



**World Health  
Organization**

Regional Office for the Eastern Mediterranean

# WHO's work in emergencies 2016: the year in review

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This newsletter aims to connect WHO with donors and partners, providing an update on the health situation and response in emergency countries in the Eastern Mediterranean Region.

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#### IMAGE CREDITS

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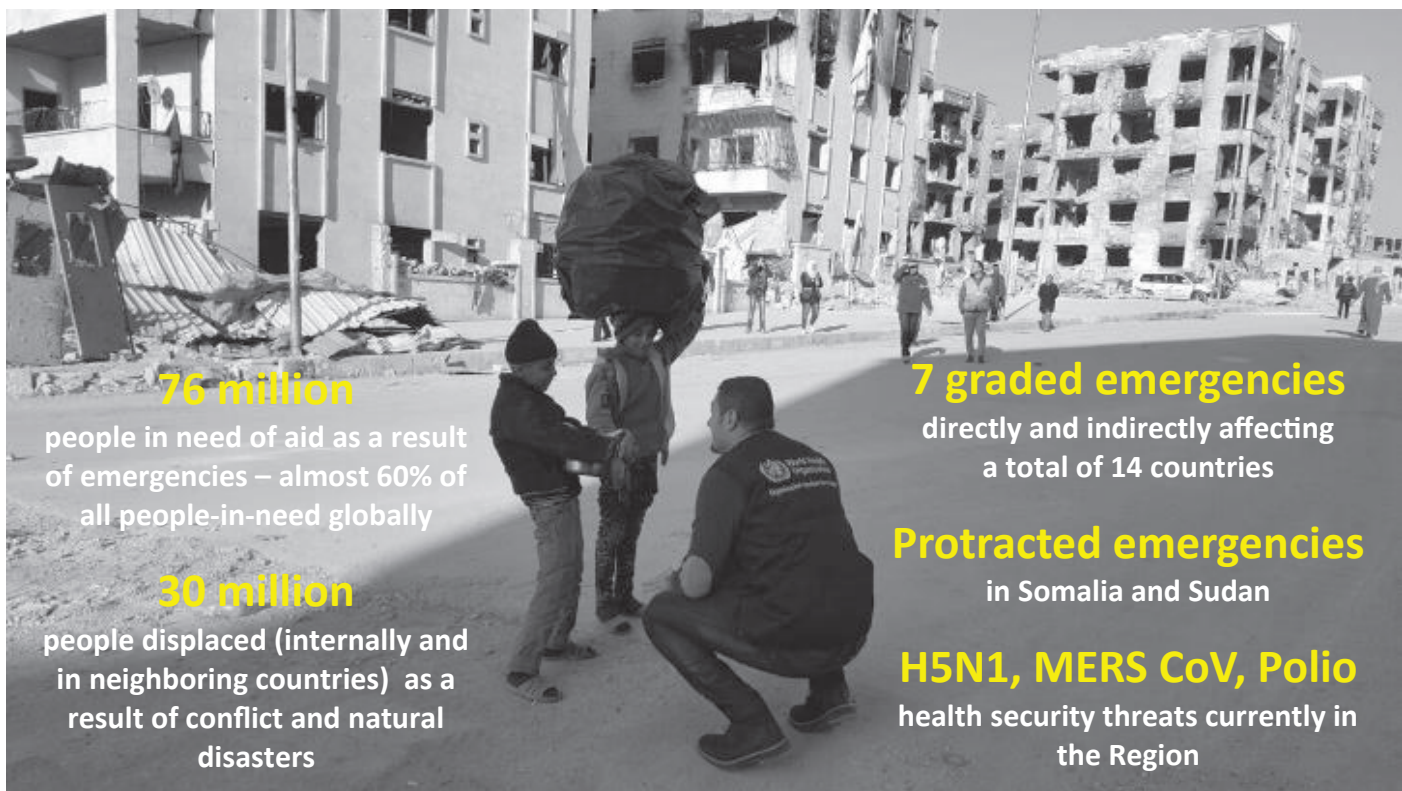
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# Overview



**76 million**

people in need of aid as a result of emergencies – almost 60% of all people-in-need globally

**30 million**

people displaced (internally and in neighboring countries) as a result of conflict and natural disasters

**7 graded emergencies**

directly and indirectly affecting a total of 14 countries

**Protracted emergencies**

in Somalia and Sudan

**H5N1, MERS CoV, Polio**

health security threats currently in the Region

The Eastern Mediterranean Region experienced **continued deterioration of the humanitarian and health situation in 2016**. As conflict raged in a number of countries, tens of thousands of men, women and children were killed and injured, hundreds of thousands were besieged and deprived of basic aid, and millions more were forced to flee their homes.

From children injured by explosive weapons, to pregnant women unable to give birth in a safe setting, to cancer patients deprived of essential treatment, **more than 66 million people in the Region are affected** by some of the world's most violent and longstanding humanitarian crises.

In countries facing conflict and ongoing violence, **the operating environment for humanitarian actors remained volatile**, with fragile security, limited access, threats to and attacks on health care workers, and increased social and economic challenges increasing humanitarian needs.

## 1. STRENGTHENING PARTNERSHIPS TO REACH ALL PEOPLE IN NEED

**Limited access as a result of ongoing conflict and insecurity** in a number of countries in the Region has resulted in WHO exploring more innovative ways to reach populations in need. This included expanding and strengthening collaboration and coordination with local health partners who have greater access to vulnerable affected populations in areas that international agencies find hard to reach.

The year 2016 marked the first time in several years that

WHO was able to **reach all 18 besieged areas in Syria**. This was made possible only through OCHA-supported inter-agency convoys and WHO's strong partnerships with more than 140 international partners and local nongovernmental organizations. Through its hubs in Syria (Damascus), Turkey (Gaziantep) and Jordan (Amman) **WHO and partners engaged in essential cross-line and cross-border humanitarian responses that covered all parts of the country**, taking the most direct route to people in need, regardless of geographical location or political affiliation.

During the military operations in Eastern 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. Finally, after months of negotiations for safe access and several failed cease-fires, on 15 December, the long-awaited evacuations began. As WHO and other UN staff monitored the operation, **811 wounded and critically ill patients were successfully transported to hospitals in Western Aleppo, Idlib and cross-border to Turkey**. WHO delivered health supplies to hospitals treating the wounded and deployed ambulances for referrals. **WHO-supported mobile clinics located along the evacuation route and in collective shelters for displaced persons** provided essential primary health care services, mental health screening, nutrition screening to tens of thousands of people.

As military operations intensified in Iraq, partnerships with local health actors were enhanced. This allowed WHO to reach populations in some inaccessible areas as well as in

newly accessible areas in and around Anbar and Mosul. **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 people who had been cut off from aid since June 2014.

Despite several failed cease-fires in Yemen, in early 2016 **WHO was able to deliver much-needed medicines and medical supplies to Taiz city**, where more than 250,000 people had been living for months in a state of virtual siege. WHO provided trauma kits, interagency emergency health kits, diarrhoeal disease kits, intravenous fluids, as well as oxygen cylinders to five main hospitals that were struggling to function amid dwindling supplies.

## 2. SAVING THE LIVES OF CIVILIANS CAUGHT IN THE CROSSFIRE

Increasing numbers of people injured in armed violence placed greater demands on WHO and partners to **fill critical gaps in the provision of trauma care and surgical services**, as well as referral services.

In Iraq, more than 2500 people required hospitalization for trauma injuries in the first nine weeks of the Mosul crisis. Lack of functioning referral hospitals near Mosul resulted in delays of up to four hours before patients were able to



receive medical attention at the closest hospitals in Northern Iraq. To increase their chances of survival during this time, **WHO established four Trauma Stabilization Points along the referral route from Mosul to Erbil**, and positioned 66 ambulances and 59 mobile medical clinics in six other conflict-affected governorates. In addition, **WHO provided trauma and surgical kits to national health authorities and partners** to treat thousands of patients requiring trauma and surgical care. WHO trained 60 medical doctors in Erbil and Ninewa and Dohuk and 33 paramedical teams on trauma management before their deployment to hospitals, ambulances and Trauma Stabilization Points.

Recognising that more lives could be saved if they received treatment within the critical “golden hour”—the first hour after an injury is sustained—in November 2016 WHO



11-year-old Omar from Aleppo, Syria was diagnosed with type 1 diabetes at age nine and is currently insulin-dependent. Every month Omar and his mother head to the nearest primary health care centre to collect his monthly supply of insulin. “The needed dose of Insulin will increase as the child grows up” says the doctor at the primary care clinic while explaining to Omar’s family how to properly administer his Insulin.

