

Progress reports

Report by the Secretariat

1. At the request of Member States, information on WHO's work in crisis response during the period from May 2012 to April 2013 is provided below to supplement progress report D.

D. STRENGTHENING NATIONAL HEALTH EMERGENCY AND DISASTER MANAGEMENT CAPACITIES AND THE RESILIENCE OF HEALTH SYSTEMS (RESOLUTION WHA64.10)

Context

2. Building on resolution WHA64.10, resolution WHA65.20 reinforced WHO's role in responding to health needs in humanitarian emergencies, calling on the Director-General, inter alia, to enable the Organization to discharge its function role as Inter-Agency Standing Committee Health Cluster Lead Agency and operationalize the WHO Emergency Response Framework. This report summarizes the humanitarian emergencies for which the Secretariat provided a response between May 2012 and April 2013, and provides further detail on three major crises with which the Organization is currently involved.

Overview

3. WHO's Emergency Response Framework outlines a common organizational approach for responding to emergencies. It includes new processes for assessing and communicating the scale and severity of an emergency and its implications for health, and sets out performance standards and procedures that guide the response from all three levels of the Organization. Between May 2012 and April 2013, WHO undertook risk assessments of 24 acute humanitarian events with potential health consequences. One event resulted in the activation of an Organization-wide response in support of the relevant WHO country offices; five events required substantive support from the Organization for the in-country response; 12 events required limited WHO support through the country offices; and a further six events were monitored, but either required no country office response or did not involve a request for support from the Member State concerned.

4. The five humanitarian events that triggered substantive WHO support through country offices are: the food security crisis across the Sahel; the conflict in North Kivu Province in the Democratic Republic of the Congo; the floods in Nigeria; the conflict in Mali; and the conflict in the Central African Republic. The crisis in the Syrian Arab Republic led to the activation of Organization-wide support through the country offices in Iraq, Jordan, Lebanon, Syrian Arab Republic and Turkey. The three humanitarian events requiring the most substantive support through WHO country offices are

reviewed below in terms of their public health impact and the progress made by the Secretariat in supporting Member States and partners in responding.

Syrian Arab Republic

5. The crisis in the Syrian Arab Republic began in 2011 and has now affected all 14 governorates. As at 6 May 2013, 6.8 million people were in need of assistance, including 4.25 million internally displaced persons.¹ Since late 2012, the number of Syrians crossing into neighbouring countries has increased substantially. As at 15 May 2013, there were 474 461 Syrian refugees in Lebanon, 473 587 in Jordan, 347 815 in Turkey, 147 464 in Iraq and 66 922 in Egypt.² It is estimated that 80 000 people have been killed, and a further 400 000 injured, as a result of the crisis.³

6. The health system in the Syrian Arab Republic has been severely disrupted, compromising the provision of primary and secondary health care, including the following: the referral of injured patients; the treatment of chronic diseases; and the provision of maternal and child health services, vaccinations, nutrition programmes and communicable disease control. There is overcrowding in public shelters due to internal displacement, water and sanitation infrastructure is damaged, and there is a lack of waste management. Measles vaccine coverage has declined to an estimated 45% from a pre-crisis level of over 95%. There are increasing cases of typhoid, hepatitis A, measles and cutaneous leishmaniasis; and mental health problems are a growing concern in both the short- and long-term. A large proportion of health facilities have been directly affected or damaged by the conflict and those that remain functional are overburdened. Of the 88 public hospitals in the country, 33 are out of service, 18 are partially functional and 37 are largely functional.⁴ Shortages of health staff are particularly acute in areas experiencing high levels of violence. There are critical shortages of medicines and supplies as a result of both damage to pharmaceutical infrastructure and the combined effects of economic sanctions, currency fluctuations, scarcity of hard currency and fuel shortages.

7. WHO has taken a multi-pronged approach to improving access to services; this has included the following actions: subcontracting 24 local nongovernmental and community-based organizations;⁵ supporting mobile clinics, including in heavily-affected areas of Damascus, rural Damascus, Homs, Hamah, and Aleppo; establishing an operational hub in Homs; and conducting cross-line operations in Aleppo, Homs, Idlib and Derezor. WHO and health sector partners, including the Syrian Arab Red Crescent, had reached 72% of the targeted 4 million beneficiaries by the end of April 2013. National staff and local nongovernmental organizations from across the country have been trained in emergency medical and trauma care, and on the Early Warning Alert and Response Network. Assessments of health facility functionality and service availability have been conducted where feasible.

¹ United Nations Office for the Coordination of Humanitarian Affairs, Syria Humanitarian Bulletin, Issue 24, 23 April–6 May 2013.

² United Nations High Commissioner for Refugees, Syria Regional Refugee Response Inter-agency Information Sharing Portal, 16 May 2013.

³ Source: information on deaths from Syrian Observatory for Human Rights and the President of United Nations General Assembly, 15 May 2013; injuries estimated based on a 1:5 death-to-injury ratio.

⁴ Source: Ministry of Health, Syrian Arab Republic, April 2013.

