
Shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO 2012-2016

Mid-term progress report

Introduction

1. WHO aims to make a difference by 2016 in the Eastern Mediterranean Region in five key areas that will lay the foundation for continued positive development in health: health systems strengthening for universal health coverage; maternal and child health; communicable diseases; noncommunicable diseases; and emergency preparedness and response. These priorities are in line with, and relate closely to, the five technical categories of work that came into action in January 2014 with the implementation of WHO's Twelfth General Programme of Work 2014–2019 (GPW12). A sixth priority is to implement WHO management reforms, also in line with GPW12. The WHO Regional Committee for the Eastern Mediterranean, at its 59th session in 2012, welcomed the strategic directions proposed by the Regional Director, Dr Ala Alwan, for the five-year period 2012–2016 and requested him to take steps to implement them.^{1,2}

2. In 2012 it was noted¹ that the health status of the populations of the Region is changing rapidly, driven by socioeconomic development and the evolving demographic and epidemiological transitions. Life expectancy in the Region had increased by more than 12 years between 1980 and 2007. Advances had been made in combating malaria and poliomyelitis, and routine immunization against vaccine-preventable diseases had been consistently above 85% in the previous 5 years.

3. However, there were still major challenges to health, and health gains at regional level masked inequities in health between and within countries. Regional under-5 mortality was still unacceptably high, estimated at 68 per 1000 live births in 2010, and likewise regional maternal mortality which stood at 250 per 100 000 live births in 2010³. Some countries had among the highest levels of maternal and child deaths in the world. Protracted humanitarian emergencies and the complex dynamics of sociopolitical change affected almost 37 million people in 13 countries in 2012. Nearly a third of male deaths in the age group 15 to 59 years were attributable to injuries, of which 40% were war- and violence-related, and 31% due to road traffic events. Noncommunicable diseases were estimated to be responsible for over 50% of mortality and more than 60% of disease burden, mostly due to cardiovascular diseases, diabetes, cancers and chronic lung disease which largely share the same risk factors, namely tobacco use, physical inactivity, and unhealthy diet⁴. The prevalence of smoking among adult men was reported to be as high as 50% in some countries⁵, more than 50% of

¹ Shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO. Cairo: WHO Regional Office for the Eastern Mediterranean; 2012. (WHO-EM/RDO/002, http://applications.emro.who.int/dsaf/EMROPUB_2012_EN_742.pdf accessed 11 April 2014.)

² Resolution of WHO Regional Committee for the Eastern Mediterranean, Fifty-ninth session. Annual report of the Regional Director for 2011 and progress reports. Cairo: WHO Regional Office for the Eastern Mediterranean; 2012. (EM/RC59/R.1, http://applications.emro.who.int/docs/RC_Resolutions_2012_1_14690_EN.pdf?ua=1 accessed 11 April 2014.)

³ Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA and The World Bank estimates. Geneva: World Health Organization; 2012. (<http://www.who.int/reproductivehealth/publications/monitoring/9789241503631/en/> accessed 12 May 2014.)

⁴ Plan of action for the prevention and control of noncommunicable diseases in the Eastern Mediterranean Region. Cairo: World Health Organization, Regional Office for the Eastern Mediterranean, 2011.

⁵ WHO Report on the Global Tobacco Epidemic, 2013. Geneva: World Health Organization; 2013.

women in the Region were overweight, and the Region had one of the highest rates of insufficient physical activity and diabetes.

4. Individual countries differ widely in regard to the specific challenges faced and were categorized into three groups based on population health outcomes, health system performance and level of health expenditure. Group 1 comprises countries where socioeconomic and health development has progressed considerably over the past decades. Group 2 comprises largely middle-income countries which have developed extensive public health infrastructure but face resource constraints. Group 3 comprises countries which face constraints in improving population health outcomes as a result of lack of resources, political instability and other complex development challenges.

5. In order to understand the reasons for the health inequities within the Region, the challenges hindering lack of progress were identified for each of the five specific technical areas, together with the relevant gaps in WHO capacity, and achievable goals and targets were set to address these. Emphasis was placed on improving health outcomes for marginalized and disadvantaged populations, primary health care-based approaches and regional public health capacity, and enhancing outreach and partnership. The purpose of this paper is to describe the progress made in 2012–2014 towards achieving those goals, and the remaining ground to be covered by the end of 2016.

