February 2013

This monthly report, which is not exhaustive, is designed for operational use and does not reflect any official position of the WHO Secretariat.

The Democratic Republic of the Congo

Statistics

Total population***	67 700 000
Gross national income per capita*	320
Life expectancy at birth m/f (years)	47/51
Probability of dying between15 and 60 years m/f **	442/331
Total expenditure on health per capita* (2010)	27
Total expenditure on health as % of GDP (2010)	7.9

* purchasing power parity international $
** per 1000 population
*** Source: PNUD 2011
Source: WHO/GHO.

Funding US$ 2013	Health Cluster	WHO
Requested	**79 506 600**	**47 700 000**

WHO received US$ 12 580 474 in 2012, 33% of the funds requested.

Source: OCHA/FTS.

WHO's emergency activities in 2012 in the Democratic Republic of the Congo have been supported by Finland, Italy, the Russian Federation, the Central Emergency Response Fund, and the Common Humanitarian Fund.

For more information:
http://www.who.int/hac/crises/cod

Situation highlights

Prolonged instability, conflict and chronic emergencies in eastern Democratic Republic of the Congo (DRC) have had a significant impact on the health of displaced and vulnerable populations throughout the country. Heavy fighting in January 2013 caused massive population displacement in Punia (eastern DRC), causing the deterioration of the humanitarian situation. OCHA reports that nearly a third of the population of Punia (a town with 53 000 inhabitants) fled to the forest or other areas around the town. An inter-cluster assessment mission was conducted from 7 to 14 February 2013.

In the Katanga region, according to UN estimates, violent clashes have led to the displacement of more than 300 000 people (beginning December 2012 – end February 2013) .

The affected population is having difficulties in accessing water, health care and basic services, which puts thousands of people at risk of disease outbreaks. There was a major increase in epidemics across the whole country in 2012, including measles, cholera and viral haemorrhagic fevers among others.

- While cholera cases have decreased in the western provinces, eastern provinces are experiencing a resurgence of cholera cases since July 2012. Triggering factors include the lack of latrines and clean water sources and renewed violence. Over the course of 2012, DRC registered 30 753 cases of cholera with 709 deaths.
- For the first eight weeks of 2013, 6954 cases of cholera were reported across the country with 166 deaths – 97% of these cases are concentrated in eastern DRC.
- In Katanga, (1 Jan. – 27 Feb.), there have been 4326 cases of cholera, 145 deaths - 61% of the country's cholera cases were reported from Katanga.

Health Cluster priorities

- Increase access to a minimum package of health services including required life-saving interventions such as basic health care, surgical services and emergency obstetric care to reduce maternal and child mortality.
- Promote access to water and sanitation in areas at high risk for the spread of epidemics.
- Strengthen technical and institutional capacities in the surveillance and response to diseases with epidemic potential.
- Strengthen coordination of health partners to improve contingency plans and adapt responses to emerging situations.
- Strengthen capacities of communities, women and men, girls and boys, to reduce the risk of communicable diseases and to mitigate the impact of recurrent epidemics.

Health Cluster response

In response to the cholera outbreak in Katanga:

- Cholera kits (23) and medical supplies have been provided by WHO and UNICEF to cover 4326 cases
- Seven cholera treatment centres are operational and 281 points of water chlorination have been installed
- 2166 hygiene kits have been distributed

During the inter-cluster mission in Punia, emergency health interventions included:

- The general reference hospital was supplied with 90 blood bags
- WHO provided four Inter-agency Emergency Health Kits (each providing essential medicines to cover 10 000 persons for three months), one malaria module, 24 litres of ringer lactate, two maternity kits and other medical equipment
- Support was provided for a measles vaccination campaign including immunization supplies and transportation
- Essential medicines were supplied to health centres and the general reference hospital in Punia.

Somalia

Statistics

Total population	9 331 000
Gross national income per capita*	NA
Life expectancy at birth m/f (years)	51/51
Probability of dying between15 and 60 years m/f **	382/350
Total expenditure on health per capita* (2010)	17
Total expenditure on health as % of GDP (2010)	2.2

* purchasing power parity international $
** per 1000 population
Source: WHO/GHO.

Funding US$ 2013	Health Cluster	WHO
Requested	**90 219 661**	**18 811 556**

WHO received US$ 4 406 961 in 2012, 41.7% of the funds requested.

Source: OCHA/FTS

WHO's emergency activities in Somalia in 2012 have been supported by the United States of America and the Common Humanitarian fund.