However, access to insulin is not easy as Omar lives in Jabal Samaan District, a conflict-ridden area where market prices are high and cooling conditions for vaccines are not always available. People like Omar were only able to receive life-saving treatment because WHO used funds from the Government of Kuwait to provides medicines, including insulin vials, to public health facilities and local health partners operating in rural and hard-to-reach areas. □



Nazir, an 11-year-old living in a family of five, is from Al Said Ali neighborhood in Aleppo, Syria. His family was forced to flee their home due to the insecurity, especially after his mother was severely injured. Shortly after, Nazir was also injured while on his way to school with two of his friends when a bombshell exploded. The explosion caused the immediate death of one of his friends and left Nazir with a severe abdominal injury.

Nazir was immediately taken to Al-Ihsan Charity Hospital where he was treated for his injuries. WHO’s agreement with the Al-Ihsan ensured full coverage of all expenses of Nazir’s treatment. Using funds from the UN Syria Pooled Fund, WHO supports the provision of primary, secondary, and trauma care management at Al-Ihsan Hospital, targeting a total of 13,434 beneficiaries in a number of areas in Aleppo Governorate. □



## KEY CHALLENGES



### Scale and magnitude of crises

More than 76 million people-in-need live in countries directly or indirectly affected by political conflict and natural disasters.



### Ongoing insecurity

Three countries facing highest level (Grade 3) emergencies and the greatest number of countries facing protracted emergencies.



### Limited funding for health

Humanitarian response appeals for emergencies in the Region for 2016 were 42% funded for WHO.



### Increasing trauma injuries

Thousands of civilians are injured every month as a result of escalating conflict.



### Limited humanitarian access

Almost one-third of all people-in-need in Syria, Yemen and Iraq live in besieged, hard-to-reach or opposition-controlled areas.



### Mass population displacement

More than half of all refugees globally come from the Region. The Region also hosts the greatest number of internally displaced persons worldwide.



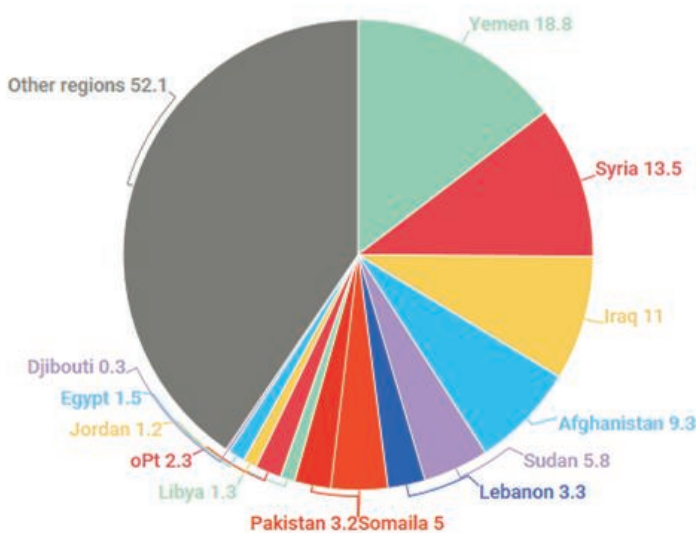
### Attacks on health care

More than 252 attacks in the Region in 2016, including 207 incidents in Syria alone.

began plans to **establish the first trauma field hospital in Iraq**. The hospital opened in January 2017, receiving patients from Mosul, the majority suffering from gunshot wound and shell and mine injuries. **Similar hospitals will be established in early 2017 as part of a larger trauma care plan** to address the short-term challenges of providing trauma and surgical support to people in conflict-affected areas.

In Syria, a staggering 30,000 people were injured each month and required trauma care in 2016. From its hubs in Damascus, Gaziantep and Amman, **WHO delivered trauma and surgical supplies to meet the most urgent needs**. In a joint effort with Turkey-based health cluster partners, more than 190,000 injured people were treated. From inside Syria, health cluster partners distributed **life-saving medicines, surgical supplies and trauma kits for more than 2 million trauma surgical interventions and treatments**. More than 17,000 medical workers and first-line responders were trained on various health, nutrition and WASH interventions. In areas where access was restricted, **WHO trained medical staff remotely using information and communication technology**.

In Yemen, the number of reported conflict-related injuries declined by 57% from 28,277 in 2015 to 12,206 in 2016. However, patients still struggled to access health services, including surgical care, due to critical shortages of specialized health staff amid a financial crisis and no operational budget for the Ministry of Health. To help fill



People in need of aid in the Eastern Mediterranean Region compared to other WHO regions

Source: Country response plans 2016-2017

It was a shattering blow to Basheer Thabet from Sana'a, Yemen, when he learned that his eight children and wife tested positive for cholera in October. A cholera outbreak was officially announced in the country in September.

Basheer's children and wife were suffering from severe diarrhoea and vomiting. After being hospitalized and medically tested in Al-Thawra Hospital in Sana'a, Basheer received the most shocking news of his life - all his children and wife were infected by cholera.

"I thought they were all going to die. At the time, I perceived cholera to be an incurable and fatal disease," Basheer said.

The children, ranging from ages 13 years to 3 years and their mother, who was nine months pregnant at the time, were referred to the isolation section in Al-Sabeen Hospital in Sana'a. There, they received medical care and were later moved to the hospital's newly rehabilitated diarrhoea treatment centre, established by WHO with support from the Office of U.S. Foreign Disaster Assistance and the UN Central Emergency Response Fund.

WHO has rehabilitated and fully equipped a total of 26



diarrhoeal treatment centres in affected governorates in Yemen to treat patients based on WHO case management, infection prevention and control standards. WHO also provided medicines and medical supplies, including oral rehydration solutions and IV fluids and is paying incentives for medical staff to ensure the centres remain functional.

"It took nearly 15 days until my children and wife recovered. These days were an absolute nightmare for me," Basheer recalled. Three months after this experience, Basheer said that a new life was granted for him and his family. □

this gap, **WHO supported 12 surgical teams in eight governorates** by providing them with medicines, medical supplies and financial incentives.

Following an attack on a Médecins Sans Frontières hospital in October 2015 in Kunduz, Afghanistan, WHO and partners worked to fill critical gaps and strengthen trauma care to save lives in conflict-affected Kunduz province. In July 2016, WHO **established a trauma care unit at Kunduz Regional Hospital** to manage mass casualties and injuries. WHO also supported the **establishment of a physical and psychological rehabilitation centre** at the hospital. From July to December 2016, more 2,400 patients were treated at the trauma care unit and surgeons conducted 1045 major and minor operations.

In Libya, **two field hospitals procured with the support of WHO were established in priority locations where existing health facilities were no longer functioning**. A field hospital in Benina, 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 (Mekhili), with a catchment population of more than half a million, where nearby armed conflict was continuous and no trauma care was available. **Two additional field hospitals are planned for 2017**. To help fill the gap in the availability of trauma care, WHO also supported the **establishing of a trauma care hospital near Al Baida City**, which provided care to war wounded patients, in addition to capacity building of

national health professionals.

### 3. MITIGATING DISEASE OUTBREAKS THROUGH SURVEILLANCE

Enhancing disease surveillance in collaboration with national authorities is a priority for WHO. Early Warning and Response Networks (EWARN) fills gaps caused by deterioration in routine disease surveillance systems in disaster and crisis affected countries. **WHO helps countries affected by crises to establish EWARN systems when the routine disease surveillance systems are disrupted**, in order to scale up early detection, alert and rapid response to disease outbreaks.

In Iraq, surveillance reporting sites for EWARN increased from 84 in late 2015 to 170 by the end of 2016. These include clinics in the retaken areas in Al Anbar and Ninawa governorates and new camps established to host displaced persons in areas facing military operations. This marks **the first time that the EWARN surveillance system has been functional in most parts of these governorates since 2013**.

In Yemen, the number of **surveillance reporting sites for EWARN increased** from 408 in 2015 to 1982 in 2016, and coverage was expanded from 16 to 23 governorates.

A cholera outbreak in Yemen in September challenged the capacity of WHO and partners to respond in the face of insecurity and limited funding. However, the EWARN surveillance data helped the country to monitor the progression of the outbreak as well as identify hotspots for



#### MONITORING ATTACKS ON HEALTH CARE

Attacks on health care in the Eastern Mediterranean Region continued relentlessly in 2016. **More than 252 attacks were reported from eight countries in the Region, making up 83% of all reported attacks globally.** Syria remained the most dangerous country in the world for health workers, with almost 70% of all reported attacks globally.

