued to assist countries in the Region to enhance their emergency risk communication capacities for the prevention and control of emerging infectious disease outbreaks. A workshop was held to complete the first three steps (training, capacity-mapping and planning development) of a five-step emergency risk communication package in Egypt, with over 30 participants, including biohazards experts and staff from different sections of the ministries of health and agriculture and the Food and Agriculture Organization of the United Nations (FAO). A key outcome of the workshop was the drafting of two risk communication plans on influenza preparedness and all-hazards preparedness, which will be finalized by the Ministry of Health and Population.

41. Managing infectious disease threats in the Eastern Mediterranean Region, particularly those which are epidemic or pandemic-prone, remains difficult. Challenges facing countries include: weak preparedness and response capacities, especially in those countries with ongoing complex humanitarian emergencies; limited investment in strengthening and sustaining national and subnational capacities for emerging disease outbreak prevention, preparedness, detection and response; inadequate and untimely information-sharing by countries with WHO regarding disease outbreaks; poor laboratory diagnostic capacities to detect and confirm high-threat pathogens in some countries of the Region; inadequate resources to support the implementation of priority activities for prevention, preparedness, detection and timely response; and recurring shortages in diagnostic kits and other laboratory supplies.

### **Responding to health emergencies**

42. The Eastern Mediterranean Region is home to 101 million people requiring humanitarian assistance (43% of the global total) and is the source of 64% of the world's refugees. Protracted emergencies, compounded by the risk of attacks on health care, present a convergence of humanitarian and health security concerns. Political uncertainties and varying levels of economic development across the Region hinder timely and proper management of public health emergencies.

43. In 2020, the WHO Regional Office initiated its response to the COVID-19 pandemic, while balancing concurrent emergencies from multiple hazards – societal, natural and technological. Nine of the 22 countries/territories in the Region experienced large-scale humanitarian emergencies during the year.

44. In Yemen, WHO continued to support health service delivery in 72 hospitals. Over 40 000 children were treated for severe acute malnutrition, with a 91% cure rate, while the case fatality ratio was maintained at well below 1%, consistent with international standards.

45. In Yemen and Somalia, WHO continued to support the provision of primary and secondary health care services, with prioritization of vulnerable populations. WHO, in collaboration with partners, conducted oral cholera vaccination campaigns in high-risk districts in both countries, administering 3.8 million doses. In Yemen, more than 1 million children were protected from vaccine-preventable diseases; severe acute malnutrition was prevented in more than 100 000 children aged under five years; and around 24 500 children were treated for diseases such as diarrhoea, malaria and pneumonia. WHO and Health Cluster partners provided financial incentives to almost 25 000 frontline staff in Yemen.

46. In Somalia, a three-level WHO mission sought to agree on the most effective approach to simultaneously advance health systems strengthening, promote health security and ensure a comprehensive response to humanitarian needs. The most significant outcome of the mission to date has been an updated essential services package.

47. In Syrian Arab Republic, WHO maintained its response to meet the health needs of populations affected by conflict, filled critical gaps in primary and secondary health care, provided essential medicines and supplies, and strengthened cross-border medical supply chains. WHO continues to apply an all-modalities “whole of Syria” response approach. The United Nations Security Council decision to discontinue the cross-border operation to north-east Syrian Arab Republic required WHO and partners to find solutions to constraints to cross-line operations. In response, WHO deployed staff to north-east Syrian Arab Republic to engage in dialogue and coordination with partners. In 2020, WHO arranged six road convoys and 13 airlifts, covering 45% of the estimated needs. A robust cross-border operation was maintained from Gaziantep in southern Turkey into north-west Syrian Arab Republic, despite the closure of the Bab Al Salam border crossing. In non-government-held areas of Syrian Arab Republic, service delivery was supported largely through nongovernmental organization partners. Across the whole country, a consultation rate of 1.15 consultations per person per year was achieved (consistent with international standards), in addition to the provision of 270 221 trauma consultations and 241 423 mental health and psychosocial support services.

48. In Sudan, a Grade 2 emergency was assigned during the devastating floods in September 2020. An incident management system was established and activated to coordinate the operational response. Technical expertise was provided to health authorities in-country and resources were mobilized through the Contingency Fund for Emergencies (CFE) to mount a rapid response.

