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Poliomyelitis eradication

The global progress towards poliomyelitis eradication in 2014 was substantial. However, the disease remains endemic in the Region. Of the 215 polio cases reported globally in the second half of 2014, 213 (99 %) are from the Eastern Mediterranean Region (Pakistan 192 cases, Afghanistan 20 cases and Somalia 1 case). Iraq and the Syrian Arab Republic also reported poliomyelitis cases in the first half of 2014 (two cases and one case respectively).

Pakistan suffered from the highest levels of wild poliovirus transmission in more than a decade. It faced significant and unique challenges, including bans on immunization by militant groups in parts of the Federally Administered Tribal Areas which restricted access to children, and multiple deadly attacks on frontline workers during polio campaigns in several parts of the country. Health workers and volunteers continued to demonstrate great courage in carrying out immunization activities. In addition to access and security issues, governance, operational and communication issues hampered eradication efforts in endemic parts of the country.

In Afghanistan, both endemic transmission and importations of wild poliovirus from Pakistan occurred, and barriers to access and the inadequate quality of some campaigns hindered reaching every child with vaccine, particularly in the eastern and southern regions. Nevertheless, the national programme has continued to implement activities with great determination.

In 2015, if the trend continues, it is highly likely that Afghanistan and Pakistan will be the only two countries in the world with active wild poliovirus transmission. This transmission is currently the greatest threat to the achievement of global eradication. The spread of the virus from these reservoirs poses a significant risk to polio-free countries in the Region.

Pakistan is implementing a detailed plan of action for the low transmission season (December 2014 to May 2015), focusing on innovative strategies and on endemic transmission zones within the country. Afghanistan also has an emergency action plan which aims to ensure high levels of immunity for the whole population, while interrupting transmission in the remaining infected zones. Full implementation of these plans will be critical to making progress with eradication in 2015. Review of epidemiology during the first half of 20015 already demonstrates a positive trend with a substantial reduction of cases compared to 2014.

The challenge of the spread of poliomyelitis in the Region brought an unprecedented response from Member States. The multi-country response to the Middle East outbreak which began in late 2013 was swift, coordinated and of high quality and, despite the conflicts and population displacement in the affected countries and their neighbours, this averted a major epidemic. The Syrian Arab Republic has not confirmed a case since January 2014 and Iraq since April 2014. In the Horn of Africa, following a sustained multi-country outbreak response there is also evidence that transmission in Somalia is coming under control, with only 5 cases reported in 2014, the latest having onset in August 2014.

The polio partnership is enhancing its support to both endemic countries through multiple interventions. These include: deploying the best available professionals; mobilizing resources to comprehensively implement all the planned activities; developing strong coordination mechanisms under the umbrella of the emergency operation centres at the federal and provincial levels; monitoring progress closely through development of a comprehensive monitoring framework and regular programme review by the technical advisory group; and implementing a strict accountability framework to ensure a high level of staff performance.

In 2015, WHO will escalate its support to the governments of Afghanistan and Pakistan to stop endemic transmission of poliovirus. WHO will continue to support other countries of the Region to enhance the sensitivity of the surveillance system and to improve the capacity to detect early and effectively respond to poliovirus importations. The mechanisms of the International Health Regulations (IHR 2005) are being used in order to reduce the risk of the international spread of poliovirus and to ensure a robust response to new polio outbreaks in polio-free countries. Support will be provided to Member States in developing plans for phased withdrawal of oral polio vaccine and containment of wild and vaccine-derived polio viruses.

The Islamic Advisory Group established at the regional level and a national advisory group in Pakistan are promoting polio eradication and immunization in general. The scope of work of the Islamic Advisory Group will be expanded to help in addressing other key health issues in the Region.

HIV, tuberculosis, malaria and tropical diseases

The HIV epidemic is still growing despite the overall prevalence remaining low. Regionally, the number of people living with HIV (PLHIV) who are receiving antiretroviral therapy (ART) increased from 32 000 in 2013 to 38 000 in 2014. Despite this progress, ART coverage has not increased significantly and at 10% still remains far from global targets.

