World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

EM/RC65/5
October 2018

Regional Committee for the Eastern Mediterranean
Sixty-fifth session
Provisional agenda item 4(b)

Protecting people from the impact of health emergencies

Executive summary

1. Addressing health emergencies is one of the most important issues in international public health and is recognized as such within the 2030 Agenda for Sustainable Development. The World Health Organization's thirteenth general programme of work 2019−2023 (GPW 13) identifies it as one of the Organization's three strategic priorities and sets the goal of ensuring that 1 billion more people are better protected from health emergencies by 2023. Work is ongoing globally to quantify how different world regions and countries can contribute to that 1 billion target, but this paper aims to give a preliminary estimate of the potential impact of improved emergency preparedness in the Eastern Mediterranean Region.

2. A regional risk assessment was conducted in February 2018 using the WHO strategic tool for assessing risk (STAR) to identify potential natural and human-induced hazards in the Region. Twenty-three risks were identified as potential hazards that currently and/or could require regional intervention, including three very high risks – armed conflict, forced population displacement and radio-nuclear (CBRN) events. Vulnerability to these and other risks is increased by factors including, among others, low immunization rates in some conflict-affected countries and very high numbers of internally displaced people. Furthermore, full achievement of the public health capacities required under the International Health Regulations (IHR 2005) to effectively prevent, detect and rapidly respond to any public health threat is still a work in progress. IHR (2005) evaluations have identified various strengths and gaps across all countries in the Region.

3. Implementing the IHR (2005) capacities and capacities for disaster risk management as required under the Sendia Framework are essential to achieve protection from all-hazard emergencies. Furthermore, ensuring that all countries are equipped to mitigate risk from high-threat infectious hazards and that populations affected by health emergencies have access to essential life-saving health services and public health interventions are also essential to minimize the impact of emergencies. Based on data from the WHO Global Health Observatory, this paper gives projected IHR implementation levels for each country of the Region by 2023. If proposed WHO strategic directions and country recommendations are implemented with the support of WHO and partners, implementation will range between 30% and 100% in countries of the Region.

Introduction

4. In May 2018, the Seventy-first World Health Assembly approved the thirteenth general programme of work 2019−2023 (GPW 13) of the World Health Organization (WHO) *(1)*. GPW 13 was developed through extensive consultation, and will guide the Organization's work for at least the next five years. It identifies three interconnected strategic priorities and ambitious goals related to the 2030 Agenda for Sustainable Development. The strategic priorities and goals encapsulate the step-change in public health that needs to be achieved globally by 2023 to keep on track with achievement of the health-related Sustainable Development Goals by 2030.

5. What needs to be done in order to implement GPW 13 in WHO's Eastern Mediterranean Region? This paper is one of a series intended to foster discussion at the 65th session of the WHO Regional Committee for the Eastern Mediterranean. It focuses on the strategic priority of addressing health emergencies and its related goal: to ensure that 1 billion more people are better protected from health emergencies. That goal is based on SDG indicator 3.d.1: International Health Regulations (IHR 2005) capacity, health emergency preparedness and timely response. Work to reach the goal will make the world better prepared for and capable of dealing

with health emergencies by measurably increasing the resilience of health systems for a population of 1 billion more people. WHO will measure progress towards the goal based on the Organization's activities supporting countries to strengthen their preparedness for health emergencies.

6. This paper aims to:

- outline the current situation in the Region regarding health emergencies;
- identify major risks and the strengths and weaknesses of health systems in the Region in terms of emergency preparedness and response;
- explain WHO's approach to health emergencies and its intended impact on emergency preparedness and response; and
- propose some strategic directions for WHO and recommend some action by countries of the Region to contribute to the goal of 1 billion more people protected from health emergencies.

7. This paper includes projections of the impact of proposed policies in relation specifically to strengthening national preparedness and response capacities and mechanisms and the implementation of the IHR 2005. While work is ongoing on other aspects of impact measurement and on identifying the Region's share in achieving the global goal of 1 billion people better protected from health emergencies, this paper does not attempt to calculate the Region's contribution to the 1 billion target.