49. In response to the massive explosion at Beirut port, Lebanon, in August 2020, trauma care supplies were distributed from WHO’s logistics hub in Dubai, United Arab Emirates, within 26 hours. At a later stage, the COVID-19 response was integrated into the ongoing blast response, with WHO playing a coordinating role. WHO procured personal protective equipment and surgical and trauma kits for hospitals affected by the blast, supported the national mental health programme in the development of awareness materials, relocated damaged warehouses to new premises, and assessed the damage in hospitals.

50. In Afghanistan, the recently initiated withdrawal of the foreign military presence has increased the risk of violence and internal displacement, with regional implications, including spill-over into neighbouring countries such as Pakistan, Islamic Republic of Iran, Tajikistan, Turkmenistan and Uzbekistan. It has also hindered the capacity of agencies to deliver humanitarian assistance due to the limited spaces for operation. Lack of medicines and supplies have impacted the COVID-19 response in Afghanistan. By May 2021, the number of trauma cases had increased by 58% compared to 2020. WHO has activated its incident management system and is working with partners to build capacity in mass casualty management and trauma care, with the aim of cascading knowledge to hard-to-reach areas.

51. In Palestine, aerial bombardment of the Gaza Strip during the escalation of tensions with Israel in the West Bank, including East Jerusalem, resulted in a substantial number of fatalities and injuries. During 7–19 May, there were 227 fatalities and 1620 injuries reported in the Gaza Strip; 27 fatalities and 6772 casualties in the West Bank, including East Jerusalem; and 91 attacks against health care facilities in both the Gaza Strip and the West Bank, including East Jerusalem. In the Gaza Strip, 19 health care facilities were damaged, including the Hala Al-Shawa primary health care clinic. The Palestinian Ministry of Health activated the Joint Emergency Operations Room for the West Bank and Gaza Strip, with technical support and representation from WHO. Additionally, WHO locally procured essential medicines and disposable items worth US\$ 160 000 to support trauma care and ambulance services in the Gaza Strip. WHO also procured and delivered US\$ 200 000 worth of essential medicines and disposables to the Palestine Red Crescent Society and Makassed hospitals in East Jerusalem to provide care for about 1000 injured persons.

52. Despite advocacy efforts by the WHO and partners, attacks on health care facilities are still being reported in some countries/territories of the Region. In 2020, 228 instances of attacks on health care were recorded in six countries/territories (Afghanistan, Libya, Palestine, Somalia, Syrian Arab Republic and Yemen). These incidents resulted in a combined 89 fatalities and 197 injuries of health care workers and



patients. According to the WHO's Surveillance System for Attacks on Health Care, in 2020, Afghanistan accounted for the highest number of attacks on health care among the 14 countries reporting to the system globally, with 63 reported incidents that resulted in 36 fatalities and 61 injuries of health care workers and patients as of 5 December 2020.

## **Progress of States Parties in implementing the IHR (2005), including report of the Regional Assessment Commission**

### **IHR monitoring and evaluation framework**

53. The IHR monitoring and evaluation framework continues to be widely accepted and used by countries in the Eastern Mediterranean Region. In 2020, 20 countries/territories completed the State Party Annual Reporting (SPAR) on the achievement of IHR-related core capacities, in accordance with Article 54 of the IHR (2005).

54. As reported in the 2019 IHR report, a joint external evaluation (JEE) has been conducted in 18 countries of the Region. The WHO Regional Office supported the conduct of the self-assessment phase of the JEE for Syrian Arab Republic in 2019; however, the external evaluation phase, which was scheduled to take place in April 2020, was postponed due to the COVID-19 pandemic and will instead take place in 2021. There has not yet been an update concerning the external evaluation phase in the Islamic Republic of Iran. An external evaluation of the IHR was conducted in Palestine in 2016 and resulted in a five-year plan of action to strengthen the implementation of IHR capacities. Although the tool was derived from the 2010 IHR annual report and not expanded to cover the JEE technical areas, it was decided to build on this exercise. A JEE may take place once the IHR plan has been fully implemented. Discussions are ongoing with Yemen on planning for a JEE to take place this year.

55. The majority of countries in the Region have conducted table-top and simulation exercises to test their operational readiness for roll-out of COVID-19 vaccine. A WHO package for conducting the exercises was developed and shared with countries. Virtual training was conducted to facilitate operationalization of the package.