Within the framework of the regional initiative to end the HIV treatment crisis, WHO provided technical and financial support to priority countries to revise their treatment guidelines and train health care providers. Thirteen countries now have national guidelines in line with the current WHO recommendations. Five countries received support to conduct HIV test–treat–retain cascade analysis, to establish evidence-based HIV testing and treatment targets and to develop treatment acceleration plans. Six countries developed national strategic and operational plans.

A regional viral hepatitis plan for 2014–2015 was developed and funds are being sought to enable implementation. The focus of activities is on the two high-burden countries, both of which developed national hepatitis strategies.

WHO is developing three related global health sector strategies for HIV, viral hepatitis and sexually transmitted infections. Two regional consultations will be organized in the first half of 2015 to provide regional inputs to the HIV and viral hepatitis strategies.

During 2013 [1] , over 448 000 cases of all forms of tuberculosis were notified in the Region. Nearly half of these were in two high-burden countries, Afghanistan and Pakistan. Still, 40% of estimated cases are missed or not reported in the Region. The treatment success rate was 87%, slightly higher than the global target of 85 %, and this has been maintained for 2 years.

10 countries have achieved or exceeded the 70% target of case detection and 9 countries have reached or exceeded the global target of 85% treatment success rate. There was slow but steady improvement in regard to management of multidrug-resistant tuberculosis (MDR-TB). Out of 17 000 estimated cases, only around 3687 were detected and 2013 were put on treatment. The treatment success rate reached 64%.

The current crises have had an impact on tuberculosis control. Population movements, the destruction of many health facilities, including tuberculosis facilities, and the deterioration of the economic situation have affected both patients and human resources. One of the implications of the current situation is the decrease in case detection (58% compared to 63% in 2012). Meanwhile, further scale-up of MDR-TB treatment is hindered by lack of proper infrastructure and financial constraints.

In response to the regional challenges, WHO developed guidance on control of tuberculosis in

complex emergencies, as well as a package of tuberculosis services for cross-border tuberculosis and MDR-TB patients. The Green Light Committee supported countries to improve diagnostic capacity and scale up treatment of MDR-TB . Monitoring missions to seven countries reviewed the MDR-TB management situation and advised on challenges. Access to new diagnostics continued to increase in the Region, with 4% of tuberculosis laboratories now using LED microscopy. However, domestic financing for tuberculosis controls continues to be less than 30%.

Within the strategic direction to scale up planning for tuberculosis control, review missions were conducted in several countries in 2014. Countries were supported technically to ensure smooth access to better financing from the Global Fund.

In 2014, six countries had areas of high malaria transmission (see Table 1) while transmission is focal in Islamic Republic of Iran and Saudi Arabia. The number of deaths due to malaria in the Region has more than halved since 2000 (from 2166 deaths compared with 1027 in 2013). In 2014, Pakistan and Sudan accounted for over 90% of the deaths (67% and 24%, respectively). The number of confirmed malaria cases reported in the Region decreased from 2 million in 2000 to 1 million in 2013, with Sudan and Pakistan accounting for 84% of cases (57% and 27% respectively).

Table 1. Reported malaria cases in countries with high malaria burden

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Country Name	2012	2013	2014
	Total reported cases	Total Confirmed	Total reported cases	Total Confirmed
Afghanistan	391365	54840	319742
Djibouti	25	25	1684

Pakistan	4285449	290781	3472727
Somalia	59709	18842	60199
Sudan	1001571	526931	989946
Yemen*	165678	109908	149451

* The estimated reporting completeness is 30% in 2014 due to current situation in Yemen

