Emergency preparedness and response

The Eastern Mediterranean Region has a high risk for natural hazards such as earthquakes (Islamic Republic of Iran), floods (Pakistan) and drought (which has resulted in famine in Djibouti, Somalia and South Sudan since 2011 and is expected to re-emerge in 2013). Political instability and civil conflict in countries such as South Sudan, Sudan, Syrian Arab Republic and Yemen have resulted in millions of people in need of emergency and basic health services, especially the most vulnerable populations, such as women, children and the elderly. More than 50% of the world's refugees originate from the Eastern Mediterranean Region. In light of the increasing number and magnitude of emergencies in the Region, in March 2012 the Regional Director identified the area of emergency preparedness and response as one of five priority areas with the goal of increasing the resilience of countries to emergencies, disasters and other crises, and subsequently ensuring effective public health response to risks and threats. A new set of strategic priorities was defined to outline the way forward, including offering support to countries in developing clear policies and legislation based on an all hazard and 'whole health' approach, and paying special attention to safeguarding health facilities and the health workforce in times of emergency.

In all countries facing emergencies, there was a highlighted need in 2012 to ensure that health services for vulnerable populations, especially

↑ Health facilities often function under severe constraints during emergencies, such as in this hospital in the Syrian Arab Republic where a nurse uses the light from a mobile phone to check on a newborn baby during a power cut

women and children in the most affected areas, were made available. Priorities included the provision of obstetric and gynaecological health services, as well as vaccinations for children below the age of 5 years. In countries with on-going conflict and violence, mental health services were largely unavailable due to a lack of qualified health staff. Increasing numbers of refugees and internally displaced persons in countries such as South Sudan, Syrian Arab Republic and neighbouring countries, Sudan and Yemen highlighted the need for effective disease monitoring and response systems for the prompt control of communicable disease outbreaks. In both acute crises and protracted emergencies, the burden of noncommunicable disease also came to the fore as patients lost access to essential drugs and life-saving treatment.

Reform in WHO's work in emergencies, specifically the Emergency Response Framework, stressed the need for strengthening country office capacity to prepare for and respond to crises. To ensure a more rapid response, an emergency surge roster was developed with identified expertise on standby. Additionally, the process of establishing a regional WHO hub for medicines and medical supplies and equipment was initiated. On a regional level, medicines, medical supplies, logistics, and office and laboratory equipment worth almost US$ 120 million were provided to six countries facing emergency (Afghanistan, Libya, Pakistan, Somalia, Sudan and Syrian Arab Republic), amounting to almost 40% of WHO procurement on a global level.

Despite an increase in the funding of health activities in emergencies, only 38% of the Region's health funding requirements was met in 2012. The health sector continues to be severely underfunded, emphasizing the need for a more

Photo: ©WHO/Abdul Malik

↑ **Emergency supplies are checked following arrival in Afghanistan**

coordinated approach by traditional and non-traditional partners to address the health needs of affected populations in the Region.

An evolving leadership role in health emergencies

In all countries experiencing emergencies, WHO supported health authorities to lead a coordinated and effective health sector response together with the national and international community, in order to save lives and minimize adverse health effects, with specific attention to vulnerable populations. One of the main challenges was lack of accessibility and humanitarian space. The delivery of health services to affected populations in Palestine, South Sudan and Syrian Arab Republic was impeded by the limited access by health humanitarian partners and by health care workers to their place of work due to insecurity. Twenty-three months into the crisis in the Syrian Arab Republic, for example, 70% of health workers in heavily affected areas reported difficulties in accessing their workplace.

Similar challenges associated with inaccessibility and insecurity that impeded the delivery of emergency and basic health services were faced in Afghanistan, Somalia, South Sudan and Yemen.

The delivery of basic and emergency health care services was also impeded as an indirect result of economic sanctions on countries such as Islamic Republic of Iran, Libya and Syrian Arab Republic. For example, pharmaceutical plants in the Syrian Arab Republic that had previously produced almost 90% of the country's medicines were forced to halt production due to the combined effects of economic sanctions, fuel shortages and damage to infrastructure. Consequently, health facilities received insufficient supplies from the central authorities due to critical shortages in life-saving essential medicines.

To ensure that urgently needed medicines and medical supplies were available, WHO worked with governments and partners to broker the procurement and provision of supplies. Examples of these partnerships included those with the League of Arab States for the provision of medicines and medical supplies to Syrian Arab Republic and Yemen, and with local authorities and the Organization of Islamic Cooperation to coordinate access of the population to health services in Somalia.