56. The WHO Regional Office has been promoting intra-action reviews (IARs), which are modelled on the WHO after-action review, and providing countries with guidance on these. So far, 11 countries, including Afghanistan, Bahrain, Egypt, Jordan, Iran (Islamic Republic of), Iraq, Kuwait, Lebanon, Pakistan, Syrian Arab Republic and Tunisia, have conducted IARs to review their response to COVID-19, with a focus on all strategic pillars, including maintenance of essential services and vaccination. Additional countries (Qatar, Saudi Arabia, Somalia and Sudan) have requested support from WHO to carry out IARs, scheduled to take place between September and December 2021. Islamic Republic of Iran has also requested a second IAR, scheduled to take place in September 2021. Conducting IARs is highly recommended to ensure continued focus on the best approaches to controlling outbreaks.

### **IHR core capacities**

57. Analysis of the 2020 SPAR data indicates that the average overall IHR core capacity score for the Region in 2020 was 66%, ranking slightly higher than the regional average of 63% reported in 2019 and the global average of 65%. The highest average implementation scores were for capacities related to surveillance, laboratory, and zoonotic events and the human–animal interface, at 73% each, followed by IHR coordination (70%). Less well-performing areas included capacities related to managing chemical events (56%), followed by points of entry (58%), food safety (60%) and risk communication and managing radiation emergencies (61%). Scores for the 13 IHR capacities in each country are presented in the Annex.

58. A summary of findings from the 11 IARs revealed that despite the multiple crises, countries in the Region were able to sustain an effective response to the COVID-19 pandemic: ministry of health and government officials provided strong leadership in the response and many initiated a whole-of-government approach; countries invested in a COVID-19 national task forces to coordinate the response; all countries took early decisions, such as the suspension of flights, closure of schools and public settings and several other social measures, which may have contributed to lower transmission rates at the beginning of the pandemic; countries expanded their laboratory, testing and sampling capacities; critical care capacities increased significantly, although falling well short of needs in many low-income and low-middle-income countries; routine vaccine

supply and service provision were not largely disrupted; and ministries of health and partners led awareness campaigns to strengthen public confidence in ministry of health leadership by controlling misinformation and the “infodemic” and empowering the public with accurate information on preventive public health and social measures. However, inadequate infection prevention and control measures were observed in many countries, including a lack of national programmes, and (aside from routine immunization) health service utilization was significantly compromised due to restrictions in movement, fear of COVID-19 and other factors. Findings from the second round of WHO’s national pulse survey on continuity of essential health services during the COVID-19 pandemic have shown that one year into the pandemic, health systems around the world are still being challenged. Nearly every responding country (21 from the Eastern Mediterranean Region) reported disruptions to one or more essential health service, and disruptions were reported across all service delivery platforms and health areas. The disruption of these essential services will have consequences for health and development for many years to come.<sup>1</sup>

59. While the overall response to COVID-19 has demonstrated many positive elements, the effectiveness of the response has varied across countries and many challenges were identified. Among these were fragmented surveillance systems, deficiencies in information-sharing by Member States, gaps in infection prevention and control, poor adherence to public health and social measures, the persistence of rumours and misinformation, and deficiencies in community engagement and behaviour change capacities. In short, the observation of Independent Panel for Pandemic Preparedness and Response that collectively, the world was not prepared for a pandemic is highly accurate. The IARs concluded with set of recommendations to address these challenges. Ministries of health, with the support of the WHO and other partners, need to urgently invest in the political, financial, technical and operational resources to implement the recommended actions.

### **National action plans for health security**

60. Following JEE missions, national action plans for health security have now been completed in 19 countries/territories (including Palestine). These plans will need to be reviewed in the context of the COVID-19 response, taking into consideration lessons learned from the response to the pandemic and recent review committees. Evaluation of progress in implementing these plans is currently ongoing to understand the level of implementation and the successes and challenges. Once complete, the national action plans for health security will be updated accordingly. A regional working group involving experts from the Region in the areas of IHR and health system development will be established to guide the process of updating national action plans for health security as an integral part of health system strengthening. A regional guide on updating the plans will be produced from this process to aid countries in future reviews.

### **Procedures under the Regulations**

#### *Public health emergency of international concern*

61. A declaration of a public health emergency of international concern (PHEIC) was issued concerning the COVID-19 outbreak on 30 January 2020 by the WHO Director-General. The temporary recommendations subsequently issued by the Director-General under the framework of the IHR (2005) were accepted and finalized upon the advice of the Emergency Committee convened due to the outbreak. The Emergency Committee has met collectively eight times since the initial declaration and each time has agreed unanimously that the outbreak continues to constitute a PHEIC, revising the temporary recommendations accordingly each session to reflect evolving needs. Implementation of these recommendations for States Parties is ongoing, with progress observed in several areas such as surveillance, laboratory diagnostics, maintenance of essential health services and risk communication. Other recommendations that have not been fully implemented in some State Parties include those related to the timely and comprehensively sharing of information and data with WHO on COVID-19 epidemiology, surveillance for variants of concern, infection control, case management and critical care, appropriate social restriction measures, travel measures and advice based on risk assessments, strengthening community engagement, participation in the COVAX facility and equity in accessing the COVID-19 vaccine.