Until a political solution is found, WHO will continue to **monitor attacks, collect information on their impact, and call for the safety of health workers and health facilities.**

Updated information management systems are being established in key countries in the Region to ensure **better data collection and verification** of attacks. WHO is also **increasing advocacy** for the protection of health workers and health facilities, **calling for the safety and neutrality of health workers, health facilities and medical supplies** as per international humanitarian law. □



control measures. **WHO released internal contingency funding for the immediate provision of medicines and supplies, to strengthen surveillance activities** to detect and respond to suspected cases, and to establish **26 Diarrhoea Treatment Centres** in the most affected governorates.

Acute Watery Diarrhoea/cholera, measles, malaria, and other communicable diseases outbreaks are constantly reported in many areas in Somalia, including in settlements for internally displaced persons. Additionally, cholera outbreaks are now being reported in places that had not previously been considered as hotspots. In December, a cholera outbreak in Middle Shebelle 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 from EWARN helped the country to monitor the 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.

In Libya, **a disease early warning system was established for the first time** throughout the country, and a total of 23 surveillance officers were trained to collect and enter data electronically, and report weekly through mobile devices at facility level. Cascade training activities for rapid response teams, including surveillance officers, is planned to increase the number of reporting sites for EWARN to 100 by the end of 2017.

#### 4. PROTECTING CHILDREN AGAINST INFECTIOUS DISEASES

Despite insecurity and limited access, immunization activities continued to ensure that children, especially those living in hard-to-reach areas, were protected against vaccine-preventable diseases. Vaccinators travelled from house to house in sometimes remote and unsafe areas.

WHO and partners supported a **landmark national multi-antigen immunization campaign in Syria** 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 Syria. Despite a number of challenges in the lead-up and during the campaign, including heavy fighting, delays in transporting some



20 million

Litres of fuel provided by WHO in Yemen in 2016 to keep hospitals and other health facilities functional



55%

Percentage of health facilities in Yemen closed or only partially functioning due to shortages in staff, medicines, fuel and other resources

vaccine shipments and attacks on health care facilities in Idleb and Aleppo, **more than 400,000 children were successfully reached in hard-to-reach and besieged areas** from inside Syria and cross-border from Turkey in each round.

WHO also provided assistance to millions of men, women and children who continue to be affected by protracted emergencies. Despite ongoing challenges for healthcare workers in Somalia, and chronic under-funding of WHO and the health sector, the efforts of WHO and partners led to some notable results: in July, Somalia announced that due to continuous immunization efforts, **no polio cases have been reported in the country for the last year.**

Strong progress continues to be made in the **fight to eradicate polio.** 2016 saw the lowest number of wild poliovirus cases recorded globally in history (37 cases), with the Region's last remaining endemic countries, Pakistan and Afghanistan, recording 20 and 13 cases respectively, down from 54 and 20 in 2015.

Transmission remains limited to pockets of both countries. Through **Emergency Operation Centres established at the national and sub-national levels**, both governments supported by Global Polio Eradication Initiative partners continue to **implement National Emergency Action Plans** to bring cases down to zero. These plans place a strong emphasis on reducing the number of chronically missed children in polio immunization campaigns through innovative approaches. In 2017, focus remains on **building immunity amongst high-risk population groups and**

**improving surveillance quality**, whilst sustaining high levels of immunization coverage and outbreak preparedness in other countries in the Region, particularly those at high risk of poliovirus importation.

## 5. MEETING THE HEALTH NEEDS OF DISPLACED POPULATIONS

The Eastern Mediterranean Region bears the greatest burden of displaced populations. By the end of 2016, **more than half of all refugees globally originated from just three countries in the Region: Syria, Somalia and Afghanistan.** Syria remains the world's greatest producer and host of displaced populations, with more than 6.8 million people internally displaced, and 4.8 million Syrians in neighboring countries.

On average, almost 80% of all people displaced in the region live outside camps, placing additional burdens on vulnerable host communities. **In some countries, displaced populations found themselves living among the poorest communities.** Lebanon has the highest concentration of refugees per capita in the world, with refugees comprising more than 30% of the country's total population. As of December 2016, almost 70% of Syrian refugees in Lebanon and 25% of Lebanese nationals were living below the poverty line.

Demand for health services by displaced populations continues to place a large burden on national health systems across the region. In all countries hosting displaced populations, WHO worked with partners and national health authorities to help **ensure health services for displaced populations living in camps, and among host**

In early December 2016, a rocket struck the home of 16-year-old Sitara in her village in Kunduz province, Afghanistan, as her family was sleeping. Sitara and her four sisters sustained serious injuries in the attack and were brought to the WHO-supported trauma care unit at Kunduz Regional Hospital where surgeons immediately operated on them.

Sitara remained at trauma unit for over a month, and is recovering well from her severe injuries. "The doctors are very friendly and visit us many times a day to check on us and give medicines," Sitara said.

To strengthen trauma care and save lives in conflict-ridden Kunduz and surrounding provinces, WHO supported the establishment of a trauma care unit at Kunduz Regional Hospital in July 2016. The UN Central Emergency Response Fund (CERF) enabled WHO and partners to construct the trauma unit and equip it with essential medicines as well as medical and non-medical supplies and equipment.

Through support from the United States Agency For International Development, WHO is further



strengthening the trauma unit by providing additional medical supplies and equipment and staff salaries until March 2017 when the Ministry of Public Health will take over operations.

Since its opening, more than 2,400 patients have been treated at the trauma care unit and surgeons have conducted 1,045 major and minor operations. □





This baby is one of 500,000 patients in Gaza who benefitted from medicines and essential disposables provided by WHO with funding from the Government of Turkey.



12 year-old Omar is one of 25 Syrian children in Egypt who benefitted from WHO's rehabilitation and early intervention programme for disabled children, made possible with funding from the Government of Kuwait.

communities, as well as the host communities themselves. WHO provided mobile medical clinics, medicines and medical supplies, and trained medical teams to deliver health services. Immunization and surveillance activities in camps and areas hosting displaced populations were scaled up, as overcrowded living conditions and poor sanitation services increased the risk of communicable disease outbreaks.

#### 6. PROVIDING LIFE-SAVING TREATMENT FOR PATIENTS WITH NONCOMMUNICABLE DISEASES

As health facilities and treatment centres shut down and medicines became increasingly unavailable, patients with noncommunicable diseases such as cancer, high blood pressure and renal failure found themselves increasingly without access to life-saving treatment.

Even before the current crisis in Yemen, **noncommunicable diseases accounted for 39% of all deaths**. As shortages increased and stocks of medicines for chronic diseases reached zero in the country, the risks to patients reached critical levels. In November 2016, Yemen's Ministry of Public Health and Population warned that life-saving programmes for chronic disease patients were at risk due to lack of medicines for the treatment of cancer, kidney failure and cardiac problems. Soon after, the Dialysis Centre in Ibb Governorate closed due to lack of funding, putting the lives of more than 500 patients at serious risk, and the orthopedic section in Al-Thawra Hospital, Taiz City also closed. By year-end, additional health facilities, such as the national blood bank and national oncology centre in Sana'a, were on the verge of closure. To fill shortages in medicines, **WHO distributed medicines and supplies for the treatment of patients with diabetes, kidney diseases, and hypertension**.

Dialysis-dependent patients in Syria face many challenges to staying alive, including a lack of haemodialysis equipment, shortages of skilled medical personnel and

electricity cuts in dialysis centres. In 2016, WHO supported **more than 50,000 haemodialysis sessions and provided 34 dialysis machines** to health facilities across the country.

One of the leading causes of civilian deaths in Yemen's conflict is not trauma injuries but mothers and children dying due to lack of routine health services. Almost 4.5 million people in Yemen, including 2 million children, require services to treat or prevent malnutrition, representing a 148 percent increase since late 2014. Of special concern are almost **462,000 children suffering from severe acute malnutrition** and at risk of life-threatening complications such as respiratory infections or organ failure. **WHO supported the establishment of 12 therapeutic feeding centres in 5 governorates**, and trained 60 nutrition specialists from around the country in order to **launch an integrated nutrition surveillance system with 100 sentinel sites in 10 governorates**. Many children suffering from severe acute malnutrition in Yemen are alive today only because they were provided with treatment made possible with support from WHO.

As violence raged and civilians were exposed to unimaginable horrors, mental health needs also increased, especially among women and children. More than 50% of the population in Syria was estimated to be in need of mental health and psychosocial support services by year-end. **Mental health services were provided with support from WHO for the first time** at about 200 primary and secondary health facilities in 11 governorates, including those most affected by the crisis.

