World Health Organization
Regional Office for the Eastern Mediterranean

Health in emergencies *update*

September-October 2016

Yemen: Providing health care to children on the brink of starvation

Even before the current crisis in Yemen, the country faced one of the highest rates of child malnutrition in the world, with more than one million children suffering from acute malnutrition. Almost 20 months into the ongoing conflict, shortages of food, medicine and basic supplies are placing millions of people on the brink of starvation.

Today, more than 4 million people in Yemen are acutely malnourished, including 2 million children. **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.** According to the World Food Programme, 10 out of the country's 22 governorates are classified as reaching emergency levels, one step from famine levels.

Almost 462,000 children suffering from severe acute malnutrition and at risk of life-threatening complications such as respiratory infections or organ failure. If not immediately treated, these symptoms can reach life-threatening levels or have serious short and long-term consequences on their physical and intellectual growth. With less than 40% of all children in Yemen immunized, those who suffer from malnutrition are also more vulnerable to infectious diseases such as pneumonia, diarrhea, malaria and measles.

As food restrictions continue and health services collapse, mortality rates among Yemeni children are also expected to increase. A recent survey by WHO revealed that 55% of all health facilities in 16 priority governorates in Yemen are closed or partially functioning. Child health and nutrition services are fully available in only 40% of facilities.

Despite being only 24% funded under the 2016 Yemen Humanitarian Response Plan, WHO's response to the health needs of malnourished children remains a key priority.

WHO-supported Therapeutic Feeding Centres in 11 governorates provide severely malnourished children with full treatment, medicines and milk at no cost. The centres also conduct health education sessions for family members attending the facility. Since August 2015, these centres have treated more than 2,700 children. Additionally, 11 mobile nutrition teams supported by WHO continue to conduct integrated outreach activities, offering primary health care and nutrition services.

In September, a high-level meeting took place in New York focusing on food security, nutrition and health in Yemen. The event, co-chaired by the UK Department for International

Salim on the day he was admitted to the WHO-supported centre (left) and after 45 days of treatment (right)

Salim's story

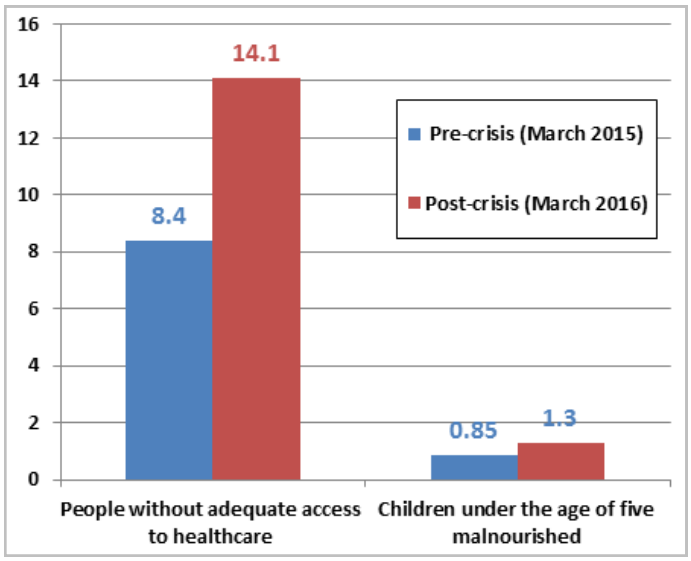
Poised between life and death, seven-year-old Salim was admitted to a WHO-supported Therapeutic Feeding Centre in Al-Hudaydah governorate in early September 2016. He was diagnosed with acute malnutrition and other medical complications, including brain atrophy and severe diarrhoea. After receiving intensive nutritional treatment for 45 days, Salim's condition improved. Without access to health services supported by WHO, Salim would have died.

Since the beginning of the conflict, the number of cases received by this centre in Al-Hudaydah governorate alone has increased by 70%.

This newsletter aims to connect WHO with donors, partners and key stakeholders, providing an update on the health situation in emergency countries in the Eastern Mediterranean Region and highlighting WHO's progress in in this area of work. We value your feedback. Please send suggestions and comments to emrgoehanews@who.int.