Regional challenges and achievements 2012–2014

Health system strengthening for universal health coverage

Challenges

6. The main challenges in the area of health systems were identified as high rates of out-of-pocket payment in low-income and middle-income countries (ranging from 28% to 78%), inequities in access to health care, the absence of long-term strategic planning for the health workforce, and inadequate national capacity in key areas, such as public health and family medicine. Two other key challenges were identified that impact on these. First, despite the large presence of the private sector in provision of health services in the Region, its potential is not being exploited to best advantage nor is it being regulated with regard to quality of services. Second, health information systems are fragmented, with gaps in cause-specific mortality, facility records, regular health surveys, and routine and other data collection activities, resulting in inability to monitor and plan efficiently and effectively.

7. In 2012, and following a clear situation analysis and identification of strategies and options for health system strengthening in seven priority areas⁶, progress towards universal health coverage was identified by the Regional Committee at its 59th session as the overarching priority. Other priorities include strengthening leadership and governance in health; strengthening health information systems; promoting a balanced and well managed health workforce; improving access to quality health care services; engaging with the private health sector; and ensuring access to essential technologies.

Progress

8. Initiatives were undertaken in the seven priority areas. In order to support countries in moving towards universal health coverage, a strategy and roadmap was presented for discussion to the Regional Committee⁷ outlining what countries can do to move away from out-of-pocket direct

⁶ Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. Cairo: WHO Regional Office for the Eastern Mediterranean; 2012. (EM/RC59/Tech.Disc.1, http://applications.emro.who.int/docs/RC_Tech_paper_2013_tech_disc_2_15016_EN.pdf?ua=1, accessed 11 April 2014.)

⁷ Towards universal health coverage: challenges, opportunities and roadmap. Cairo: WHO Regional Office for the Eastern Mediterranean; 2013. (EM/RC60/ Tech.Disc.2 Rev.1, http://applications.emro.who.int/docs/RC_Tech_paper_2013_tech_disc_2_15016_EN.pdf?ua=1, accessed 11 April 2014.)

spending on health care by citizens, and to adopt a multisectoral approach by engaging relevant stakeholders. A resolution was adopted outlining a way forward for the development of country-specific roadmaps. Two regional meetings were held in 2013 to raise awareness among countries on universal health coverage and develop a regional framework for action, and two subregional meetings helped take that work further forward.

9. Capacity was developed through workshops on health system strengthening and use of health care financing tools. OASIS assessment studies to strengthen health financing were conducted in five countries and health system profiles were developed for all countries, providing a baseline for performance monitoring. Intensive technical support is being provided at the national level to several countries to advance progress.

10. To strengthen health information systems a situation analysis of civil registration and vital statistics was undertaken in all countries using a rapid assessment approach and the results were discussed in a regional meeting of stakeholders with the aim of reaching consensus on ways and means to improve the level and quality of registration of births and deaths. Further in-depth assessments were conducted in nearly half of the countries, and the results were used to develop a regional strategy to strengthen civil registration and vital statistics, which was endorsed by the Regional Committee⁸. In order to help countries to strengthen their health information systems, particularly data sources, collections, analysis and dissemination, a core list of indicators covering health risks and determinants, health system performance and health outcomes was developed in close coordination with Ministries of Health and Interior, as well as Central Statistics Departments of Member States.⁹ WHO will organize a regional meeting in September 2014 to launch the health information systems indicators (HISI) and the regional strategy. In the meantime, a regional health observatory was launched to ensure that all health-related information is accessible and used for better planning at both regional and country level.

11. To improve access to quality health care services work has started on developing guidelines on a strategic approach to family practice. The patient safety assessment tool was revised, and a curriculum for medical and nursing schools finalized and translated to Arabic. A study of public sector hospitals in the Region was conducted to establish an overview of the situation, a position paper was developed on home health care and a mapping of providers and facilities in the private sector was presented to the Regional Committee in a pre-session meeting. To strengthen leadership and governance in health, an analysis was conducted in four countries on the situation with regard to public health law. This was followed by a regional meeting on public health law at which recommendations were made on the roadmap to develop comprehensive guidance to countries.

12. A strategic framework is being developed to promote a balanced and well managed health workforce. A discussion paper is being developed for discussion in a regional meeting organized later in 2014. A study on the status of medical education in the Region was launched, with all medical schools invited to participate. The results are expected to be presented in a regional meeting in August 2014. Strengthening the role of nursing and midwifery is essential for achieving universal health coverage. The Regional Office will work with regional and international experts to review the current situation, identify gaps and develop a comprehensive vision and plan on nursing and midwifery.