Only 40 psychiatrists remain in Yemen, leaving critical gaps in the availability of urgently-needed mental health services. WHO conducted **two workshops for 60 psychologists and primary health care workers from conflict-affected governorates of Sana'a, Tazi, Dhamar and Amran**. WHO's strategic goal is to train 200 health and community workers from all governorates in 2017.



## 7. ENSURING RELIABLE INFORMATION FOR AN EFFECTIVE HEALTH RESPONSE

Even in the most difficult circumstances in Libya, in 2016 WHO was able to **conduct a national health assessment for the first time since 2012**, which identified some significant needs. Overall, out of 98 hospitals assessed, 16% were non-functional, 30% functioning at 50-75% of their full capacity, and 28% functioning at less than 25% capacity. Benghazi was the worst affected district, with more than 50% of all hospitals closed.

In April, WHO Somalia in collaboration with partners and national health authorities, **initiated a comprehensive assessment focusing on approximately 1074 public health facilities across Somalia**. This health facility assessment was the **first of its kind** to be conducted in Somalia by health authorities and partners. Data analysis and reporting are ongoing, and are expected to play a key role in driving in-country health programme priorities.

## 8. LOOKING AHEAD

While much was achieved in 2016, **humanitarian efforts must be stepped up in 2017** to ensure that all people in need are able to meet their basic needs and access life-saving health services. More action is needed from all stakeholders to ensure sufficient funding for health,

humanitarian access to all people, and the safety of health workers who risk their lives every day.

As emergencies continue to cross national borders, there is a need to ensure a **more systematic and effective cross-country and cross-regional approach** to responding to the health needs of affected populations and ensuring that health systems in all affected countries continue to deliver urgently needed services to displaced populations and host communities. To monitor and control outbreaks, WHO will ensure that adapted disease surveillance, early warning and response systems are in place, and that they are resilient in times of crisis.

The **expansion of vaccination activities into hard-to-reach areas** is essential to achieve broader population coverage. This is of key importance if transmission of vaccine-preventable diseases such as polio, measles and tuberculosis, is to be halted, particularly in the present context of high population mobility and overcrowded living conditions.

An effective health strategy involves **fully engaging with the affected communities themselves**. WHO will continue strengthening preparedness by capacity-building of health workers, and diversifying its approach with increased



In a remote village in the Hiran province of south-central Somalia, health workers found cases of acute watery diarrhoea that they suspected were cholera. They quickly collected and shipped stool samples for testing to the national laboratories in Mogadishu. The transportation costs were covered by WHO. However, given the limited infrastructure in the area, the samples took nearly two weeks to reach the capital city. When they were received, the lab realized in dismay that the samples were in used test tubes that had previously contained blood samples.

"In the end, it was very disappointing that after two weeks of effort, we got nothing – all the samples had to be rejected," said Dr Sahra Isse Mohamed, head of the

Microbiology department that runs the National Public Health Reference Laboratory.

Conflict, food insecurity and internal displacement of population have left many parts of Somalia with limited access to basic amenities including health services. With a population facing increased vulnerability to communicable diseases, it is critical to correctly diagnose epidemic-prone diseases early. Specialized training for front-line health workers is an effective and critical means to provide care to a vulnerable population.

With this aim, WHO conducted a 5-day training in Hargeisa for Dr Mohamed and her colleagues across the nation who form Somalia's Rapid Response Teams (RRTs) –a multi-disciplinary team of medical officers, surveillance officers, coordinators and data managers responsible for outbreak detection, response and containment. RRTs are set up at national and local levels to investigate and respond to outbreaks as they occur anywhere in Somalia. The workshop provided an opportunity to identify gaps in the RRT system in Somalia such as the need for improved referral systems, stronger communication networks and formalized procedures.

Investing in more training for health workers will ensure scaling up of Somalia's national capacity for a better response to health crises and emergencies. □

On 26 December 2016, four-year-old Farouk\* was at a water distribution site near his home in Mosul, Iraq with his father when they were injured. A military ambulance team transported them to a hospital in Erbil, making multiple stops at trauma stabilization points to monitor their condition and provide care. They had to endure the 4-hour trip from their village to Erbil because health facilities in the newly liberated areas of Mosul are non-functional.

Farouk's condition was critical. He had sustained serious injuries to his left chest and lower abdomen. In his right hand, Farouk was tightly holding on to a coin and two keys. He would not let go and when the medical team attempted to remove the items before his surgery he refused. After his surgery, Farouk was moved to the intensive care unit, and continued to hold on to his keys and coin. Doctors at the hospital believe that Farouk drew his strength and comfort from these objects. Eight days later, Farouk recovered and was ready to be discharged with his father.

Farouk and his father are just 2 out of thousands of trauma patients who have been treated at hospitals in Erbil since the Mosul crisis began. To make sure patients



survived the long journey without additional risk, WHO has established trauma stabilization points and a field hospital close to the front lines in Mosul. WHO has also donated 10 ambulances and is supporting hospitals in Erbil through building staff capacity and providing medicines and supplies for trauma and surgery care.

This response was made possible with support from the European Union, the Office of U.S. Foreign Disaster Assistance and the Government of Kuwait. □

reliance on non-traditional activities such as training nongovernmental organizations, empowering affected communities through building stronger social mobilization networks and activities.

In counties experiencing conflict, and where insecurity restricts access to all affected areas, the humanitarian response is often impeded by a lack of information on the scope and nature of the needs of the affected population. **Well-functioning health information systems are critical** in ensuring the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.

Solutions to major health challenges require **enhanced coordination and engagement with other sectors**. For efforts to succeed, stakeholders from different disciplines, government, non-state actors and parliament, need to come together. This includes **stronger partnerships** with nongovernmental organizations, community leaders, and engagement with academic institutions.

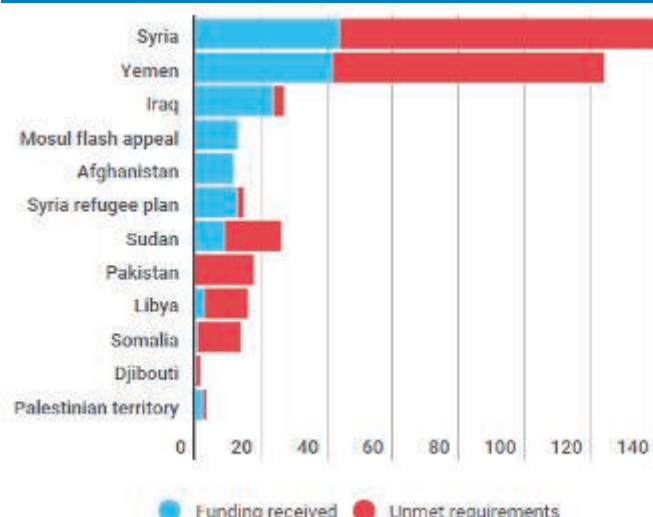
Decreased ability of governments to deliver on planned development goals will continue to place greater pressure on WHO to support a coordinated and effective health response through **enhanced leadership of the health cluster and increased partnerships on the ground**. Greater advocacy is also required for increased, sustained humanitarian health access in conflict countries.

Recognizing that emergencies know no national borders and that all countries of the Region are vulnerable, there is an urgent need for countries to show **political will and commitment to invest in preparedness and response** for emergencies, as well as to establish **intercountry agreements** for mutual aid, political will/investment/coordination at all sectors and levels.

The funding gap is a major issue in humanitarian health response in the Region, with WHO total requirements for appeals in 2016 only 42% funded. More innovative **and sustainable resource mobilization approaches with non-traditional donors** are needed to bridge this gap. There is also a greater need for **multi-year planning** to promote a more predictable humanitarian response.

