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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, pursuant to resolution EBSS3.R1 (2015) of the WHO Executive Board and decision WHA68(10) (2015) of the Sixty-eighth World Health Assembly. Except where otherwise stated it covers the period from 1 June 2021 to 31 May 2022, and data on outbreaks cover the calendar year 2021.

2. The report also provides an update on progress in implementing the International Health Regulations (IHR) (2005) in the WHO Eastern Mediterranean Region in the context of Regional Committee resolution EM/RC64/R.1 (2017), related to the monitoring and evaluation of IHR implementation, and of resolution WHA61.2 (2008) of the Sixty-first World Health Assembly, related to annual reporting on the implementation of the Regulations by States Parties, pursuant to paragraph 1 of Article 54 of the IHR.

3. The report further provides an update on progress in implementing the plan of action for accelerating health emergency preparedness and response in the Eastern Mediterranean Region in the context of Regional Committee resolution EM/RC68/R.2 (2021).

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 3 June 2022, WHO was responding to 16 graded emergencies across the Region, including nine complex humanitarian emergencies as well as the COVID-19 pandemic. Six of these emergencies are grade 3 (COVID-19 pandemic; complex emergencies in Afghanistan, Somalia, the Syrian Arab Republic, Yemen; and the food security crisis in the Horn of Africa). Three are multi-regional and multi-country (COVID-19 pandemic, food security crisis in the Horn of Africa, monkeypox epidemic). At the time of writing, WHO was also managing or monitoring 42 additional public health events across the Eastern Mediterranean Region, most of which were disease outbreaks or natural disasters in the context of an ongoing complex emergency. 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. The COVID-19 pandemic has highlighted the critical need to expand efforts for enhancing preparedness to all hazards, to ensure effective emergency response and resilience. The IHR (2005) continue to be the legal framework adopted by Member States in the Region for building country capacity to prevent, prepare for, detect, investigate and respond to public health events and emergencies. Much progress has been made in implementing the Regulations, as described later in this report.

6. The COVID-19 pandemic has also highlighted additional cross-cutting areas that need to be addressed in preparedness, such as utilizing a whole-of-government and whole-of-society approach to emergency management, strengthening readiness, establishing proper emergency care systems, integrating primary health care (PHC) into preparedness and response, fostering the One Health approach, empowering and engaging communities, managing misinformation, empowering and protecting the health workforce and promoting financing for health security through different means, including by increasing domestic financing.

7. Several plans exist in countries to manage emergencies, including public health emergency preparedness and response plans, disaster risk reduction strategies, hazard-specific plans such as those for climate-related and other natural disasters, and disease-specific plans such as those for influenza, cholera and COVID-19. These plans are not fully integrated across all concerned sectors. Furthermore, a clearly defined national structure for emergency management involving all sectors (whole-of-government and whole-of-society) is lacking in most Member States; the Incident Management System – a best practice for emergency response – is also inconsistently applied for the management of COVID-19. Building on several discussions related to preparedness for and response to health emergencies, the WHO Regional Office is currently working on an operational guide for countries to establish and strengthen their emergency management systems.

8. Progress has been made in the area of operational readiness. A checklist for assessing the operational readiness of WHO country offices has been updated and piloted in four countries. A country guide for assessing and enhancing operational readiness for all-hazard emergencies has also been developed and is currently being finalized. The Strategic Toolkit for Assessing Risks (STAR) continues to be used in countries to further develop their risk profiles. Somalia and Sudan were supported in developing risk profiles and associated multi-hazard response plans, including for national and subnational levels. STAR was also used in Qatar to develop a risk profile in the context of the upcoming FIFA 2022 World Cup. Support was also provided to Somalia to develop business continuity plans and to the United Arab Emirates to develop a national policy for health emergencies and disaster risk management.

9. Several countries have developed disaster risk reduction plans with WHO support. Jointly with the UN Office for Disaster Risk Reduction (UNDRR), several consultative meetings were conducted in Egypt, Jordan and Lebanon to update their disaster risk reduction plans to reflect lessons learned from the COVID-19 pandemic. Discussions are ongoing with other countries to develop and update their plans; however, an integration of disaster risk reduction and emergency risk management for health is generally lacking. Furthermore, engagement of the health sector in work relating to disaster risk reduction is limited, with such work mainly being carried out by other sectors such as ministries of the interior and civil defence.

10. Public health emergency operations centres (PHEOCs) continue to demonstrate their important role in preparedness and readiness for, and response to, health emergencies. However, in most countries in the Region, PHEOCs were not fully utilized to manage the COVID-19 pandemic or other emergencies that required the engagement of sectors beyond that of the health sector. An assessment of all national PHEOCs was conducted in the Region to identify gaps and priorities related to legal mandates, infrastructure, human resources, and plans and procedures. A five-year strategic plan has been developed jointly with the WHO Regional Office for Africa to address these gaps. The draft plan was further elaborated and finalized through a bi-regional meeting to guide the provision of support to countries. Capacity-building activities for PHEOCs have also been carried out in Djibouti, Jordan, Libya, Palestine, Somalia, Sudan, Tunisia and Yemen. The electronic software for managing PHEOC data has been enhanced and deployed to countries in the Region, such as Jordan, Sudan and Tunisia, as well for use by the WHO Regional Office for Africa and WHO headquarters.

11. The COVID-19 pandemic identified weaknesses and gaps in emergency care systems, including facilities, across the Region. Despite efforts to support eight countries in assessing their emergency care systems and developing roadmaps to strengthen these systems, the roadmaps were not fully implemented. Assessment tools for emergency care systems are currently under review to ensure they cover the pathway of prehospital care, referral systems and transportation, and emergency, operative, critical and rehabilitation care. Revisiting the roadmap in Jordan and assessing emergency care systems in Afghanistan, Iraq, Somalia and Yemen has been the focus of support this year.

12. Hospitals continue to be extensively sought out during emergencies. WHO is working with countries this year to roll out the Hospital Safety Index and the SMART health facility initiative to assess the capacity of hospitals and PHC centres for emergency preparedness and response. Further discussion and work with countries is needed to enhance the preparedness capacities of centres and ensure their full utilization during emergencies.

13. Establishing and building the capacity of Emergency Medical Teams (EMTs) using the WHO classification is a work in progress. Several countries have EMTs, and these have played a major role in managing COVID-19 cases across several WHO regions. Further building of the capacity of these teams across the Eastern Mediterranean Region is needed in order to align them with the WHO classification. A series of webinars was conducted jointly with the International Federation of Red Cross and Red Crescent Societies (IFRC) to raise awareness of EMTs. In Iraq, an EMT capacity-building workshop was conducted targeting different levels of the medical workforce, and a mentorship mission is planned to Kuwait and Saudi Arabia to facilitate the process of the international classification of their EMTs. The value and support of international EMTs was demonstrated by their deployment to Djibouti, Palestine and Yemen to support the COVID-19 response.