13. With regard to ensuring access to essential technologies, the first regional health technology assessment workshop was held in 2013 to raise awareness, triggering the setting up of national

⁸ Resolution of WHO Regional Committee for the Eastern Mediterranean, Sixtieth session. Regional strategy for the improvement of civil registration and vital statistics systems 2014–2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2012. (EM/RC60/R.7, http://applications.emro.who.int/docs/RC60_Resolutions_2013_R7_15140_EN.pdf, accessed 11 April 2014.)

⁹ Resolution of WHO Regional Committee for the Eastern Mediterranean, Sixtieth session. Monitoring health situation, trends and health system performance. Cairo: WHO Regional Office for the Eastern Mediterranean; 2012. (EM/RC60/R.8, http://applications.emro.who.int/docs/RC60_Resolutions_2013_R8_15141_EN.pdf, accessed 11 April 2014.)

programmes and mapping of existing national and region-wide health technology assessment resources. Development of national pharmaceutical sector profiles is in progress to provide each country with a quick overview of the pharmaceutical sector, as is the development of a regional prequalification programme for vaccines and biologicals.

14. In 2012, the Member States requested¹⁰ WHO to take a number of steps to support them in strengthening health systems.

Maternal and child health

Challenges

15. Almost 899 000 children under 5 years of age and 39 000 women of childbearing age are still dying each year. With progress towards Millennium Development Goals (MDGs) 4 and 5 in jeopardy for nearly half the countries in the Region, WHO committed to scaling up support for maternal and child health with special emphasis on nine priority countries with a high burden of morbidity and mortality among mothers and children.

Progress

16. An initiative entitled “Saving the lives of mothers and children: rising to the challenge” was launched in partnership with UNFPA and UNICEF, countries and other stakeholders at a high-level meeting in Dubai, January 2013. Comprehensive acceleration plans were developed and costed for the nine priority countries. Several countries launched their plans formally in order to further advocate for maternal and child health and ensure high-level commitment. In 2013, the initiative was endorsed by the Regional Committee which urged the countries to strengthen multisectoral partnerships in order to implement the maternal and child health acceleration plan¹¹. WHO provided US\$ 2.6 million to kick start implementation. National workshops were conducted to finalize country accountability frameworks and develop roadmaps for the priority countries concerned.

17. In March 2014, experts reviewed progress and identified the steps required for supporting implementation of the plans in countries. A series of joint WHO-UNFPA-UNICEF country visits to the countries concerned has been initiated to monitor progress in implementation, identify health system-related gaps and determine the actions needed to bridge them, such as human resources, life-saving medicines and equipment, infection control and quality assurance measures, reporting and information systems, and implementation and operational research. Whether the acceleration plans will be fully implemented will depend on national commitment, solidarity from other countries and the support of partners.

Communicable diseases

Challenges

18. One of the key challenges to scaling up coverage of prevention and control measures for communicable diseases is the need to strengthen and sustain adequate surveillance and response capacities for identification, detection, assessment, prevention and control of emerging disease threats. Implementation of the International Health Regulations (2005) is a major commitment of all Member States and yet capacity to implement and monitor implementation of the regulations remained

¹⁰ Resolution of WHO Regional Committee for the Eastern Mediterranean, Fifty-ninth session. Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. Cairo: WHO Regional Office for the Eastern Mediterranean; 2012. (EM/RC59/R.3, http://applications.emro.who.int/docs/RC_Resolutions_2012_3_14693_EN.pdf, accessed 11 April 2014.)

¹¹ Resolution of WHO Regional Committee for the Eastern Mediterranean, Sixtieth session. Saving the lives of mothers and children. Cairo: WHO Regional Office for the Eastern Mediterranean; 2012. (EM/RC60/R.6, http://applications.emro.who.int/docs/RC60_Resolutions_2013_R6_15139_EN.pdf, accessed 11 April 2014.)

inadequate, as did coordination between the different stakeholders at country level, particularly with the non-health sectors. Laboratories are not given adequate priority and recognition in most national health delivery systems, resulting in lack of national policy and strategy for laboratory services.