Situation analysis

Risks associated with exposure to all hazards

8. A regional risk assessment was conducted in February 2018 using the WHO strategic tool for assessing risk (STAR) to identify potential hazards in the Region.[1] Hazards were identified based on their historical and/or potential effects that could necessitate an emergency response from the WHO Regional Office. All possible natural and human-induced hazards (based on the tool classification) were discussed in the hazards identification process, and 23 risks were identified as potential hazards that currently and/or could require regional intervention. Based on the risk classification system used, the risks of the identified hazards were classified as follows.

- Very high risk (three hazards): armed conflict, forced population displacement, and chemical, biological and radio-nuclear (CBRN) events.
- High risk (six hazards): cholera, measles, diphtheria and pertussis, Middle East respiratory syndrome coronavirus (MERS-CoV), earthquakes, and dust storms.
- Moderate risk (nine hazards): Dengue fever, Rift Valley fever, Crimean-Congo haemorrhagic fever, polio, extensively drug-resistant tuberculosis, droughts, floods, cyclones, and industrial accidents.
- Low risk (four hazards): yellow fever, novel influenza viruses, cold waves, and heat waves.
- Very low risk (one hazard): wet and dry landslides.

9. The health consequences of these 23 hazards vary from increased morbidity and mortality associated with pathogens to mass casualties, vaccine-preventable diseases, waterborne diseases, mental health conditions, noncommunicable diseases and increased burden on the health system due to natural disasters, armed conflict and displacement of populations. The frequency, severity and length of many natural disaster hazards are being exacerbated by the onset of climate change and extreme weather effects, and this in turn exacerbates their impact on health.

[1] The purpose of STAR is to identify and prioritize risks to support health emergency planning that will catalyse action to prevent, prepare for, and reduce the level of risk associated with a particular hazard and its consequences on health. Strategic risk assessment captures natural or man-induced hazards, events under IHR and events in neighbouring countries or regions. The scope of the tool is flexible and adaptable but it recognizes the need for multisectoral risk management and addresses similar parameters of identification of hazards, evaluation of level of exposure, analysis of context and vulnerabilities, and estimation of impact.

10. The likelihood of the emergence and rapid transmission of high-threat pathogen diseases has increased in the Region as many countries are affected directly or indirectly by acute, protracted humanitarian emergencies. Other risk factors include rapid urbanization, climate change, weak surveillance, limited laboratory diagnostic capacity, and increased human–animal interaction. For example, insufficient capacities to manage outbreaks of MERS-CoV mean that its risk is ranked as high. Furthermore, novel influenza viruses may or may not have pandemic potential, but if they do, there will presumably be no immunity and as such they may pose a "very high to high risk".

11. The severe impact of some natural disasters, such as earthquakes, makes them high risk in spite of the lower likelihood of them happening. The cyclone that hit Oman, Somalia and Yemen in May 2018 severely affected Somalia and Yemen, but in Oman it was a good example of how a well-prepared health system can rapidly and efficiently respond to the consequences of such an event.

12. Mass gatherings pose unique risks to health security. The Region is host to a number of such gatherings, including annual events, such as the Hajj in Saudi Arabia, and Muharram and Arba'een in Iraq, as well as regular sporting and social events that draw hundreds of thousands of people in some countries of the Region, and which can aid the spread of infectious diseases, lead to accidents and exceed the routine public health capacity of countries.

Vulnerability factors

13. Using the same STAR tool, it was found that the three identified very high risks – armed conflict, forced population displacement and CBRN events – are almost certain to happen within the coming 12 months with a severe impact in the country where any of these events may take place. Dust storms, cholera and measles were also found to be "almost certain" to happen in the next 12 months. However, their impact on the Region is expected to be moderate due to high capacities to cope with cholera and measles, and the moderate severity of dust storms.