With no political solution in sight for countries experiencing conflict, and as the region is prone to natural disasters, the number of people affected by emergencies is likely to increase in 2017. Unless significant development assistance is injected into health systems, the region will continue to be plagued by human, health, financial and political losses. □

# Donors and funding



Funding status of appeals by country in 2016

## 42% funding for WHO

US\$ 181 million received  
out of a required  
US\$ 430 million for  
regional appeals in 2016



## TOP DONORS TO THE REGION IN 2016

1. United States (US\$ 51m)
2. Japan (US\$ 33m)
3. OCHA (US\$ 31m)
4. CERF (US\$ 23m)
5. ECHO (US\$ 20m)
6. UAE (US\$ 12m)
7. Norway (US\$ 11m)
8. Kuwait (US\$ 8m)
9. China (US\$ 3m)
10. United Kingdom (US\$ 1.6 m)

## DONOR SUPPORT TO WHO IN 2016 IN US\$ (THROUGH WHO OR JOINT APPEALS)

<b>Syria</b> USAID 17.50 m Norway 8.55 m ECHO 6.73 m OCHA 5.86 m Kuwait 2.00 m United Kingdom 1.58 m China 2.00 m Spain 0.32m Japan 0.10m  <i>Total for WHO: 44.64 m (28% of requirements)</i>	<b>Libya</b> CERF 2.00 m WHO Contingency Fund for Emergencies 0.35 m France 0.16 m  <i>Total for WHO: 2.51 m (17% of requirements)</i>	<b>Yemen</b> United Arab Emirates 12.00 m USAID 10.00 m OCHA 8.96 m Japan 6.00 m CERF 3.50 m Contingency Fund for Emergencies 0.51 m RESF 0.50 m Global Health Council 0.24 m League of Arab States 0.20 m  <i>Total for WHO: 41.9 m (33.8% of requirements)</i>
<b>Syria Refugee Plan</b> ECHO 4.38 m Japan 3.15 m Norway 1.84 m China 1.00 m Kuwait 1.00 m US State Dept. 1.00 m CERF 0.21 m  <i>Total for WHO: 12.6 m (88% of requirements)</i>	<b>Afghanistan</b> OCHA 6.50 m USAID 2.99 m ECHO 2.78 m CERF 0.95 m  <i>Total for WHO: 12.4 m (fully funded)</i>	<b>Djibouti</b> CERF 0.30 m  <i>Total for WHO: 0.30 m (16% of requirements)</i>
<b>Iraq</b> USAID 6.40 m ECHO 5.97 m CERF 4.00 m OCHA 3.90 m Japan 3.00 m Republic of Korea 0.70 m RESF 0.39m  <i>Total for WHO: 24.36m (89% of requirements)</i>	<b>Occupied Palestinian Territory</b> Turkey 1.50 m Japan 1.00 m  <i>Total for WHO: 2.5 m (70% of requirements)</i>	<b>Somalia</b> CERF 0.96 m RESF 0.46m  <i>Total for WHO: 1.42 m (10% of requirements)</i>
<b>Mosul flash appeal</b> CERF 9.00 m USAID 8.00 m OCHA 5.40 m Kuwait 5.00 m  <i>Total for WHO: 27.4 m (fully funded)</i>	<b>Sudan</b> USAID 5.12 m UNDP 1.79 m CHF 1.70 m CERF 1.78 m Italy 0.22 m OCHA pooled fund 0.24 m  <i>Total for WHO: 10.9m (42% of requirements)</i>	<b>Pakistan</b> OCHA 0.061m  <i>Total for WHO: 0.061m (0% of requirements)</i>

**CERF:** United Nations Central Emergency Response Fund

**CHF:** Common Humanitarian Fund for Sudan

**ECHO:** European Commission Humanitarian Aid Office

**OCHA:** United Nations Office For The Coordination Of Humanitarian Affairs

**RESF:** WHO Regional Emergency Solidarity Fund

**UNDP:** United Nations Development Programme

**USAID:** United States Agency For International Development



# WHO emergency reform



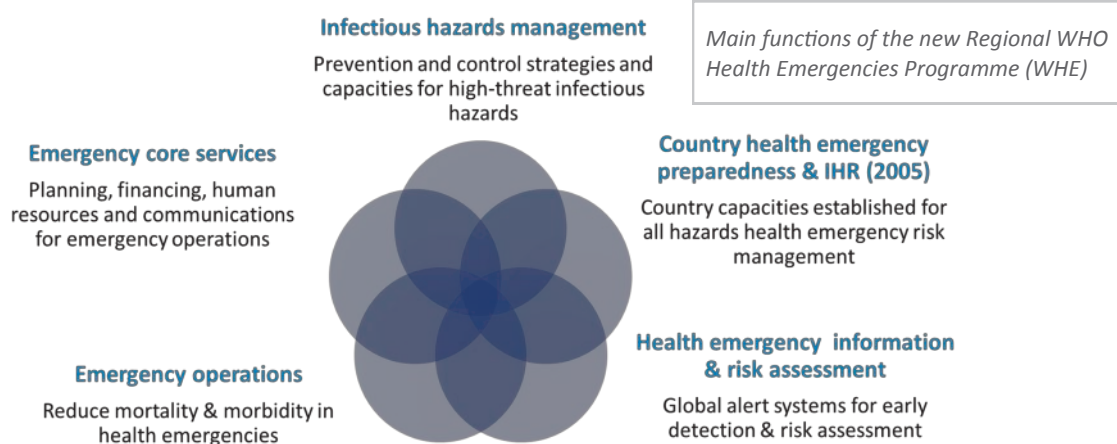
WHO has an essential role to play in supporting countries prepare for, respond to and recover from emergencies with public health consequences. WHO also has obligations to the Inter-Agency Standing Committee (IASC) as Health Cluster Lead Agency, to the International Health Regulations (2005) and to other international bodies and agreements. **WHO's responsibilities unequivocally extend beyond technical and normative functions and include a clear operational role** in both acute and protracted emergencies.

However, despite clear reforms, mandates and guidelines, WHO has not been systematic in preparing for and responding to outbreaks and crises in the Region, and will be further challenged if new events emerge. Based on lessons learnt from previous emergencies, 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.

In May 2016, Member States endorsed **WHO's new Health Emergencies Programme (WHE)**. The programme reinforces WHO's traditional technical and normative role

and provides the organization with new operational capacities and capabilities for its work in outbreaks and humanitarian emergencies. It aims at **improving WHO's predictability** using an all-hazards approach, promoting collective action, and encompassing preparedness, readiness, response and early recovery activities. It adopts the principles of a single programme, with **one line of authority, one workforce, one budget, one set of rules and processes, and one set of standard performance metrics**. This common structure is applied across the organization with the goal to optimize intra-agency coordination, operations and information flow.

In line with these reforms, and in order to improve WHO's work in this area, **the Region is undergoing restructuring and an internal cultural shift** that not only recognizes WHO's operational role in theory, but ensures more rapid and streamlined rules and work in practice, both within the house and in its work with partners and countries. This landmark chapter in WHO's work in emergencies will serve as a unique **opportunity to further challenge the organization to achieve its full potential** and bolster emergency work, irrespective of hazard type. □





# Syrian Arab Republic (Grade 3 emergency)

## 2016 RESPONSE IN NUMBERS

**9.4 million** treatments provided through distribution of health kits, medicines and medical supplies



**2 million** children vaccinated in three national polio campaigns



**1112** disease early warning sites reporting on communicable diseases

**68** local nongovernmental organizations working with health partners



**6 million** consultations supported

**2 million** trauma surgical interventions and treatments provided

**600,000** children under five screened for malnutrition

**17,826** national health staff trained in areas including trauma care, mental health care and nutrition

**20** fully equipped ambulances provided



## CHALLENGES

**Attacks on health facilities** continue. More than half of all public hospitals and primary health care centres have **closed or are only partially functioning**.

**Government withholding approvals** for delivery of medical supplies and equipment (including blood and blood products) to hard-to-reach and besieged areas.

**Lack of funding** impeding the procurement of cancer medicines; structural rehabilitation of health facilities; and establishment of physical rehabilitation centres.

## WHO HIGHLIGHTS IN 2016

**Supported the first national multi-antigen immunization campaign** since the beginning of the crisis, with a focus on children under 15 years in hard to reach and besieged areas. More than 500,000 children were reached from inside Syria and cross-border from Turkey.

**Ensured the provision of mental health services** for the first time in more than 150 primary and secondary health facilities in 11 governorates.

**Reached all 18 besieged areas in the country.** 30% of all deliveries of medicines and medical supplies were to hard-to-reach, opposition-controlled, and besieged areas.

**Developed a medical evacuation plan** for eastern Aleppo and supported the evacuation of 811 patients from to hospitals in Idlib, western Aleppo and Turkey.

**Increased the number of nutrition surveillance sites** from 193 in 2015 to 445 (located in health centres distributed across the country except Ar Raqqa. 600,000 children were screened for malnutrition.