Development (DFID) and the Organisation for Islamic Cooperation (OIC), was held with the aim of finding concrete measures to improve the humanitarian response, and highlighting the need for additional funding for the health cluster. Pledges for additional funding for Yemen totaling almost US$ 100 million were made by Canada, the European Union, Germany, Japan, Norway, Spain, Switzerland, the United States and the World Bank. However, while specific pledges were made for food security and nutrition, no specific allocations were made for the health cluster.

Until a political solution is found to resolve the current, tragic humanitarian situation in Yemen, it is imperative that the work of WHO and health partners continues, unimpeded by funding restrictions. The country's economic crisis has further aggravated the situation, negatively affecting both the national health budget and the ability of Yemenis to pay for health services. It is only through continued and sustained support from donors to the health response, providing unmarked funding that can be used to cover critical areas as needed, that more children can be reached and treated before it is too late.□



Number of people with access to health care, and number of malnourished children in Yemen, pre-crisis in 2015, and post-crisis in 2016

Syria crisis response update (October 2016)

In October, WHO and its implementing partners delivered almost 1.2 million treatments in nine governorates in Syria, including 461,900 treatments* (39%) cross-border from Turkey and 338,923 treatments (29%) across conflict lines from inside Syria. Of these, 187,782 treatments (16%) were delivered to besieged areas, and 121,987 treatments (10%) were delivered to hard to reach areas. Life-saving and life-sustaining medical items sufficient for 45,346 treatments were removed by national security from WHO convoys.

A national polio campaign was launched from inside Syria on 16 October for five days in all governorates except Idleb (conducted only in Foah and Kafraya) and Ar-Raqqa (conducted only in Tel Abyad). The campaign reached 83% of a total target of more than 2.8 million children under 5 years of age across the country. Cross-border from Turkey, 45,084 children were vaccinated in October as part of the second round of the national multi-antigen campaign.

Despite these achievements, serious challenges remain in ensuring humanitarian access to a number of areas, including East Aleppo City, which has been under siege since July 2016.

Attacks on healthcare continue to create serious setbacks for the affected community and additional challenges to humanitarian work.

Twenty five incidents were reported against the health sector in October, of which 13 were confirmed and 12 are being verified by the Turkey health cluster hub. Out of the 13 confirmed attacks, eleven were on hospitals (six in Aleppo governorate, one in Idleb governorate, three in Rural Damascus and one in Hama). Additionally, a primary health care centre in Kafr Zeita, Hama governorate was hit twice within 72 hours. **Collectively, these attacks resulted in the death of at least 15 people including at least two medical personnel, and wounding at least 51 people, including 12 medical personnel.** □

**One standard treatment course (e.g. a course of antibiotics for eight days) is considered as treatment for one person. Treatment courses are determined for each medicine distribution based on international WHO standards.*

Cholera resurgence in the Eastern Mediterranean Region

Cholera remains a major public health problem in the Eastern Mediterranean Region, (EMR) with the disease **endemic in nine out of 22 countries in the Region**. The risk of a cholera epidemic is higher than usual in EMR because many countries are experiencing protracted and complex emergencies resulting in massive displacement of people, with limited access to safe drinking water and sanitation services.

The Region hosts the largest number of displaced populations globally. Many live in overcrowded shelters and host communities with limited access to life-saving services. The extent of the burden of cholera and other epidemic diarrheal diseases globally and regionally is hard to estimate due to weak surveillance systems, varied case definitions, laboratory diagnostic capacities and under-reporting of cases.

By the end of October 2016, a total of 15, 969 cases of suspected cholera with 543 deaths (a case fatality ratio of 3.4%) were reported from Somalia and Yemen. These recurring epidemics have negatively affected the health of populations, as well having a social, trade and economic impact on countries. As communicable disease outbreaks respect no borders, an outbreak that affects one country can potentially affect others. Some recent examples of local outbreaks that have gone global are Ebola, Zika, SARS and MERS-CoV. As a result, it is important that countries facing cholera outbreaks put in place necessary public health measures to contain its spread and limit transmission to prevent spillovers that are often associated with population movement.