For more information:
http://www.who.int/hac/crises/som

Situation highlights

Conflict and instability over the last two decades have caused massive displacement, destroyed local social mechanisms, and prevented institutional investment critical to ensure services and livelihoods. Furthermore, the 2011 famine in Somalia led to the loss of livestock which are the prime family asset for Somali rural populations. It also created displacement as households went off in search of food and other resources. The quality of health, nutrition, education and water and sanitation services across the country remains extremely poor due to conflict, weak governance, lack of access, insufficient numbers of skilled staff, as well as low and irregular salaries.

Child and maternal mortality rates continue to be among the highest in the world: one out of ten Somali children dies before seeing their first birthday. Almost a third of all deaths under the age of five are birth-related, another quarter can be attributed to pneumonia and 16% caused by diarrhoea. One out of twelve women dies due to pregnancy-related causes. The lack of adequate pre-natal and maternal care, coupled with a high fertility rate (6.3), put women at elevated and recurrent risk.

Maternal and child malnutrition is the cause of more than one quarter of all deaths of children under five. An estimated 215 000 children under five years are in urgent need of health care due to increased vulnerability to health complications related to malnourishment. Malnutrition rates in Somalia are still among the highest in the world, with one in seven children acutely malnourished, and one in thirty-three severely malnourished. Two thirds of these children are in South and Central Somalia

Throughout the country, an estimated 236 000 children are acutely malnourished and in need of specialized nutrition treatment services.

Health service provision is weak with one physician per about 25 000 and a nurse/midwife per 9000 people, respectively. An estimated 71% of the Somali population does not have access to safe water throughout the year, and 77% of the population does not have access to adequate sanitation facilities.

- As new areas of South and Central Somalia have become accessible to humanitarian partners, WHO supported the expansion of emergency health care services, in collaboration with the health authorities, UN Agencies and Health Cluster partners.
- The Health Cluster Coordinator in Mogadishu is coordinating the health response through 162 health partners including 118 national NGOs. The health response is largely provided through national NGOs for reasons of access.
- During a consultation at the end of February, it was established that the national health authorities would co-lead the Health Cluster along with WHO.
- The Health Cluster (together with the WASH and Food Security) has implemented the cluster performance monitoring tool and the partners have rated the functions of the cluster as satisfactory or good. A report of the complete findings and recommendations for follow-up will be available in March.

Health priorities

- Prevent and control epidemic-prone and other communicable diseases through expansion of surveillance, disaster risk reduction, emergency preparedness and life-saving humanitarian health services for various Somali zones and target populations (e.g. internally displaced persons, returnees and vulnerable groups) in line with the national Health Strategic Frameworks.
- Increase access to high-impact emergency obstetric and routine reproductive, maternal and newborn and child health services as per national priority packages (e.g. the Minimum Initial Service Package) to harness stability, resilience and facilitate progress towards health related Millennium Development Goals.
- Facilitate early recovery and transition of health systems through enhanced coordination with humanitarian and development partners and provision of technical support and capacity-building of partners outlined in the humanitarian partnership principles.

Health Cluster response

- In 2012, three makeshift hospitals were established, one in Bakool region and two in Lower Juba region for initial emergency response, with the plan to later expand them into permanent hospitals. Another two hospitals were built, one in Gedo region and another in Galgaduud region. A further three hospitals in Bay region, in Lower Shabelle and in Lower Juba were scaled-up continue to be supported for emergency surgery and caesarean section. The hospitals serve a total catchment population of almost a million people, and each of them acts as a referral facility for the respective region. An estimate of 10 000 patients per month receive consultations.
- WHO and UNICEF provide and distribute needed medical supplies and equipment to partners and support health facilities. In 2012, WHO provided more than 220 tons of emergency medical supplies, including 36 blood transfusion kits, 67 Diarrhoeal Disease Kits, 104 Interagency Emergency Health Kits, 21 Reproductive Health Kits, and 15 Surgical Supplies Kits, serving more than 350 000 beneficiaries in a year.
- Two mobile clinics were set up in Bay region, to provide access to essential life-saving services to about 80 000 people.
- In South Central Somalia, including newly accessible areas, over 400 health workers have been trained in disease classification and outbreak response. Another 545 were trained in comprehensive emergency obstetric surgery and trauma surgery.
- For the first time in four years, vaccination campaigns were conducted in 14 districts of South and Central Somalia that were previously not accessible, including: Afgooye, Afmadow, Badade, Balad, Kismayo, Baidoa, Beletweyn, Berdale, Elberde, Huddur, Jowhar, Qansahdera, Rabdurr and Warsheik.
- Between November 2012 and January 2013, over 383 000 children under the age of five were targeted with polio vaccination and almost 80 000 children were vaccinated against measles.
- In January 2013, a vaccination site was set up in Dhobley (transit point on the Kenya-Somali border), targeting Somali returnees. In the first week, 839 children under the age of five were vaccinated against polio.