**Rehabilitated five groundwater wells in Aleppo** serving five hospitals and 32,000 inhabitants with clean water.



**US\$ 45 m**

WHO funding in 2016  
(28% of requirements)

**US\$ 455 m**

Health sector funding requirements for 2017

**US\$ 164 m**

WHO funding requirements for 2017

## WHO PRIORITIES FOR 2017

- Align developmental and humanitarian work plans to establish clearer links between humanitarian and recovery/resilience interventions (as per the UN Strategic Framework for Syria).
- Enhance trauma care/mass casualty management
- Strengthen secondary health care, obstetric care and referral services
- Sustain delivery of Primary Health Care
- Reinforce polio eradication activities and immunizations
- Establish quality water supplies
- Enhance/expand the communicable disease early warning alert system/network
- Integrate mental health services at primary, secondary and tertiary levels
- Reinforce health information systems
- Enhance the prevention and early detection of malnutrition in children under five



# Syria refugee response (Grade 3 emergency)

## 2016 RESPONSE IN NUMBERS



**1.1 million** children in Jordan vaccinated in national polio campaign

**163,780** patients in Lebanon treated for chronic diseases

**100,000** beneficiaries in Jordan of health kits, medicines & supplies



**72,500** beneficiaries in Iraq of lifesaving medicines, including for chronic diseases

**19,200** insulin vials provided to cover 754 Syrian and Lebanese children with Type II diabetes and **30,900** desferal vials to cover 137 Syrian and Lebanese children with Thalassemia

**1811** health workers in Egypt trained on integration of noncommunicable diseases and mental health; and communicable disease surveillance

**738** health staff in Jordan trained on outbreak and noncommunicable disease surveillance

**661** health workers in Lebanon trained on Mental Health Gap Action Programme and psychological first aid



**342** Syrians in Egypt treated for life-threatening medical emergencies, fully covered by WHO



## CHALLENGES

**Lack of sufficient funding** to ensure sustainable and continuous programming.

**High mobility and poor living** conditions of refugees, especially in informal settlements, creating a high risk of communicable disease outbreaks.

**Changing population** demographics and disease epidemiology in host countries.

## WHO HIGHLIGHTS IN 2016

**Trained 604 healthcare staff** from primary health care facilities in Lebanon on surveillance of priority diseases (polio, measles, rubella and cholera).

**Developed 7 health contingency plans at governorate level in Lebanon** to ensure an efficient and coordinated response to health emergencies and **established a multi-sectorial health HazMaT team** to handle any chemical biological radiological and nuclear event.

Conducted an **assessment of mental health sector services** in all governorates to inform policy revision in Jordan.

**Provided two mobile clinics and two health caravans to support primary health care services** for Syrian refugees and vulnerable host communities in Jordan.

**Scaled up national integrated disease surveillance** in Jordan to 6111 primary health care facilities and hospitals for reporting on communicable diseases, noncommunicable diseases and mental health conditions.

**Established a rehabilitation and early intervention programme** for children with disabilities in Egypt.

**Developed a mobile application showing locations of health care facilities** offering services for Syria refugees in 6 governorates in Egypt.

**Integrated all 8 camps hosting Syrian refugees into the early warning disease surveillance system** in Iraq, with all alerts investigated and verified within 72 hours.



**US\$ 169 m**

Health and nutrition sector funding in 2016  
(56% of requirements)

**US\$ 373 m**

Health and nutrition sector funding requirements for 2017

**US\$ 34 m**

WHO estimated funding requirements for 2017

## HEALTH AND NUTRITION SECTOR PRIORITIES FOR 2017

- Support primary, secondary, and tertiary health services in camps, rural and urban settings and reinforce capacity of national health systems.
- Increase access to reproductive and new-born health services, routine immunization, trauma and rehabilitation, care for the disabled, mental health, outbreak control, management of noncommunicable diseases and nutrition services.
- Build robust health information systems and logistics networks that include Syrian refugees to ensure the health response continues to be as needs-based as possible.
- Ensure equitable access to quality and continuous care regardless of refugee status.

# Iraq (Grade 3 emergency)

## 2016 RESPONSE IN NUMBERS



**1.1 million** people provided with direct access to essential medicines

**5.8 million** consultations supported

**5.8 million** children vaccinated in three national polio campaigns



**684,195** children vaccinated against measles

**699,256** children under five screened for malnutrition

**5,760** national health staff trained in areas including trauma care, mental health care and nutrition

**2,500+** trauma cases treated through distribution of trauma and surgical medicines and supplies

**190** Early Warning Alert and Response Network reporting sites

**338** health staff & partners trained on the early warning alert and response network system (EWARNs)

**52** mobile teams supported

**40** fully equipped mobile medical clinics and **37** ambulances provided



**36** local nongovernmental organizations working with health partners



## CHALLENGES

**Insecurity** makes access to many camps and internally displaced persons very difficult, limits time spent in the field and increases operational costs.

**Inadequate availability of skilled human resources** for health at the governorates, and health facility level to deliver health services for people in the newly liberated areas.

The **rapidly evolving humanitarian context** also continues to challenge priority setting, planning and coordination of health response.

## WHO HIGHLIGHTS IN 2016

**Established and fully equipped 3 trauma stabilization points** in Gogjali, Al Zahra and Karamlees in Ninewa for referrals from Mosul.

**Provided medical equipment and devices to 11 main hospitals** in six governorates.

**Established 9 Primary Health Care Centres** in camps and informal settlements in Iraq.

**Provided 33 health caravans to camps and health facilities** to expand health service delivery in camps and informal settlements.

**Expanded capacity of 2 hospitals in Al Fallujah, Anbar** with emergency and drug store prefab units, providing ICU equipment, and medical equipment.

**Established and supported 14 community houses** in Dahuk to provide services for internally displaced persons and returnees in newly liberated areas of Ninewa.

**Trained 90 medical staff** from Erbil, Dahuk, Sulaymaniyah, Kirkuk and Ninewa on **chemical weapons preparedness** and response.

**Trained 60 medical doctors** from Erbil, Ninewa and Dohuk and 33 paramedical teams on **managing civilian casualties**.



**US\$ 24 m**

WHO funding in 2016  
(89% of requirements)

**US\$ 110 m**

Health sector funding  
requirements for 2017

**US\$ 52 m**

WHO funding  
requirements for 2017

## WHO PRIORITIES FOR 2017

- Strengthen the Ministry of Health and Departments of Health's capacities to prepare and respond to emergencies.
- Increase WHO's presence and support to newly liberated areas and sites hosting internally displaced persons.
- Enhance trauma care/mass casualty management, including the construction of field hospitals.
- Conduct emergency immunization campaigns targeting measles and polio.
- Strengthen disease surveillance and early warning systems.
- Ensure psychosocial support and mental health services.
- Strengthen and establish decontamination capabilities for chemical incident preparedness.

# Yemen (Grade 3 emergency)

## 2016 RESPONSE IN NUMBERS



**3 million** beneficiaries of health kits, medicines and medical supplies provided

**4.5 million** children immunized against polio

**2.4 million** children immunized against measles



**20 million** litres of water delivered to health facilities, camps and areas hosting displaced persons

**2 million** litres of fuel delivered to hospitals and other health facilities

**1982** sentinel sites detecting and responding to diseases outbreak alerts



**1,500+** children under five treated for severe acute malnutrition at WHO-supported therapeutic feeding centres

**537** tonnes of medicines and medical delivered to health facilities in all governorates

**7** nongovernmental organizations working with health partners



## CHALLENGES

**Access restrictions**, especially in areas where ground fighting is ongoing.

Almost 55% of **health facilities closed or only partially functioning**. Shortages of health staff, medicines, medical supplies and fuel for health facilities.

**Lack of funding** impeding availability of emergency obstetric and neonatal care, treatment for noncommunicable diseases, and secondary and tertiary hospital care.

## WHO HIGHLIGHTS IN 2016

**Provided overall coordination of the humanitarian health response** by leading the Health Cluster comprising 42 partner organizations.

**Trained and deployed** 28 mobile teams and 29 fixed facility teams to 11 governorates to provide primary health care services and surgical interventions.

Conducted **five rounds of integrated outreach activities** in remote and rural areas, providing more than 250,000 children with nutrition, immunization and other health services, vaccinating 85,000 pregnant women and women of childbearing age against tetanus

Supported **establishing 26 Diarrhoea Treatment Centres** in response to a cholera outbreak announced in September 2016. Patients are treated based on WHO case management, infection prevention and control standards. WHO also provided medicines, medical supplies and incentives for health staff.

Supported **12 therapeutic feeding centres** in 5 governorates. Trained 60 nutrition specialists to launch an integrated nutrition surveillance system in 10 governorates.

**Expanded the number of electronic sentinel sites** from 408 health facilities in 16 governorates in 2015 to 1982 facilities in 23 governorates in 2016.

Adopted a **national strategy for dengue** control and implemented dengue control measures.



