WHO Health Emergency Programme

Introduction

The Eastern Mediterranean Region is witnessing an unprecedented magnitude and scale of crises. Almost two thirds of countries in the Region are directly or indirectly affected by emergencies, including four countries (out of a total of six globally) experiencing major emergencies designated by WHO and the United Nations as Level 3: Iraq, Somalia, Syrian Arab Republic and Yemen. The Region also hosts countries witnessing protracted emergencies, including Afghanistan, Lebanon, Libya, Pakistan, Palestine and Sudan. Many of the remaining countries in the Region are affected by the crises in neighbouring countries.

WHO's response

Increasing numbers of people in need of health services continue to challenge the capacity of WHO and health partners to respond. By the end of 2016, out of a total of 140 million people in need of health services globally, more than 76 million (54%) lived in the Region in countries directly or indirectly affected by emergencies. Ongoing insecurity and limited access by humanitarian workers to people in need continued to challenge WHO's response. In Iraq, Syrian Arab Republic and Yemen, almost 30% of all people in need are living in hard-to-reach, inaccessible or opposition-controlled areas.

Attacks on health care in the Region continued relentlessly. In 2016, more than 252 attacks were reported from eight countries, accounting for 83% of all reported attacks globally. The Syrian Arab Republic remained the most dangerous country in the world for health workers, with almost 70% of all reported attacks globally.

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↑ A field assessment was conducted in Bekaa Valley, Lebanon, as part of efforts to strengthen preparedness for cholera outbreaks

Thousands of civilians sustain trauma injuries every month in the Region as a result of escalating conflict. In the Syrian Arab Republic alone, more than 25 000 people are injured every month and require trauma care. In Iraq, more than 3000 people were injured in the first 10 weeks following the launch of military operations in Mosul in October 2016.

The Region also bears the greatest burden of displaced populations, with more than 30 million displaced people across the Region. More than half of all refugees globally come from the Syrian Arab Republic, Somalia and Afghanistan. The Syrian Arab Republic accounts for the largest number of refugees and internally displaced persons, with more than 65% of the population displaced both inside the country and in neighbouring states.

Demand for health services by displaced populations continues to place a large burden on

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↑ **In 2016, WHO with humanitarian partners delivered medical supplies to all besieged areas in Syria for the first time since the conflict began**

national health systems across the Region. The high cost of services, human resource shortages, insufficient medicines and equipment and economic deterioration are some of the many barriers facing refugees seeking health care.

The year 2016 marked the first time in several years that WHO was able to reach all 18 besieged areas in the Syrian Arab Republic. During the military operations in East Aleppo, WHO played a key role in negotiations with all parties to the conflict, and developed a comprehensive medical evacuation plan designed to save the lives of hundreds of wounded and critically ill patients trapped inside the city. 811 patients were successfully transported to hospitals in western Aleppo, Idleb and across-the border to Turkey.

WHO and partners supported a landmark national multi-antigen immunization campaign in the Syrian Arab Republic, taking place over three rounds in April, July and November 2016. The accelerated immunization campaign was the first opportunity for thousands of children living in many besieged and hard-to-reach areas to be immunized since the beginning of the conflict.

In Iraq, WHO supported the provision of trauma care for people affected by the Mosul crisis by establishing four trauma stabilization points and a field hospital near the front lines. As military operations continued, WHO-supported mobile medical clinics and mobile medical teams were sometimes the first to reach newly accessible areas to deliver health care services to thousands of

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Photo: ©WHO

↑ **WHO and partners provided life-saving medical supplies including ambulances and mobile clinics to support humanitarian missions in countries such as Yemen (left) and Iraq (right)**

people who had been cut off from aid since June 2014.

An attack on a Médecins Sans Frontières hospital in October 2015 in Kunduz, Afghanistan, required WHO and partners work to fill critical gaps to save lives in the conflict-affected province. In July 2016, WHO established a trauma care unit at Kunduz Regional Hospital to manage mass casualties and also supported the establishment of a physical and psychological rehabilitation centre at the hospital. From its opening in July until December 2016, more than 2400 patients were treated at the trauma care unit and surgeons conducted 1045 major and minor operations.