14. Empowering countries to be better prepared for, and to efficiently respond to, health threats at the human–animal–environment interface under the One Health approach has gained ground. The partnering of the United Nations Environment Programme (UNEP) with the One Health Tripartite – composed of WHO, the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (WOAH, formerly known as OIE) – thereby creating a Quadripartite, has highlighted the key role of the environment in preventing and combating One Health threats. The Joint Risk Assessment operational tool and process for assessing risks posed by zoonotic disease hazards was rolled out in Egypt and Sudan. Support was also provided to Qatar and Sudan to conduct disease prioritization exercises, and to Jordan in assessing surveillance of One Health threats and information-sharing among One Health sectors. A multisectoral coordination mechanism operational tool has been introduced to countries in the Region to enable them to enhance their internal coordination and response to One Health threats. Acknowledging the rapidly increasing need to advance the One Health approach, a technical paper will be submitted to the 69th session of the Regional Committee with a One Health operational framework for countries to adapt and implement. Quadripartite partners are collaborating at the regional level to harmonize and coordinate support to countries. This collaboration will be further strengthened through the establishment of a high-level regional One Health body and technical working group to provide the needed support to countries.

15. The need for advanced risk communication and community engagement (RCCE) efforts to address community perceptions, behavioural patterns, rumours and misinformation became clearer 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 in Arabic, English and French were rapidly developed by WHO's regional team to help countries quickly raise awareness about how to decrease the risk of infection among different target populations. Posters targeting health care workers, travellers and schoolchildren were designed, distributed, printed and 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. "Mythbuster" infographics and expert video recordings addressing rumours and misinformation about the disease and how it spreads have been prepared regularly and posted on social media to keep pace with the infodemic that has emerged online alongside the pandemic. Through collaboration with initiatives at WHO headquarters, WHO Health Alert chatbots on WhatsApp, Viber and Facebook Messenger were translated into some of the Region's local languages to help respond to people's questions on their social media platform of choice. Daily messages have been prepared and sent by the Regional Director through WhatsApp to ministers of health to keep them informed of WHO's latest technical guidance, initiatives, news and scientific research on pandemic preparedness and response.

16. Support has also been provided to countries to strengthen their preparedness and readiness capacities for mass gathering events. In particular, support has been given to countries hosting some of the world's largest mass gatherings, such as the Hajj in Saudi Arabia, Arba'een in Iraq and the upcoming FIFA 2022 World Cup in Qatar.

17. An increase in domestic financing is important for health security. An assessment of financing systems has taken place in several countries in the Region, highlighting substantial variation in financing health security. In 2021, Bahrain, Egypt, Kuwait, Saudi Arabia and the United Arab Emirates reported sufficient budgetary allocations for health security available at national, intermediate and local levels and across all sectors, with predictable and flexible finances that can be distributed in a timely manner. The Islamic Republic of Iran and Qatar reported sufficient budgetary allocations and predictable finances that can be distributed in

a timely manner at the national and intermediate levels. Five countries reported conducting financial planning based on identified gaps and estimated resource needs, with budgetary allocations and/or substantial external financing at national level. Eight countries reported limited financial planning, with budgetary allocations or substantial external financing made available to finance health security at the national level.

18. WHO and partners have been conducting capacity-building activities to ensure a multisectoral workforce exists in countries that is trained to enable the early detection and prevention of, preparedness for and response to public health emergencies. Despite these efforts, which were further intensified during the response to the COVID-19 pandemic, countries have varied levels of health security capacity. In 2021, Kuwait, Qatar and the United Arab Emirates reported having documented policies or procedures for sustainable appropriate human resources in all relevant sectors at all levels that are evaluated and updated on a regular basis, while Jordan and Sudan reported a lack of appropriate human resource capacity in relevant sectors. The remaining countries reported workforce capacity at only the national level (seven countries), national and intermediate levels (two countries) or all levels (six countries). Bahrain, the Islamic Republic of Iran, Qatar and Saudi Arabia reported having a national multisectoral workforce surge strategic plan for emergencies, evaluated and updated annually and implemented at all levels, with procedures and adequate capacity to deploy and receive multidisciplinary personnel within the country (shifting resources), including government and nongovernmental partners.

Detecting public health events

19. WHO continues to provide technical support to Member States to strengthen epidemiological surveillance and information management. This has included developing and customizing tools to collect, manage and analyse data on public health events, including the COVID-19 pandemic, and communicate the results of the analysis, while also providing support to countries to strengthen their information management capacities and enhance their response.

20. In October 2021, the 68th session of the WHO Regional Committee for the Eastern Mediterranean adopted a regional strategy for integrated disease surveillance aimed at overcoming data fragmentation across the Region. Effectively integrated disease surveillance requires good governance and multisectoral coordination to organize the convergence of disease- and programme-specific systems towards integration. The corresponding Regional Committee resolution (EM/RC68/R.3) requested Member States to take the necessary steps to achieve effective, integrated national surveillance systems connected to global surveillance systems by the end of 2025 and requested WHO to coordinate different surveillance programmes within the Organization through a working group to move towards consolidation and provide the needed support.

21. Support to countries in the Region to enhance and improve their surveillance systems has been pursued. Development of the national integrated disease surveillance strategy has been supported in two countries (Pakistan and Somalia).

22. Seven countries have received support to establish and/or enhance the event-based surveillance component of their surveillance systems, and thereby improve their capacity for early detection of public health events. They include Afghanistan, Iraq, Jordan, Libya, Morocco, Sudan and Tunisia.

23. Epidemic Intelligence from Open Sources (EIOS), the WHO-led initiative improving country detection capacity using open sources, has been implemented in 10 countries of the Region.

24. Between 1 June 2021 and 31 May 2022, 9785 signals were captured and 25 new public health events were monitored. Fourteen rapid risk assessments and six public health situation analyses were conducted, including for civil unrest and measles in Afghanistan, civil unrest in Libya, undiagnosed disease and measles in Somalia, civil unrest, dengue fever and hepatitis E in Sudan, measles in north-west Syrian Arab Republic and cholera in Yemen. The Region contributed to five global risk assessments, including four for COVID-19 and one for acute hepatitis of unknown origin, and 14 updates were posted on the IHR Event Information Site, nine Disease Outbreak News were published on the WHO regional website, and 250 daily bulletins of signals and events and 52 weekly summaries of events were disseminated.

