Emergency preparedness and response

Overview

2015 saw a significant deterioration in the humanitarian situation in the Eastern Mediterranean Region. The crisis in Yemen was designated a Level 3 emergency by the United Nations in July 2015 and the Region now hosts three Level 3 emergencies, including the crises in Iraq and the Syrian Arab Republic. Overall throughout the Region, more than 62 million people were in need of health services as a result of emergencies by the end of 2015, placing a significant strain on already weakened and overwhelmed health systems. Shortages in specialized medical staff, medicines and medical equipment, and other health resources, especially in areas where access for WHO and partners was limited, had severe impact on the delivery of health services, contributing to the deterioration in the health status of some patients and an increased number of preventable deaths.

Following the escalation of violence in Yemen in March, the humanitarian and health situation rapidly deteriorated into one of the worst humanitarian crises in the world. More than 14 million people, including 2.4 million internally displaced, were in need of health services by the end of the year. Shortages in health workers and medicines, coupled with fuel shortages, led to a gradual collapse of the health system. By December, almost 25% of all health facilities were non-functional, and immunization coverage had decreased by 15% compared to the same period in 2014. Limited access to health care services and the breakdown in safe water supplies and sanitation services led to increased cases of endemic diseases, such as malaria, dengue fever and acute diarrhoeal diseases.

As a result of the conflict in Iraq, a total of 3.2 million people were forced to flee their homes in several big waves of displacement, and multiple smaller ones between January 2014 and January 2016. This is in addition to 1.1 million people already displaced from earlier violence. It is estimated that about 10 million Iraqis are in need but only 7.3 million in greatest need are targeted for assistance by humanitarian partners, due to limited available resources. Meanwhile, more

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↑ **WHO-supported mobile clinics are providing basic health care services in several countries, including Afghanistan *(left)* and Syria *(right)***

than 220 000 Syrian refugees are now residing in Iraq, mainly in the Kurdistan region.

In the Syrian Arab Republic, 2015 was the most challenging year for both Syrians and humanitarian responders since the beginning of the crisis, with the number of people in need increasing from 12.2 million in 2014 to 13.5 million in 2015 and more than 1.2 million people internally displaced during the course of the year. The health system continued to face challenges in the provision of health care as a result of damage, with more than half of all public hospitals and public primary health care centres closed or partially functioning. Syrians faced increasing needs for trauma and injury care, with more than 25 000 injured each month, as well as increasing needs for mental health services, reproductive health services and treatment for noncommunicable diseases, such as diabetes and kidney diseases. Malnutrition rates increased, especially among children under 5 years of age. Almost two thirds of the population had no access to safe water, increasing their risk of waterborne diseases.

The health situation in Libya rapidly worsened due to expanding conflict and political disagreements, the inherited weaknesses of the health system and the decreasing investment in the health sector. To better reflect the scale of needs, the crisis in Libya was designated a Grade 2 emergency in early 2016. A total of 2.8 million people were in need of humanitarian assistance by year-end, including 1.9 million people in need of health services. More than 430 000 people were internally displaced as a result of ongoing violence. Hospitals are both overcrowded and functioning at severely reduced capacity, essential medicines and supplies are lacking, electricity and water supplies are frequently disrupted and foreign health workers have left the country. Patients with noncommunicable diseases and mental health disorders have limited access to health care, and there is a marked absence of services for the disabled and tens of thousands of war-wounded patients.

In Sudan, almost a quarter of a million newly displaced were added to the already massive protracted caseload in 2015. By the end of the year, a total of 420 000 internally displaced persons in need remained in Darfur states, with limited access to essential primary health care services. In the five states of Darfur, 36% of public health facilities are non-functional, and only 24% of those functioning are providing a standard service package. Shortages of medicines and supplies and insufficient staff and facilities continued to hamper the quality of health services.

In Pakistan, the sudden influx of internally displaced persons from North Waziristan to Bannu resulted in an overburdening of health resources and services and an increased need for management of risks related to environmental health and communicable disease outbreaks.

Natural disasters continued to have a devastating effect on populations in the Region. In October 2015, a 7.5 magnitude earthquake struck northern Afghanistan and Pakistan, killing hundreds, injuring thousands and damaging and destroying thousands of homes. Access was the most significant challenge in reaching people in need in at least 194 villages affected by the earthquake. A second 6.3-magnitude earthquake struck the Afghanistan-Tajikistan border region in December, injuring tens of people.