⁵ Including Islamic Charity Organization, Syrian Association for Health Promotion and Development, Syrian Family Planning Association, Alber Hospital and Social Services Association and Syria Trust for Development.

8. The Secretariat supported Syrian health authorities in developing an Essential Medicines List and, from January 2012 to March 2013, the Organization provided medicines and supplies for the health needs of 1.95 million people. An Early Warning Alert and Response Network has been established with 135 sentinel sites in 14 governorates; expansion to 350 reporting sites is planned and an outbreak preparedness plan is under development. WHO and UNICEF supported the vaccination of 1.3 million children against measles and 1.5 million children against poliomyelitis in late 2012; a further 2.5 million children are targeted for vaccination by June 2013.

9. In neighbouring countries, host governments continue to provide the majority of health services to Syrians, particularly outside camp settings. In camps that are operated by host governments, health services are provided primarily by the government; in camps operated by UNHCR, services are provided by that agency and its implementing partners. In certain settings, UNHCR funds nongovernmental organizations to deliver health services and provides vouchers so that refugees can access care through the national system. Owing to the large refugee influx, host communities and health infrastructure, resources and systems are overstretched, particularly those in Jordan, Lebanon and Turkey. In Lebanon and Jordan, for example, Syrians now account for, respectively, 30%–40% and 50% of primary health care visits in some areas.¹

10. Health priorities among the refugee populations include dealing with noncommunicable diseases, war injuries and disabilities, maternal and child health, and mental health. Infectious diseases such as measles, leishmaniasis and multidrug-resistant tuberculosis have been reported. The Secretariat is enhancing its support in the countries concerned to tackle gaps in health service delivery, providing technical support for priority health issues (e.g. chronic diseases), training staff, assisting with the procurement and distribution of medicines, assessing the health, nutrition and mental health status of refugees and the capacities of national health systems, strengthening outbreak surveillance and response, and extending preventive programmes, such as vaccination, to all populations in the host communities.

11. An Emergency Support Team was established in Amman to provide dedicated technical and operational support to WHO offices in the Syrian Arab Republic and surrounding countries. WHO is also establishing a temporary field presence in south-eastern Turkey in order to support the response through the health authorities, other United Nations agencies and international partners.

Mali

12. The conflict that began in 2012 in northern Mali escalated further in 2013; as at 8 May 2013, there were 300 783 internally displaced persons and 174 129 refugees in neighbouring countries.² This crisis occurred against the background of the major food insecurity crisis that affected Mali and eight other Sahel countries from late 2011 through to mid-2012. The entire country is now affected, with over 80% of the needs reported to be in the south of the country, owing to faltering social services and the movement of internally displaced persons. Food insecurity is again imminent with the arrival of the “lean” season in the northern regions of Timbuktu, Gao and Kidal. Security remains a major concern owing to the persistent presence of well-armed insurgents.

¹ Source: WHO, and the health ministries of Lebanon and Jordan.

² Source: Commission of Population Movements and UNHCR, in report by Office for the Coordination of Humanitarian Affairs: Mali: Complex Emergency Situation Report No. 32, 8 May 2013.

13. Access to basic social services such as water, education and health is now very limited in the north, as a result of the low number of humanitarian agencies, the physical destruction and looting of facilities, and the departure of health workers. Over 90% of community health centres are closed. Throughout the country, government resources for health are scarce, the national supply chain has been disrupted, and large displaced populations have strained health services. The major health concerns are malnutrition and its related consequences, such as the increased incidence and severity of diarrhoea, pneumonia and measles. An estimated 660 000 children aged less than five years will suffer from acute malnutrition in 2013.¹

14. WHO has revitalized the Health Cluster to support the Ministry of Health's sector coordination. Partner agencies have been mapped, cluster bulletins are communicating health needs and activities, and sector response and contingency plans have been developed. Two health sub-clusters have been established in Mopti and Gao. A detailed health system capacity and needs analysis is continuing in southern and, where security permits, northern regions. Advice is being provided to support the restoration of essential health services and the return of national health workers.

15. In the northern areas of Segou, Mopti, Gao and Timbuktu, hospital services, emergency medicines and supplies, and mobile clinics are being provided by international nongovernmental organizations² and the International Committee of the Red Cross. Since January 2013, WHO and the Medical Association of Mali have organized two missions that deployed 70 health workers, who conducted 32 000 interventions including primary care consultations, caesarean sections, and surgeries; in 2012, 25 000 interventions were conducted during three similar missions. Development partners are being mobilized to close gaps and support a policy of free health care in crisis-affected regions.

16. The national Early Warning Alert and Response Network is being strengthened as health care facilities reopen, and drugs and supplies are being prepositioned for diarrhoeal disease outbreaks. International nongovernmental organizations and the International Committee of the Red Cross have responded to measles outbreaks in Gao. WHO, UNICEF and Health Cluster partners supported poliomyelitis immunization days in Sikasso, Ségou and Mopti, where 1.5 million children were vaccinated. A further 6.7 million children were vaccinated against poliomyelitis during a national immunization campaign in April 2013.