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<sup>1</sup> Second round of national pulse survey on continuity of essential health services during the COVID-19 pandemic: January–March 2021. Interim report, April 2021. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS-continuity-survey-2021.1>, accessed 10 June 2021).

62. Members of the Emergency Committee were selected from the IHR roster of experts. The Eastern Mediterranean Region has been represented by regional experts selected from this roster. Additional experts have also been selected from the Region in the capacity of advisers to the Emergency Committee.

63. As mandated by resolution WHA73.1 (2020) on the COVID-19 response, the IHR Review Committee has convened between September 2020 and May 2021 to review IHR functionality during the COVID-19 response with reference to IHR provisions related, but not limited, to: outbreak alert, verification and risk assessment, information-sharing and communication; international coordination and collaboration for response; convening the Emergency Committee, its working modalities, and declaration of a public health emergency of international concern, including an intermediate level of alert; additional health measures in relation to international travel; IHR core capacities implementation and reporting; examining progress made on the implementation of recommendations from previous IHR Review Committees; and any other relevant provisions that pertain to the rights and obligations of States Parties and WHO responsibilities during the outbreak response.

64. The Review Committee conducted this work through four subgroups on alert, preparedness, response and governance. Throughout the process, the Emergency Committee conducted 28 weekly three hour plenary meetings, weekly virtual meetings for each subgroup and open meetings for Member States, United Nation agencies and non-State actors. Experts from the Islamic Republic of Iran, Morocco, Oman and Tunisia were part of the review in the capacity of members of the Emergency Committee. An expert from Jordan was also part of the review in the capacity of a WHO expert. A thorough report detailing the findings of the review has been published and was presented during World Health Assembly.<sup>1</sup> Eight key messages came out of this report:

- Lack of compliance of States Parties with certain obligations under the IHR, particularly on preparedness, contributed to the COVID-19 pandemic becoming a protracted global health emergency.
- Responsibility for implementing the IHR needs to be elevated to the highest level of government.
- A robust accountability mechanism for evaluating and improving compliance with IHR would strengthen preparedness, international cooperation and timely notifications of public health events.
- Early alert is important for triggering timely action, notably to enable the WHO Secretariat to use the powers conferred to it by the IHR.
- Early response requires better collaboration, coordination and trust.
- Applying the precautionary principle in implementing travel-related measures could enable early action to be taken against an emerging pathogen with pandemic potential.
- Effective IHR implementation requires predictable and sustainable financing at both the national and international levels.
- A new era of international cooperation is required to better support IHR implementation.

#### *IHR national focal points and event-related information*

65. Continuous support has been maintained for IHR national focal points to enhance their knowledge and capacities to implement the IHR (2005). This has included a series of virtual meetings and webinars held with IHR national focal points to strengthen their capacity and scale up preparedness and operational readiness and response capacities, including for COVID-19.

66. IHR national focal points in the Region have accessed the Event Information Site for National IHR Focal Points (EIS) 1012 times during the period from 1 June 2020 to 24 May 2021, with the IHR national focal points of Kuwait, United Arab Emirates, Islamic Republic of Iran, Morocco, Egypt, Iraq and Oman being the most frequent users of the site.

67. In accordance with Article 6 of the IHR (2005), countries are obligated to notify and sufficiently share with WHO detailed information, in a timely manner, of public health events that may constitute a public health emergency of international concern. Despite repeated efforts made by both regional and country levels

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<sup>1</sup> WHO's work in health emergencies. Strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005). Report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 response. Geneva: World Health Organization; 2021 (A74/9 Add.1; [https://apps.who.int/gb/ebwha/pdf\\_files/WHA74/A74\\_9Add1-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_9Add1-en.pdf), accessed 25 May 2021).

of the Organization, the timely sharing of detailed information about COVID-19 cases has remained a challenge in most countries of the Region. In some instances, national IHR focal points needed the approval of the higher authority to share information, which is not consistent with the terms of reference of national IHR focal points as explicitly defined within Article 4 of the IHR (2005).

