Response to the crisis in the Democratic Republic of the Congo

November 2012

The Health cluster is requesting US$ 39.5 million to address the health needs of the population affected by recurrent diseases in vulnerable areas.

Current situation

The humanitarian crisis in the Democratic Republic of the Congo (DRC) has continued for more than 10 years. The population of the DRC lives in an environment of insecurity and poverty (70% of the population lives below the poverty line). The number of displaced people has increased throughout 2012 and was estimated at 2.4 million in October. This population movement is mainly affecting the provinces of South Kivu, North Kivu, Orientale and Katanga.

Key health indicators such as maternal mortality (540/100 000 live births) in the DRC are alarming. There is low access to basic health services and a continuation of major outbreaks of cholera, malaria and measles. According to the Nutrition cluster, 2 439 469 children suffer from malnutrition in the country.

Stability has been returning to the western provinces. However, provinces in eastern DRC, are experiencing widespread insecurity caused by conflict between armed groups and government forces. In North Kivu, 60 000 people recently fled IDP camps near Goma to seek shelter in a camp in Mugunga. The DRC Civil Protection Service estimates that there are 140 000 displaced people in and around Goma (November 2012).

Health situation and health risks

There are many factors affecting the health and humanitarian situation across DRC. Conflict, population movements, a food crisis and disease outbreaks are taking place in a country with a weak health system.

There has been a major increase in epidemics, including largely preventable fatal diseases, e.g. measles, diarrheal diseases and cholera, across the whole country. In 2012, the effect of diseases such as cholera, measles, bloody diarrhoea outbreaks, Ebola and rabies has tripled the needs in primary health care, prevention and capacity-building activities.

Prolonged instability and chronic emergency in eastern DRC has had a significant impact on the health of displaced and vulnerable populations. The affected population is having difficulties in accessing water, health care and basic services, which puts thousands of people at risk of disease outbreaks. Health partners are facing major challenges in terms of security, access, communication and logistics. Communication challenges affect surveillance and early warning in remote areas of this vast country.
In the east of the country, the main causes of mortality are communicable diseases such as malaria, diarrhoeal diseases, acute respiratory infections, measles and cholera. Malnutrition and injuries related to violence are also of concern. Health partners are also reporting an increase in obstetrical emergencies.

Cholera
While cholera cases have decreased in the western provinces, eastern provinces are experiencing a resurgence of cholera cases since July 2012. In North Kivu, cholera is on the rise again, especially in Masisi and Kirotse health zones, where fighting continues. In Karisimbi health zone, where Kanyaruchinya refugee camp has been established, there has been a worrying increase in cholera cases. Triggering factors include the lack of latrines and clean water sources and renewed violence.

In 2012, 151 health zones in eight provinces (out of a total of 11 provinces) were affected by cholera. From January - November, 28 089 cases of cholera were reported with 671 deaths (with a case fatality of about 2.0%) compared to 21 692 cases and 584 deaths in 2011.

The trends in cholera in the western provinces have to be carefully monitored, as the rainy season (November - December) has just started. The risk of renewed appearance and spread is enhanced if cholera control activities are halted.

Measles
From January - November, 54 909 cases of measles, with 1509 deaths (case fatality rate of 2.7%) in 102 health zones were reported.

Yellow fever
There has been an outbreak of yellow fever in Equateur province. There hasn’t been a vaccination campaign for yellow fever in this area for the past 10 years.

Ebola haemorrhagic fever
As of 6 November, 77 cases (36 laboratory confirmed, 17 probable, 25 suspected) of Ebola haemorrhagic fever have been reported in Orientale Province. Of these, 36 have been fatal (12 confirmed, 13 probable).

Food crisis
It is estimated that more than 17.3 million people are in an acute food crisis, of whom more than 315 000 are facing a humanitarian emergency. The causes of the food crises include factors such as: population displacement, insecurity, lack of access to food, and loss of livelihood.

Nutritional surveys conducted by the National Nutrition Programme (Pronanut) and UNICEF between March and June 2012 revealed a global acute malnutrition (GAM) rate of over 15% in Katanga and severe acute malnutrition (SAM) rates varying from 3.6% to 5.4% in Katanga and East Kasai. Acute malnutrition affects 2 439 469 children every year, 975 000 of these being classified as severe.

To prevent further increases in disease and death, the primary and secondary health care system must be strengthened and access to water and sanitation improved. The health care system needs improved capacity for disease surveillance and response to better manage disease outbreaks.

Health priorities
The health priorities for the country must consider the differing needs of the health zones in the east and west of the country. The western provinces have a persistently weak health system which increases the risk of disease outbreaks. The conflicts in the eastern provinces are causing an alarming humanitarian situation.

Planning figures for North Kivu indicate 250 000 people in need of urgent health assistance. There
is a need for medical supplies for emergency health services including surgery (trauma kits, transfusion kits), basic health services with preventive care and response to disease outbreaks.

The main health priorities are to:
1. 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.
2. Promote access to water and sanitation in areas at high risk for the spread of epidemics.
3. Strengthen technical and institutional capacities in the surveillance and response to diseases with epidemic potential.
4. Strengthen coordination of health partners to improve contingency plans and adapt responses to emerging situations.
5. 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 Activities

1. Support the provision of a minimum package of services in primary health care and a supplementary package for secondary health care.
2. Provide essential medicines and medical supplies. For example 135 cholera kits, 490 measles kits (200 already distributed) and 250 malaria kits (IEHK basic malaria modules) have been provided.
3. Support the Integrated Management of Childhood Illnesses. A measles vaccination campaign, conducted in 2012, reached about 6 414 742 children out of 5.9 million children targeted (children 6-14 years old in 135 health zones, with significant challenges related to insecurity and population movement).
4. Support the rehabilitation of health centres, hospital infrastructures and maternity wards.
5. Continue the provision of education activities on the prevention of transmission of diarrhoea and cholera. More than 1.4 million women, men, girls and boys have benefited so far from these education activities.
6. Provide health care workers with training and refresher training for outbreak early warning and response and preposition medical supplies for outbreak response.
7. Train health care workers in the management of cases of severe acute malnutrition with medical complications in children under five.
8. Provide medical care and psycho-social support for victims of sexual violence.

Funding required

WHO is supporting health authorities and health partners to coordinate the response to the affected population.

The Health cluster budget in the 2012 Humanitarian Action Plan for DRC is US$ 64 607 584.

The health cluster urgently requires US$ 39.5 million to carry out the priority health interventions listed below.

<table>
<thead>
<tr>
<th>Priority interventions (12 months)</th>
<th>Cost US$</th>
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<tbody>
<tr>
<td>1. Response to the cholera outbreak in 165 health zones</td>
<td>12 000 000</td>
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<td>2. Response to measles outbreaks (immunization and case management)</td>
<td>16 000 000</td>
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<tr>
<td>3. Minimum health care package (mainly in eastern provinces)</td>
<td>11 000 000</td>
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<td>4. Support to coordination</td>
<td>500 000</td>
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<td><strong>Total</strong></td>
<td><strong>39 500 000</strong></td>
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The following donors have supported Health cluster activities in 2012: the Central Emergency Response Fund, the Common Humanitarian Fund (DRC), Denmark, Estonia, European Commission Humanitarian Aid Office, Finland, Germany, Italy, Japan, Luxembourg, Norway, OCHA Emergency Response Fund, the Russian Federation, Sweden, Switzerland and the United States of America.