In countries such as Afghanistan, Libya, Pakistan and Syrian Arab Republic, where health care workers and health facilities were intentionally targeted or indirectly affected, WHO condemned the attacks in the regional and international media and through advocacy campaigns, referring to World Health Assembly resolutions and human rights laws prohibiting the targeting of health staff in times of conflict.

Saving lives and meeting health needs

Incapacitated health systems in countries experiencing emergencies often result in vulnerable populations having little or no access to health care services. In the Syrian Arab Republic, more than 50% of public hospitals had been damaged or destroyed as a result of the conflict as of December 2012. To ensure the continuity of health care services, WHO partnered with 13 local nongovernmental organizations to ensure the provision of treatment, medicines and medical supplies. By the end of 2012, WHO had provided medicines and medical supplies for 1.2 million treatments, and more than 195 000 blood safety kits to the national blood bank, trauma surgery and emergency care supplies, intravenous nutrition fluid and intravenous supply sets to hospitals in affected areas.

Vulnerable populations in Afghanistan and Somalia, especially women and children, were reached through field hospitals and mobile clinics. In Somalia, children and women of childbearing age in remote communities and underserved areas were reached thorough health interventions on Child Health Days, in partnership with the national authorities and UNICEF. Nationwide emergency vaccination campaigns were conducted with health partners in Afghanistan, South Sudan and Sudan, as well as in Syrian Arab Republic where WHO and UNICEF supported the Ministry of Health in measles and polio vaccination campaigns for 2 million and 2.5 million children under 5 years of age, respectively. WHO provided vaccines, paracetamol and multivitamin syrups, as well as ensured capacity-building for national staff to implement the campaign effectively and efficiently.

Photo: ©WHO/A. Alhassan

↑ Emergency response can involve extraordinary effort, as here in eastern Sudan where WHO staff and volunteers carry boxes of medicines and supplies across a flooded area to reach a health facility

In order to detect, and provide a timely and effective response to confirmed outbreaks, ministries of health strengthened the Early Warning Alert and Response (EWAR) systems in six countries (Afghanistan, Iraq, Jordan, Pakistan, Somalia and Sudan). These systems allowed WHO and partners to detect and manage outbreaks of cholera in southern and central Somalia, yellow fever in Sudan, acute watery diarrhoea in South Sudan, cholera in Iraq and tuberculosis among Syrian refugees in Jordan. As a result of the deteriorating heath situation in the Syrian Arab Republic, WHO established an early warning and response system and provided training to national surveillance focal points from around the country. Data collection began in September 2012 and enabled WHO and national authorities to monitor and control reported cases of hepatitis A, typhoid and leishmaniasis.

Incapacitated health systems and shortages in medicines also increase the burden of noncommunicable diseases as populations are no longer able to get regular treatment or access to essential, life-saving medicines. This has highlighted the need to update national lists of urgently required essential medicines in emergency countries based on disease profiles, current gaps and critical needs, with the Syrian Arab Republic identified as a priority country in early 2013.

Ensuring the collection and dissemination of health information in emergencies

One of the biggest challenges faced during emergencies is obtaining timely information on the health system so that health risks, needs and gaps can be accurately assessed. This challenge can be further aggravated during complex emergencies where access to this information is hindered. To ensure an efficient approach in managing

health information, WHO worked with national authorities and health partners to establish emergency health information management systems and coordinated the collection, analysis and dissemination of essential information.

In the Syrian Arab Republic, WHO participated in two interagency assessment missions and conducted rapid assessments of public health facilities in all governorates to determine accessibility and functionality. In the neighbouring countries of Iraq, Jordan and Lebanon, nutrition assessments were conducted among Syrian refugees living in both the refugee camps and within the host communities. Nutrition assessments were also conducted in Afghanistan, Pakistan and Yemen to ensure capacity-building for response to severe and acute malnutrition.

In Pakistan, the Health Resources Availability Mapping System (HeRAMs) was integrated into the national health system to ensure good practice in the mapping of health resources and services availability in emergencies and to strengthen informed based decision-making by the Health Cluster. Inter-agency partnerships were also strengthened through WHO support of the assessment of 65 UNHCR-administered health facilities.

Strengthening country office capacity

Natural disasters and political unrest can occur at any time and are often difficult to predict. In order for WHO's country offices to efficiently support country response operations, the deployment of health experts and procurement of medicines during emergencies must be as rapid and streamlined as possible. Challenges encountered at the onset of emergencies include the need to

be able to identify and deploy qualified expertise rapidly and the lengthy procurement procedures within WHO for medicines and medical supplies.