68. Under Article 10, concerning verification, the IHR (2005) stipulate that Member States acknowledge these verification requests and provide the information requested regarding potential public health events in a timely fashion. During the period from 1 June 2020 to 31 May 2021, verification requests regarding 70 signals for public health threats, including for COVID-19, were issued; these were all diligently addressed, albeit not comprehensively, in the timely fashion required by the Regulations.

#### *Travel and additional health measures*

69. Travel advice and recommendations in relation to COVID-19 have been consistently provided to countries on an ongoing basis, including the recommendations of the IHR Emergency Committee for performing risk assessment to inform travel-related decisions.

70. In accordance with mutual obligations outlined in Article 43 of the Regulations and to meet the exigencies of discrepancies and challenges in reporting and cataloguing these measures during the COVID-19 pandemic, the WHO Regional Office developed the Eastern Mediterranean Region Travel Measures Platform in November 2020. The Platform enables each national IHR focal point to report weekly measures via a secure log-in, while a dashboard function reflects the weekly regional epidemiological situation for each measure implemented in each country. Therefore, users across all countries in the Region can connect to this platform and access data in real-time. Thus far, all countries have utilized the platform to provide validated information.

71. After the widescale resumption of international commercial traffic during late summer 2020, countries in the Eastern Mediterranean Region continued to adjust their travel-related measures in response to evolving public health concerns throughout the end of 2020 and into 2021, including the application of quarantine and testing requirements. Entry restrictions have followed suit. For example, in late 2020, countries within the Region began implementing restrictions in response to the emerging COVID-19 variants of concern: currently (as of August 2021), 12 countries are implementing entry restrictions concerning travel from India (11 countries), Brazil (five countries), South Africa (five countries), Viet Nam (five countries) and the United Kingdom (one country).

72. A few countries have kept their borders largely closed, but are continuing to accept travel related to repatriation, cargo and humanitarian needs. The situation for maritime traffic has followed a similar fashion, with many countries of the Region easing restrictions on crew changes and the overall movement of seafarers, given previous consequences for the global supply chain and the health of seafarers operating vessels.

73. Currently, countries in the Region are pursuing national strategies in order to mitigate risk associated with international travel and are increasing their capacities at points of entry as well as placing certain measures on passengers, including testing requirements before or on arrival, screening for both exiting and entering passengers, and quarantine for a set period.

74. Countries of the Region have relied on enhanced testing strategies, with all reporting a requirement to demonstrate a negative PCR test result for COVID-19 before travel, stipulating differences in pre-travel windows ranging from 96 hours to 48 hours (with an average of 72 hours). Given the evolving global epidemiological situation, 15 countries in the Region also require testing upon arrival (11 require PCR tests and six require rapid tests, with two countries offering the option of a PCR or rapid test).

75. The countries of the Region have adopted mixed approaches to quarantine measures, with four countries employing home quarantine, eight countries providing institutional quarantine, and five countries mandating a mixture of both. Quarantine times range from three to 21 days (with an average of 14 days). There is no mandatory quarantine in the other five countries of the Region.

76. Given the recent introduction of vaccines and the global, albeit unequal, roll-out of mass immunization campaigns, vaccination presents a future parameter to monitor regarding travel measures. Thus far in the Region,

six countries are exempting fully-vaccinated passengers from mandatory testing and 10 countries are exempting fully-vaccinated passengers from mandatory quarantine. Vaccination is an entry requirement in three countries and three countries recognize immunity certificates of recovery from a previous COVID-19 infection.

### *Yellow fever*

77. Yellow fever vaccination is required for travellers to certain countries and is recommended for all travellers to areas that are subject to endemic and epidemic yellow fever disease. As of May 2021, 16 countries, including Afghanistan, Bahrain, Djibouti, Iraq, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Saudi Arabia,<sup>1</sup> Somalia, Sudan, Syrian Arab Republic, Tunisia and United Arab Emirates, had responded to the annual questionnaire on requirements for yellow fever vaccination for international travellers. Out of the 16 countries, seven countries request a vaccination certificate against yellow fever for incoming travellers and confirmed that the international certificates of vaccination against yellow fever, using WHO-approved vaccines, are now accepted as valid for the life of the person vaccinated, in accordance with Annex 7 of the Regulations, as amended by resolution WHA67.13 (2014).

