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Progress report on emergency preparedness and response

Introduction

1. The Eastern Mediterranean Region is facing an unprecedented scale of humanitarian crises and needs. More than half of the countries in the Region are experiencing emergencies, with a total of more than 58 million people affected and in need of humanitarian aid. More than half of the world's refugees come from three countries in the Region, Syrian Arab Republic, Afghanistan and Somalia, and are hosted in just 4 countries: Pakistan, Islamic Republic of Iran, Jordan and Lebanon. In 2015, refugees comprised almost 25% of Lebanon's total population as a result of the crisis in the Syrian Arab Republic. The Region also hosts the largest number of internally displaced persons as a result of conflict: Syrian Arab Republic, Iraq and Sudan are currently among the top five countries in the world hosting internally displaced persons.

2. Ongoing violent conflict in the Syrian Arab Republic has had profound effects on the Syrian population and on national economic and social development. More than 11 million Syrians, or 45% of the country's population, have been displaced: 7.6 million people inside the country and almost 4 million people outside the country. More than 4.5 million people are living in very difficult conditions in 14 hard-to-reach areas. As at July 2015, 56% of public hospitals are either partially functioning or completely out of service, and local production of medicines has been reduced by 70%, with many life-saving treatments not available, including antibiotics and intravenous fluids.

3. In Iraq, almost 7 million people were in need of health services as at July 2015. Across the five unstable governorates of Anbar, Ninewa, Kirkuk, Salah Aldin and Diyala, 14 major hospitals and over 160 primary health care facilities (more than 25%) are nonfunctional, leaving millions of people without life-saving treatment. 77 health facilities, representing more than 83% of all current WHO and partners' health projects, and health care delivery in conflict-affected areas were threatened with closure at the end of June due to a funding gap of US$60 million, of which WHO requires US$22.5 million. As of June, only US$1 million had been received, leaving a funding gap of 96%.

4. In June the United Nations designated the crisis in Yemen as Level 3, the highest level on the emergency scale. It is the third Level 3 crisis in the Region in addition to those in Iraq and the Syrian Arab Republic. More than 20 million people across the country are currently in need of humanitarian assistance and 15.2 million people are in need of basic health care as at July, an increase of more than 40% since March. More than one million people have been internally displaced (double the number since early May). Serious shortages of medicines and medical supplies, as well as acute fuel shortages, have resulted in a gradual collapse of the health system.

5. WHO and health partners in Somalia announced in June that they would be unable to continue providing life-saving health services at the scale required as a result of declining funding. As at July 2015, out of a required US$ 71.5 million, only US$ 6.1 million (8.5%) has been received, the lowest level of funding since 2008. Lack of funding and lack of prioritization of secondary health service provision has left more than 1.5 million people without access to primary or secondary health care services. As of May 2015, at least 10 hospitals across the country have either been closed or have majorly curtailed their services, and at least three other hospitals are at risk of closure in the near future. Basic health posts and clinics are currently struggling to meet primary health needs, and many aid agencies have withdrawn health workers from high-need areas.

6. Despite increasing needs, consolidated United Nations strategic response plans for eight countries in the Region for 2015 were funded at 20.3% for health as of July, with US$ 83.5 million received out of a requested US$ 411.5 million. This funding gap not only impedes the capacity of the health cluster to respond, but also threatens the closure of existing public health functions and health services, most significantly in Iraq and Somalia.

WHO response

7. In the Syrian Arab Republic, WHO provided almost 14 million treatments of life-saving medicines and medical supplies, including for surgical interventions to all 14 governorates between January and June 2015. More than 2.6 million children below 5 years of age were vaccinated against polio during 2 national immunization campaigns across the country, and over 1.6 million children were immunized against measles. Thirty mobile clinics were delivered to nongovernmental partners and health authorities in hard-to-reach areas, and 68 nongovernmental organizations have been receiving WHO support across the country to improve access to hard-to-reach areas. WHO has further strengthened its decentralized presence throughout the country by establishing a system of 57 medical focal points (36 in hard-to-reach areas) and increasing the number of sub-offices to Aleppo, Al-Hassakah and Homs.

8. In Yemen from March to July 2015, WHO distributed more than 181 tonnes of medicines and medical supplies and more than 500 000 litres of fuel to maintain the functionality of main hospitals, vaccine stores, ambulances, national laboratories, kidney and oncology centres, and health centres in 13 governorates, reaching a total of almost 5 million people, including 700 000 internally displaced persons and 140 000 children under the age of 5 years. In June, an immunization campaign against polio, measles and rubella was conducted by the Ministry of Health and WHO for internally displaced populations in 9 governorates for around 50 000 children below the age of 15 years. In response to increasing cases of suspected dengue fever and malaria, WHO delivered anti-diarrhoeal kits to Aden and Hodiedah. As health facilities shut down as a result of medicine and fuel shortages, WHO supported shelters in Sana'a with mobile health teams, and set up fixed medical clinics. WHO also supported two mobile medical teams operated by a local nongovernmental organization.

