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Situation in 2012-2016

The social and political conflicts of 2011-2012 exploded into the unprecedented scale of humanitarian crises and health needs that more than half of the countries are facing today. In 2012 it was estimated that 40 million people were in need of health services as a result of emergencies. Today that figure stands at more than 62 million. Since 2012, three countries - Syria, Iraq and Yemen - have been designated Level 3 emergencies, the highest level under the United Nations emergency designation system. Neighbouring countries have been severely affected.

More than half of the world's refugees come from the Eastern Mediterranean Region, and the Region also hosts the largest number of internally displaced persons as a result of conflict. 30 million people are now displaced, two thirds within their own countries and the rest in other countries. Registered Syrian refugees in Lebanon now account for a third of the total population of 4 million, while in Jordan they make up 10% of the population. Most refugees are living within host communities.

The deteriorating situation has meant that both displaced populations and host communities are at increased risk of infectious diseases due to overcrowded living conditions, limited access to safe water and sanitation, and varying degrees of access to primary health care services. Outbreaks of disease have been a major concern, highlighting the need for improved detection and response capacities to public health threats.

In countries with ongoing conflict and violence, mental health services are largely unavailable due to a lack of qualified health staff. The delivery of basic and emergency health care services has often been impeded as a result of shortages in basic and life-saving medicines and medical supplies, as well as supplies of fuel to ensure continuing functioning of health facilities. Incapacitated health systems and shortages in medicines increase the burden of noncommunicable diseases as populations are no longer able to get regular treatment or access to essential, life-saving medicines.

Among the main challenges preventing an effective response in emergency settings have been lack of access to hard-to-reach populations and reduced humanitarian space. In a worrying new trend, in some countries health care workers and health facilities have been directly targeted, or otherwise indirectly affected, resulting in vulnerable populations having little or no access to health care services. Many health workers have fled with their families.

Funding is a major impediment to effective emergency response. In 2012 only 47% of health sector requirements were met, emphasizing the need for a more coordinated approach by partners to address the health needs of affected populations. In 2013, funding increased but by 2015 had fallen back to below 40% (Table 1).

Table 1. Funding for the health sector component of UN strategic response plans 2011-2015 for c

US$ requested

US$ received

% funded

2016 (as of 16 May)

1.3 billion

124 million

9%

2015

1.2 billion

470 million

39%

2014

1 billion

560 million

54%

2013

795 million

512 million

64%

2012

774 million

366 million

47%

2011

537 million

417 million

78%

Despite the large number of acute and protracted emergencies in the Region and the vulnerability to natural disaster, many countries lacked, and continue to lack, the necessary policies and legislation to support or facilitate emergency preparedness and response at all levels across sectors and only a third have institutionalized emergency preparedness and response programmes within the health sector.

Progress 2012-2016

Leadership

An ambitious programme of reform has been ongoing since 2014 following the request of the Regional Committee to enhance the emergency and humanitarian action capacity in the Region. A new organizational structure rolled out in 2015 is comprised of dedicated capacity for emergency response, partner coordination and emergency core services. A regional centre for emergency readiness and polio eradication was established in Amman. The work of the centre has also focused on building capacity and developing mechanisms to deploy external experts during emergencies.

A regional solidarity fund has been established to ensure the immediate availability of financial resources and to trigger action as early as possible when crisis strikes. A dedicated WHO regional logistics hub in Dubai's International Humanitarian City has been established and pre-positioning of critical medical supplies in Dubai is now helping ensure the timely provision of critically-needed medicines, medical supplies, medical equipment, vehicles, and ambulances to countries in the Region. For example, in the Gaza war in July-August 2014, WHO and partners were able to respond timely to urgent needs for medical and surgical supplies through an air bridge from Dubai.

Response

WHO has been leading the health sector response in all countries in crisis, including Iraq, Syria and Yemen. In order to ensure the availability of health services for vulnerable populations, especially women and children in the most affected areas, WHO scaled up the provision of medical supplies, strengthened early warning systems to monitor and control disease outbreaks, established mobile clinics to increase access to health services, and provided fuel to keep health facilities running. The provision of obstetric and gynaecological health services was supported, as well as vaccinations for children below the age of 5 years. Mental health services were also supported and an emergency health kit was developed to respond to the needs of populations affected by emergencies for management of noncommunicable diseases.

Partnerships with nongovernmental organizations were forged and strengthened on the ground to ensure access to health care for populations living in hard-to-reach areas and WHO continued to advocate for unhindered access to health care for all patients.

Across the Region the number of health staff trained was increased to enhance national capacity, including 20 000 health staff trained in Syria alone since 2012. Trainings covered the areas of trauma care, basic routine immunization services and vaccine management, infection control, chronic disease care and management, mental health care, disease surveillance, nutrition and reproductive health care.

The Region introduced pioneering approaches for strengthening routine public health surveillance through mobile technology and an online platform. The number of sentinel sites for the early warning alert and response network (EWARN) was expanded in hard-to-reach areas.

Following outbreaks of polio and measles in the Region, the Middle East Polio Outbreak campaign immunized more than 27 million children in eight countries from 2013 to 2015. This multi-country campaign, which successfully stopped the transmission in Syria and Iraq, is seen by the Polio Independent Monitoring Board as an example of a very well managed outbreak control. Partnerships were strengthened and expanded with key religious institutions and nongovernmental organizations, especially those working in opposition-controlled areas.

Preparedness

A comprehensive emergency preparedness framework was developed highlighting 10 priority actions to be implemented at country level. Emphasis was placed on capacity development with curricula, tools and training courses developed to support emergency preparedness and response in health, including the first regional emergency pre-deployment training course conducted in early 2016 to enhance the surge capacity in the Region.

Way forward

Tens of millions of displaced persons, large cities heavily damaged or destroyed, ongoing hostilities and targeting of sub-populations, and all the related humanitarian disasters ensure that the health problems associated with these crises will be with us for years to come. As such, strategies and groups developed to specifically deal with crises-related health problems must be institutionalized and sustained. Restructuring of country and regional health entities, including the Regional Office itself, must be accomplished in a way that allows us to face both acute and protracted health crises in an adequate manner.

In the coming years, WHO will continue to scale up its work to support Member States in the Region to develop effective emergency preparedness programmes with emphasis on communities most at risk. Stronger partnerships between health authorities, nongovernmental organizations, community leaders, academic institutions, donors and other stakeholders will need to be fostered.

The funding gap is a major issue, as countries with protracted crises and destroyed urban

infrastructure and housing will not have the resources to rebuild or to provide health care for their populations. More innovative and sustainable resource mobilization approaches with non-traditional donors will be needed to bridge this gap.

Increased advocacy for the protection of health care workers and health facilities, as afforded under international humanitarian law, including the Geneva Conventions, is necessary. Targeting of health care workers and facilities must be stopped. Greater advocacy is also required for increased access to besieged populations. Humanitarian pauses can be used to advocate for health as a bridge for peace.

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