Two field hospitals procured with the support of WHO were established in priority locations in Libya where existing health facilities were no longer functioning. A field hospital in Benghazi helped fill critical gaps in a context where 10 out of the city's 14 hospitals were non-functional. A second field hospital was established in the green mountain area, with a catchment population of more than half a million. Even in the most difficult circumstances in Libya, in 2016 WHO was able to conduct a national health assessment for the first time in four years. The assessment identified some significant needs, most significantly in Benghazi where more than 50% of all hospitals were non-functional.

In April, WHO initiated a comprehensive assessment in Somalia focusing on approximately 1074 public health facilities across the country. This health facility assessment was the first of its kind to be conducted in Somalia by health authorities and partners. In December, a cholera outbreak in the Middle Shebelle region of Somalia was contained and the number of cases declined as a result of strong coordination between health partners, a successful public information and prevention campaign and training conducted for health workers. The surveillance data helped the country to monitor transmission, as well as take appropriate control measures in the hotspots. Samples were sent to Somalia's first-ever national laboratory, established in 2016 with support from WHO, and which significantly reduced waiting times for results.

Emerging infectious diseases

Emerging infectious diseases, including the outbreaks in recent years, occurred in security-compromised countries with complex and

protracted humanitarian emergencies where large populations are internally displaced and there is inadequate access to clean water, sanitation and basic health services. Surveillance systems in fragile health systems may not be able to detect all health threats in a timely manner. This compromises the effectiveness of public health response measures and makes populations more vulnerable to infectious diseases. The potential for Zika spreading into the Region remains a real concern. Additionally, as the population has no immunity to this new virus, preparedness measures need to be continued to prevent any introduction.

Cholera outbreaks in Yemen and Somalia were effectively responded to through appropriate public health interventions which helped to avert major international spread. The Early Warning Alert and Response Network in Iraq demonstrated its flexibility by rapidly expanding to address a large number of displaced populations from Mosul, following escalation of military activities in September 2016.

Surveillance systems for influenza-like illness and severe acute respiratory infections in 16 countries aided detection and response to epidemic influenza and other acute respiratory infections in the Region. Technical missions were conducted to enhance preparedness and response capacities in Saudi Arabia for MERS-CoV, and in Egypt, Pakistan and Sudan for Zika virus infection.

The Global Outbreak Alert and Response Network (GOARN) was expanded in the Region to include new international partners together with a pool of regional experts for responding to infectious disease outbreaks and other health emergencies. National rapid response teams were trained in Saudi Arabia and Somalia for deployment across the country to manage outbreak detection, response and containment. In order to enhance readiness for international outbreak response a pool of public health experts received training on field investigation and response to public health emergencies as part GOARN activities in the Region. The Regional Office supported Saudi Arabia with public health preparedness measures by deploying a team of experts who provided necessary advice for preventing any major health emergency during the hajj.

Five countries (Jordan, Somalia, Sudan, Syrian Arab Republic and Yemen) received technical support in developing comprehensive cholera preparedness and response plans that promote integrated prevention and control interventions. As part of such cholera elimination plan, an oral cholera vaccination campaign was conducted in the White Nile State in Sudan targeting refugees and host communities in order to prevent the spread of cholera among refugees fleeing South Sudan.

Under the Pandemic Influenza Preparedness Framework and as part of Regional Office's work in pandemic influenza preparedness, epidemiological and virological surveillance for influenza-like illness and severe acute respiratory infections were enhanced in 16 countries. A web-based interactive platform, Eastern Mediterranean Flu Network, was deployed for countries to share epidemiological and virological data on influenza regularly.