14. In 2017–2018, the Region faced 10 graded emergencies. These were rated as grade 3 emergencies in Somalia, Syrian Arab Republic and Yemen; grade 2 in Iraq (downgraded from grade 3 in 2017 to grade 2 in February 2018), Libya, occupied Palestinian territory and Sudan; and grade 1 in Afghanistan, Pakistan and Saudi Arabia. Pakistan and Saudi Arabia, were graded for dengue fever and MERS-CoV outbreaks, respectively.

15. Current routine immunization coverage is low in several conflict-affected countries in the Region. Over 90% of the children unvaccinated with diphtheria-tetanus-pertussis (DTP3) immunization live in countries experiencing different degrees of humanitarian emergency. Vaccine-preventable diseases have been the major cause of morbidity and mortality during most humanitarian emergencies in the Region. As diphtheria and pertussis are less likely to occur than measles, vulnerability to measles is higher in the Region. Large-scale vaccine-preventable disease outbreaks, such as measles in Libya, Pakistan, Somalia, Sudan and Syrian Arab Republic,[2] and diphtheria in Yemen, have been documented in 2017-2018.[3]

16. The war in the Syrian Arab Republic has plunged 80% of its people into poverty, reduced life expectancy by 20 years, and led to massive economic losses estimated at over US$ 200 billion since the conflict began *(2)*. In 2017, Somalia experienced one of the worst cholera outbreaks recorded, with a high case fatality rate, combined with prolonged drought, food insecurity and malnutrition, and Yemen continues to face the world's largest cholera outbreak on record amid the world's largest humanitarian crisis. Chemical attacks have been documented in Iraq and the Syrian Arab Republic.

[2] http://www.emro.who.int/vpi/publications/measles-monthly-bulletin.html

[3] http://applications.emro.who.int/docs/epi/2018/Epi_Monitor_2018_11_29.pdf?ua=1

17. Limited electricity, limitations put on fuel supplies and lack of fuel for back-up generators in Gaza are severely disrupting the delivery of basic services such as health, water and waste management, while in Iraq a new phase in humanitarian assistance has been initiated since the recapture of Mosul, shifting the focus to rebuilding the health system and support for returnees.

18. In 2017, there were 17 million internally displaced persons (IDPs) in the Region out of 39 million globally, nearly 44% of the world's IDPs. Syrians made up 36% of the Region's total (6.2 million) and Iraqis 15% (2.6 million). In the same year, there were 17 million refugees from countries of the Region, 67% of the world's total of 25.4 million, and 11 million of those 17 million were resident in the Region. Palestinian refugees were reported to number 5.3 million *(3,4)*. Major outbreaks of cholera occurred among refugee and IDP populations in Iraq during 2015–2016. A significant increase in cases of leishmaniasis has been reported in the Syrian Arab Republic and among Syrian refugees in Gaziantep, Turkey.

19. Some of the refugees and IDPs have started to return to their original lands. At the end of 2017, returnees in the Region included 4.1 million IDPs and 460 000 refugees. These returnees have not always been included in national planning, resulting in an additional burden to health systems that are facing difficulties in coping with the increase in numbers.

20. Climate change and environmental degradation, whose impacts are often aggravated in humanitarian emergency settings, have both direct and indirect effects on the occurrence and spread of infectious disease. Available evidence suggests an increasing emergence and burden of mosquito-borne diseases such as dengue (Egypt, Pakistan, Saudi Arabia, Somalia and Sudan), chikungunya (Pakistan and Yemen), tick-borne diseases such as Crimean-Congo hemorrhagic fever (Afghanistan, Islamic Republic of Iran and Pakistan), parasitic diseases such as leishmaniasis (Afghanistan, Pakistan, Somalia, Sudan and Syrian Arab Republic), and zoonotic diseases such as MERS-CoV (Oman, Qatar, Saudi Arabia and United Arab Emirates). Climate change also has an impact on noncommunicable diseases due to increased exposure to heat waves, chemicals, malnutrition and mental stress. It may also drive mass migration from affected areas, causing new and/or aggregated pressures and demand on host communities and countries.