19. With regard to vaccine-preventable diseases, in 2010, 1.8 million infants did not receive their third dose of DPT vaccine while the Region missed the target for measles elimination, postponing it to 2015. Poliomyelitis continued to be endemic in two countries of the Region. Middle-income countries were experiencing financial and operational difficulties with the introduction of new life-saving vaccines. Specific challenges were identified for the target diseases of MDG 6. Coverage with HIV treatment for those in need was low (just 15% in 2012), national tuberculosis control programmes were still missing a large number of the estimated cases (estimated at 250 000 in 2012) and most malaria-endemic countries had inadequate malaria surveillance and laboratory capacity for parasitological diagnosis. The regional confirmation rate for malaria was below 20%.

Progress

20. A roadmap for establishing integrated disease surveillance and response systems was developed and a consultative meeting to develop a regional framework was held. A consultation was also held on establishing a regional GOARN to facilitate mutual support and solidarity arrangements between countries in times of crisis and 24 regional experts are now trained in outbreak response and members of the GOARN network, compared with 11 in 2012. An early warning and alert response network (EWARN) system and epidemic readiness measures were established in countries affected by the Syrian crisis.

21. Countries affected by the emerging Middle East respiratory syndrome (MERS-CoV) were provided with guidance on conducting epidemiological studies to understand the risk factors for exposure and risk behaviours that result in human infection, as well as technical support to contain the outbreak. Three global technical consultations were held in the Region. Strategic approaches were developed to combat the threats posed by antimicrobial resistance, supported by the Regional Committee, and gap analysis was conducted.

22. The low level of readiness in the Region to implement the International Health Regulations was brought to the attention of the Regional Committee and, by April 2014, six more countries indicated readiness to implement the Regulations. Review missions were conducted for most countries in the Region and technical support provided to countries requesting further extension to 2016. The main gaps in capacity to implement the Regulations were identified and support is being provided to enhance preparedness capacities, particularly those related to mapping out potential hazards and developing public health emergency preparedness and response plans based on the all-hazards approach.

23. High routine immunization coverage ($\geq 90\%$) was maintained for DPT3 in 14 countries, despite the continuing regional challenges. There was a 42% reduction in the number of measles cases in 2013 compared with 2011 following supplementary immunization activities covering 94 million people in 12 countries. New vaccines against childhood diseases were introduced in nine countries. The situation with regard to polio deteriorated, with a substantial increase in the number of cases in Pakistan due in part to a ban on vaccination by local militants in a few areas and attacks on health workers, and outbreaks in 2013 in Somalia and Syrian Arab Republic. The Regional Committee declared polio a regional emergency in 2013. WHO established the Global Islamic Advisory Group (IAG), with support from the Grand Imam of Al Azhar and religious scholars in Egypt, Saudi Arabia and Pakistan to enhance outreach efforts. A major meeting of the IAG was held in Jeddah with the participation of the Secretaries-General of the Organization of Islamic Cooperation and the Islamic Development Bank and the Deputy Grand Imam of Al Azhar.

24. With regard to immunization strategy, comprehensive evaluation of national EPI programmes was undertaken followed by development of national comprehensive multi-year plans (cMYP) and measles elimination reviews in countries close to achieving elimination. Regional guidelines for verification of measles/rubella elimination were developed, a regional measles elimination verification commission was established and support provided for establishing national measles elimination verification committees. In coordination and collaboration with partners, WHO started implementing the pooled vaccine procurement initiative in stages. During the initial stage, interested middle-income countries can utilize UNICEF Supply Division services from 2014. A work plan was developed to strengthen the organizational structure of national laboratory systems and empower leadership, to ensure a safe, secure laboratory environment and to implement quality management system practices in all health laboratories.

25. With regard to MDG 6, 19 countries currently participate in reporting progress on implementation of the regional strategy (compared with 20 in 2012). A regional initiative to end the HIV treatment crisis was launched in 2013. The number of people receiving treatment in the Region rose from an estimated 25 000 in 2012 to over 38 000 by the end of 2013. Situation analysis to identify lost opportunities to engage and retain PLHIV in testing, treatment and care was conducted in several key countries and development of action plans for treatment acceleration was supported.

26. There was no change in the situation with regard to tuberculosis in 2014 with the MDG target for halving mortality by 2015 compared to 1990 standing at just 16%. The number of countries with complex emergencies and hosting refugees receiving support for tuberculosis and MDR-TB control increased from 5 in 2012 to 12 in 2014, and the number of countries receiving support to expand MDR-TB management increased from 9 to 14.