Since the declaration on 1 February 2016 that the clusters of microcephaly thought to be associated with Zika virus constituted a public health emergency of international concern, WHO rapidly scaled up preparedness and readiness measures to prevent introduction of the Zika virus

into the Region. The Regional Office developed a regional preparedness plan for Zika virus in collaboration with countries. As part of the plan, systematic risk assessments were conducted in the Region, entomological surveillance for competent vectors was strengthened in all high-risk countries, appropriate risk communication materials were developed and disseminated and a group of health managers was trained on roles and responsibilities in an incident command system, an important response mechanism during health emergencies.

Preparedness

Additional challenges remain related to building and enhancing national preparedness and disaster risk reduction. National public health plans for preparedness and response to all hazards and national assessment of potential hazards in countries of the Region are mostly lacking. Several activities were conducted to enhance national capacities for disaster risk reduction based on the Sendai Framework; yet, more needs to be done. Major mass gatherings in the Region require enhanced action by WHO and health partners in the areas of evidence-based planning for all public health emergencies and scaling up national capacities to respond to acute health needs during these events.

Developing and costing national plans of action for health security based on the outcomes of the joint external evaluation of IHR capacities requires the involvement of all relevant national stakeholders, including civil society and the private sector, and the positioning of responsibility for health security at the highest levels of authority to ensure implementation of the plans. Aligning national plans for health security with other existing plans and mobilizing domestic and external resources to fund and implement these plans remain key challenges.

Donor support for the regional health emergency programme continues to be weak. In 2016, WHO appeals for the Region were 39% funded, with US$ 164 million received out of US$ 425 million requested. Restricted access to affected

Photo: ©WHO

↑ National response teams in Lebanon were trained to deal with potential threats involving chemical, biological, nuclear and radiological materials

populations because of high levels of ongoing conflict and violence remains a significant impediment to increased donor support.

Between April and December 2016, WHO and partners supported 10 countries in the Region to conduct joint external evaluations of IHR capacities: Afghanistan, Bahrain, Jordan, Lebanon, Morocco, Pakistan, Qatar, Somalia, Sudan and Tunisia. Plans to support the remaining countries to conduct the evaluations are ongoing. Support was given to Pakistan and Jordan to develop and cost their national action plan for health security based on the outcomes of the joint external evaluation. Discussion with partners is ongoing to coordinate the support to the rest of the countries that conducted the evaluations to develop and cost their plans of action.

The new IHR monitoring and evaluation framework was introduced to countries through a regional meeting with focus on the joint external evaluations and on ways to improve how they are conducted in countries. The Regional Office led the global efforts to develop guidance on conducting the joint external evaluation in crisis countries. The guidance will be pilot tested in Iraq and Libya as a first step for conducting the evaluations in these countries.

The first phase of an all-hazard risk assessment was successfully carried out in priority provinces in Afghanistan in 2016 to support operational planning for emergency response. The second phase is expected to take place in 2017. The Regional Office hosted the first workshop on the Capacity for Disaster Reduction Initiative, aimed to enhance the capacity of partners to support the implementation of the Sendai Framework for Disaster Risk Reduction. The workshop was attended by representatives of the Food and Agriculture Organization of the United Nations, the World Food Programme, the United Nations Office for the Coordination of Humanitarian Affairs, the United Nations Development Programme and by WHO regional and country office staff.

To scale up emergency preparedness, training was organized for emergency focal points in countries of the Region, in partnership with the Asian Disaster Preparedness Center, Johns Hopkins University and the Centers for Disease Control and Prevention (CDC), Atlanta, to enhance multisectoral leadership and coordination in responding to all-hazard public health emergencies. WHO worked closely with the Inter-Agency Standing Committee to assess readiness capacity of country offices to respond to priority hazards. Assessments were conducted in Sudan and Somalia in 2016, and action plans were developed aligning the outcomes of the joint external evaluation missions and country capacity assessments for emergency preparedness.

To enhance the capacity of countries to cope with the additional demand on health services resulting from hosting refugees and migrants, a working group from all concerned international and regional organizations and academic institutions is currently under development. WHO and the International Organization for Migration will be the secretariat for this working group. The working group will aim at supporting countries in the Middle East and North Africa to operationalize and implement the strategic, global and regional priorities and framework on migrant health.