25. Under Article 10, concerning verification, the IHR (2005) stipulate that Member States acknowledge verification requests and provide the information requested regarding potential public health events in a timely manner. During the period from 1 June 2021 to 31 May 2022, verification requests regarding 81 signals for public health threats, including for COVID-19, were issued; these were all diligently addressed, albeit not comprehensively, in the timely manner required by the Regulations.

26. Between 1 June 2021 and 31 May 2022, more than 7533 signals related to COVID-19 were captured. Daily, weekly and monthly products to communicate the epidemiological situation were designed and improved. This included over 500 daily updates, more than 250 daily, 50 weekly and 12 monthly WhatsApp posts, and 24 epidemiological updates included in biweekly situation reports. WHO also produced and updated thematic maps illustrating various COVID-19 data analyses, including the evolution of numbers of cases and deaths at national and subnational levels, and the distribution of SARS-CoV-2 variants.

27. Existing indicators to monitor the weekly evolution of the COVID-19 pandemic were improved and new ones were built. Automated analysis tools were improved and additional datasets, such as Google mobility and vaccination, were integrated to facilitate the triangulation of information. Research projects were implemented to estimate vaccination coverage and investigate the potential impact of new variants on COVID-19 evolution in the Region.

28. Daily counts of SARS-CoV-2 infections and COVID-19 cases and deaths were compiled by the WHO regional team, which received data either directly from Member States or through extraction from official government public sources (i.e. ministry of health websites). The number of confirmed infections and deaths was regularly reported in situation reports and on the global dashboard.

29. Regional contact tracing strategies were initiated – and contact tracing activities supported – in Afghanistan, Jordan, Lebanon and Tunisia. Training on Go Data, an electronic contact tracing tool, was conducted at the regional level, including participants from all countries of the Region, and subsequently followed by in-depth training in Egypt, Libya, the Islamic Republic of Iran, Qatar, the Syrian Arab Republic and Yemen.

30. WHO has established a training site for the Field Epidemiology Training Programme (FETP) in the Region, in collaboration with the Eastern Mediterranean Public Health Network. Three FETP fellows from Sudan have been hosted so far. Fellows from other FETPs within the Region are expected in 2023.

31. WHO initiated the development of the Regional Response Monitoring Framework, which includes a revised set of indicators to be used in fragile, conflict-affected and vulnerable (FCV) countries. The Framework will facilitate the measurement of humanitarian health response effectiveness. Five FCV countries/territories were selected (Libya, Palestine, Somalia, the Syrian Arab Republic and Yemen) for pilot testing; a desk review and interviews with emergency focal points in ministries of health, nongovernmental agencies and WHO country offices were conducted. A workshop was then held to introduce the Framework to the five countries. In addition, further consultations were conducted with departments in the WHO Regional Office to identify additional indicators. Operational plans were then developed to roll out the Framework in the five countries. WHO also conducted several training sessions on various information management-related topics, including a three-day course on the R programming language for 21 participants in Beirut, Lebanon.

32. Technical and financial support was provided to Pakistan (for the province of Balochistan), Afghanistan, Somalia and Yemen to deploy the Health Resources Availability Mapping System (HeRAMS), an electronic system developed by WHO for standardizing and assessing the availability of medical services during emergencies.

33. Between June 2021 and May 2022, more than 500 maps were developed to support WHO Regional and country offices and Member States.

34. Collaboration was established with the United Nations High Commissioner for Refugees (UNHCR), the UN Global Pulse initiative and the United States Centers for Disease Control and Prevention to employ new geographic information system (GIS) technologies, such as remote sensing and spatial modelling for the estimation of population size in emergency settings.

35. The development of a regional GIS roadmap was initiated, with the objective of streamlining and standardizing GIS functions at country level, and a GIS national assessment survey was conducted to identify the current status of GIS activities in Member States.

36. The development was initiated of a regional GIS portal for health emergencies that will include an online geodatabase repository and permit the automatization of map production for country geoprofiles.

37. District Health Information Software version 2 (DHIS2) was deployed in pilot districts of Iraq to digitalize the collection, management, storage, analysis and communication of health information management data.

38. Epidemiologists were deployed to provide surveillance support to Afghanistan, Iraq, Libya, Morocco, Pakistan and Sudan. Assessments of event-based surveillance were conducted in Afghanistan, Libya and Sudan, followed by the development of national event-based surveillance guidelines in these countries. WHO's COVID-19 Incident Management Support Team surveillance pillar contributed to field missions in Afghanistan, Iraq, Jordan, Lebanon, Libya, Pakistan, Qatar, Sudan, the Syrian Arab Republic and Tunisia.

39. Training for information management using DHIS2 and R software was conducted in Afghanistan, Iraq and Lebanon.

40. Challenges facing countries include a lack of strong governance related to surveillance activities, shortages of trained human resources and frequent turnover of personnel, high workload due to COVID-19 and staff shortages, limited alignment of activities with other departments and political instability.

41. The Eastern Mediterranean Flu (EMFLU) regional platform continued to be used for collecting and managing COVID-19 forms from Member States, although a decreasing number of countries contributed. As of 24 May 2022, seven countries continue to send COVID-19 weekly aggregate forms, three continue to send case report forms and the database contains a total of 3.65 million stored COVID-19 reports.

Preventing and managing epidemics and pandemics

42. The Region continues to confront serious public health threats from emerging and re-emerging infectious disease outbreaks and other public health emergencies. Complex humanitarian emergencies and protracted conflicts in nine countries of the Region further damage and degrade already fragile health systems, making the prevention and control of emerging infectious diseases extremely challenging. WHO provides Member States with strategic, operational and technical support to prevent, 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, all countries in the Region remain vulnerable to emerging infectious disease threats.

43. In 2021, all 22 countries and territories of the Region continued to suffer from the negative health consequences of the ongoing COVID-19 pandemic. More than 12 million COVID-19 cases were reported cumulatively across the Region in 2021, including 194 245 associated deaths, with a case fatality ratio of 1.8%. Furthermore, 31 outbreaks of other emerging infectious diseases were reported from 11 countries, including: acute watery diarrhoea/cholera in Afghanistan, Somalia and Yemen; dengue fever in Afghanistan, Pakistan, Sudan and Yemen; diphtheria in Sudan and Yemen; Crimean-Congo haemorrhagic fever in Afghanistan, Iraq and Pakistan; Middle East respiratory syndrome (MERS) in Saudi Arabia and the United Arab Emirates; hepatitis E virus in Sudan; extensively drug resistant (XDR) typhoid in Pakistan; measles in the Syrian Arab Republic, Somalia and Afghanistan; wild poliomyelitis in Afghanistan and Pakistan; and vaccine-derived polio virus type 1 and 2 (cVDPV2 and cVDPV2) in Afghanistan, Djibouti, Egypt, Pakistan, Somalia, Sudan and Yemen. The total number of reported cases of all these outbreaks was 398 140, with 682 associated deaths. Over 80% of these outbreaks were reported from FCV countries in the Region.