Haiti

Statistics

Total population	9 993 000
Gross national income per capita*	1180
Life expectancy at birth m/f (years)	60/63
Probability of dying between 15 and 60 years m/f **	278/227
Total expenditure on health per capita* (2010)	76
Total expenditure on health as % of GDP (2010)	6.9

* purchasing power parity international $
** per 1000 population
Source: WHO/GHO.

Funding US$ 2013	Health Cluster	WHO
Requested	**90 219 661**	**18 811 556**

WHO received US$ 1 700 075 in 2012, 39.4% of the funds requested.

Source: OCHA/FTS

WHO's emergency activities in Haiti in 2012 have been supported by Canada, Finland, the Central Emergency Response Fund, and the OCHA Emergency Response Fund.

For more information:
http://www.who.int/disasters/crises/hti

Situation highlights

Three years have passed since the devastating earthquake that struck Haiti in January 2010 and caused more than 217 000 deaths, destroyed the homes of more than two million people and displaced more than 1.5 million people. The Government and humanitarian actors were able to help return or relocate almost 80% of these people out of camps. However, despite some improvements in the lives of the disaster affected population, significant humanitarian needs remain. Even though the overall number of cholera cases following the 2011 outbreak has decreased, localized outbreaks in remote areas are on the rise while response capacities have diminished due to lack of available funding. Another concern is the food security situation which is deteriorating and now affecting over two million people. The 2012 tropical storms Isaac and Sandy have re-emphasized the fragility of both the population and the national disaster response capacity.

Cholera continues to be an important public health concern. As of 6 February 2013, the UN reported 645 964 cases of cholera and 8020 deaths since the onset of the cholera epidemic in October 2010. While the epidemic saw a steady decline in new infections and case fatality rates in 2012, Haiti is presently facing an increase in the frequency and number of cases of cholera in several departments identified as the most vulnerable: the West (including Port-au-Prince), Artibonite, the Centre, the South, the South-east, Jeremie, Cap Haitien and Port de Paix.

Considering the current trends of morbidity, an estimated 118 000 people could fall victim to the epidemic during 2013. The precarious situation with regard to water supply systems and poor access to sanitation facilities throughout the country is the key determinant of the evolution of the disease. The epidemiological surveillance system established by the Ministry of Health does not provide comprehensive, reliable data. A strengthening of the system is urgently needed, particularly at the commune level.

On 27 February, the Pan American Health Organization/World Health Organization (PAHO/WHO) called on the international community to provide financing for a new US$2.2 billion plan from the Haitian government to eliminate cholera transmission over the next 10 years through major investments in water and sanitation. The new National Plan for the Elimination of Cholera in Haiti provides a blueprint for increased investments in water and sanitation infrastructure, water-quality monitoring systems and water and sanitation management. It also includes health measures for prevention, surveillance, and case management; interventions for community-based behaviour change; and vaccination for targeted groups against cholera.

Health priorities

1. Prevent the spread of cholera and other infectious diseases
2. Provide swift and adequate medical care to victims of the cholera outbreak by supporting health authorities in their efforts to strengthen medical response capacities at the decentralized level
3. Reinforce the national public health emergency preparedness and response capacities

WHO response

- An outbreak alert and response system has been put in place to detect and respond quickly to disease outbreaks.
- PAHO/WHO is also working with Haiti's Ministry of Public Health and GAVI to ensure universal immunization coverage, to protect Haitian children and adults from vaccine-preventable diseases. Nearly 3 million children under 10 have been vaccinated against polio, measles and rubella.
- PAHO/WHO has been working with Haiti's Ministry of Public Health, to ensure that hospitals and other health facilities are repaired and built to be safe in the event of future disasters.
- PAHO/WHO has helped mobilize a regional coalition of cooperation agencies, NGOs, governments and other organizations to bring together technical expertise and financial support for water and sanitation to ensure the elimination of the transmission of cholera.