27. Surveillance and confirmation was improved in two of the six countries with a high burden of malaria. A regional malaria database was developed and country profiles published for 2012 and 2013. Support continued for countries targeting malaria elimination and the first regional malaria elimination course was conducted.

Noncommunicable diseases

Challenges

28. In 2011, Heads of State and government adopted the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases. The Declaration committed both Member States and WHO to action to implement its recommendations. WHO's priorities are to advocate for higher levels of political commitment and multisectoral engagement, to provide technical support to Member States in developing multisectoral plans and implementing the actions recommended in the Declaration, and to develop monitoring frameworks, including a set of national targets and indicators.

Progress

29. A number of initiatives were undertaken to support implementation of the UN Political Declaration. The International Conference on Healthy Lifestyles and Noncommunicable Diseases in the Arab World and the Middle East, held in Riyadh in 2012, provided an opportunity to raise awareness and to call for stronger action to implement the UN declaration. The 59th session of the Regional Committee endorsed a regional framework for action, which includes key measures that have to be implemented by countries in four areas: governance, surveillance, prevention and health care. WHO strengthened its own capacity at regional and country level, and established a regional technical advisory group, a roster of experts and a network of international and regional experts to support its collaborative work with countries. The unit for noncommunicable diseases was upgraded to a department, a director was appointed and additional staff were recruited. The Regional Office played an important role in strengthening WHO's global response to the noncommunicable diseases

challenge. The Second Regional Meeting on Noncommunicable Diseases made an important contribution in preparing for the High-level Meeting of the UN General Assembly on noncommunicable diseases, which will be held in New York in July 2014.

30. EMRO developed concrete technical guidance on implementing the evidence-based prevention measures “best buys” recommended by WHO. Guidelines on salt reduction and replacement of trans-fat, developed with top international experts, are now available to Member States. A set of training modules for countries on implementing the WHO noncommunicable disease surveillance framework has been developed in collaboration with a network of regional and international experts. A project to develop a dashboard of legislation and legal instruments for prevention and control of noncommunicable diseases has been initiated, in collaboration with one of the international collaborating centres based in New York. Guidance on breastfeeding was developed in consultation with governments. A ministerial multisectoral meeting was held to raise awareness of the impact of physical inactivity on population health and approaches to combat it. Other initiatives focused on building capacity for comprehensive surveillance systems, strengthening cancer registration, prevention, control, research and palliative care, in collaboration with the International Agency for Research on Cancer (IARC). In 2012, WHO Regional Office for the Eastern Mediterranean joined the international network of the Diseases Control Priorities Project (DCP3). A network of young economists working on economic evaluation of noncommunicable disease interventions was established as part of this project.

Emergency preparedness and response

Challenges

31. The increasing frequency and scale of emergencies in the Region (both natural hazards and political conflict) poses specific challenges and contributes to the overall challenge of tackling the other four priority areas in the countries affected. More than half of the countries in the Region are experiencing emergencies, ranging from civil conflict to natural hazards such as drought, earthquakes and floods. Four of these countries are faced with the additional burden of hosting more than half of the world’s refugees: Pakistan and the Islamic Republic of Iran remained the top two refugee-hosting countries by mid-2013, while Jordan and Lebanon moved up to the third and fourth positions, respectively, as refugee-hosting countries as a result of the Syrian crisis. Since the beginning of the year, Jordan’s refugee population doubled while that of Lebanon tripled. According to United Nations data, since 2012, the number of refugees in the Region has increased by almost 20 million.

32. One of the main challenges facing relief agencies in providing an effective humanitarian response in areas where emergencies, especially political conflict, are ongoing, is lack of access and the increased security and mitigation measures needed to access the most vulnerable populations. Further impeding the work of health care workers are violations of international humanitarian law and the Geneva Conventions through attacks on health facilities and health personnel. Additionally, the flight of health care workforce from countries in crisis can drain local capacity and result in shortages of qualified staff in the areas that most need them.

33. Emergencies deprive affected countries of resources for future generations and bring about socioeconomic setbacks, impeding long-term relief and development goals of affected countries, and setting back efforts by decades. A report prepared for the United Nations Economic and Social Commission for Western Asia (ESCWA) in 2013 estimated the losses of the Syrian economy at about US\$ 48.4 billion in 2012 as a result of the ongoing political conflict.