44. In addition to close monitoring, WHO continued to provide technical, management and logistical support to affected countries to prevent, prepare for, detect, confirm and contain outbreaks, limit their geographical spread and mitigate their impact through the application of appropriate public health interventions, including

the use of evidence-based control measures. WHO deployed over 20 technical experts to countries affected by disease outbreaks, including Afghanistan, Libya, Sudan, the Syrian Arab Republic and Yemen.

45. In FCV countries, WHO developed and supervised the implementation of a strengthening plan for the Early Warning Alert and Response Network (EWARN), including for expansion, maintenance, staff capacity-building and rapid response team (RRT) training. Libya, Somalia, the Syrian Arab Republic and Yemen were supported to develop an electronic platform and assess EWARN performance to update transition plans. In addition, WHO developed a training package for the implementation of the EWARN evaluation protocol and organized the annual EWARN meeting – with participation of all countries with functioning EWARN systems– introducing basic front-line field epidemiology training. WHO facilitated training to build the capacity of national and subnational outbreak RRTs in Afghanistan, Iran (Islamic Republic of), Iraq, Jordan, Saudi Arabia, Sudan and north-west Syrian Arab Republic. In total, 172 RRT members were trained in concepts of outbreak investigation and response. WHO's regional team conducted a baseline assessment to map RRT capacity and operation in countries of the Region. The survey revealed notable variations in RRT structure, capacity and functions across the Region. Several gaps in outbreak response were identified, and recommendations on RRT capacity and operations and ensuring effective and efficient early detection and rapid response were provided.

46. WHO's regional team conducted a survey in 2021 to identify and map potential Global Outbreak Alert and Response Network (GOARN) partners in the Region with whom GOARN could develop a working relationship and build a strong network. Technical and operational support was provided to seven countries that experienced emerging infectious disease outbreaks. WHO also supported GOARN surge mission deployment to support disease outbreak investigation and response in Afghanistan, Somalia, Sudan and Yemen.

47. WHO continued supporting countries in the Region to sustain and enhance the influenza surveillance system, which had been impacted by the COVID-19 pandemic. Due to this support, 19 out of the 22 countries and territories have maintained the functioning of sentinel surveillance systems for influenza-like illness and severe acute respiratory infections. Moreover, WHO has developed an operational framework to promote the building and sustaining of an efficient system – built on existing influenza infrastructure and capacities – to integrate influenza surveillance with that of other respiratory viruses with epidemic and pandemic potential. Currently, the integrated surveillance system focuses on influenza and SARS-CoV-2 and will provide the foundations for preparedness and response to future pandemics. To enhance the uptake and utilization of seasonal influenza vaccines in the Region, WHO's regional team drafted a five-year (2022–2026) regional roadmap to guide Member States.

48. WHO supported the capacity-building of 18 designated influenza centres (NIC) and four influenza laboratories. Accordingly, 21 of the 22 countries and territories of the Region had real-time reverse transcription-polymerase chain reaction (rt-RT-PCR) capacity for detecting influenza viruses, 13 countries had virus isolation capacity, 15 countries had sequencing capacity and 11 countries had capacity for antiviral resistance testing. Moreover, WHO supported the establishment of genetic sequencing facilities in eight NICs by procuring sequencing equipment and ancillary supplies for eight emergency-affected countries. WHO conducted subregional training on SARS-CoV-2 sequencing and molecular phylogenetics for NICs, with the participation of 14 laboratory technicians representing seven priority countries (Afghanistan, Iraq, Lebanon, Libya, Sudan, Syrian Arab Republic and Yemen). In addition, WHO organized in-country sequencing training for staff in three influenza laboratories in Somalia. In 2021, WHO's regional team facilitated the participation of 18 NICs and other influenza laboratories in the WHO External Quality Assessment Programme, and 83.3% of the participating laboratories reported correct influenza RT-PCR results for all samples.

49. WHO supported and coordinated a three-day training workshop in Jordan for pandemic influenza preparedness focal points. The participants were also introduced to infodemic management and the Early AI-supported Response with Social Listening tool (EARS) that will be piloted in Jordan along with a limited number of other countries globally. WHO's regional team supported the development of a package of information, education and communication materials for 15 high-threat pathogens with epidemic and pandemic potential. For each disease, the materials address three to four target audiences. WHO supported two countries (Afghanistan and Iraq) to use these materials for rapid response to outbreaks of anthrax, cholera, hepatitis and dengue and other viral haemorrhagic fevers.

50. WHO contributed to the capacity-building of front-line health workers and local health authorities – particularly in FCV countries – on comprehensive clinical management and critical care and intensive care units (ICUs). A regional standardized introductory ICU/critical care training package for doctors and nurses was developed to meet urgent needs at country level. Consequently, the total number of health care workers trained in COVID-19 clinical management exceeded 40 000 in the Region by the end of 2021. In addition, WHO supported countries in accessing oxygen and other life-saving biomedical equipment and therapeutics – 16 countries received medical oxygen and biomedical equipment and supplies, 18 countries participated in the Live Oxygen Platform, nine countries received technical biomedical support, and 13 countries received tocilizumab and other life-saving therapeutics for COVID-19.

51. Despite the prioritization of the COVID-19 response by countries, WHO continued providing technical support in preparedness and response to emerging vector-borne and zoonotic disease outbreaks such as dengue fever, chikungunya, Rift Valley fever, Crimean-Congo haemorrhagic fever, yellow fever and rabies. WHO also worked with countries on enhancing clinical management capacity for priority emerging vector-borne and zoonotic diseases. WHO contributed and provided technical support for developing or updating national guidelines for vector-borne and zoonotic disease prevention and control.

52. Despite all these efforts, managing high-threat pathogens with epidemic and pandemic potential in the Region remains challenging. The main challenges encountered include the protracted emergency situations in nine countries, which continue to negatively impact routine service delivery and limit access to vulnerable populations. Poor governmental investment in infectious hazard preparedness plans contributed to delays in responses to outbreaks of high-threat pathogens. Furthermore, delays in data sharing by countries and the inconsistency of shared data represent additional challenges.

