

**{loadposition annualreport2014} Overview**

2014 saw an escalation in emergencies and associated health needs of affected populations in a number of countries. A total of 58 million people are affected by emergencies in the Region, including 16 million refugees or internally displaced persons. More than half of the world's refugees come from three countries of the Eastern Mediterranean Region (Afghanistan, Somalia and Syrian Arab Republic) and are hosted in just four countries (Islamic Republic of Iran, Jordan, Lebanon and Pakistan). As a result of the Syrian crisis, in 2014 the refugee population in Jordan doubled and that in Lebanon tripled. Today, almost 25% of Lebanon's total population comprises refugees. The Region also hosts the largest number of internally displaced persons as a result of conflict, with Iraq, Sudan and Syrian Arab Republic among the top five countries globally hosting internally displaced persons.

In Iraq, almost 5.2 million people across the country were in need of humanitarian assistance by May 2015, of whom more than 2.9 million were internally displaced, one of the largest internally displaced populations in the world. In security-compromised governorates an estimated 80% of health facilities were partially functional and 4% were non-functional as of December 2014. The departure of almost half of all health professionals, created a gap in the provision of primary health care, trauma surgery and obstetric care in areas where violence was ongoing. Supplies of medicines and equipment were irregular due to road inaccessibility and power/fuel shortages. In the three governorates forming the Kurdistan region, the rapid and massive influx of internally displaced persons overwhelmed the health system, causing critical medical shortages and overburdening health facilities. Due to the unprecedented scale, urgency and complexity of the conflict, in August 2014 the Inter-Agency Standing Committee declared the Iraq crisis a Grade 3 emergency, representing the highest level of emergency, and the second in the Region following the designation of the crisis in the Syrian Arab Republic as Grade 3 in 2012.

In the Syrian Arab Republic, by December 2014, almost 12.2 million people had been affected inside the country, including 7.6 million internally displaced and 4.8 million living in hard-to-reach or besieged areas. An additional 4 million were refugees taking shelter in Egypt, Iraq, Jordan, Lebanon and Turkey. By the end of March 2015, out of 113 public hospitals assessed, 44% were reported fully functioning, 36% partially functioning and 20% non-functioning. Populations had increasingly limited access to basic services, including life-saving health care, and functioning health facilities were unable to cope with the increasing needs of affected populations in conflict areas. Overcrowded living conditions, together with a significant drop in the overall vaccination coverage, left populations increasingly vulnerable to communicable diseases such as measles, typhoid and whooping cough.

In March 2015, the conflict in Yemen escalated, with violence reaching 19 out of Yemen's 22

governorates. By June, more than 20 million people were affected, with almost 15 million people requiring health care services. The number of internally displaced persons almost doubled in May, reaching more than 1 million people. Serious shortages of medicines and medical supplies, as well as lack of fuel to operate hospital generators and maintain the vaccine cold chain, resulted in a gradual collapse of the health system. Fuel shortages also resulted in an estimated 9.4 million people with no or limited access to safe water. Surges in suspected cases of malaria and dengue fever were reported, with more than 3000 suspected cases and a number of deaths. Lack of access prevented WHO and partners from assessing the situation and providing vector control measures. Significant incidence of diarrhoeal diseases and pneumonia also continued to be reported. Delays and cancellations of vaccination campaigns increased the risk of measles outbreaks, and risked the reintroduction of polio into the country, although as of June, no polio cases were reported. A 5-day humanitarian pause in May allowed WHO and partners to scale up the response around the country. However, calls for a second pause during the month of Ramadan failed.

In Pakistan, military operations in the North Waziristan Agency resulted in the displacement of 500 000 people in June 2014, bringing the total number of displaced persons to 1 million, 74% of whom were women and children. Bad weather conditions, overcrowded housing in host communities, and poor nutrition increased the risk of waterborne diseases, such as cholera, dehydration, diarrhoea and heat stroke, as well as airborne diseases, such as pneumonia and measles.

In Libya, in June 2014, clashes between rival forces erupted in the cities of Tripoli and Benghazi. By December 2014, more than 2.5 million people were in need of humanitarian aid, including 400 000 displaced. Shortages in medicines and medical supplies, together with the evacuation of many of the country's international health workforce left the health system weak and functioning health facilities overwhelmed.