Challenges and WHO response

The Region is the world's biggest producer of displaced populations, mainly as a result of the Syria crisis. More than 60% of all refugees and

internally displaced persons originate from the Region. Refugees originated mainly from Syria, Afghanistan and Somalia, while Syria, Iraq, Sudan and Yemen hosted the greatest number of internally displaced persons. While Turkey became the largest host of Syrian refugees in 2015, Lebanon, a country of four million people, remains the highest per capita host of refugees in the world, with refugees comprising a third of the total population. In Jordan, Syrians make up 10% of the population.

In November, WHO organized a high-level meeting on refugee and migrant health in Rome. Countries agreed on the need to develop a framework for collaborative action on refugee and migrant health and acknowledged the urgent need to strengthen collaboration among the countries of origin, transit and destination. To build on this interregional collaboration, a technical consultation was hosted in Cairo in May 2016.

Significant demand for health services across the Region by refugees and vulnerable host communities continued to place enormous strain on public health infrastructure, resulting in overwhelming caseloads, overworked health staff and shortages of medicines and equipment. In some health facilities serving Syrian refugees and displaced Iraqis in northern Iraq, heath staff reported that their patient caseload had increased by almost 200%.

Priority needs for Syrian refugees included mental health care, reproductive, maternal and child health services (including immunization), communicable disease surveillance, care for noncommunicable diseases, environmental health services and care for trauma and burn injuries. Trauma and surgical care continued to be a priority for the refugee population. Acute malnutrition in refugee children under the age of 5 years and women of reproductive age was a key issue. Additional problems included low use of antenatal care and high rates of caesarean section, child diarrhoea, acute respiratory infections and micronutrient deficiencies.

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↑ **WHO supports delivery of public health and health care services for internally displaced persons and host communities in several countries, including Iraq *(left)* and Yemen *(right)***

With the majority of refugees living outside camp settings, both refugees and host communities were at increased risk of infectious diseases due to overcrowded living conditions, limited access to safe water and sanitation and varying degrees of access to primary health care services. . In countries hosting Syrian refugees, WHO provided technical support to ministries of health and other partners on priority public health issues. It also supported the provision of trauma care services, management of noncommunicable diseases, and scaling up of urgently needed mental health programmes. WHO also strengthened and expanded communicable disease early warning alert and response systems (EWARS). To scale up national capacity, partners, front-line health workers and surveillance officers were trained on detection and rapid response to outbreaks and public health threats.

In all countries experiencing political conflict, the provision of humanitarian aid was impeded by security constraints and limited access for health partners to populations in some areas, as well as blocked roads and points of entry preventing the transportation and provision of medicines and medical supplies. In Syria, Iraq and Yemen, an average of 30% of affected populations were located in hard-to-reach or besieged areas.

As part of the Whole-of-Syria approach adopted as a result of UN Security Council resolutions 2165 and 2191, in 2015 WHO led the health sector/cluster coordination in three hubs (Damascus, Amman and Gaziantep). WHO's emergency health response aimed to reach Syrians in all parts of the country, including hard-to-reach and besieged areas.

Across the country, WHO expanded and strengthened its partnerships with a total of 67 local nongovernmental organizations in Syria, many of them operational in hard-to-reach and opposition-controlled areas; 34 mobile clinics were donated to nongovernmental organizations to support the provision of basic health care services across the country. WHO also decentralized its presence in Syria through a system of 59 medical focal points, including 36 in hard-to-reach and besieged areas, providing regular situation updates to WHO.

Since January 2016, greater access to hard-to-reach and besieged areas in Syria has been granted. For the first time in over two years, WHO was able to deliver life-saving medicines and medical supplies to 11 out of 18 besieged locations. In 2015, 27% (4.2 million) of medical treatments provided were delivered for people in need in 127 hard-to-reach and besieged locations across the country.

In Iraq, WHO continued to lead the humanitarian health cluster in different parts of the country and to provide health support, including provision of basic health care through mobile clinics and health centres in camps, as well as ambulances and medical supplies to the federal and local health authorities. WHO continues to meet its mandate as the provider of last resort as the humanitarian situation worsens and the number of internally displaced increases. More than 4 million medical consultations were provided throughout the year, exceeding the initial target of 3.2 million consultations. More than 1.8 million people directly benefited from medicines/supplies and medical equipment procured by WHO and distributed across the country. Access to primary health care services in camps and host communities, including in hard-to-reach areas was made possible through the deployment of 27 mobile clinics.