17. Humanitarian needs in Mali will persist for the foreseeable future, requiring continuing support to health services in areas hosting internally displaced persons, the restoration of health services in the north of the country, gap-filling for health service delivery in areas requiring staff redeployments, and the continued supply of medicines.

¹ Source: Assessment Capacities Project. Global Overview. Mali country analysis, 13 May 2013.

² International Committee of the Red Cross, Médecins Sans Frontières (Belgium, France and Spain), the Alliance for International Medical Action, Alliance Médical Contre le Paludisme, Santé Mali Rhône-Alpes, and Médecins du Monde (Belgium and France).

Central African Republic

18. The internal conflict that culminated in the events of March 2013 has affected 4.6 million people, with more than 70% of the population lacking any access to health services as at May 2013.¹ Health care delivery in Bangui and most rural areas has been severely disrupted as a result of insecurity, widespread looting of health care facilities, warehouses and offices, and the absence of health workers. The security situation remains unstable throughout the country, severely hampering access by the remaining humanitarian actors.

19. Communicable diseases, especially malaria, pneumonia and diarrhoea, complications of pregnancy, perinatal conditions and malnutrition are responsible for the majority of morbidity and mortality.² There is a high risk of outbreaks due to the poor access to potable water and sanitation, the weak surveillance system, and low vaccination coverage (55% for three doses of diphtheria-tetanus-pertussis vaccine in 2012).³ A measles outbreak has been continuing in Bangui and two outlying regions since April 2013. Work with the Ministry of Health and partners is continuing in order to restore the disease surveillance system, establish a rapid response mechanism and, where possible, resume immunization services. Health services are resuming in some areas with the support of partners.⁴ WHO, UNICEF and UNFPA have procured medical, surgical and obstetric kits for 28 hospitals and 236 health centres and health posts.

20. WHO is also coordinating the Health Cluster's collaboration with the Ministry of Health, mapping of health partners, and activation of interagency contingency plans. Where security allows, service delivery is being supported through the provision of medicines and supplies, and the deployment of health workers and mobile teams. A rapid assessment of services has been initiated with the Ministry of Health and health partners in Bangui and 22 health districts; more in-depth assessments are planned as security allows. A measles vaccination campaign is planned in Bangui from 22–26 May 2013. The restoration of security, the protection of humanitarian and health service providers and facilities, and an increase in nongovernmental organizations are essential to enhancing the health response.

Way forward

21. Systematic implementation of the Emergency Response Framework will help WHO achieve its overarching emergency response goals of preventing or reducing excess morbidity and mortality among affected populations, and of monitoring and mitigating the impact of the emergencies on affected health systems.

22. Constraints to the health sector response in the major crises detailed in this report include continuing insecurity, shortages of health personnel and supplies, escalating costs and difficulties associated with transportation, insufficient financing and, in some circumstances, complicated

¹ Source: Office for the Coordination of Humanitarian Affairs, Central African Republic: Humanitarian Dashboard, 7 May 2013.

² Source: World Health Organization Regional Office for Africa. Central African Republic Factsheets of Health Statistics 2010.

³ Source: World Health Organization Regional Office for Africa.

⁴ Médecins Sans Frontières (Holland, France, Spain), International Committee of the Red Cross, International Medical Corps, Medical Emergency Relief International, Agency for Technical Cooperation and Development, Cooperazione Internazionale and Action Contre la Faim.

clearance processes. Although funding has improved in 2013, only 35% of the health sector requirements in the Syrian Humanitarian Assistance Response Plan were funded in 2012; the Regional Response Plan was 77% funded. In Mali, only 30% of the health sector requirements in the 2013 Consolidated Appeal have been funded; in the Central African Republic, the figure is 13%.¹ In all of the crises included in this report, insufficient core financing and rapid response funds were the primary constraints to the WHO's capacity to mount and sustain a comprehensive response.

23. Profoundly concerned by attacks on health workers, facilities and services, particularly in the Syrian Arab Republic, WHO will continue to advocate strongly for the neutrality of health workers, facilities and services, for that neutrality to be protected and respected by all parties, and for health workers to deliver services in an impartial and ethical manner. In this regard, the Secretariat appreciates the statement, signed recently by 57 countries,² affirming the obligation of all parties to conflicts to respect the rules of international humanitarian law.

24. Building on experience with the Emergency Response Framework over the past 12 months, WHO will further strengthen its capacity to: (i) lead and coordinate with health ministries a rapid health sector response to the needs of emergency-affected populations; (ii) provide timely information on health needs and trends among affected populations, on the impacts on health systems, and on priorities; (iii) facilitate access to health services, ensuring there is a basic service package and strategy for service provision; (iv) facilitate early detection of, and rapid response to, infectious disease outbreaks and other public health threats; and (v) provide technical advice and support on key public health issues such as trauma care, communicable and noncommunicable diseases, maternal and child health, and mental health.

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¹ Source: Office for the Coordination of Humanitarian Affairs, Financial Tracking Service, 18 May 2013.

² The Common Statement on Access to Medical Care in Syria.