34. Lack of funding remains a key challenge in ensuring an effective health response in emergencies. Consolidated appeals for the Region are currently funded at 38% for health, leaving critical health needs of affected populations unmet as a result. The establishing of a Regional Emergency Solidarity Fund as defined in a 2005 Regional Committee Resolution would facilitate the

availability of funding for health response activities in emergencies, yet this initiative remains inactive due to lack of support by Member States.

35. Many countries lack the necessary policies and legislation to support or facilitate emergency preparedness and response at all levels across sectors and only a third have institutionalized emergency preparedness and response programmes within the health sector. To address the challenges in this area, WHO has defined a set of strategic priorities aimed at increasing the resilience of health systems and strengthening their ability to respond effectively. This would be achieved through: support for development of policy and legislation; promotion of a disaster risk management strategy based on an all-hazard and whole health multisectoral approach; an increased investment allocation of 10% for emergency preparedness at country level; and sharing the national thematic platform for health with the United Nations International Strategy for Disaster Reduction (UNISDR).

Progress

36. Initiatives undertaken to ensure national preparedness for emergencies included support for the integration of the International Health Regulations within the emergency risk management framework in three countries to scale up emergency preparedness and response, and institutionalizing of emergency risk management within the health sector in seven countries. A hospital safety programme was implemented in five countries. WHO stepped up advocacy to prevent attacks on health facilities and health care workers. A competency-based curriculum to enhance support for systematic capacity development and a comprehensive protocol for risk assessment to facilitate vulnerability analysis and underscoring priority actions were developed.

37. With the implementation of reforms in WHO's response activities in emergencies, an emergency support team was established in Amman to provide a dedicated, consolidated regional response to the crisis in the Syrian Arab Republic. Capacity-building of health professionals in countries experiencing emergencies was conducted, included training on responding to chemical hazards management for health personnel in four countries.

38. A regional emergency roster of health experts was set up for deployment to countries when needed and a regional hub was established in Dubai in collaboration with the World Food Programme for emergency distribution of medicines and medical supplies. The standard operating procedures for procurement of health relief supplies were revised and streamlined.

39. Early warning and response systems were established or strengthened in seven countries to detect and manage communicable disease outbreaks. The Health Resources Availability Mapping System (HeRams) was integrated into the national health system in Pakistan and Syrian Arab Republic to ensure good practice in the mapping of health resources and health service availability and nutrition assessments were conducted in Iraq, Jordan and Lebanon. In the Syrian Arab Republic, the national list of urgently required essential medicines was updated, reflecting disease profiles, current gaps and critical needs.

The next two years

Health systems strengthening for universal health coverage

40. In the coming two years Member States need to start taking action on the seven priorities: move towards universal health coverage; strengthen leadership and governance in health; strengthen health information systems; promote a balanced and well managed health workforce; improve access to quality health care services; engage with the private health sector; and ensure access to essential technologies (essential medicines, vaccines, medical devices and diagnostics).

41. WHO will continue to support countries to develop a national strategy and roadmap for universal health coverage. It will develop country profiles that include both health system and disease

data. It will direct specific support to strengthening health policy and planning units, developing health policy and strategy and a framework for governance and accountability, and advising on essential public health functions. It will support capacity strengthening in hospital management. WHO will develop workable models of health care delivery and appropriate tools to make reliable future workforce projections. It will review regional and international experience in family medicine training programmes, and document best practices of performance-based incentive schemes for health workers. It will also focus on strengthening of national regulatory authorities, promoting rational use of medicines, developing laboratory support to primary and secondary care and review of the traditional medicine situation in the Region.

Maternal and child health

42. In the coming two years Member States need to maintain high-level advocacy for the maternal and child health acceleration plans in order to sustain commitment at different levels of the government and among partners and mobilize resources to bridge funding gaps. The regular flow of funds committed to the acceleration plans to the different implementation levels needs to be ensured, as does regular availability of skilled human resources and life-saving medicines and commodities. Quality of care and the health information system up to the health district level need to be improved. The quality of implementation of acceleration plans needs to be monitored and appropriate operational research conducted.

43. WHO will support Member States to maintain a high level of commitment; invest in close partnership and collaboration with UNFPA and UNICEF and key stakeholders; and support resource mobilization efforts to address gaps in funding of the acceleration plans. WHO will also support the strengthening of country capacity to implement the plans and will follow up on implementation, jointly with key partners to ensure smooth implementation and optimal outcome. Coordination mechanisms with partners will be further strengthened to monitor progress and address bottlenecks.