WHO encourages countries to use the standard WHO case definition for reporting cholera cases in order to ensure consistency and to avoid delays in identifying a potential outbreak.

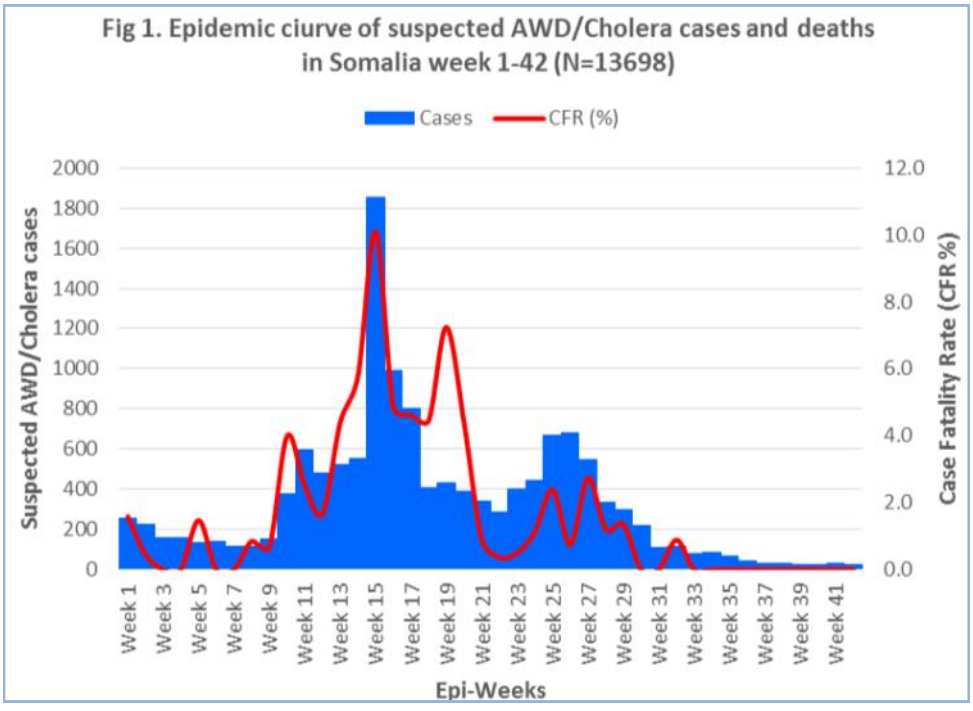
The main cause for the resurgence of cholera in the region is not yet clear, however, experts suggest that natural disasters, violence resulting from political conflict, climate change and deteriorating environmental health conditions are major contributors to the occurrence and spread of cholera.

Despite these difficult conditions, countries in the Region continue to make remarkable progress in scaling up the preparedness and response interventions to prevent and control potential cholera outbreaks. Nevertheless, significant challenges remain.

Some cholera-endemic countries lack a comprehensive and integrated cholera preparedness and response strategy. WHO's Regional Office for the Eastern Mediterranean has been working closely with Member States to mobilize adequate technical and financial resources for them to effectively prevent and control the resurgence of cholera epidemics.

The Regional Office continues to work with its Member States to build their capacities for enhanced surveillance, early detection, risk assessment, laboratory services, case management and information sharing for cholera and other epidemic-prone diseases.

Lack of funding remains a key challenge in controlling cholera and epidemic diarrheal diseases in the Region. Countries that have experienced outbreaks are among the most underfunded. As of October 30, 2016 the health component of the Somalia Humanitarian Response Plan is only 26% funded according to the United Nations. □



Somalia: WHO supports first national public health laboratory

WHO and the Ministry of Health for the Federal Republic of Somalia have established the country's first national public health laboratory, marking a vital first step towards improving patient care, controlling health-associated infections and managing disease outbreaks.

Prior to the opening of the laboratory, all samples needed to be sent out of the country for testing and diagnosis, a procedure that could take one week. The new facility in Mogadishu provides reliable laboratory results to clinicians within 48 hours, and is equipped to provide direct identification of bacteria, significantly reducing waiting time for results. The short turn-around time for getting crucial results will contribute significantly to ensuring a timely response and thereby reducing the number of mortalities.