Gaps and challenges

21. Full achievement of the public health capacities required under the IHR (2005) to effectively prevent, detect and rapidly respond to any public health threat is still a work in progress. IHR evaluations conducted in countries in the Region using the voluntary and mandatory instruments have identified various strengths and gaps across all countries. The identified common strengths lie in indicator-based surveillance (including for zoonoses), food safety, immunization, diagnostics of known pathogens, collection and referral of laboratory samples, activation of emergency response operations, medical countermeasures, personnel development, and linking public health with security domains. The gaps relate to legislation, antimicrobial resistance, biosafety and biosecurity, maintenance of the cold chain at different administrative levels, management of zoonotic and foodborne diseases, event-based surveillance, data analysis and management for public health, risk communication, and public health management of chemical and radiation events.

22. Challenges in the prevention and control of emerging and epidemic-prone diseases in the Region include weakened or fragmented disease surveillance systems for early detection of health threats, limited laboratory diagnostic capacities for disease detection, and the absence of cohesive and inclusive national strategies for the prevention, containment and control of emerging and epidemic-prone diseases.

23. Many countries have well-developed disease-specific preparedness and response plans, but nevertheless lack a comprehensive public health emergency preparedness and response system incorporating all IHR-bound sectors, including points of entry. Public health risk and resource mapping has been inconsistently performed across the Region, with only a few countries having national profiles of their risks compiled and prioritized utilizing a collaborative multisectoral approach.

24. The health systems in countries of the Region, and particularly in those experiencing emergencies, tend to be fragmented, pluralistic, expensive and unable to cope with the increased demands. Refugees and migrants may find access to health services difficult to navigate, expensive and inappropriate to their needs. Furthermore, chronic shortages of essential services, medicines and supplies have been documented, and have had an impact on the disease profile of these countries.

25. Public health emergency preparedness capacity that incorporates an all-hazards approach involving all IHR-bound sectors is insufficient in most countries of the Region. Emergency preparedness capacity includes having defined stakeholders with clear roles and responsibilities to manage the response, including logistics, expertise and workforce, procurement and the supply chain for equipment and supplies, and the funding of response operations. The system should also have surge capacity and the ability to expand response operations to effectively respond to all potential public health emergencies of international concern. The elements of preparedness capacity need to be responsive and able to address the migration and displacement of populations and mass gathering events, where relevant.

26. Significant public health threats exist in many countries within the Region and globally. Increased population movement, whether due to tourism, migration or as the result of disaster, the growth in international trade, and social and environmental changes mean that an infectious disease in one country is only a few hours away from becoming a threat to another country, and potentially a concern for the entire world. IHR (2005) requirements at points of entry still need to be met to minimize the risk of the international spread of disease, and to avoid the implementation of additional measures in accordance with Article 43 of IHR (2005), such as the closing of borders, denial of entry visas and suspension of airline flights that could significantly interfere with international traffic and trade. Arrangements for cross-border collaboration related to public health events in the form of information-sharing and joint risk assessment and response need greater attention.

27. Under IHR (2005), States Parties are required to carry out an assessment of public health events occurring within their territories utilizing the decision instrument provided in Annex 2 of the IHR, and then to notify WHO of all qualifying events within 24 hours of such an assessment. Although the situation has improved, States Parties are still generally reluctant to share information related to public health events of potential international concern that might have negative political and socioeconomic implications. This compromises the rapid response to public health events and increases the likelihood of these events spreading globally.

28. While in many countries a great deal of data are collected as part of different health information tools, this does not always cover important priority areas and the coordination and linkages needed to make meaningful and timely analysis of the data possible are lacking. This means that in many countries the development of indicators for certain populations at a national level and in a centralized fashion remains impossible or subject to concerns over accuracy. Robust health information systems are integral to any long-term planning.

29. The estimated ratio of skilled health professionals in the Region is low at 26.3 per 10 000 population (2005–2015). While the health care workforce for many countries hosting refugees is adequate, adding an additional 2 million displaced people to the populations of Jordan and Lebanon has put a strain on their health care services.