Communicable diseases

44. In the coming two years Member States need to establish strong district health information and national communicable diseases databases. Sufficient funds need to be allocated to support surveillance and laboratory capacity-building activities for emerging infectious disease, including antimicrobial resistance, as well as for immunization, including regular procurement of vaccines, introduction and sustainability of the new life-saving vaccines and implementation of planned supplementary immunization activities to achieve measles elimination. Sustainable laboratory strategies need to be developed to improve laboratories in a cross-cutting manner, to improve health care and public health generally, including better preparedness for, surveillance of and response to epidemic-prone diseases and other potential public health emergencies of international concern. Multisectoral committees need to be set up with defined terms of reference and high-level representation of the different sectors concerned to allow timely decision-making, with active involvement of each department, in the development and implementation of the plan of action for the International Health Regulations by the 2016 deadline.

45. National malaria programmes need to strengthen diagnostic testing, quality-assured treatment and surveillance, in line with the T3 initiative. Tuberculosis case detection and laboratory performance need to be improved. HIV testing and treatment targets need to be set and HIV treatment acceleration plans developed and implemented. Costed eMTCT plans need to be developed and resources to support implementation mobilized.

46. WHO will increase its capacity in communicable diseases at a regional level. It will develop an evidence-based strategic framework for the Region for prevention and control of emerging zoonotic infections. It will make use of the opportunity afforded by the newly launched global health security initiative and further enhance collaboration with donors and technical institutions to mobilize

technical and financial resources to support the implementation of the International Health Regulations. It will continue to facilitate dialogue between neighbouring countries to establish a mechanism to enhance cross-border surveillance and response and facilitate the sharing of experience with other countries in the Region and other WHO regions.

47. WHO will continue to support Member States for the implementation of the Global Vaccine Action Plan (GVAP) and of the regional strategy for measles elimination. It will also support the development of national health policies and plans to strengthen the public health laboratory network. It will continue to support countries to update their strategies, policy and guidelines in line with the recommendations of the WHO and Malaria Policy and Advisory Committee (MPAC), to reduce their malaria burden and accelerate efforts toward elimination. It will provide support to priority countries to conduct test-treat-retain cascade analysis to identify where gaps and missed opportunities lie along the continuum of care, to set targets and develop, implement and monitor HIV treatment acceleration plans and support countries to revise HIV treatment national guidelines in line with the new WHO recommendations.

Noncommunicable diseases

48. In the coming two years Member States need to scale up implementation of their commitments under the UN Political Declaration based on the regional framework for action, and especially the best buys.

49. WHO, in the area of governance, will develop model legal instruments and will support Member States in developing national targets, multisectoral action plans and platforms, scaling up use of dual-purpose fiscal measures, and integrating noncommunicable diseases in UNDAF. It will also support the strengthening of national institutional capacity, and reporting on progress to UN bodies.

50. In the area of prevention and reduction of risk factors, WHO will continue to support implementation of key interventions and will support Member States to identify gaps, challenges and the way forward in implementing each of the best buys, as well as to carry out operational and implementation research to address key gaps.

51. In the area of surveillance, monitoring and evaluation, WHO will strengthen the network of international and regional experts and will support Member States to lay the foundation for comprehensive surveillance systems, strengthen national capacities and integration of noncommunicable diseases in national health information systems.

52. In the area of health care, WHO will assess health system constraints at various levels, especially primary health care and develop a clear regional roadmap for strengthening health system response to noncommunicable diseases, particularly integration in primary health care.

Emergency preparedness and response

53. In the coming two years, WHO will provide technical support to Member States in the Region that committed to developing an effective emergency preparedness programme with emphasis on communities most at risk. This will be achieved through the development of a strategy and supporting a preparedness plan of action with the goal of building local and national capacities to increase resilience towards emergencies and crises, under the auspices of health security.

What WHO has done to improve performance

54. Where organizational issues are the cause of constraint, WHO has worked to find solutions, in line with the commitments made under WHO management reform. Structural reorganization was implemented to strengthen technical work, particularly in the area of health systems, noncommunicable diseases, health information systems and knowledge management, and measures

were put in place to improve transparency and accountability. Country offices are being strengthened to assure more efficient managerial processes, better linkage between the country cooperation strategies and operational planning, and an adequate control environment.