53. Leveraging influenza surveillance systems and other infrastructure for the COVID-19 response led to the delayed implementation of many planned influenza activities and interruption of surveillance data reporting. In addition, some countries experienced operational obstacles in sharing influenza viruses with NICs due to challenges in access to courier services. The fast-paced developments in the COVID-19 response have stretched human resources at both regional and national levels, making responses to other high-threat pathogens harder to achieve.

Responding to health emergencies

54. The Eastern Mediterranean Region is home to 102 million people requiring humanitarian assistance (34% of the global total) and is the source of over 60% 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 the timely and proper management of health emergencies.

55. In 2021, WHO's regional team maintained its response to the COVID-19 pandemic, while balancing concurrent emergencies from multiple hazards – societal, natural and technological. Nine of the 22 countries and territories in the Region experienced large-scale humanitarian emergencies during the year.

56. In Afghanistan, the withdrawal of foreign military presence in 2021 posed an increased risk of violence and internal displacement. WHO assessed the resulting humanitarian crisis as a grade 3 emergency, leading to a response that leveraged resources from across the Organization. WHO activated its incident management system and scaled up its response, together with partners, to address the broad range of humanitarian needs – displacement, violent trauma, high levels of acute malnutrition, and disease outbreaks (e.g. measles, acute watery diarrhoea); this was done in addition to the ongoing management of the COVID-19 pandemic and endemic wild poliovirus across the country. Cessation of international funding for the Sehatmandi project – the main source of primary and secondary health care across the country – threatened a precipitous decline in the availability of essential health services. In partnership with UNICEF, WHO secured funding and contracted with nongovernmental organizations to deliver the basic package of health services and the essential package of hospital services. Over a period of approximately four months, the percentage of fully functional WHO-supported facilities increased from 17% to 99%; over the same period, the percentage of facilities with stock-outs decreased from 77% to less than 1%. In March 2022, WHO and UNICEF convened a high-level meeting in Doha to agree on interim health priorities for Afghanistan.

57. In Yemen, WHO continued to support the provision of primary and secondary health care services, with prioritization of vulnerable populations. The recent ceasefire agreement provided a golden opportunity to reach out to more vulnerable populations. WHO, in collaboration with partners, conducted oral cholera vaccination campaigns in high-risk districts. More than 1 million children were protected from vaccine-preventable diseases, and severe acute malnutrition was prevented in more than 100 000 children aged under five years. WHO continued to support health service delivery in 72 hospitals. Over 40 000 children were treated for severe acute malnutrition, with a cure rate of over 90%, while the case fatality ratio was maintained at well below 1%, consistent with international standards. WHO also supported surveillance and response to outbreaks of disease and provided leadership and coordination of emergency preparedness and response through its national and subnational emergency operations centres, allowing for early detection and timely response to disease outbreaks. WHO and Health Cluster partners provided financial incentives to almost 25 000 front-line health care staff in Yemen.

58. In Sudan, health needs remain high due to inflation, the economic crisis, poor investment in infrastructure, localized conflicts and a potential new refugee influx. Overall, 14.3 million people will require humanitarian assistance in 2022 – a 7% increase from 2021. The October 2021 change in political leadership contributed to high turnover of Ministry of Health staff. Technical assistance was provided to health authorities in-country and resources were mobilized through the Contingency Fund for Emergencies to mount a rapid response to increasing humanitarian needs. In addition, over 5.6 million people are affected by the combined impact of prolonged dry spells and crop failure in 115 localities in 14 states across Sudan; more than 22 million people (50% of Sudan's population) live in the 115 affected localities. WHO supported surveillance and response to outbreaks of diseases, including water quality monitoring and vector control and support for delivery of essential health services in underserved and conflict-affected areas.

59. In Somalia, following three poor rainy seasons and soaring food prices, communities along with others across the Horn of Africa are experiencing one of the most severe droughts in decades, leading to the declaration of a national emergency by the Federal Government in November 2021. By the end of the first quarter of 2022, the drought situation had rapidly deteriorated, raising a credible risk of famine in pockets across the country and also causing large scale displacements and the worst water scarcity in 40 years in some parts of the country. In May 2022, a three level teleconference was held involving WHO country offices in Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda, as well as the WHO regional offices for Africa and the Eastern Mediterranean and WHO headquarters, and the situation was designated a grade 3 public health emergency. As such, WHO objectives are clearly set to: strengthen governance and coordination mechanisms to ensure the development and implementation of appropriate measures for rapid response and early recovery; strengthen cross-border collaboration, surveillance and information exchange among countries in the subregion; build local capacity for strengthened surveillance of nutritional status linked to appropriate referral and management of all cases of acute malnutrition; and strengthen monitoring and evaluation of the drought response.

60. In the Syrian Arab Republic in 2021, WHO continued leading the health sector and coordinating health emergency preparedness and response. 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 and crossline medical supply chains. A robust cross-border operation was maintained from Gaziantep in southern Türkiye into north-west Syrian Arab Republic, despite the closure of the Bab Al Salam border crossing. In non-government-held areas of the Syrian Arab Republic, service delivery was supported largely through nongovernmental organization partners. Training workshops supported 38 057 health care workers in a variety of skills and fields and 2 730 436 medical procedures were provided, including outpatient, trauma and mental health consultations, physical rehabilitation sessions, vaginal deliveries, caesarean sections and referrals. For WHO, the Whole of Syria (WoS) approach remains essential for creating opportunities to reach the most vulnerable populations in different parts of the country using all operational modalities, including both cross-border and cross-line. The WoS approach has been essential in ensuring the delivery of much needed health capacity and services in an equitable manner across the country.

61. Considering the ongoing COVID-19 pandemic and protracted complex emergency, the escalation of the ongoing conflict in Palestine is adding an additional burden to an already overstretched health system. In

addition, there have been positive polio environmental samples and cases of undefined hepatitis. The health needs are urgent given the chronic shortages of lifesaving medical supplies and the fragmented nature of the health system. WHO and partners continue to build the capacity of local health providers and their response capacity. WHO also continues to document attacks on health care. In 2021, 235 attacks were recorded, including the beating and arrest of paramedics, prevention of access for ambulances and paramedic teams, physical attacks against ambulances and incursions into health care facilities.

62. In Libya, reliance on the life-saving and life-sustaining health care services supported by the humanitarian response continues across the country amidst chronic insecurity and the COVID-19 pandemic. While improving coordination with health authorities at all levels and acknowledging their lead role, WHO supports disease surveillance, the delivery of medicines and supplies, and the implementation of vaccination campaigns in areas where needs are greatest. As health sector lead, WHO supports advocacy to improve access to deliver supplies, assess health needs, monitor the health situation and adjust operations. WHO aims for an equitable distribution of humanitarian aid and is increasing services in neglected vulnerable areas in the east and south of the country. To achieve this goal, WHO deployed mobile medical teams, expanding the presence of field coordinators in each district, and a network of community health workers has been established.