### **IHR Regional Assessment Commission**

78. The IHR Regional Assessment Commission (IHR-RAC) was established at the request of the 62nd session of the Regional Committee in October 2015 in resolution EM/RC62/R.3 on the assessment and monitoring of the implementation of the International Health Regulations (2005), as an independent body, comprising experts from States Parties of the Region and WHO, to assess implementation of the Regulations in the Region and to advise Member States on issues relating to implementation of the national core capacities required under the Regulations.

79. Since its establishment, the IHR-RAC has held five meetings in parallel with the regional annual IHR stakeholders' meetings. An initial meeting took place to agree and finalize the terms of reference for the Commission. Recommendations to Member States from each meeting have been followed up and progress on their implementation presented in regional IHR meetings. As reported in the 2019 IHR progress report, the implementation of the recommendations of the IHR-RAC's fifth meeting was delayed due to COVID-19. However, some of these recommendations were consistent with the recommendations of the IHR emergency committees; in particular, those related to risk communication, community engagement, One Health, enhancing preparedness and accelerating the implementation of national action plans for health security.

80. The first round of the IHR-RAC came to an end in February 2020. According to the terms of reference of the Commission, at least one third of the members must remain for the second round of the Commission to ensure continuity of work. Discussions are currently ongoing concerning new global processes to facilitate the implementation of the IHR and the terms of reference of the IHR-RAC will need to be reviewed along with its membership to ensure alignment with global processes to address lessons learned from the response to COVID-19. The refined terms of reference along with the membership will be reported to the 69th session of the Regional Committee for the Eastern Mediterranean.

### **Action by the Regional Committee**

81. The Regional Committee is invited to note this report and to: encourage investment in preparedness and response systems in view of the persistent threat posed by emerging and re-emerging infectious diseases with epidemic and pandemic potential; promote the development and implementation of national plans and strategies on the prevention and control of infectious disease threats; allocate sufficient resources to effectively implement these national plans and strategies; encourage implementation of the temporary recommendations of the seven IHR Emergency Committees and the key messages and recommendations of the IHR Review Committee; promote the implementation of the intra-action review of the COVID-19 response; update national action plans for health security as an integral part of health system strengthening; and allocate resources to implement the plans.

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<sup>1</sup> The report of Saudi Arabia is not included in the online international travel and health report due to late submission. The received report confirms that a yellow fever vaccination certificate is required for travelers aged 9 months and over arriving from countries and territories at risk of yellow fever transmission.

## Annex

## International Health Regulations (2005) national capacity monitoring: capacity scores (%) for all reporting States Parties for 2020

Member State	Legislation	Coordination	Zoonoses	Food safety	Laboratory	Surveillance	Human resources	National health emergency framework	Health service provision	Risk communication	Points of entry	Chemical	Radiation
Afghanistan	33	90	80	20	60	70	40	80	53	20	30	20	20
Bahrain	—	—	—	—	—	—	—	—	—	—	—	—	—
Djibouti	27	30	40	20	27	40	60	20	33	40	30	40	0
Egypt	93	90	80	80	73	100	80	100	100	60	100	80	80
Iran, Islamic Republic of	100	90	80	80	93	90	80	100	100	80	70	100	80
Iraq	47	70	100	40	73	70	100	87	80	100	60	40	100
Jordan	53	50	60	40	53	40	20	40	67	20	80	20	20
Kuwait	100	100	60	80	100	80	80	100	67	80	100	60	80
Lebanon	80	60	60	60	73	70	40	60	87	80	70	60	100
Libya	73	90	80	60	73	80	80	33	53	40	0	20	80
Morocco	87	50	80	80	87	80	80	80	67	80	70	80	60
Oman	80	90	80	80	80	90	40	93	93	60	80	80	80
Pakistan	33	50	60	40	60	60	60	60	47	20	40	40	100
Palestine	40	40	40	20	60	40	20	35	50	40	20	20	20
Qatar	93	100	100	80	100	100	80	80	100	100	80	80	100
Saudi Arabia	87	90	60	80	73	60	80	87	87	80	80	80	80
Somalia	—	—	—	—	—	—	—	—	—	—	—	—	—
Sudan	47	60	60	80	60	80	60	60	27	40	40	40	40
Syrian Arab Republic	47	40	60	40	47	60	40	53	53	60	60	60	20
Tunisia	67	70	100	80	100	80	80	73	80	60	50	80	40
United Arab Emirates	100	100	100	100	100	90	60	100	100	100	100	100	100
Yemen	47	40	80	40	67	80	80	60	47	60	0	20	20