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Address by

DR. ALA ALWAN

REGIONAL DIRECTOR

WHO EASTERN MEDITERRANEAN REGION

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Universal health coverage in the context of emergencies

Excellencies, Ladies and Gentlemen,

Let me start by thanking H.E. the Minister of Health of Turkey for inviting me to this important meeting. I would also like to congratulate the Turkish government for their impressive achievement in universal health coverage (UHC). What has been achieved here in ten years is inspiring and provides many important lessons for other countries that are committed to moving in the same path.

Coming from a region of many crises is probably why I have been asked to talk about emergencies in the context of UHC. So I will provide some examples from my region. Also, at one stage in my WHO career, I was in charge of WHO's work in emergencies and crises. So I will try to give you impressions based on my limited experience on some of the key aspects related to this subject.

We are all currently witnessing the humanitarian crisis in Syria as it unfolds with unprecedented magnitude and with catastrophic humanitarian impact inside Syria, and in neighbouring countries. We continue to follow other acute crises as well chronic emergencies in many parts of the world. We have all seen the destructive effects of natural disasters like the recent floods

across central Europe, and each year we anticipate the after-effects of hurricanes, tornadoes, rains and forest fires that regularly affect countries around the world. We know that these emergencies result in enormous loss of life and suffering. Emergencies represent a major impediment to UHC and therefore ensuring that health care reaches all people affected by emergencies is a great challenge to global health today.

Let us look at the magnitude of emergencies and crises. Over a ten-year period from 2001–2010, we had an average of more than 700 natural and manmade emergencies occurring globally every year, affecting approximately 270 million people and causing over 130 000 deaths annually. We know also that almost half of these deaths occurred in less developed countries with limited capacity to prepare for an effective response.

Data show that natural disasters are progressively increasing in magnitude worldwide but the magnitude of manmade crises is equally serious. According to the World Bank, over 1.5 billion people – or about one quarter of the world's population currently live in countries affected by violent conflicts.

Emergencies also impose a huge burden on socioeconomic development. It is reported that the year 2011 witnessed the greatest losses in history, reaching US$ 386 billion as a result of physical damage caused by natural disasters. In 2010 alone, it is estimated that more than US$ 18.2 billion was spent on the provision of humanitarian assistance around the world. Imagine the substantial impact if these funds had instead been invested in improving health system resilience and the socioeconomic development of vulnerable communities.

In WHO's Eastern Mediterranean Region, in which I serve as the Regional Director, 13 out of the Region's 23 countries are currently experiencing complex humanitarian emergencies, affecting more than 40 million people.

The Eastern Mediterranean Region is also where more than 55% of the world's refugees originate: according to a new report by UNHCR. Out of 7.6 million people who became refugees in 2012, more than 4 million originated from Afghanistan, Somalia, Iraq, Syria and Sudan. Although this is the highest number reported since 1994, this figure is already outdated, obviously, the worsening situation in Syria being a major factor.

The damage to health systems is enormous. Access to basic public health functions and basic health services is impeded. The damage to health systems takes many forms. Health infrastructure itself may be destroyed, and medical staff killed or displaced. The increased health needs of affected populations and reduced supply result in shortages of medical equipment, supplies, and critical medicines. Power, fuel and water supplies may not be available or may be interrupted frequently. And the damage can be very sudden. For example, on the 7th of October 2005, the Pakistan earthquake occurred. In just a few seconds, a population of 4 million people was displaced with almost complete collapse of the health system in the affected areas. Hundreds of thousands of people were suddenly out of reach.

On the other hand, the more protracted emergency situations become, the more likely it is that populations will suffer from social and societal disruption, infectious diseases, acute malnutrition, trauma, and life threatening complications of chronic diseases, disabilities and mental health conditions.

Let me now focus on health relief and care during emergencies. As you know, UHC has three dimensions: the first is coverage for all people which means extending coverage to those who are not covered; the second is coverage with all essential services, prevention, promotion, treatment and rehabilitation services; and the third is coverage with financial risk protection and reducing cost sharing, so that these services do not expose the user to financial hardship. And UHC obviously means that all situations are covered including during emergencies.

The principle of all people and equal access is very much consistent with the humanitarian principles which have been universally accepted by countries and which are the basis for emergency management and the humanitarian reform endorsed by the United Nations General Assembly in 2005.

These principles are intersectoral action, neutrality, solidarity, equity and social justice; participation; accountability and reliability; and the fundamental right to health for all.

This means that universal health coverage in its three dimensions is an integral part of these humanitarian principles.

In big emergencies, the international community plays an important role. In these situations, and based on these principles, humanitarian health relief, humanitarian relief has three basic pillars: strengthening of health systems; improved financing; and strengthened partnerships and coordination through the establishment of the health cluster which includes national and international players, coordinated by WHO. In addition to the provision of essential health care in coordination with the government, the health cluster has the responsibility to provide key public health functions.

In all national and international emergencies, access to essential services and financial risk protection, which is fundamental to the achievement of universal health coverage in normal situations, is also a prerequisite for effective humanitarian health relief. This means that vital services in emergency situations must be freely accessible to all. These services specifically involve basic public health interventions like strong surveillance and early warning systems, immunization, safe water and sanitation, as well as access to primary health care supported by effective referral systems to secondary and tertiary facilities.