Diarrheal and respiratory diseases are major causes of morbidity and mortality for children in Somalia. From 1 January to 9 October 2016, more than 13,600 cases of Acute Watery Diarrhea/Cholera were reported, of which 60% were children below the age of five. With this initiative, the Ministry of Health is now supported with a facility that is fully equipped to provide identification and antibiotic susceptibility testing for all pathogens associated with diarrheal and respiratory infections.

Equally important, the laboratory can provide timely diagnosis of vector-borne diseases such as malaria, Dengue, Chikungunya and rift valley fever, for which a rapid response is critical.

It is a significant achievement for the Ministry of Health for the Federal Republic of Somalia to have its own national public health laboratory, fully managed by national staff, and a demonstration of the Federal Government's commitment to improve the disease surveillance system at the national level.

The laboratory has a modern infrastructure and diagnostic platforms to engage in complex laboratory analysis and engaging in evidence based public health research. WHO developed the laboratory's operational procedures in July 2016 prior to its opening, and WHO technical teams are working with national staff to ensure that the laboratory adheres to standards that will qualify it for international certification, including capacity-building for staff.

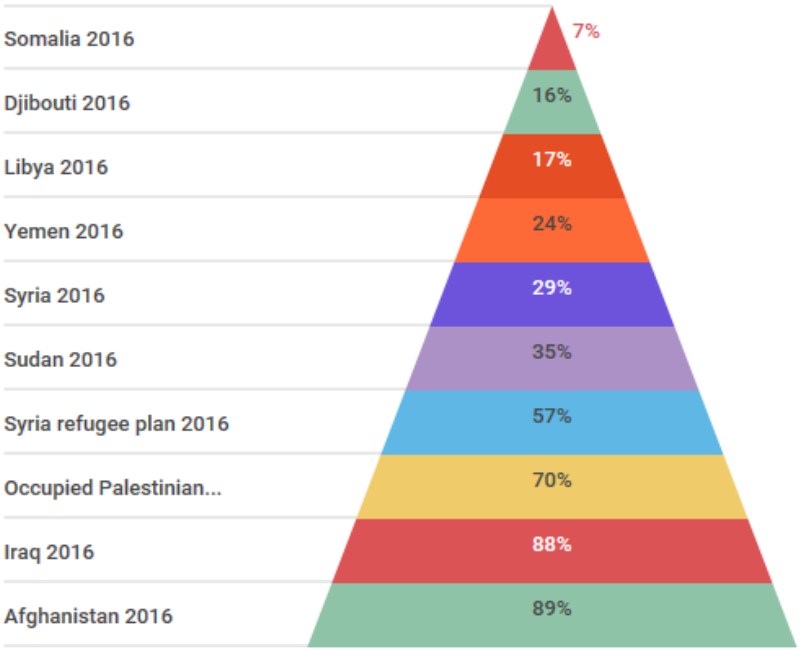
The entire project including facility renovation, staff training, and provision of equipment, basic supplies and reagents was made possible with funds partly from the Joint Health and Nutrition Programme and CDC-Biosecurity Engagement Program. Major donors for the Joint Health and Nutrition Programme in Somalia include the UK Department for International Development, Sweden, the United States Agency for International Development, Switzerland and Finland. □

Funding for emergencies

53% funding for WHO

WHO funding: Out of a total of **US$ 271 million** required by WHO in UN Humanitarian Response Plans for the Eastern Mediterranean Region for 2016, **US$ 142 million (53%)** has been committed or contributed.

Health sector funding: The health sector requires **US$ 1.5 billion**, out of which **US$ 448 million (29%)** has been committed or contributed *(OCHA/FTS, 7 September 2016).* □



Percentage of funding requested by WHO that has been received or committed, by response plan *(WHO PRIME, 2 November 2016)*

Contributors to this issue: Abdinasir Abubakar, Regional Health Emergencies Programme | Tania Seburyamo, WHO Somalia | Inas Hamam, Regional Health Emergencies Programme
For information, to subscribe or unsubscribe: emrgoehanews@who.int **Website:** http://www.emro.who.int/entity/eha/index.html