30. Government health expenditure in the Region remains low at 8.8% of general government expenditure. In 2014, the regional average out-of-pocket expenditure as a percentage of total health expenditure was estimated at 38%, with countries such as Afghanistan (64%), Pakistan (56.3%), Sudan (76%) and Yemen (76%) having very high rates. In 2016–2017, the health sector was among the least funded sectors in the Region, while in 2018, out of a total of US$ 1.4 billion required by the health sector, only US$ 284 million (21%) had been received as of 5 June 2018.

31. While some countries of the Region have a strategy for resource mobilization and surge capacity corresponding to their emergency response needs, a systematic approach is often lacking. Although external funding increased steadily between 2016 and 2017, simultaneous large-scale crises have overstretched the

capacity of donors to fully meet the humanitarian needs, including health needs. Official development assistance from traditional donor countries is either stagnating or being redirected to address new challenges.

Intended impact

32. WHO's approach to health emergencies and all hazards response is described in the WHO Emergency Response Framework *(5)* and in the results framework of its health emergencies programme *(6)*. WHO seeks to ensure that: populations affected by health emergencies have access to essential life-saving health services and public health interventions; all countries are equipped to mitigate risk from high-threat infectious hazards; all countries assess and address critical gaps in preparedness for health emergencies, including in core capacities under the IHR (2005) and in capacities for all-hazards health emergency risk management; and national health emergency programmes are supported by a well-resourced and efficient WHO Health Emergencies Programme *(1)*. The impact framework of GPW 13 outlines three intended outcomes for this approach: country health emergency preparedness is strengthened; the emergence of high-threat infectious hazards is prevented; and health emergencies are rapidly detected and responded to. These strategic directions will be considered for implementation during 2019–2023. They may be modified based on the outcome of monitoring and evaluation of their implementation.

33. Implementing the IHR (2005) capacities is essential to achieve protection from emergencies. IHR (2005) implementation will be measured through the annual IHR reporting mechanism and adjusted using data coming from the joint external evaluation exercise. Table 1 details projections for IHR implementation by 2023, if proposed strategic directions and country recommendations are implemented.

34. WHO will work with partners to identify the Region's share in achieving the global goal of 1 billion more people better protected from health emergencies. This will be actively discussed with countries so that plans can be put forward to help them achieve their share of the 1 billion goal.

Proposed approach for WHO by outcome

Country health emergency preparedness strengthened

35. Support countries in their implementation and strengthening of IHR (2005), in alignment with the global five-year strategic plan to improve public health preparedness and response, adapted to regional parameters and priorities.

36. Champion the voluntary and mandatory instruments used to monitor and evaluate the implementation of IHR (2005) and action-oriented approaches designed to capture the functionality of national capacities. WHO will continue to work with countries to develop and cost national action plans for health security. This represents a key strategic area of work for WHO with countries of the Region.

Table 1. Projections of IHR implementation by 2023, using IHR annual reporting from 2017 and joint external evaluations as a baseline

Countries	Projected IHR implementation scores by 2023 (%)
Djibouti, Somalia	30–40
Afghanistan, Libya, Syrian Arab Republic, Yemen	40-50
Pakistan, Palestine	50–60
Iraq, Jordan, Lebanon, Morocco, Sudan, Tunisia	60-70
Egypt, Islamic Republic of Iran, Kuwait, Qatar	70–80
Bahrain, Oman, Saudi Arabia	80–90
United Arab Emirates	90-100

Sources: WHO Global Health Observatory data on IHR core capacities implementation status, 2016 (http://www.who.int/gho/ihr/monitoring/region_eastern_mediterranean/en/, last accessed 13 August 2018); WHO Eastern Mediterranean Region: JEE mission reports (http://www.who.int/ihr/procedures/mission-reports-eastern-mediterranean/en/, last accessed 13 August 2018).

37. Align preparedness with health systems strengthening by adopting an all-hazards approach for implementing IHR (2005) and the Sendai Framework for Disaster Risk Reduction 2015–2030 (Sendai Framework).