55. New cost-effective products and services have been rolled out aiming to create healthy, productive and safe work environments in the Regional Office and country offices. The Libyan and Syrian crises triggered emergency responses to procure medicines, as well as, medical, hospital and laboratory supplies. Training on procurement resulted in improvements in local procurement processes. Procurement of goods by the Regional Office (US\$ 171 604 324 in 2012–2013) represents 41% of total WHO goods procurement. Due to frequent non-availability of emergency supplies (especially medicines) for immediate delivery to countries in acute emergencies, the process of establishing a hub in Dubai for emergency storage was initiated.

56. Greater attention has been given to performance management, especially to managerial aspects of performance at senior level, with the aim of improving compliance and adherence to the WHO regulatory framework. Staff development initiatives are being linked to gaps in performance identified through the performance management process.

57. The main challenge in the area of human resources is the emergency and crisis situation in the majority of countries, requiring non-standard solutions and approaches to staff management. This challenge is being dealt with through creation of rosters, emergency recruitments and placements, re-grouping existing resources by reassignments and mobility of existing staff.

58. Internal control mechanisms have been strengthened through quality assurance processes and a regional compliance function, and internal financial and management reviews of key offices have been launched to complement internal and external audits. A risk management framework has been rolled out to identify strategic and operational risks, as well as mitigation measures. WHO will continue to improve performance monitoring and evaluation tools, accountability and transparency. Internal review visits to country offices by multi-functional teams are planned in order to enhance administrative capacities and better prepare for upcoming internal and external audits. This will form part of overall regional efforts to improve compliance.

59. Funding remains a challenge. Resource mobilization from within the Region, at just 8%, remains the lowest among WHO regions, and while 2014–2015 is the first time the proposed programme budget has been fully funded, awards are not evenly distributed among priority areas. Work to develop a comprehensive resource mobilization plan has been initiated to increase predictability of financing and engage better with regional donors and partners.

Conclusion

60. The two year period 2012–2014 saw major commitments on the part of Member States and WHO in laying the foundations for progress in five key areas. These commitments were made at high level through the WHO Regional Committee for the Eastern Mediterranean and through a series of high-level and intersectoral meetings in key areas. The goals set are highly focused and are considered feasible and achievable. Work started immediately on putting the commitments into action.

61. A number of regional and local constraints have affected rapid implementation by WHO. These include the need to strengthen capacity in specific areas and therefore to recruit specialist support, and the security situation in several countries of the Region which has both hampered operations and also prevented attraction of new staff. Although some progress has been made, most of the networks and rosters planned are not fully populated in terms of experience and competence to the level expected by Member States. Therefore, emphasis is being placed on strengthening technical support through the expert roster, identifying and recruiting experts, and building networks.

62. At country level additional resources are required to fully implement some programmes, both from Member States themselves and through resource mobilization. In this regard, the coordination mechanism between partners and stakeholders varies from one country to another. The lack of coordination between different programme areas also needs to be addressed, both in WHO country offices and within ministries of health, so that common goals can be achieved effectively and efficiently.

63. Emergencies and large-scale population movements impede access to health care, particularly, but not only, for affected populations. They also drain vital resources away from sustainable health system development. Frequent changes in decision-making positions have hampered consistent implementation. Health information systems in some countries are not currently able to provide timely adequate information to enable effective assessment of health needs and monitoring of implementation.

64. Over one fifth of the burden of communicable diseases, noncommunicable diseases and injuries in the Region is estimated to be attributable to modifiable environmental risks. Therefore, multisectoral action beyond the specific actions outlined needs to be taken by governments. A regional strategy on health and the environment 2014–2019 was endorsed by the Regional Committee in 2013. Member States need to implement this strategy in order to ensure all aspects of public health are addressed¹².

65. Finally, it is clear that the solutions to many of the current health challenges in the Region require political solutions and action beyond the health sector. For this reason, WHO is stepping up its advocacy in the Region for health diplomacy to ensure that Member States are fully aware of, and engaged in, negotiations at national, regional and global levels that have direct impact on the health of their populations.

¹² Resolution of WHO Regional Committee for the Eastern Mediterranean, Sixtieth session. Regional strategy on health and the environment 2014–2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2013. (EM/RC60/R.5, http://applications.emro.who.int/docs/RC60_Resolutions_2013_R5_15138_EN.pdf?ua=1, accessed 15 April 2014.)