**US\$ 41 m**

WHO funding in 2016  
(34% of requirements)

**US\$ 322 m**

Health sector funding requirements for 2017

**US\$ 126 m**

WHO funding requirements for 2017

## PLANNED AREAS OF INTERVENTION FOR HEALTH IN 2017

- Support reproductive health services, including emergency obstetric and newborn services and care for victims of sexual and gender-based violence.
- Support routine/outreach immunizations, Integrated Management of Childhood Illness and vaccine preventable disease surveillance.
- Improve access to quality curative nutrition services through systematic identification, referral and treatment of acutely malnourished cases according to national standards.
- Strengthen the management of communicable diseases, including treatment and prevention.
- Support trauma and surgical care (medicines, supplies, capacity building, deployment of surgical teams).
- Support basic repair/ upgrading of health facilities and provide equipment and supplies. Provide essential and life-saving medicines and supplies including for chronic illnesses.
- Support the provision of integrated health services through emergency mobile medical teams.
- Support capacity of health facilities to provide essential and lifesaving services.



# Libya (Grade 1 emergency)

## 2016 RESPONSE IN NUMBERS



**12.9 million** treatments provided through distribution of health kits, medicines and medical supplies

**1678** kits distributed among health facilities

**4** field hospitals handling 500 patients established in 4 areas across the country



**2** fully equipped mobile clinics provided

**2.5 million** children under 6 years covered in 2 national Immunization Days

**23** disease early warning sites reporting on communicable diseases



**625** national health staff trained in areas including health facilities assessment, surveillance, early warning alert & response system (EWARN)

**4** local nongovernmental organizations working with health partners



## CHALLENGES

**Security concerns** continue to create accessibility problems. Hostilities have stalled the procurement and distribution of essential life-saving medicines, while simultaneously triggering large-scale displacements. WHO has to rely on NGOs to deliver health interventions.

**Lack of funding** is preventing several activities related to strengthening a deteriorating health care system including the establishment of public health laboratories, and the initiation of a project for primary health care pilot models.

## WHO HIGHLIGHTS IN 2016

**Established an Early Warning and Response System (EWARN) for communicable diseases** in collaboration with the National Centre of Disease Control (NCDC). 23 EWARN sites generated 525 alerts in 2016. An Acute Flaccid Paralysis (AFP) surveillance system was also established and continues to be supported financially and technically.

**Developed the National Anti-Retroviral (ARV) Protocol in collaboration with the Libyan National Scientific Committee for HIV.** The protocol promotes for better clinical management for people living with HIV and adds a cost benefit for the procurement of ARV medicine.

**Supported a comprehensive national immunization against polio.** The campaign covered immunization of 1.5 million children 0-71 months of age by the bivalent Oral Polio vaccine (bOPV) between 10-16 December 2016. Independent monitors assessed vaccination coverage to be valid and complete.

**Supported a comprehensive Service Availability and Readiness Assessment (SARA)** of all hospitals and primary care facilities in Libya through technical and financial support to the National Health Information Centre.



**US\$ 2.5 m**

WHO funding in 2016  
(17% of requirements)

**US\$ 37.9 m**

Health sector funding requirements for 2017

**US\$ 9.7 m**

WHO funding requirements for 2017

## WHO PRIORITIES FOR 2017

- Improve access to basic life-saving primary and secondary health care services through provision of essential medicine, and medical supplies.
- Improve access to primary healthcare, disability care and life-saving emergency care through increased technical support.
- Strengthen existing health structures and avoid collapse of the health system ensuring deployment of essential health staff and a functional referral system.
- Reduce communicable disease transmission and outbreaks through implementation of effective detection and mitigation measures.

# Afghanistan (Grade 1 emergency)

## 2016 RESPONSE IN NUMBERS



**786,100** treatments provided through distribution of health kits, medicines and medical supplies

**9 million** children vaccinated against polio

**122,000** returnees & refugee children vaccinated



**50,444 children** received PENTA1 & PENTA3 vaccines

**1,500** national health staff trained in areas including trauma care, mass casualty management, emergency preparedness & response



**543** disease early warning sites reporting on communicable diseases

**41** mobile health teams & **51** health centres established

**9** hospitals supported in the area of trauma care services



**17** high-risk provinces provided with mass casualty management supplies



## CHALLENGES

**Attacks on health facilities** continue, leading to the closure of 29 facilities, depriving 377,633 people from accessing health care services.

**Difficulty in accessing remote areas & cultural barriers** hampering access to health services, especially for women. Lack of female health workers further exacerbates the issue.

**Lack of funding** causing suspension of life-saving services to over 4.6 million people in areas not covered by government health services.

## WHO HIGHLIGHTS IN 2016

**Provided polio vaccinations to over 122,000 returnee and refugee children** through WHO's polio programme and supported health service provision for Afghan returnees and internally displaced persons (IDPs) by equipping health facilities with essential medicines, medical and non-supplies and establishing mobile health clinics.

**Established a trauma care unit at Kunduz Regional Hospital** which treated over 2,400 patients and performed 1,045 major and minor operations in 2016.

**Supported the Establishment of a Command and Control Centre (CCC)** at the Ministry of Public Health to coordinate and oversee all emergency preparedness and response activities in Afghanistan.

**Supported the establishment and equipping of national and subnational isolation wards** in response to outbreaks of Crimean-Congo haemorrhagic fever (CCHF).

**Conducted a comprehensive Health Emergency Risk Assessment (HERA) in 32 provinces** on health hazards, vulnerabilities and existing capacity to respond to emergencies.



**US\$ 12.4 m**  
WHO funding in 2016

**US\$ 53 m**

Health sector funding requirements for 2017

**US\$ 12 m**

WHO funding requirements for 2017

## WHO PRIORITIES FOR 2017

- Gap-fill health care service delivery for people living in high-risk areas, including life-saving essential primary health care services, emergency mental health services and emergency trauma care.
- Stockpile and replenish essential medicines and emergency kits, including life-saving medicines, trauma kits, pneumonia kits and diarrhoea kits.
- Support public health emergencies caused by major outbreaks and strengthen prevention through public awareness and vaccination campaigns as well as enhanced surveillance and case management.
- Establish new first aid trauma posts and upgrading specialized trauma care services at provincial hospitals.

# Occupied Palestinian Territory (Grade 1 emergency)

## 2016 RESPONSE IN NUMBERS

**500,000** treatments provided through distribution of health kits, medicines and medical supplies



**77,197** children & pregnant women provided with micronutrient supplements

**17** districts developed emergency preparedness plans & **26** hospitals developed contingency plans

**124,541** beneficiaries served through mobile clinics

**1,000** national health staff trained in areas including IHR, mother & child health, and mental health care



**42** local nongovernmental organizations working with health partners



**100%** of children covered by vaccination programmes



**410** community members trained on first aid

**2.5 million** litres of fuel distributed to public hospitals in Gaza to sustain their services



## CHALLENGES

**Chronic occupation, closure of the Gaza Strip, and the physical separation of Gaza and the West Bank**, compounded by an internal political divide, challenge coordination efforts of health partners to respond on a national level.

**Continuous power outages** and increasing monthly consumption of fuel to operate electric back-up generators poses a severe threat to the health system.

**Lack of funding** caused by donor fatigue and perpetuated by 3 wars in 6 years has increased humanitarian needs and widened health gaps.

## WHO HIGHLIGHTS IN 2016

**Ensured entry of essential medical equipment into Gaza** including x-ray machines, ultrasound machines, autoclaves, and Intensive Care Unit equipment, which benefitted more than 1 million patients.

**Implemented integration of mental health in primary health care** supporting more than 1 million patients in West Bank and Gaza.

**Provided training for more than 150 health professionals** from Gaza to support the health system. Health staff were trained on patient safety, mother & child health, women's access to health, humanitarian response, noncommunicable diseases and mental health.

**Provided more than 2.5 million litres of fuel** to public hospitals in Gaza to sustain their service, benefiting over 100,000 in-patients, 300,000 outpatients, 200,000 diagnostic exams and more than 400,000 emergency room patients.

**Advocated for right to health care** based on monitoring violence against health facilities, access to medicines, and access for patients in need of medical referrals outside of Gaza and the West Bank.



**US\$ 2.5 m**

WHO funding in 2016  
(70% of requirements)

**US\$ 13 m**

Health sector funding requirements for 2017

**US\$ 1.3 m**

WHO funding requirements for 2017

## WHO PRIORITIES FOR 2017

- Enhance trauma care/mass casualty management at key primary health care centres in Gaza.
- Enhance emergency patient care, communication and documentation, management of complex trauma cases, effective triage and health emergency preparedness.
- Advocate for the right to health for Palestinians and engagement by the international community.
- Strengthen national health coordination structures for effective delivery of aid
- Reinforce health information systems.
- Integrate mental and behavioural health into disaster preparedness, response and recovery.
- Procure medical equipment for follow-up of pregnant women and improve diagnosis and early detection of diseases.
- Improve accessibility and availability of primary health services for people with disabilities.