38. Enhance the capacity of IHR (2005) national focal points. This is a work in progress and will be intensified along with advocacy activities targeting senior officials to raise awareness of compliance under IHR (2005), in particular regarding public health event notifications and travel- and trade-related measures.

39. Support countries to meet IHR (2005) requirements at points of entry and to enhance cross-border collaboration in the form of information-sharing, and joint risk assessment and response to public health events.

40. Support countries to assess the health needs of migrants and displaced populations, develop plans of action to respond to the identified gaps, and ensure that these gaps are well captured in the regional action plan for promoting the health of refugees and migrants that will be developed based on the global action plan to be submitted for the upcoming Executive Board session.

41. Update the regional risk profile and update regional public health emergency preparedness and response plans and hazard specific contingency plans accordingly and support countries to map, assess and forecast potential hazards and ensure robust levels of preparedness to all-hazards emergencies, including natural disasters, and to address specific events such as mass gatherings.

42. Support countries to review national legislation, polices, regulations and administrative procedures to enhance multisectoral coordination and facilitate the implementation of IHR (2005) capacities.

43. Support countries to assess hospitals and enhance capacity for hospital preparedness and management of all hazards, including training of hospital staff.

44. Engage countries that are transitioning from emergencies in discussion of the "humanitarian–development nexus" to identify ways to link short-term response operations on the ground with longer-term capacity-development activities and to ensure smooth recovery transitioning from emergency settings.

45. Enhance regional capacities in resource mobilization, especially at country level. This includes: strengthening South-South cooperation with donors within and outside the Region; engaging with donors on multi-year funding programmes to finance the key areas of work of the health emergencies programme; leveraging the global financing efforts to expand partnerships for the health emergencies programme and forging new collaborations according to a "whole-of-society" approach; strengthening and/or building external relations and resource mobilization capacity at Regional Office and country office levels; and establishing mechanisms to generate metrics and donor business intelligence.

46. Establish a roster of technical and managerial experts, and identify and implement the necessary operational elements required to facilitate the rapid deployment of experts to provide support to countries.

Emergence of high-threat infectious hazards prevented

47. Improve routine immunization coverage of all antigens in all countries to build population immunity against vaccine-preventable diseases and achieve the goals of immunization programmes.

48. Support countries to enhance the cold chain for vaccine delivery and improve vaccine procurement and forecasting, leading to no stock-outs at the central and district level.

49. Forge effective collaboration and information-sharing with the animal health, environment and food sectors under the "One Health" framework to enhance joint surveillance, investigation and response to emerging zoonotic infections at the human–animal interface.

50. Guide and support countries in the implementation of the strategic framework for strengthening health laboratory services 2016–2020.

51. Strengthen country surveillance systems for emerging, epidemic and pandemic-prone diseases, including the establishment of early warning systems to detect health threats in real time.

52. Accumulate evidence on the burden, risk factors and determinants of emerging diseases, including the impact of climate change, and on best practices for control interventions, to better anticipate future threats. This will be done through systematic review and by identifying and coordinating the research, development and innovation needed to better detect, prevent and respond to new and emerging diseases and other sources of risk.

Health emergencies rapidly detected and responded to

53. Contribute to strengthening regional health response systems, to respond predictably and effectively to health consequences of acute or protracted emergencies.

54. Contribute to the humanitarian programme cycle (HPC), including strategic planning, improving implementation, health leadership of humanitarian response plans, ensuring a holistic response when people's needs are multiple and interrelated, and encompassing humanitarian life-saving, livelihood, protection and basic services domains. Ensure humanitarian response plans are based on sound health analysis, are well targeted and remain effective and efficient in responding appropriately to the health consequences of emergencies. Ensure sound management of health response priorities in all phases of the HPC including early recovery.

55. Enhance the regional emergencies operation centre (EOC) to coordinate the response functions for graded and non-graded threats/events in all six critical incident emergency management areas, deployment of technical experts and surge support, and provision of financial, technical and logistics support to strengthen response capacities in line with needs. Expand its linkages with EOCs at WHO country offices and in ministries of health. Continue to work with countries to institutionalize the incident management system and ensure linkages with the EOC network.