In Yemen, humanitarian pauses allowed WHO to increase its provision of medicines and medical supplies to affected areas. WHO was also able to provide mobile clinics in areas hosting large numbers of internally displaced persons, as well as ensure the functionality of health services through the provision of fuel and safe water. In early 2016, following months of blocked access to Taiz City, and in response to mounting emergency health needs, WHO successfully delivered life-saving medicines and medical supplies. The supplies included trauma kits, interagency emergency health kits, diarrhoeal disease kits and oxygen cylinders, as well as dialysis solutions. WHO and cluster partners were able to reach 7 million people from March to December 2015 through provision of medicines, medical supplies, mobile medical teams and clinics. To ensure the functionality of the health system, WHO provided more than 1 million litres of fuel to support the operation of 72 health facilities including 51 hospitals, 7 major centres, 6 vaccine depots and 8 renal dialysis centres. To reduce the risk of water-borne diseases, WHO provided 19 million litres of safe

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↑ **WHO provided life-saving medicines and medical supplies, mobile clinics, water, fuel and other essentials to support the humanitarian mission in Yemen**

drinking-water, hygiene supplies and cleaning materials to internally displaced people in all affected governorates.

Escalating conflict and the massive scale of humanitarian needs across the Region continued to place health care workers at great risk. In 2015, attacks against health workers and facilities in Afghanistan increased by 50%, and Syria is now the deadliest place in the world for health workers. In Pakistan, five rounds of immunization campaigns were cancelled in 2015 alone because of serious security threats. The disturbing trend continues, with attacks on health care workers and health facilities in the Region reported almost every month. In a number of countries, WHO, in collaboration with health partners, is maintaining a real-time database on attacks against health care facilities and health care workers as a pilot project to provide feedback for advocacy action to stop such attacks and protect health workers.

Vaccine shortages and low vaccination rates, coupled with growing mass population movement, increased the risk of outbreaks of polio and measles among children. In the three Level 3 emergency countries more than 13 million children in total were vaccinated against polio in 2015, including in hard-to-reach, opposition-controlled and high-risk areas. For the first time in a decade, a nationwide measles immunization campaign was conducted in Somalia in 2015, targeting 4.4 million children. Following the eradication of polio in Somalia, with the last reported case in August 2014, polio vaccination campaigns are ongoing. In Afghanistan, more than 9 million children were vaccinated against polio through national and sub-national immunization in addition to 1.2 million children at the border with Pakistan. More than 6 million children were vaccinated against measles in 2015. In response to the ongoing measles outbreak in Sudan, a nationwide campaign successfully vaccinated 8.6 million children aged 6 months to 15 years.

Enhancing disease surveillance in collaboration with national authorities continues to be a priority for WHO in crisis-affected countries. In Syria, the disease early warning and response system based in Damascus was expanded from 650 sentinel sites in 2014 to 995 sentinel sites in 2015, while disease early warning and response network managed by WHO's office in Gaziantep covered 517 sentinel sites in northern Syria. Together, these surveillance systems aim to cover all governorates and people in Syria. Also in 2015, the water pollution alert and response system was introduced in Damascus and rural Damascus. In Iraq, an early warning, alert and response network (EWARN) with about 80 sentinel sites continues

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↑ More than 13 million children were vaccinated against polio in the three level 3 emergency countries in 2015

to be expanded. Preparedness efforts were also stepped up in neighbouring countries to prevent a spread of the disease across borders. For the first time in Libya, a disease early warning system was instituted in 100 sentinel sites throughout the country.

The number of patients requiring treatment for trauma injuries is progressively growing. In Syria alone, 1 million people were injured in the first quarter of 2015, an average of 25 000 injuries per month. In Yemen, the number of deaths and injuries caused by explosive weapons from January to July 2015 was recorded as the world's highest. This increase, together with a reduced presence on the ground by aid agencies as a result of the insecurity, placed more demands on WHO and partners to fill critical gaps and ensure the availability of trauma care and surgical services, as well as referral services. More than 17 million medical treatments were delivered for patients with chronic diseases, communicable diseases, trauma injuries, primary and secondary care diseases. In northern Syria, health partners in northern Syria were provided with technical, financial and/or material support to conduct 1.7 million medical consultations and deliver nearly 25 000 babies. WHO donated surgical supplies to support around 2000 major surgical interventions in an underground trauma hospital.

In Libya, WHO provided trauma kits, emergency health kits and life-saving medicines, including insulin, HIV medicines, vaccines, anaesthetics and medicines for leishmaniasis and tuberculosis, sufficient to cover 300 000 people.

In Afghanistan, more than 1.2 million people received primary health care services through temporary sub-health centres and mobile clinics supported by WHO, and more than 300 000 people benefited from delivery of emergency health kits and medical supplies.