Seven countries (Afghanistan, Iraq, Islamic Republic of Iran, Morocco, Oman, Saudi Arabia and Syrian Arab Republic) have achieved MDG6 and the targets of resolution WHA58.2 as related to malaria. Elimination programmes have been successfully implemented in Islamic Republic of Iran and Saudi Arabia, with only 370 and 51 local cases, respectively, reported in 2014 (Table 2). Iraq has not reported any local cases since 2009. However, it has been difficult to measure the progress towards MDG6 in five of the countries with a high burden of malaria owing to the weakness of diagnostic and surveillance systems. The limited WHO capacity at country level to ensure sustained technical support, as well as inadequate allocation of funds from national resources in priority endemic countries and dependency on external funds, have also affected progress.

Table 2. Parasitologically-confirmed cases in countries with no or sporadic transmission and countries with low malaria endemicity

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Country

2012

2013

2014

Total reported cases

Autochthonous

Total reported cases

Autochthonous

Total reported cases

Autochthonous

Bahrain

233

0

NA

NA

NA

NA

Egypt

206

0

262

0

313

22

Islamic Republic of Iran

1629

787

1373

519

1238

370

Iraq

8

0

8

0

2

0

Jordan

117

0

56

0

102

0

Kuwait

358

0

291

0

268

0

Lebanon

115

0

133

0

119

0

Libya

88

0

NA

NA

NA

NA

Morocco

364

0

314

0

493

0

Palestine

0

0

0

0

NA

NA

Oman

2051

22

1451

11

1001

15

Qatar

708

0

728

0

643

0

Saudi Arabia

3406

82

2513

34

2305

51

Syrian Arab Republic

42

0

22

0

21

0

Tunisia

70

0

68

4

98

0

United Arab Emirates

5165

0

4380

0

4575

0

In 2014, in-depth programme reviews, updating of national strategic plans and development of insecticide resistance management strategies were supported in different countries. The global technical strategy 2016–2030 was developed through a comprehensive consultative process with all countries; seven regional consultations were conducted in 2014. A regional action plan to implement the strategy will be presented to the Regional Committee in 2015. The goal of this plan is to interrupt malaria transmission in areas where it is feasible and to reduce the burden by more than 90% in areas where elimination is not immediately possible, so that malaria is no longer a public health problem or a barrier to social and economic development.

Promising achievements have been made in schistosomiasis control and elimination, with Yemen an excellent example of how a strong partnership among national and international institutions can contribute to overcoming the most difficult challenges. In 2014, Yemen treated over 7.2 million children and adults with praziquantel and albendazole, despite the difficult security situation. Nationwide surveys have shown a sharp decrease in infection indicators and have indicated that schistosomiasis can be eliminated as a public health problem. In Sudan, 2.4 million people were treated with praziquantel following an increase in financial commitment by the Government and new partnerships.

Immunization and vaccines

Fourteen countries continued to achieve the target of 90% routine DTP3 vaccination coverage, but around 3 million children did not receive DTP3 vaccination, around 90% of which are in four countries (Afghanistan, Pakistan, Somalia and Syrian Arab Republic). Thirteen countries achieved above 95% coverage with MCV1 (first dose of measles-containing vaccine) at national level and in the majority of the districts, while 21 countries provided a routine second dose of measles vaccine with variable levels of coverage. To boost population immunity, national or subnational measles supplementary immunization activities were conducted in Afghanistan, Iraq, Pakistan and Syrian Arab Republic. Measles case-based laboratory surveillance has been implemented in all countries, with 20 countries performing nationwide surveillance and 2 countries conducting sentinel surveillance. As a result, measles incidence was significantly lower than in 2013. Eight countries reported very low incidence of measles (<5 cases/million population) with two of these continuing to achieve zero incidence and scheduled to verify measles elimination in 2015.