In Palestine, 51 days of fighting in Gaza during July and August 2014 left 2333 Palestinians dead and 15 788 injured. Half a million people were displaced and up to 22 000 homes were destroyed or rendered uninhabitable, with 100 000 people remaining homeless at the end of the year. The conflict caused widespread damage to infrastructure, including hospitals, clinics and ambulances, as well as water and sanitation facilities, resulting in limited access to basic services.

In Afghanistan, as the armed conflict grew in intensity and geographical scope, the number of people in need of access to health services rose from 3.3 million in 2013 to 5.4 million in 2014, with the conflict continuing to cause critical disruptions to the provision of health services. More

than 30% of the population in Afghanistan still has no or difficult access to essential health care.

In Somalia, the United Nations warned in June 2014 of a “looming humanitarian emergency”. Almost half of the country’s population lack access to basic services and about 3.2 million women and men require emergency health services. The health care system remains weak and there is a critical shortage of qualified health workers. The impact of this lack of basic services is felt most strongly among the internally displaced people who continue to be affected by disease outbreaks due to overcrowded and unsanitary living conditions and limited health services.

Natural disasters claimed additional lives. In September 2014, floods in Sudan resulted in the displacement of more than 320 000 men, women and children, while monsoon rains and flash floods in Pakistan affected almost 1.8 million people and resulted in 282 deaths and 489 injuries. More than 42 000 houses were estimated to be damaged or destroyed, while an estimated 2413 million acres of farmland were flooded at a time when crops were almost ready to be harvested. Some areas affected were those that had previously experienced flooding in 2013.

WHO has been fully mobilized in responding to the above mentioned emergencies by leading the work of the humanitarian health cluster and implementing its functions in strengthening disease surveillance and early warning systems, strengthening other public health functions including control of disease outbreaks and immunization and helping to sustain basic health care and life-saving services.

## **Challenges and WHO response to emergencies in the Region**

One of the biggest challenges impeding WHO’s ability to respond is limited access as a result of insecurity. In the Syrian Arab Republic, limited access has required more innovative ways to reach populations in need. In Yemen, restricted access into the country via all ports delayed the delivery of urgently needed health supplies. Inside the country, violence and insecurity made some areas inaccessible, and increased the risk of diseases such as malaria and dengue fever as patients lack access to health care and thus timely diagnosis and treatment. Additional challenges included repeated and targeted attacks on health care workers, health facilities and health infrastructure. In 2014, WHO’s Regional Office publically condemned such attacks in Afghanistan, Iraq, Palestine, Sudan, Syrian Arab Republic and Yemen. Lack of sustainable funding for health in emergency response also posed a key challenge, impeding WHO and health partners’ capacity to respond, and risking the closure of existing health services and health programmes. In 2014, health was funded at 45.6% in the Region while coordination was funded at 84.8% and food at 61.8%. Despite increasing needs, health was only funded at 12.5% for 2015 as of May. There continues to be a heavy dependence by countries in crisis on

external humanitarian and financial aid, which may not always arrive when it is most critically needed.

While trauma care needs have increased, there is decreasing capacity among partners to respond due to the insecurity. In the Syrian Arab Republic, where 1 million people were injured in the first quarter of 2015, health partners have been forced to completely withdraw from “hot” areas, leaving a critical gap in the provision of trauma care. Mass population movement, coupled with low immunization rates and vaccine shortages place the entire region at risk of disease outbreaks. The outbreak of polio and measles in the Syrian Arab Republic as a result of the crisis led to the re-introduction of polio in Iraq in 2014 after 14 years of being polio-free.

Operational challenges faced by WHO and health partners included disrupted health systems, an increasing number of patients requiring trauma care (especially in hard-to-reach areas), growing numbers of internally displaced persons, severely reduced health workforces as health staff fled with their families, disrupted referral systems as a result of insecurity and blocked roads, and critical shortages of essential medicines and vaccines. Mass population movements increased the risk of communicable diseases as IDPs sought shelter in overcrowded camps and public spaces, and damaged water and hygiene infrastructure increased the risk of water-borne diseases. Disease surveillance systems were disrupted as a result of limited data and information. Patients with chronic noncommunicable diseases were forced to find alternate locations for treatment as health facilities shut down or reported shortages in essential medicines. As a result of the violence, mental health needs also increased.