63. WHO's logistics hub in Dubai has become an increasingly important global asset during the COVID-19 pandemic. During 2021, the hub dispatched 403 shipments of COVID-19 treatment supplies to 111 countries across all WHO regions. Moreover, the hub retains a vital stockpile of diagnostics and therapeutics for a range of epidemic and pandemic diseases, and distributes these to countries in response to emerging health threats. In response to the monkeypox outbreak, diagnostics were efficiently shipped to 17 Member States. Reviewing the national supply chain and developing effective procurement and distribution systems for medicines, vaccines and other medical products and technologies is a work in progress.

64. Despite advocacy efforts by WHO and partners, attacks on health care facilities are still being reported in some countries and territories of the Region. According to WHO's Surveillance System for Attacks on Health Care, in 2021, 364 attacks on health care were recorded in seven countries or territories (Afghanistan, Libya, Palestine, Somalia, Sudan, the Syrian Arab Republic and Yemen). These incidents resulted in a combined 89 fatalities and 292 injuries of health care workers and patients.

Progress of States Parties in implementing the IHR (2005)

IHR Monitoring and Evaluation Framework

65. The IHR Monitoring and Evaluation Framework with its four components of State Party Self-Assessment Annual Reporting (SPAR), joint external evaluation (JEE), After- and Intra-Action Reviews (AARs/IARs), and exercises continues to be widely accepted and used by countries in the Region.

66. In 2021, WHO updated the SPAR tool through a country and expert consultation process to consider lessons learned from the COVID-19 pandemic. The SPAR tool is now composed of 15 capacities instead of 13, as financing and infection prevention and control capacities were added. The SPAR tool continues to be provided in an electronic format which allows States Parties to report online and WHO to provide real-time monitoring of submitted reports and quality checks of data provided. All 22 countries or territories in the Region completed the 2021 SPAR on the achievement of IHR-related core capacities, in accordance with Article 54 of the IHR (2005).[1]

67. Through the same country and expert consultation process, the JEE tool has been updated to cover areas critical to the response to the COVID-19 pandemic. The updated JEE (2022) has 19 capacities and 56 indicators, compared with the initial 19 capacities and 49 indicators.

68. Pakistan has officially requested support to conduct a second round of JEE using the updated tool. Discussions are ongoing with Palestine, the Syrian Arab Republic and Yemen to complete a first round of JEE using the updated tool.

[1] Although Palestine is not a State Party to the IHR, it has been completing the SPAR to monitor its progress in implementing IHR-related public health capacities.

69. So far, 16 countries have completed one or two full rounds of IARs or conducted a review of targeted pillars. Discussion is ongoing to support the conduct of IARs by the remaining six countries, namely Morocco, Oman, Qatar, Sudan, the United Arab Emirates and Yemen.

70. The majority of countries in the Region has conducted tabletop and simulation exercises to test their operational readiness for rolling out COVID-19 vaccines. A tabletop exercise was conducted in Qatar to test the country's preparedness for the Arab Cup which took place in November and December 2021. In collaboration with the International Atomic Energy Authority (IAEA), a simulation exercise was conducted in the United Arab Emirates to test preparedness to respond to nuclear emergencies. A tabletop exercise was conducted in Iraq to test preparedness to respond to health emergencies as part of rollout of the Universal Health and Preparedness Review (UHPR).

71. The UHPR is a Member State-led intergovernmental mechanism where countries voluntarily and transparently review their national health emergency preparedness capacities. The UHPR was pilot tested in Iraq between December 2021 and March 2022, the second pilot of this process globally.

IHR core capacities

72. Analysis of the 2021 SPAR data indicates that the overall average score of IHR capacity is 64%, ranking slightly lower than the regional average of 66% reported in 2020. The highest average implementation scores were for capacities related to surveillance (83%), health service provision (73%) and laboratory (72%) (Annex 1). Less well-performing areas included capacities related to legislation (55%), food safety (57%), infection prevention and control, and chemicals and radiation (58%).

73. As previously reported, national action plans for health security have been developed in 19 countries and territories (including Palestine). These plans are currently under review taking into consideration the activities identified in the regional plan of action for ending the pandemic and preventing future health emergencies and the country-specific recommendations generated from the IAR for the COVID-19 response. Guidance to facilitate the process of updating the national action plans for health security was shared with IHR national focal points (NFPs) during the ninth IHR regional meeting that took place in March 2022.

Procedures under the Regulations

IHR Emergency Committees, Review Committee and related progress

74. As of 31 May 2022, the IHR Emergency Committee for COVID-19 had met 11 times since its establishment in January 2020. At its meeting on 11 April 2022, the WHO Director-General followed the advice of the Committee and maintained the status of a Public Health Emergency of International Concern (PHEIC), issuing updated temporary recommendations under the IHR (2005). Implementation of the temporary recommendations is ongoing.

75. The IHR Emergency Committee concerning events involving the transmission and international spread of poliovirus is ongoing and, as of 31 May 2022, has met 31 times since its establishment in April 2014. Following the advice of the latest Emergency Committee meeting, the WHO Director-General maintained the status of a PHEIC and issued updated temporary recommendations under the IHR (2005).

76. As mandated by resolution WHA73.1 (2020) on the COVID-19 response, the IHR Review Committee convened between September 2020 and May 2021 to review IHR functionality during the COVID-19 response. A thorough report detailing the findings of the review was published and presented during the Seventy-fourth World Health Assembly. The report included 40 recommendations to strengthen and accelerate the implementation of and compliance with the IHR (2005). These recommendations and another 91 recommendations included in the reports of the Independent Oversight Advisory Committee and Independent Panel for Pandemic Preparedness and Response (IPPPR) are being prioritized by the Working Group on Strengthening WHO Preparedness for and Response to Health Emergencies (WGPR). The WGPR has met nine times since its establishment by resolution WHA74.7 in 2021. The participation of countries in the Region in the WGPR meetings has been very limited. However, most have supported the development of a WHO convention, agreement or other international instrument on pandemic preparedness and response,

which was discussed in the World Health Assembly Special Session that took place between November and December 2021.

77. The World Together intergovernmental negotiation body was established by decision SSA2(5) of the Second Special Session of the World Health Assembly to draft and negotiate a convention, agreement or other international instrument. The body proposed potential substantive elements for a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response for the feedback of Member States through an online platform. These elements were proposed based on COVID-19-related lessons learned and recommendations and elements from WHO instruments under the WHO Constitution. Only seven countries from the Region have responded to the proposal.