In Djibouti, WHO provided trauma kits, emergency health kits, drugs for diarrhoeal, antibiotics, antimalarial drugs and medical equipment and supply to Obock Regional Hospital, which is facing a 20% increase in demand for health care services due to the Markazi refugee camp for Yemeni refugees established near that town.

In Sudan, WHO delivered around 600 tonnes of medicines, medical supplies, and WASH equipment and supplies enough to cover the needs of 1.8 million people. WHO supported the functioning of 24 static and mobile clinics in nine states covering more than 500 000 people.

WHO supported capacity-building to enhance skills of health staff and fill gaps as a result of staff shortages. In Syria, more than 20 000 managers and health workers across the country were trained in areas such as trauma management, first aid, primary health care, reproductive health, disease surveillance and the management of noncommunicable diseases. In Yemen, more than 50 mobile medical teams and 20 fixed medical teams in 11 governorates were trained and deployed to provide an integrated primary health care package. Support was provided to 18 hospitals in seven of the most affected governorates, including support for physicians, surgeons, gynaecologists, psychiatrists and nutritionists. In Iraq, more than 10 000 health professionals were trained in emergency medicine-related fields and 58 medical professionals were deployed to refugee camps in northern Iraq.

Capacity-building was also supported in Afghanistan, Libya, Somalia and Sudan, to enhance

capacity of health personnel in emergency-related and diagnostic services, surveillance, mental health and prevention and control of disease.

WHO and the health sector/cluster in emergency countries continue to be underfunded. In 2015, health sector/cluster requirements in UN response plans for eight countries in the Region were funded at 39%, while WHO was funded at 36%. As a result, several health programmes and services in Iraq and Somalia were reduced and mobile clinic services for vulnerable communities in Area C of the West Bank stopped functioning for 6 months.

Health risk management

To standardize the emergency preparedness and response actions in countries, a comprehensive all hazard emergency preparedness framework was developed through an international technical consultation, underscoring 10 priority actions to be implemented at country level and aligning with IHR. Operational research was then conducted in five countries for validation of the framework.

A generic package including standard operating procedures was developed to support contingency planning for preparedness and response to Ebola or any other infectious disease in countries. A full scale simulation package was also developed to support countries in testing the emergency preparedness of the health sector. The package was shared with all countries to accelerate the planning process.

Considerable attention was given to strengthening the capacity of health facilities and hospitals for emergency preparedness and response. A comprehensive curriculum on emergency and disaster risk management was developed to support the capacity training for hospital managers and the first round of training was conducted. The WHO health facilities safety assessment tool was finalized and translated into Arabic and French, addressing the regional need.

A public health emergency pre-deployment training package was developed and five trainingsare planned to enhance the surge capacity in the Region. This has been linked to the roster of experts for deployment in humanitarian crisis.

Implementing the strategies endorsed by the Regional Committee

The area of emergencies in the Regional Office was strengthened through restructuring and the scaling up of the emergencies team. Additional restructuring will take place as needed to ensure alignment with global reforms endorsed by the Executive Board in January 2016. The Regional Centre for Emergencies and Polio Eradication was inaugurated in Amman in January 2016 to continue WHO's work in polio eradication, as well as to ensure organizational readiness for graded and public health emergencies.

The Regional Emergency Solidarity Fund was activated in January 2016 to ensure predictable financing of surge/rapid response to natural and man-made disasters in the Region. The WHO logistics hub, established in Dubai's International Humanitarian City to ensure the timely provision of critically needed medicines, medical supplies and medical equipment to countries in the Region and beyond, was operationalized in 2015.

A regional emergency advisory group on emergency preparedness and response was

established to provide the Regional Director with independent advice and assistance on policy and strategic matters. The regional surge roster of internal and external experts for deployment in emergencies was expanded through pre-deployment trainings in the area of public health and risk communications.

As emergencies continue to cross borders, there is a need to ensure a more systematic and effective approach, both within countries and across the Region, to responding to the health needs of affected populations and to ensuring that health systems in all affected countries continue to deliver urgently needed health services to displaced populations and host communities. WHO is progressively recognizing that solutions to major heath challenges require improved and expanded coordination, action and engagement from other sectors. An effective health strategy involves including the affected communities themselves, as well as stakeholders from different disciplines, government, non-state actors and parliament. This includes stronger partnerships with health authorities, nongovernmental organizations and community leaders, and engagement with academic institutions and medical students. For efforts to succeed, WHO will continue to strengthen the humanitarian system and support ongoing reforms to improve the way it works in emergencies.

WHO is increasing advocacy for the protection of health care workers and health facilities as afforded under international law, including the Geneva Conventions, as well as for access in conflict countries.