2014 marked achievement of completing the introduction of Haemophilus influenzae type B (Hib) vaccine in all countries. Rotavirus vaccine was introduced in the United Arab Emirates and

rubella vaccine in Yemen as part of the measles/rubella vaccination campaign. Yemen is expected to introduce MR vaccine into routine immunization in 2015. Sudan implemented the first phase of a yellow fever campaign. Inactivated poliomyelitis vaccine (IPV) was introduced in Libya and Tunisia and all the countries using only oral poliomyelitis vaccine (OPV) are on track for introduction of IPV in 2015. Currently, pneumococcal vaccine is being used in 14 countries, rotavirus vaccine in 9 countries and IPV in 12 countries of the Region.

Achieving the various programme targets was constrained by several challenges. These included the current security situation that hindered access, as well as insufficient visibility of the immunization targets in many countries, inadequate managerial capacity and commitment to routine immunization, and lack of financial resources. In order to overcome these challenges, WHO intensified its support to countries, through comprehensive immunization programme reviews and assessment of effective vaccine management that were conducted in several countries. Support was also provided for development and updating of multi-year plans, resource mobilization, measles immunization campaigns, surveillance of vaccine-preventable diseases, data quality, monitoring and evaluation, and introduction of new vaccines. Special attention was given to establishing and strengthening national technical advisory groups (NITAGs), which are now available in 21 countries. The Regional Office continued to provide technical and financial support to the regional surveillance networks for new vaccines introduction and measles/rubella surveillance in most countries.

WHO will continue to provide the necessary technical support and mobilization of resources for strengthening immunization programmes and achieving the targets. Priority activities for 2015 will include: ensuring access to high quality and safe vaccines through improving the procurement systems, support for comprehensive EPI reviews and updating of comprehensive multi-year plans (cMYP) in several countries; supporting proper planning and implementation of the reach every district (RED) approach in all districts with vaccination coverage below 80% in the low coverage countries, introduction of IPV in the 10 remaining countries, measles supplementary immunization activities, and hepatitis B serosurveys to document progress towards achieving the regional target; and strengthening EPI monitoring and evaluation. Advocacy for raising visibility of the EPI targets, especially measles elimination, and mobilization of high-level government support and commitment to routine immunization will be central.

Health security and regulations

The incidence of emerging and re-emerging infectious diseases continues to escalate in the Region as evidenced by the fact that half the countries of the Region reported high incidence of emerging infectious diseases in the past year, sometimes with explosive outbreaks. These included avian influenza A (H5N1) in Egypt, Crimean-Congo haemorrhagic fever in Afghanistan, Oman and Pakistan, dengue fever in Oman, Pakistan and Sudan, acute hepatitis A and E in

Jordan, Lebanon and Sudan, and severe acute respiratory infection caused by influenza A (H1N1) pdm09 virus in Egypt and Pakistan. These events, apart from taking a huge toll of lives, have weakened the public health systems considerably. Infections caused by the Middle East respiratory syndrome coronavirus (MERS-CoV), which emerged in the Region in 2012, continued to expand geographically, with persistent transmission, and cases have now been reported in 10 countries in the Region. Cases spiked in two countries last year owing, primarily, to secondary and nosocomial transmissions in health care settings and triggering heightened international concern for the emergence of a global public health emergency.

The ongoing humanitarian crisis in a number of countries has also weakened their public health systems, while displacing a large number of populations and exposing them to poor environmental health conditions and limited access to health care services. This provides ideal ground for proliferation of diseases and repeated outbreaks of epidemic-prone diseases have reported from these countries in crisis.

Towards the end of last year, the threat of introduction of Ebola virus disease (EVD) increased significantly owing to the connectivity of the Region with west African countries. The threat of importation of EVD into the already weakened and fragile health systems of countries affected by either humanitarian crisis or repeated epidemics, and the resultant public health implications, required public health preparedness and readiness measures across all countries to be stepped up in order to prevent any introduction of the disease and its spread in the Region.

In response to such frequent health security threats in the Region, WHO continued to work with the countries with a view to building, strengthening and expanding a sustainable public health system that is required under the International Health Regulations of 2005 to monitor detect, assess and contain acute and emerging health threats in the Region.