Following the Grade 3 designation of the crisis in Iraq, which signified a global organizational response, WHO’s country office was scaled up with the deployment of more than 21 international staff in all areas of expertise, as of May 2015 and WHO hubs and/or focal points were established in all 19 provinces. Through funding from Saudi Arabia, WHO procured and operationalized 10 mobile clinics in northern Iraq covering 300 000 internally displaced people and host communities. The project is part of WHO’s broader response of providing a timely basic package of primary and secondary health care services. As of May 2015, 3.5 million people in Iraq had been provided with direct access to essential drugs and medical equipment procured and supplied by WHO.

Two cases of poliomyelitis were confirmed in Iraq in early 2014. Together with national and United Nations health partners, WHO was able to vaccinate more than 5 million children against poliomyelitis in three national immunization campaigns, as of May 2015.

In the Syrian Arab Republic in 2014, WHO delivered more than 13.8 million medical treatments to people in need across the country, with more than 32% of the deliveries distributed to hard-to-reach and opposition-controlled areas. WHO also mobilized more than 17 000 health care workers to vaccinate approximately 2.9 million children against poliomyelitis through 10 immunization campaigns and 1.1 million children immunized against measles.

In Yemen, from March to June 2015, WHO distributed almost 130 tonnes of medicines and medical supplies and more than 500 000 litres of fuel to maintain the functionality of main hospitals, vaccine stores, ambulances, national laboratories, kidney and oncology centres, and health centres in 13 governorates, reaching a total of more than 4.7 million beneficiaries, including 700 000 internally displaced people and 140 000 children under the age of 5 years. WHO also provided safe water and sanitation kits and supplies to health facilities and to internally displaced people hosted in affected communities, as well water trucking services to health facilities and communities with high numbers of internally displaced people. WHO also delivered medicines for tuberculosis and malaria and supported disease outbreak response and control.

During and after the Gaza conflict, WHO facilitated the delivery of medicines and medical supplies to hospitals and health facilities for hundreds of thousands of patients. The health cluster system was reactivated and led by WHO, together with the Ministry of Health. WHO took the lead in conducting the health component of the multi-cluster assessment, and led the health cluster in completing the joint health sector assessment. Despite the conflict, WHO ensured ongoing advocacy for access for patients with referrals abroad, working at a policy level to facilitate access for these patients.

## **Health risk management**

The Regional Committee endorsed the need to strengthen emergency preparedness and response through an all-hazard and multisectoral approach (EM/RC61/R.1) and requested enhanced technical support from WHO to scale up national emergency risk management capacity. By the end of 2014, 19 countries had received support in reviewing their existing national plans for emergency preparedness and response, with a view to adopting the comprehensive approach. Two countries finalized a national plan for all-hazard emergency preparedness and response for health. To support the planning process, the comprehensive all-hazard risk assessment protocol was piloted in the Islamic Republic of Iran, along with comprehensive vulnerability analysis. In Afghanistan mass casualty management capacity was scaled up, in collaboration with partners.

In 2014, WHO's work in emergencies in the Region was made possible with the support of

many donors, including Australia, Canada, China, the European Commission, Finland, Italy, Japan, Korea, Kuwait, Norway, Russian Federation, Saudi Arabia, Switzerland, Turkey, United Arab Emirates, United Kingdom and United States of America.

## **Implementing the strategies endorsed by the Regional Committee**

Progress was made in regard to implementing resolutions endorsed by the Regional Committee. The process of establishing a regional emergency solidarity fund was initiated with the aim of ensuring predictable financing of surge/rapid response to natural and man-made disasters in the Region. This was strengthened by the Regional Committee which urged Member States to contribute to the Fund by allocating to it a minimum of 1% of the WHO country budget, in addition to other voluntary contributions whenever possible.

With the goal of establishing a regional roster of trained experts who are able to quickly and effectively respond to any emergency, including disease outbreaks, capacity-building of emergency focal points was supported on surge training in emergencies , and will continue to be supported each year. To ensure the timely procurement and provision of critical medical supplies and equipment to countries experiencing emergencies in the Region and beyond, WHO has finalized an agreement with the Government of the United Arab Emirates to establish a dedicated WHO humanitarian operations/logistics hub.

WHO will continue to work with Member States to strengthen the capacity of health systems to prevent, mitigate, prepare for, respond to and recover from emergencies and crises following a whole-health and multisectoral approach, with special emphasis on reinforcing technical capacity in preparedness.

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