It is also important to mention that the building blocks for a well-functioning health system – like governance and leadership, workforce, information, essential medicines and technologies, and infrastructure for health care delivery – are as crucial to emergency management as they are to universal health coverage. In the international context, the United Nations health cluster approach ensures that these areas, including measurement of performance and accountability, are addressed.

Clearly then, the same principles apply to emergency management as to universal health coverage. The goal in both cases is to provide a package of essential health services to all those in need and that is free at the point of use.

So my key message is that UHC during emergencies can be achieved if the humanitarian principles are adhered to by national and international actors and effective emergency management is put in place and implemented on the ground. However, sadly that is not the case we usually see in real life during emergencies. There are often major gaps, much suffering and lives lost.

So why is this not happening in all emergency situations, what are the obstacles to effective management of emergencies?

First and foremost, is the lack of risk and vulnerability assessment and preparedness: Emergencies of any kind are the ultimate test of a health system's resilience, sustainability and robustness, and of national emergency preparedness planning.

Second is lack of security, which may result in destruction of infrastructure. Again the Syria crisis and the situation in many violent conflicts are examples of how lives are lost and disease prevails because of lack of access. People may be prevented from reaching treatment by hostilities, insecurity on the roads, lack of or difficult transport, lack of fuel, fear, and a host of other related issues. Health professionals often cannot reach people in need. In one governorate in Syria, for example, 70% of health workers in heavily affected areas reported difficulties in accessing their workplace due to insecurity. Unfortunately, we have several sad examples of health care workers being killed or kidnapped as they report to work. Ambulances have been damaged or stolen. There have also been instances of trucks carrying humanitarian supplies being attacked and hijacked.

Third, other causes of inaccessibility: Nearby health facilities may collapse or become unusable. Despite the humanitarian principles I earlier outlined, the cost of obtaining treatment may actually rise during emergencies. People may have to compete to access available medical services and supplies. User fees, which have been imposed during some chronic emergencies, will impede access to essential health services. Closure of government facilities may force people to resort to the private sector. They may become vulnerable to exploitation. Being in remote places with difficult road access, as is the case in many natural disasters, is another reason for lack of coverage.

Fourth, funding: If adequate preparedness and planning have not been put in place, a state may have to call on the international community to help support emergency response. While funding mechanisms for immediate international response may be available, the longer an emergency goes on, the more need there is for a sustainable means of funding. Here again, user fees, which may be applied in normal circumstances, impede access to health care and will have to be waived during an acute or chronic emergency.

Fifth, supply: Lack of medical supplies and essential medicines. Although emergency health kits are normally provided during acute crises, life-saving medicines and supplies for chronic diseases, maternal and child health care, mental health and psycho-social support, etc. are often forgotten or inaccessible. This gap has been encountered in almost all recent large-scale emergencies.

Sometimes the international community itself impedes prompt delivery of badly needed supplies. For example, when sanctions are imposed, immunization programmes face major difficulties because of interruption of vaccine supplies and life-saving treatment of chronic conditions like cancer or diabetes is compromised because of lack of access to medicines. There are also examples of warring factions in a country preventing entry of commodities or discriminating in to whom and to where they should be distributed.

And finally, lack of attention to the urgent needs of people with noncommunicable diseases and other chronic conditions, to maternal, newborn and child health and to psychosocial disorders.

Ladies and Gentlemen

Let me conclude with some points on the way forward.

It is clear that UHC and emergency management in health are based on the same principles. It is also clear that UHC during emergencies can be achieved if the humanitarian principles are adhered to and implemented on the ground. But there are impediments and gaps that need to be overcome. These impediments will require action by countries and also by the international community. Countries need to be better prepared for emergencies and to invest in strengthening the resilience of their health systems. A number of countries have proved that this strategy works. Countries also need to take into account international experience and lessons learned in order to address the impediments and gaps that I have mentioned. At the global level, the international community should establish stronger coordination and also learn from experiences, particularly in the last 8-10 years since the implementation of the UN humanitarian reforms. More lives can be saved and much suffering prevented if we learn from these experiences.

In our region, Member States have endorsed a strategic vision aimed at increasing the resilience of countries to emergencies, disasters and other crises, and subsequently ensuring effective

public health response to risks and threats. This includes offering support to countries to develop clear policies and legislation based on an all-hazard, multisectoral and ‘whole health’ approach, and paying special attention to safeguarding health facilities and the health workforce in times of emergencies and crises.

Additional readiness measures being taken by the Regional Office include maintaining regional emergency stockpiles, training a cadre of response experts and encouraging the establishment of intercountry mutual support and solidarity arrangements and agreements in times of crisis. The evidence base for health emergency and disaster risk-management is being strengthened, including lessons learnt, best practices and economic assessments.

The ultimate goal is to promote country and regional self-reliance in the area of emergency and crisis management and to establish efficient solidarity mechanisms in order to support the achievement of our goal, which is improved health through universal health coverage. Thank you.