In response to Regional Committee resolution EM/RC/61/R.2, rapid assessments were conducted in 20 out of 22 countries to assess their capacity to deal with a potential importation of EVD. The assessments reviewed level of preparedness and readiness, identified critical gaps or areas of concern, and recommended urgent measures to mitigate risk of importation and spread. Following these assessments, a 90-day regional action plan was developed and implemented during the first half of 2015 to help countries address the critical gaps identified in the areas of surveillance and response, in order to be able to prevent, detect and undertake effective containment measures for control of EVD threats.

Because of the rapidly expanding threat from MERS-CoV, efforts continued to be made to support countries to improve public health preparedness measures, especially infection prevention and control in the health care environment. In view of the existing knowledge gaps regarding the mode of transmission of MERS-CoV, WHO provided support to finalize and implement a public health research protocol for understanding the risk factors that result in human infection. The results of this research initiative are expected, not only to unravel the mystery of the origin of this virus, but also to pave the way for preventing a human infection which is currently presumed to be of animal origin.

In view of the need to detect epidemic health threats in the countries that are affected by the ongoing crisis early, support was continued for scaling up and enhancing disease early warning systems and improving readiness measures for rapid and timely response to contain epidemics. The activities of WHO in the area of health security contributed significantly to accelerating progress in the implementation of the core capacities required under the International Health Regulations (IHR 2005). However, concerns remain for the countries that have yet to meet the deadline or achieve compliance with the requirements. By June 2014, which marked the expiry of the first two-year extension for IHR (2005) implementation, only eight States Parties in the Region had declared compliance with the requirements while the remaining 14 requested and were granted a second extension. With the expiry of the second extension due in June 2016, and in view of the recurrent health security threats in the Region, the sustainability, functionality and quality of the core capacities attained by the countries under the IHR (2005) are gaining increasing importance.

Also in response to Regional Committee resolution EM/RC61/R.2 as well as the recommendations of the IHR emergency and review committees, a set of strategic priorities at regional level, and a corresponding implementation plan, are being developed to plug the important gaps identified through the assessment of preparedness and readiness measures for EVD and to strengthen the required capacities. The third annual meeting of IHR stakeholders critically reviewed the gaps and the progress achieved so far and made pragmatic and targeted recommendations from a strategic perspective to push the IHR and global health security agenda forward. The strategic focus for country support under IHR now targets multisectoral coordination, legislative sufficiency, surveillance, response, infection control, zoonoses and food safety, all of which are key core capacity deficits that are common to States Parties.

Important steps were taken in 2014 to contain the threat posed by antimicrobial resistance. A rapid country assessment launched in 2013 was finalized, the findings of which were published in the WHO global report in 2015. A regional steering committee has been established to provide policy and strategic advice to the Regional Director on containing the threat of antimicrobial resistance and also to develop a regional framework for action in line with the One Health approach agreed between WHO, FAO and the World Organisation for Animal Health

(OIE). Country support will now be provided for developing and implementing national plans for curbing the threats of antimicrobial resistance, based on countries' health systems, in support of the global action plan and the regional framework for action.

Progress was also made in strengthening national laboratory capacity to support disease-specific programmes. However, substantial challenges remain, principal among which is the need to develop a comprehensive national laboratory policy encompassing issues like funding, human resources, quality assurance as well as bio-risk management. The assessments for EVD highlighted gaps in bio-safety and quality management, and intensive efforts have therefore been undertaken for a number of countries in regard to shipment of biological materials as well as effective bio-safety procedures for handling of dangerous pathogens. Regional strategies for laboratory services and blood safety were developed through a consultative process, in collaboration with experts in the related fields from Member States, institutes and ministries from the Region and from WHO headquarters and other regions.

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[1] For tuberculosis case detection, WHO receives data a year later, thus case detection data relate to 2013 and treatment outcome data to 2014.

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