# Pakistan

## 2016 RESPONSE IN NUMBERS

**37 million** children under 5 vaccinated against polio



**200,000** frontline workers trained to conduct 5 national and 4 subnational polio immunization campaigns

**742** health care providers in 36 priority districts trained to provide maternal, newborn and child health services



**150** health staff trained on management of *Crimean-Congo haemorrhagic fever*

**105** Health care providers and district managers provided with Training of Trainers on outbreak response

**83** nutrition stabilization centres supported throughout the country



## WHO HIGHLIGHTS IN 2016

**Continued polio eradication efforts** and strengthened surveillance network to detect cases across the country.

**Constructed 7 prefabricated Primary Health Care (PHC) health facilities, including a labour room**, areas hosting Internally Displaced Persons (IDPs) in Federally Administered Tribal Areas (FATA). Health facilities in these areas were totally destroyed during the conflict.

**Supported development of Integrated Reproductive, Maternal, Child, Adolescent Health & Nutrition action plans 2016-2020** at national and provincial level. **Provided supplies and equipment** to support maternal, newborn and child health care to primary and secondary level health facilities in all 4 provinces and 3 federating areas.

**Supported establishing of 83 nutrition stabilization centres** with capacity building and medical supplies.

**Ensured water quality monitoring and health care waste management** to strengthen service delivery to Internally Displaced Persons and host communities.

**Supported implementation of the Integrated Disease Surveillance & Response System** and investigated all alerts and outbreaks in Khyber Pakhtunkhwa province.

## CHALLENGES

**Insecurity and delays in approvals** for project implementation in Federally Administered Tribal Areas .

**Financial constraints** at all levels for implementation of priority health programmes.

**Lack of funding** impeding training of Rapid Response Teams and provision of medicines and medical supplies.

**Lack of sufficient resources and facilities** in areas hosting returnees, depriving 460,000+ beneficiaries of essential life saving health services.



**US\$ 610,000**

WHO funding in 2016  
(0% of requirements)

**US\$ 14.7 m**

Health sector funding  
requirements for 2017

**US\$ 4.6 m**

WHO funding  
requirements for 2017

## WHO PRIORITIES FOR 2017

- Reactivate and revitalize Primary Health Care services (PHC) in Federally Administered Tribal Areas (FATA) where health facilities are devastated due to conflict.
- Strengthen Mother and Child health and Reproductive Health care, as the system is extremely weak in FATA with no single lady doctor serving in the area.
- Establish and strengthen the Disease Surveillance System in Federally Administered Tribal Areas (FATA).
- Support capacity building of the government health department and staff on preparedness and disaster risk reduction/management.
- Support transition from humanitarian to development by supporting the health department through strengthening capacities in coordination, assessments, prioritization and response mechanisms

# Somalia

## 2016 RESPONSE IN NUMBERS

**1 million** people provided with primary and secondary health services



**2.3 million** children under five vaccinated in national polio campaigns

**40,000** beneficiaries of medicines and supplies provided for drought response in Puntland and Somaliland

**260** disease early warning sites reporting on communicable diseases in the South and Central Zones, Somaliland and Puntland

**240** national health staff trained in cholera case management, control and prevention



**98** partner nongovernmental organizations

**11** regions supported to train rapid response teams to improve response capacity to emerging epidemics



## CHALLENGES

**Insecurity** due to long lasting civil war and armed conflict and frequent **natural disasters**.

**Weak** central government and **challenging coordination and cooperation** between the Somali regions.

**Weak health infrastructure** and shortages of qualified health staff.

## WHO HIGHLIGHTS IN 2016

The **cholera outbreak declined** from 1853 cases and 187 deaths during its peak in April to 380 cases and 15 deaths in December, due in part to the public information and prevention campaign and health worker trainings.

Conducted a **cholera risk assessment** to identify cholera hot spots, vulnerable populations and drivers of the epidemic. The assessment served as a benchmark for a comprehensive cholera preparedness and response plan.

Established **the country's first national laboratory** to provide reliable laboratory results within 48 hours, significantly reducing waiting time for results.

Evaluated the **communicable disease surveillance system** to improve coordination and response between all surveillance systems in all regions.

Initiated a **comprehensive assessment** focusing on approximately 1074 public health facilities — the first of its kind to be conducted in Somalia.

**Scaled up WHO's presence** in three accessible zones throughout the country.



**US\$ 1.4 m**

WHO funding in 2016  
(10% of requirements)

**US\$ 70.4 m**

Health sector funding  
requirements for 2017

**US\$ 12.3 m**

WHO funding  
requirements for 2017

## WHO PRIORITIES FOR 2017

- Pre-position health emergency supplies in high-risk areas and settlements hosting displaced people.
- Provide medical supplies to primary and secondary health care facilities.
- Provide capacity-building to front line health workers on topics such as essential use of medication, emergency management, public health promotion.
- Support establishing health care facilities to cover gaps and provide quality primary health care services to the most vulnerable.
- Strengthen routine immunization service delivery and expand emergency obstetric care services.
- Strengthen emergency preparedness and response capacities of health authorities and cluster partners including disease surveillance and response capacity to disease outbreaks.
- Enhance public awareness on preventive and demand creation for health services; intensify social mobilization and communication activities and capacity building for community health mobilizers and members.

# Sudan

## 2016 RESPONSE IN NUMBERS

**4 million** children immunized against national polio campaigns



**1.2 million** beneficiaries of integrated campaigns for control of vector-borne diseases

**574,000** beneficiaries of health kits, medicines, medical supplies provided

**4298** health workers and community volunteers trained on Integrated Management of Childhood illnesses



**192** sentinel sites detecting and responding to diseases outbreak alerts—225 alerts were investigated in 2016

**14** nongovernmental organizations working with WHO



## CHALLENGES

**Lack of sufficient funding** affecting provision of primary health care service, and increasing risk of maternal and child morbidity and mortality

**Access to basic services in some areas** remains challenging due to new and protracted displacements.

**Continued refugee movement** in the country.

## WHO HIGHLIGHTS IN 2016

**Supported scholarships for 210 students of Health Sciences in Darfur States.** The students are members of nomadic, returnees, displaced and underserved populations in five Darfur states who have committed to working in these areas once they complete their studies. The initiative aims to ensure the availability of qualified medical staff in selected return areas in a sustainable manner.

**Supported the establishing of a midwifery training school in Kutum** to contribute to the reduction of Maternal Mortality Rates by addressing shortages and inequitable distribution of midwives in remote locations.

**Conducted 79 vector surveillance missions**, inspecting 32,746 households between July and September. Supported 32 integrated vector control campaigns, reaching a total of 223,628 households and benefitting 1.2 million individuals.

**Supported maintenance and strengthening of the disease surveillance system** in areas affected by an Acute Watery Diarrhea outbreak announced in August 2016. Provided technical and operational support to Cholera Treatment Centres; supported vector control and environmental sanitation activities, including water quality sampling and checking; and provided medicines, supplies and laboratory reagents. WHO also **deployed 10 technical officers** to support response operations in affected area.

More than 255,000 people fleeing conflict in South Sudan arrived to Sudan in 2016. In White Nile camps, where 42% of all new arrivals settled, **WHO supported the strengthening of 8 health facilities** providing emergency health services. WHO also supported the **operation of a newly established clinic in Khor Waral** in June 2016 to handle additional patient caseloads.

**Conducted a risk assessment of cholera importation** in White Nile camps. Following the introduction of the Oral Cholera Vaccine, two immunization rounds were implemented with 95.6% coverage of South Sudanese refugees and nearby host communities.



**US\$ 10.9 m**

WHO funding in 2016  
(42% of requirements)

**US\$ 66 m**

Health sector funding requirements for 2017

**US\$ 26 m**

WHO funding requirements for 2017

## WHO PRIORITIES FOR 2017

- Provide primary health care services, including referral services, for vulnerable populations affected by conflict and natural disasters.
- Strengthen national capacities to prepare, detect and respond promptly to public health risks or events at federal, state and locality level.
- Ensure Maternal and Child Health (MCH) services for the reduction of maternal and child morbidity and mortality among vulnerable populations.





These 3-year-old Yemeni triplets and their siblings were diagnosed and treated for cholera in one of 26 diarrhoea treatment centres rehabilitated by WHO, using funds from the United Nations Central Emergency Response Fund and the Office of U.S. Foreign Disaster Assistance.