78. Targeted amendments to the IHR (2005) have also been proposed. The United States of America has submitted a proposal for IHR targeted amendments, which was transmitted by the WHO Director-General to States Parties in January 2022, pursuant to Article 55 of the IHR (2005), for discussion during the Seventy-fifth World Health Assembly. Another proposal was submitted by the Russian Federation, on behalf of Eurasian Economic Union Member States, and was also transmitted to States Parties in April 2022. The latter was not subject to discussion at the Seventy-fifth World Health Assembly as it did not meet the requirement of being submitted at least four months before the World Health Assembly, in accordance with Article 55 of the IHR (2005). The United States of America has held bilateral discussions with countries in the Region to provide explanations and seek feedback on its proposal. The Seventy-fifth World Health Assembly discussion concluded with continuing negotiations and discussion to inform the amendment of the targeted Articles.

IHR national focal points and event-related information

79. Support continued to be provided to IHR NFPs to enhance their knowledge and capacities in the implementation of the IHR (2005). This included a series of virtual meetings and webinars held with IHR NFPs to strengthen and scale up their preparedness and operational readiness and response capacities, including for COVID-19. For the first time since the start of the pandemic, a meeting was conducted where IHR NFPs from all countries in the Region attended in person. The meeting was an opportunity to provide updates on progress and to discuss challenges and the way forward on IHR (2005) implementation. Continuing to advocate for health security through the implementation of IHR (2005) and updating the terms of reference of the IHR NFP centres were among the main recommendations of the meeting, as well as making the necessary changes in organizational structure and legal status so that IHR NFP centres are linked to the overall emergency management structure in the country and are provided with the needed financial and human resources to facilitate the functions of IHR NFPs.

80. IHR NFPs in the Region accessed the Event Information Site 1628 times during the period from 1 June 2021 to 31 May 2022, with the IHR NFPs of Egypt (364), Kuwait (345), Iraq (251) and the United Arab Emirates (179) being the most frequent users of the site.

Travel and additional health measures

81. According to the 2021 SPAR, countries of the Region have designated 100 ports, 96 airports and 75 ground crossings for IHR implementation, while 17 countries reported having authorized ports to issue ship sanitation certificates in accordance with Annex 3 of the IHR (2005). The Eastern Mediterranean Region has the second lowest capacity of IHR (2005) implementation at points of entry (60%), after the WHO African Region (47%). The WHO Region of the Americas has the highest level of implementation (72%), while the global average is 62%.

82. Travel advice and recommendations in relation to COVID-19 and emerging variants of concern have been consistently provided to countries, including the recommendations of the IHR Emergency Committee on performing risk assessment to inform travel-related decisions.

83. 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, WHO's regional team developed the Eastern Mediterranean Region travel measures platform in November 2020. The platform enables each IHR NFP to report weekly travel 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.

84. After the widescale resumption of international commercial traffic and relaxation of public health and social measures, countries in the Eastern Mediterranean Region have continued to adjust their travel-related measures in response to evolving public health concerns throughout the course of the pandemic, including the application of testing, isolation, quarantine and vaccination requirements. Entry restrictions have followed suit, with countries within the Region implementing restrictions in response to the emerging COVID-19 variants of concern. As of 31 May 2022, three countries are implementing entry restrictions, of which two are implementing travel restrictions due to variants of concern, including on travel from India (two countries), Brazil (one country), South Africa (one country) and Viet Nam (one country).

85. 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.

86. Countries in the Region are pursuing national strategies in order to mitigate risks associated with international travel and are increasing their capacities at points of entry, including updating their continency plans and standard operating procedures, revising and adjusting entry and exit screening measures, building the capacity of the workforce at points of entry, and reviewing and updating public health collaboration across borders.

87. Countries in the Region have relied on enhanced testing strategies. As of May 2022, 14 countries report 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). Eight countries in the Region require testing upon arrival (six require PCR tests and three countries offer both options of PCR or rapid testing).

88. Nine countries in the Region have adopted mixed methods for quarantine measures, with two countries employing home quarantine and three countries providing institutional quarantine. Quarantine times range from three to 21 days (with an average of 14 days).

89. Given the introduction of vaccines and the global, albeit unequal, roll-out of mass immunization campaigns, vaccination has been added as another parameter to monitor travel measures. Thus far in the Region, 11 countries are exempting fully vaccinated passengers from mandatory testing and eight countries are exempting fully vaccinated passengers from mandatory quarantine. Vaccination is an entry requirement in 13 countries, with five countries recognizing immunity certificates of recovery from a previous COVID-19 infection.

Yellow fever

90. As of May 2022, all 22 countries and territories of the Region had responded to the annual questionnaire on requirements for yellow fever vaccination for international travellers. Nine of the 22 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).

Conclusion

91. The implementation of the IHR (2005) continued to be a challenge in 2021–2022 due to the COVID-19 pandemic and competing priorities. Enhancing regional and country efforts to accelerate the implementation of the Regulations is critical. Effective engagement of countries of the Region in the ongoing related global processes is also needed to ensure better reflection of the regional situation and the development of effective and regional tailored solutions.

Progress in implementing the plan of action for accelerating health emergency preparedness and response

Ending the pandemic

92. WHO's regional team continue to promote strong leadership and management of the pandemic response at the country and regional levels. WHO and its partners continue to lead and coordinate efforts to reduce inequities and prioritize access to COVID-19 vaccines. As of 14 June 2022, the vaccination coverage target of 70% has been achieved in Bahrain, Qatar, Kuwait, Saudi Arabia and the United Arab Emirates. Coverage is still below 10% in Somalia and Yemen. Regional coverage is 10% fully vaccinated and boosted, 43% fully vaccinated and 8% partially vaccinated.

93. Risk assessment has been increasingly used to inform decisions related to public health and social measures (PHSMs), including those related to international travel. Socioeconomic contexts have also been considered when deciding on PHSMs. Nevertheless, in some instances risk-based guidance is not directly implemented, as other considerations are also factored into executive decisions on PHSMs. Levels of compliance with these measures has been varied across countries and is associated with several constraining factors, including inefficiencies in multisectoral coordination, ability to enforce implementation of PHSMs and community resistance, complacency and fatigue. Behaviour change interventions have been implemented in several countries with the support of WHO and its partners, targeting different communities to increase compliance with PHSMs and COVID-19 vaccine uptake. Capacities have also been built for establishing and utilizing systems for social listening and community feedback.

94. Laboratory capacities have been substantially expanded in the Region. Over 600 laboratories across the Region now have PCR capacities, and genomic sequencing capacity has been established and/or expanded in 17 countries, with three reference laboratories being established.