International Humanitarian Pledging conference for the Syrian Arab Republic

On 30 January 2013, representatives from Member States, UN agencies and nongovernmental organizations gathered in the city of Kuwait to attend the International Humanitarian Pledging Conference for the Syrian Arab Republic. This was the first International Humanitarian Pledging Conference for the Syrian Arab Republic in order to provide life-saving aid to more than four million people over the first six months of 2013.

US$ 1.5 billion was pledged in support of the humanitarian response to the crisis in the country. Numerous donors indicated they would be supporting delivery of health services, including medicines.

Emergency Support Team

Following the WHO Director-General's declaration of Grade 3 emergency in the Syrian Arab Republic on January 11, a WHO Emergency Support Team was set up in Amman, Jordan on January 12 to provide technical and operational support to its offices in the Syrian Arab Republic and the neighbouring countries of Jordan, Lebanon, Iraq, Egypt and Turkey.

The Emergency Support Team (EmST) provides a consolidated, dedicated response to the crisis at the regional level by back-stopping WHO's four critical functions (coordination, information, technical expertise and core services). This is the first time WHO's Emergency Response Framework has been applied in a Grade 3 emergency. When the Inter-agency Standing Committee announced a Level 3 emergency in the Syrian Arab Republic on January 15, the EmST also served as WHO's input in the IARRM (Inter-Agency Rapid Response mechanism).

Regions, country offices and headquarters (HQ) all contributed to the establishment of the EmST. Staff was sent from HQ and regional offices to run the emergency team, set up health sector coordination and assist in the information management. Staff from the WHO country offices in Jordan and Iraq were also re-purposed to strengthen the team.

Coordination of regional support teams took place in Amman under the umbrella of OCHA, while WHO set up the health sector coordination for all agencies involved in health in order to exchange information, update the Who does What Where file, provide technical advice on health issues (e.g. leishmaniasis, malnutrition, etc.) and initiate strategic planning.

4th Session of the Global Platform for Disaster Risk Reduction, Geneva, 19-23 May 2013

WHO is co-organising a series of events at the Global Platform for disaster Risk Reduction to address the health dimensions of disaster risk reduction, including a Feature Event on the Health Imperative for Community Safety and Resilience, meetings of the Thematic Platform on Disaster Risk Management for Health, and a Market Place booth on Health. WHO invites organizations to share and display information on health-related projects on emergency and disaster risk management at the Health stand at the Global Platform. All people interested in participating in the Global Platform are encouraged to consult the Global Platform website for instructions on registration http://www.preventionweb.net/globalplatform/2013/registration/ and to make their accommodation arrangements as soon as possible. For further information on the health aspects of the Global Platform, contact Jonathan Abrahams (abrahamsj@who.int) in the ERM Department.

Analysis of financing mechanisms and funding streams to enhance emergency preparedness

Emergency Preparedness has become increasingly prominent on the agenda of the Inter-agency Standing Committee (IASC). Building the resilience of nations and communities to crises not only requires the assessment and prevention of natural and man-made risks; it also requires international, national and local actors to be prepared to deliver an effective response to such risks. For the development community this means not only engagement with emergency preparedness but a call for it to become a core body of its work, included in its plans and programme finance.

In order to move the humanitarian system towards a more sustainable, risk-aware position regarding crisis, with as much emphasis on being ready for events, as reacting to them, the IASC is undertaking a two-phase study to analyse financing mechanisms and funding streams for emergency preparedness.

WHO is a key stakeholder in this project, as an active member of the project advisory team, a financial contributor to the project and supporter of FAO (project lead).

Phase I was completed in September 2012 and it looked at institutions, mandates and mechanisms from the global level. The study highlights the challenges and opportunities in financing emergency preparedness, and develops specific recommendations for change, with regards to the financing architecture, the risk context, financing mechanisms, clarification of leaderships and roles of institutions involved in preparedness and reporting.

Phase II is entitled 'Analysis of financing mechanisms and funding streams to enhance emergency preparedness' and is being conducted by the consultancy firm Overseas Development Institute (ODI). Its objective is to investigate the state of play of preparedness financing in six countries and field test the findings of Phase I, to understand from the 'demand' side where funding for preparedness is coming from, how it is being spent and on what types of activities, where the gaps and issues lie, and how funding could be better prioritized and mobilized. The last objective of the Phase II study will be to outline, review and further elaborate the links between preparedness funding and the broader, developing resilience agenda.

The country missions are taking place according to the following calendar:

- the Niger (24th Feb-8th March)
- the Sudan (26th Feb - 6th March)
- the Philippines (5th March - 16th March),
- Myanmar (25th March - 4th April),
- Ghana (to be confirmed)