To address these challenges, a regional emergency roster of public health experts was developed to enable WHO to respond in a more timely and effective manner to emergencies in the Region, with a number of public health experts identified and on standby. Negotiations were initiated in December 2012 with the United Arab Emirates Government to establish a dedicated hub for WHO in Dubai's Humanitarian City. This hub will ensure that standard medical kits and supplies are stockpiled for more rapid deployment as needed in emergencies, and streamline the procurement process for WHO's health relief operations in the Region and around the world. The standard operating procedures, developed in 2010 to streamline WHO's work in emergencies, continued to be adhered to in addressing these challenges.

Emergency risk management

The growing number of large-scale emergencies enhanced the momentum of engaging Member States in multisectoral emergency risk management in the Region. It also highlighted the need to strengthen the emergency preparedness and response capacity of health systems, including the coordination among national and private sector partners.

Advocacy continued throughout 2012 in order to ensure that health is one of the priorities addressed in the global, regional and national development and disaster risk management agendas, in partnership with UNISDR, League of Arab States and UNDP. As a result, health has been underscored as one of the priority areas in

↑ **WHO staff conduct water quality monitoring during the 2012 floods in Pakistan**

Photo: ©WHO/KPK Pakistan

the policy guidance for disaster risk reduction for Arab, African and Asian Member States, developed by all key partners. WHO was invited to participate in the First Arab Conference on Disaster Risk Reduction in 2013, where the regional disaster risk reduction platform was planned to be launched. A side meeting on multisectoral health is planned to be held during the conference for representatives/delegates of participating Member States.

Recognizing that incapacitated health systems impede national ability to respond to emergencies in a timely and efficient manner, emergency risk management was one of the areas highlighted for action within the context of the regional strategic priorities endorsed by the Regional Committee. This has spearheaded the impetus

towards building national capacity with an all-hazard risk management approach incorporating the International Health Regulations (2005). As a result, the regulations have been included in national and regional training curricula for public health emergency management. To meet the challenges, even countries with protracted emergencies (Afghanistan, Pakistan and Sudan) are developing capacity in managing crises in a more institutional manner. This has also become evident in Islamic Republic of Iran, Oman and Pakistan, which are managing acute emergencies at the national level with minimal external support.

So far, seven countries (Afghanistan, Bahrain, Islamic Republic of Iran, Oman, Pakistan, Qatar and Sudan) are on track to institutionalize emergency risk management within the health sector. In light of this, preparation was undertaken to launch comprehensive risk assessment in Qatar and Sudan in the coming year. While establishing emergency risk management programmes remains a priority, simultaneous training in the areas of hospital preparedness, public health emergency management and disaster risk reduction also remain in focus in many countries. Recognizing that the safety of health facilities and health workforce is of utmost importance in the response to any public health emergency, several countries, including Bahrain, Islamic Republic of Iran, Lebanon, Oman and Sudan, are continuing to implement the hospital safety programme. WHO also worked with partners to develop a training programme on hospital preparedness in conflict situations.

To harmonize the national capacity-building activities from an all hazard approach at WHO, preparedness activities for emergencies, including epidemic and pandemic preparedness

and core capacities for implementation of the International Health Regulations, were merged into one technical body ensuring optimum use of resources within the framework of health security and regulations under the auspices of of the Department of Communicable Disease Control. This was done in alignment of 2014–2015 biennium planning priorities.

Scaling up emergency response in the Region

With the deterioration of the situation inside the Syrian Arab Republic and the increasing scale and complexity of health issues and response in the neighbouring countries, the emergency was designated Grade 3 by WHO in December 2012 – the first time a Grade 3 was announced in the history of the Organization. As outlined in WHO's Emergency Response Framework, a Grade 3 emergency called for the establishment of an emergency support team (EmST) to provide a consolidated, dedicated response to the crisis at the regional level by reinforcing WHO's four critical functions: 1) coordination; 2) information; 3) technical expertise; and 4) core services. Plans for the immediate establishment of the EmST were finalized in December 2012 in a meeting in Beirut attended by senior representatives from all three levels of the Organization.

In addition to consolidating WHO's response on a regional level to the Syrian crisis, the establishing of the EmST also reinforced the one-WHO model as other regions expressed their support. Despite its own financial limitations, the Regional Office for Africa donated US$ 100 000 to support EmST operations while WHO headquarters and the Regional Office for Europe deployed technical expertise as part of the emergency team.