56. Ensure that life-saving health services, including management of trauma and injuries, essential first level and secondary level care, medical referral, enhancing access to life-saving health services, health promotion and disease prevention and management, as well as mental health and psychosocial support, reach the people most in need, and develop operational guidance documents on the prevention and management of disease outbreaks in emergency settings.

57. Continue the roll-out of a regional health resources availability mapping system (HeRAMS) and disease early warning and response system (EWARS) to ensure up-to-date information is available to inform public health interventions and response operations and for monitoring purposes.

58. Strengthen logistics services, medical logistics and a predictable supplies management including contingency planning through the prepositioning of supplies for emergency response in emergencies and at the regional hub.

59. A priority for research is the tracking of WHO's emergency response work in affected countries by measuring access to and the delivery of interventions.

60. Enhance and expand the capacity of country multidisciplinary rapid response teams and foster networking with and membership of the Global Outbreak Alert and Response Network to guide and advise the investigation and implementation of rapid public health containment measures. Enhance emergency medical teams and identify champion countries in the Region to provide the needed support to other countries.

61. Ensure adequate and safe environmental conditions in health care facilities in countries that are facing emergencies, specifically regarding drinking water, medical solid waste management and vector control activities. Support ministries of health to establish units for environmental health within their structures to assure the quality of the relevant services.

62. Scale up work with partners and strengthen health sector coordination, including with United Nations agencies, civil society and other stakeholders within and beyond the health sector, to ensure adequate response to health emergencies and health effects of emergencies. Enhance WHO's leadership in the global health cluster response and in health diplomacy. Ensure the role as last-resort provider is fulfilled under the Inter-Agency Standing Committee (IASC) transformative agenda.

63. Explore and enhance synergies between governments, health, humanitarian and development actors in joint analysis, planning and monitoring and coordinated implementation of humanitarian and early recovery interventions to achieve collective outcomes that maximize the impact of the health response, especially in fragile and conflict-affected settings.

Recommendations for Member States

64. Create an enabling environment for the integration of all hazard emergency preparedness and response approaches into health system strengthening, including in primary health care, particularly in emergency-prone countries, and ensure the capacity-building of health care providers in disaster risk assessment, management and response.

65. Continue to work with IHR-bound sectors to meet IHR (2005) and Sendai Framework requirements, in order to have a resilient health system against health emergencies and the health impact of emergencies, including climate-related and other environmental disasters. The use of the mandatory and voluntary instruments to monitor and evaluate IHR (2005) capacities and monitor the implementation of the Sendai Framework is necessary to ensure progress and identify bottlenecks.

66. Continue to develop national action plans for health security in alignment with health sector planning, and strengthen national mechanisms for resource identification and mobilization for plan implementation.

67. Scale up prevention and control efforts for emerging and epidemic-prone diseases systematically, using an evidence-based risk approach and implementing disease-specific elimination and control measures for priority high-risk infectious disease threats prevalent in the Region.

68. Assess national financial systems to identify opportunities for securing domestic and external resources to support rapid response to emergencies.

69. Identify and assess the essential package of health services at primary and secondary level that can be provided to nationals in emergency situations based on the health system's capacity and needs, and identify ways to ensure continuity of service provision during emergencies.

70. Ensure that country support workplans address the strategic goal of "1 billion more people better protected from health emergencies" so that individual countries contribute to achieving the global target.

71. Map the health facilities destroyed by disasters and other emergencies and identify the potential impact on their catchment areas and the potential burden on other facilities.

72. Consider optimizing and utilizing capacities and testing systems and rapid response mechanisms in countries that are facing emergencies to share knowledge and experience with other countries regarding the surveillance and management of public health events during emergency situations.

73. Establish and strengthen coordination and oversight mechanisms at country level through intersectoral linkages at national and subnational levels, and expand links with national technical institutions and universities.

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