95. Countries, with the support of WHO and its partners, have been expanding and strengthening: surveillance, testing and genomic sequencing; RCCE; clinical management; infection prevention and control; and research and innovation. The provision of and access to essential health services has been resumed in all countries following the significant disruption caused by the pandemic. Capacity-building, including technology transfer for COVID-19 vaccine production, has been carried out in Egypt and Tunisia. Support has also been provided for medical oxygen production and distribution in health facilities. Further details about these core elements for the response to COVID-19 can be found in the COVID-19 progress report.

Preventing and controlling future pandemics and other health emergencies

96. Efforts are ongoing to assess and develop models for governance of health disasters and emergency risk management, including adoption of an incident management system, strengthening public health emergency operations centres and facilitating their implementation at the country level. The launching of the UHPR in the Region is a step forward in enhancing health emergency preparedness using a health system approach, including establishing sustained financing for health security.

97. Delegates at the Seventy-fifth World Health Assembly agreed a landmark decision on sustainable financing for WHO, adopting a series of recommendations from the Working Group on Sustainable Financing to make WHO's funding more predictable and flexible, and less dependent on voluntary contributions. This will facilitate the implementation of WHO's programmatic areas and the provision of needed support to countries, including in the area of health emergency preparedness and response.

98. Country-to-country support has been provided, in accordance with Article 44 of the IHR (2005), to respond to COVID-19. This includes a twinning programme on clinical management between Oman and Yemen; support by the governments of Qatar, Pakistan and the United Arab Emirates for airlifting lifesaving supplies — including supplies for COVID-19 treatment — during the humanitarian crisis in Afghanistan; and the sharing of vaccines by several countries. The Regional Office is collecting and documenting these and other success stories to build on, expand and further facilitate country-to-country support in health emergency preparedness and response, including collaboration across borders.

99. Collaborative efforts to implement integrated disease surveillance are ongoing or planned in several countries (e.g. Jordan, Lebanon, Pakistan) following the endorsement of the related technical paper at the Regional Committee and resolution EM/RC68/R3. Similarly, genomic sequencing capacity is now available in 20 countries/territories for COVID-19 and is currently being expanded to support other emerging infectious disease. For the other two countries (Sudan and Yemen), genomic testing arrangements with regional reference laboratories are in place; and regional reference laboratory capacities have now been established in Morocco, Oman and United Arab Emirates. Additionally, all 22 national reference laboratories and over 300 other laboratories successfully passed a COVID-19 external quality control review. Capacity-building and technical support are also being continuously provided to ensure the rigorous implementation of biosafety and biosecurity measures in all countries/territories.

100. WHO recognizes that epidemics and pandemics begin and end in communities. Assessments have therefore been undertaken in Afghanistan, Somalia and the Syrian Arab Republic to identify localized interventions for building resilient communities for health emergency prevention, preparedness, readiness and response.

101. There is increasing recognition at global and regional levels of the growing health threats at the human–animal–environment interface, as well as of the need to consistently apply the One Health approach to prevent, prepare for, detect, respond to and recover from these threats and consequent emergencies. A regional operational framework for One Health has been developed through an extensive consultative process with countries and partners and forms part of a technical paper for discussion at the 69th session of the Regional Committee. A quadripartite regional coordination mechanism between FAO, WOAH (formerly OIE), UNEP and WHO will be established to coordinate efforts to support countries in adapting and implementing the operational framework.

102. A regional oversight committee with high level country representation and a technical working group with a varied level of technical capacities are is being established per the terms of reference presented in annex 2 of technical paper EM/RC68/4 on accelerating health emergency preparedness and response. The committee and technical working group will have their first meetings in September 2022 to review progress made on the plan of action and advise the Secretariat on the way forward. The meeting is also expected to discuss challenges in implementation and identify regional and country mechanisms to facilitate the review and implementation of national action plans for health security.

103. The global architecture for health emergency preparedness, response and resilience presented and discussed during the Seventy-fifth World Health assembly provides clarity on the main measures to enhance governance, systems and tools, and mobilize resources. Concrete steps and approaches for operationalizing these measures at the country level are under discussion. Finalizing these discussions will further facilitate the review and implementation of national plans for health security.

Annex 1

IHR (2005) national capacity monitoring: capacity scores (%) for all reporting States Parties and territories in the Region for 2021

Member State	Legislation	Coordination	Financing	Laboratory	Surveillance	Human resources	Health emergency management	Health service provision	Infection prevention and control (IPC)	Risk communication	Points of entry	Zoonosis	Food safety	Chemical	Radiation
Afghanistan	20	60	40	52	80	30	53	60	47	40	27	60	20	20	0
Bahrain	100	67	100	96	100	70	80	100	73	80	100	40	100	40	60
Djibouti	30	40	40	52	70	50	27	47	33	40	33	40	60	40	20
Egypt	90	87	100	76	100	80	100	100	80	53	100	80	80	80	80
Iran (Islamic Republic of)	100	93	80	92	90	90	100	93	73	73	87	80	80	100	60
Iraq	50	67	30	60	60	40	40	40	33	67	20	60	40	40	40
Jordan	40	40	40	64	40	40	47	60	53	40	73	80	40	60	60
Kuwait	20	80	100	80	100	90	80	87	100	87	80	80	80	100	80
Lebanon	80	73	40	84	100	60	73	67	60	33	60	80	40	60	80
Libya	30	60	30	56	80	60	67	67	33	20	7	60	40	20	40
Morocco	50	53	80	80	80	80	80	73	47	73	73	80	80	80	80
Oman	40	60	50	96	100	40	87	100	87	93	87	60	60	80	80
Pakistan	30	33	60	60	80	30	47	53	40	27	40	100	40	40	100
Palestine	70	53	30	40	70	50	27	53	47	67	20	80	0	20	20
Qatar	70	87	90	100	100	100	100	100	67	100	87	100	100	80	100
Saudi Arabia	100	93	100	80	100	90	93	93	93	93	87	60	100	80	100
Somalia	20	40	20	56	90	30	40	60	27	20	7	20	20	20	20
Sudan	40	73	60	52	50	30	60	33	33	53	40	60	20	20	40
Syrian Arab Republic	60	53	60	52	50	40	53	60	53	60	87	60	60	60	60
Tunisia	40	80	60	88	100	50	60	93	47	33	60	80	80	80	40
United Arab Emirates	100	100	100	100	100	80	100	100	100	100	100	80	80	100	100
Yemen	30	60	50	68	90	70	67	73	60	60	20	60	40	60	20