9. In Iraq from June 2014 to July 2015, WHO provided essential medicines and technologies, together with medical consultations, to more than 3 million internally displaced persons in camp and non-camp settings, including in hard-to-reach areas. Some 1400 health care facilities around the country received more than US$19 million in essential life-saving medicines and medical supplies to replenish emergency stocks. To improve access to preventive and curative health services, WHO provided 27 fully equipped mobile medical clinics and 30 ambulances equipped with essential medicines and supplies to address communicable and noncommunicable diseases including diabetes, hypertension and heart disease. The total number of consultations conducted by these mobile and fixed clinics exceeded 820 000. Of these, 300 000 emergency and complicated cases, including maternity and paediatric patients, were referred to specialized hospitals. More recently, with the new waves of displacement in Anbar in early 2015, WHO and the Department of Health in Anbar established 14 medical outposts providing a wide range of primary health care services to displaced people, including antenatal care for pregnant women.

10. A total of 57 emergency deployments took place as part of WHO's response to emergencies in the Syrian Arab Republic, Iraq, Yemen, Libya and Somalia from January to July 2015. Experts deployed were specialized in the areas of cluster coordination, various technical programmatic areas, disease surveillance, information management, communications, programme management, logistics, procurement, information technology and human resources.

Progress and achievements

11. Timely response is critical for effective humanitarian action, but even in acute emergencies, donor support cannot be relied on to arrive at an early enough stage. To address this challenge, the Regional Office is establishing a regional emergency solidarity fund to ensure a more predictable and reliable funding mechanism for emergency response in the Region and trigger action for health as early as possible to prevent unnecessary morbidity and mortality. The fund, which will be activated in January 2016, will provide financial support at the onset of an emergency in countries in the Region for the first three months to meet immediate needs and fill critical gaps.

12. A regional emergency advisory group has been established and will hold its first meeting during the 62nd session of the Regional Committee meeting in October 2015. The overall purpose of the advisory group is to provide independent advice and assistance to the Regional Director on policy and strategic matters related to emergency preparedness and response in the Region. The emergency advisory group is composed of representatives from 7 Member States in the Region, with consideration given to an adequate distribution of expertise and geographical representation. The Group will meet once a year and membership will rotate every two years.

13. As part of its organizational readiness measures, WHO will continue to update and maintain a regional roster of trained experts who can be deployed to ensure the availability of relevant expertise at the onset of an emergency. All roster staff will undergo surge training to ensure they are able to respond quickly and effectively to any emergency, including disease outbreaks. The first surge training for emergency focal points was conducted in 2014, and will continue to take place each year as new experts are added to the roster.

14. In light of increasing needs in the area of procurement of medicines and medical supplies for affected populations, WHO has finalized an agreement with the Government of the United Arab Emirates to establish a dedicated WHO humanitarian operations/logistics hub for crisis response. This hub will continue to manage current stocks and ensure more adequate stockpiling of critical medical supplies to support a timely response to emergency events in the Region and beyond.

Reform in the area of emergencies

15. Despite clear reforms, mandates and guidelines, WHO has not been systematic in responding to emergencies in the Region due to the enormous scale of health needs, and will be further challenged if new events emerge. Based on lessons learnt, and in light of recent reforms, fundamental rethinking and redefinition of WHO’s work before, during and after emergencies was required to deliver what is expected.

16. Regional reform in the area of emergencies has been ongoing since October 2014. In line with the recommendation of the 61st session of the Regional Committee to establish sub-offices in the Region, a new centre for emergency readiness and polio eradication was established in Amman in 2015.

17. In line with the restructuring to improve emergency response, readiness and coordination, a unit focusing on organizational readiness is being established in Amman to build capacity and ensure that WHO is ready to respond to public health emergencies in the Region. A second entity based in Cairo and comprising two units, for emergency response and coordination, will provide leadership and coordination and ensure an effective response mechanism and timely support to countries in crisis.

18. On 13–14 June 2015, a review meeting was convened in Cairo to discuss recent global reforms in WHO’s work in emergencies following the Health Assembly, review its ongoing work in the Region, identify key gaps and propose solutions in a number of areas to improve its response, including whether a restructure of the area of emergencies was required.

19. In the area of leadership, it was agreed that WHO's leadership in health needs to be enhanced with the right profiles representing WHO at cluster and emergency coordinator level. More emphasis needs to be placed on regional resource mobilization, with innovative methods identified as part of an overall regional strategy. Resource mobilization should also be complemented by clear reporting and documentation, which is currently weak at country level, as well as with greater and more regular visibility to donors promoting their contributions to WHO's work.

20. In the area of technical expertise, there was a recognized need to increase internal surge capacity. Relevant technical experts working in all programmatic areas in the Regional Office will be identified and trained to work in emergency response. A surge roster for disease outbreak experts will also be established, and regular training conducted for roster staff.

21. In the area of information, there was agreement that information management capacity is lacking at country level, resulting in critical gaps in health information during emergencies. Also needed is stronger data analysis, which is crucial for monitoring and assessing WHO's regional response. In the area of communications, a crisis communications plan and standard operating procedures will be developed and implemented at the onset of an emergency, complemented by simulation exercises.

22. In the area of core services, one of the key discussions of the meeting focused around the need to streamline and expedite procedures related to administration, finance and human resources. Recognizing that work in these areas needs to move in a more expedited and streamlined manner in an emergency context, it was decided that a dedicated team would be established specifically to deal with administrative and finance processes related to emergencies. Lengthy, multi-layer approvals that delay WHO's capacity to respond will be resolved by updating the emergency standard operating procedures.

The way forward

23. Given the increasing magnitude and scale of humanitarian emergencies in the Region, WHO will continue to review its work and ensure a more streamlined and enhanced response. These reviews will take place within the context of global reforms in the area of emergencies, the revised Emergency Response Framework and resolutions of the Regional Committee related to this area of work.