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Responding to health emergencies in the Eastern Mediterranean region in times of conflict

WHO's Eastern Mediterranean region (EMR) is facing emergencies on a scale that is perhaps unprecedented in its history. There is armed conflict in 12 of the region's 22 countries.^{1,2} The region's 680 million people³ represent 9% of the global population, yet the EMR is home to 43% of those who need humanitarian assistance⁴ and is the source of 64% of the world's refugees.⁵

The health effects of these crises are immense. Direct health consequences include trauma-related deaths and disability, gender-based violence, and mental disorders. Disruption of health systems contributes to increased morbidity and mortality from infectious diseases, malnutrition, obstetric complications, and non-communicable diseases (NCDs). Health indicators in the EMR are among the worst in the world.⁶ State fragility and conflict are among the biggest challenges to attainment of Sustainable Development Goal 3.⁷ Conflict is a global health security threat because affected countries are less able to prevent, detect, and respond to disease outbreaks. More than 70% of disease outbreaks worldwide occur in fragile and conflict-affected settings.⁸ Yemen has experienced the largest cholera outbreak in history.⁹ During the second half of 2019, there were six concurrent disease outbreaks in Sudan.¹⁰ Wild polio virus returned to Syria due to conflict,¹¹ while Afghanistan and Pakistan are two of three countries where the virus remains endemic.¹² The average International Health Regulations (IHR) core capacity score is much lower for the 12 conflict-affected countries than for the other countries in the region,⁶ placing them at greater risk of spread and public health consequences of the ongoing outbreak of coronavirus disease 2019 (COVID-19) and other epidemic-prone diseases. WHO's global COVID-19 strategic preparedness and response plan¹³ therefore prioritises countries with weak health systems for technical and operational support from international partners. COVID-19 has already affected ten countries in the region, as of Feb 28, 2020, including Afghanistan, Iraq, and Pakistan.

Effective humanitarian response is constrained by insecurity, disrupted health systems, limited local capacities, bureaucratic impediments, insufficient partners with strong operational presence, and underfunding.

Nowhere are these constraints more evident than in the currently worsening crisis of northwest Syria, where close to 1 million people have been displaced and more than 70 health facilities have ceased functioning since December, 2019.¹⁴ The growing disregard for international humanitarian law and the right to health is also deeply troubling. During 2018, WHO documented 388 attacks on health care worldwide from secondary sources; 276 (71%) occurred in the EMR.¹⁵ Humanitarian agencies have adopted various approaches to address these constraints, including investments in local partners, cross-border operations, deconfliction, remote programming, and scaled up advocacy and humanitarian diplomacy. Robust processes for duty of care of staff are essential. Local partners face the biggest risks; the Syrian Arab Red Crescent, for example, has lost more than 70 staff and volunteers since the war began in 2011.¹⁶

Despite these challenges, health partners are increasingly able to document improved service coverage and impact. During the 2017 Mosul military offensive in Iraq, a unique trauma referral pathway saved around 1800 lives;¹⁷ a similar system in the occupied Palestinian territory averted up to 1270 deaths.¹⁸ The cure rate for severe acute malnutrition in Yemen is over 90%.¹⁹ And during the 2019 cholera outbreak in Somalia, an oral cholera vaccination campaign reached more than 95% of those targeted, while the case fatality rate (0.5%)

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has been maintained within international norms.^{20,21} WHO's surveillance system on attacks on health care is active in six EMR countries;²² data are being used for advocacy and mitigation measures.

Nonetheless, the health sector has much more to do and WHO has identified priorities for improving the collective health response. First, emergency management needs to be strengthened. WHO is assisting member states to undertake all-hazard risk profiling, develop emergency preparedness plans, establish emergency operations centres (EOC), and apply the incident management system.²³ Afghanistan has improved its emergency management, now coordinated from a Crisis Control Centre in Kabul.

Second, improvements in trauma care are needed in the EMR. Violent trauma is a major problem across the region. From January to June, 2019, partners in Syria did 359 657 trauma consultations.²⁴ Afghanistan now has the highest number of civilian casualties, including deaths and injuries, since documentation began in 2009.²⁵ Effective trauma care systems have been established in Afghanistan, Iraq, the occupied Palestinian territory, and Syria. Expanding trauma care can also contribute to more comprehensive emergency medical systems.

Third, National Action Plans for Health Security (NAPHS) need to be implemented. NAPHS outline national priorities for strengthening IHR core capacities and are central to collective efforts for health security. 17 EMR countries have developed NAPHS. Accelerating implementation is a major priority for 2020, focusing on surveillance, laboratories, preparedness, EOCs, risk communications, and rapid response teams.

Fourth, operationalising the humanitarian-development nexus is crucial for the region. This new way of working leverages the comparative advantages of both humanitarian and development sectors.²⁶ The World Bank-funded Emergency Health and Nutrition Project in Yemen is an example of sustaining delivery of essential services while supporting local systems and structures.²⁷

Finally, other neglected health concerns in the EMR must be addressed. Within the context of expanding universal health coverage in fragile settings, WHO is expanding services at primary and secondary levels for NCDs (eg, Iraq and Yemen), mental health (eg, Somalia and Syria), and sexual and reproductive health (eg, Afghanistan and Sudan). Innovative tools such as the NCD kit and the Mental Health Gap Action Programme

(mhGAP), which integrates mental health services in primary health care, are being introduced throughout the EMR. Specific projects with Health Cluster partners on gender-based violence and sexual and reproductive health are scaling up in Afghanistan, Iraq, Sudan, Syria, and Yemen.^{28,29}

Conflicts across the EMR are devastating the lives of millions of people. Although health partners are documenting some impressive achievements, the right to health of the most vulnerable is far from being met and much more is required to address the needs of millions. All conflicts are political in nature, with no humanitarian or public health solutions. In these situations, the most impactful health interventions will always include a legitimate peace settlement and the restoration of basic rights.

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Richard Brennan, *Rana Hajjeh, Ahmed Al-Mandhari
hajjeh@who.int

World Health Organization Regional Office for the Eastern Mediterranean,
PO Box 7608, Nasr City, Cairo 11371, Egypt

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