1. General Context

The health situation in the drought-affected areas remains precarious. Some areas of HOA expect heavy downpour during the coming rainy season from end September 2011 into January 2012. The combination of severe malnutrition, the drought, a highly mobile population, together with poor sanitation, possible flooding and physical access problems to health facilities during the rainy season, provides ground for a highly increased risk of outbreaks of diarrhea diseases and malaria.

2. Country Specific Situation Report

2.1 Ethiopia

Malaria

According to information provided by FMOH, the malaria situation in the country remains stable.

The country reports sufficient stocks of malaria commodities either in country or under procurement including: 14 million RDTs (Rapid Diagnostic Tests), 2 million ACTs (Artemisinin-based Combination Therapies) in stock and 5.5 million under procurement. UNICEF is assisting the country in facilitating the procurement of drugs for severe malaria and to ensure timely delivery of the procured items.

Quinine for the treatment of severe malaria is under procurement, and Insecticides are available for IRS (Indoor Residual Spraying) including for spraying in drought-affected areas.

The country is short of approximately 2.7 million LLINs (Long Lasting Insecticidal Nets) to achieve universal coverage for household protection. The malaria emergency preparedness and response plan for drought-affected areas including identification of outstanding gaps is currently being finalized by the FMOH. To this effect, WHO is providing technical assistance by fielding a malaria expert to the country.

Acute Watery Diarrhea (AWD)

Four Diarrhea Disease Kits (DDK), which can treat 500 cases of AWD/cholera cases each, and one Interagency Emergency Health Kit (IEHK) for 1000 persons for 3 months have been pre-positioned around the Dolo Ado camps in anticipation of AWD outbreaks.
Response Activities
The Inter-Country Support Team deployed an Epidemiologist to the Somalia region of Ethiopia to strengthen the ongoing response and to control vaccine preventable diseases, especially measles, in the area. Furthermore, an additional 3 public health consultants have been deployed to the Dolo Ado area to strengthen communicable disease surveillance among the host population. This is in addition to the 3 consultants already deployed to the Dolo Ado camps.

WHO continues to support health coordination at national and sub-national level but access to reliable data for Ethiopia remains a key issue.

2.2 Kenya

Malaria
The estimated target population of northern Kenya for 2011 for malaria epidemic preparedness and response is 8.7 million. Some 41% (3.5 million) of this population are considered at very high risk for a malaria epidemic in the six month period spanning October 2011 through March 2012.

Efficient response currently requires the strengthening of malaria surveillance to provide real-time data for tracking transmission foci and targeting interventions.

The Ministry of Health, together with partners, is working towards protecting some 470,000 high-risk IDP households through indoor residual spraying (IRS).

The contingency plans further require the urgent procurement, distribution and stock-piling of some 3.5 million RDTs (Rapid Diagnostic Tests), 1.2 million ACTs (Artemisinin-based Combination Therapies), more than 116,000 vials of intramuscular artesunate, and nearly 36,000 Zero-fly sheeting (insecticide treated plastic sheets).

Together with partners like The Global Fund and DFID, WHO is currently working to fill the funding gap for the epidemic preparedness and response proposal of about USD 16,000,000.

Due to a global shortfall, the ACT supply for routine use is experiencing a critical deficit. Kenya had ordered 5 million treatment doses in April 2011, but less than 1 million doses had been delivered by July. The suppliers indicate that the balance has now been shipped.

2.3 Somalia

Malaria
The instable malaria transmission in Somalia combined with drought, malnutrition and a highly mobile population provides for a significant risk of a malaria outbreak with the onset of the rainy season expected late September. A combination of preventive actions such as case management and vector control are required while also ensuring capacity is in place to address the current caseload and to respond to a possible upsurge in cases.

In Central South Somalia the 3 main target groups are:

1. People Living in Communities in High Transmission/Risk Areas: In these areas high coverage of LLINs (Long Lasting Insecticidal Nets) for household protection is needed, as well as malaria diagnostics, access to treatment and possibly vector control.
2. IDPs: for this population household protection is needed and access to diagnostics and treatment.
3. Pastoralists: the strategy for this group will be treatment-based using mobile clinics and health posts/facilities.

Preparedness strategies are built around an effective emergency preparedness and response capacity mapping, and the Somali surveillance system, which is in place. Yet, the health partners have been advised to report any concerning rise in cases immediately.

WHO is preparing contingency stockpiles to diagnose and treat both uncomplicated and severe malaria in addition to routine stocks of ACTs (Artemisinin-based Combination Therapies) and RDTs (Rapid Diagnostic Tests) provided to health facilities. Contingency plans for further medical requirements are being made. UNICEF is also procuring additional drugs and RDTs and planning to expand mobile health services, including pastoralist communities, for diagnosis and treatment of malaria.

WHO is working to provide protection to 711,000 high-risk IDP households either through spraying (IRS- Indoor Residual Spraying) or providing Zero-fly sheeting in addition to an already foreseen spraying of 6,800 households in the coming weeks in the North. Funding possibilities and gaps are currently being worked out together with partners like the Global Fund and will be addressed with the health partners.

UNICEF will take the lead on cholera training at MCH and ORS centers with support from WHO and other partners, like ICDDR/Bangladesh

WHO will take the lead on cholera case management at hospitals and CTC level in collaboration with the partners. KEMRI/CDC has been contacted for support.

4. Acknowledgments
The production of this update was made possible through contributions from the health cluster partners and WHO country offices in Ethiopia, Kenya and Somalia.

3. Sub Regional Situation Report
WHO and UNICEF cooperated to arrange for the important Training of Trainers for Cholera and AWD emergency response activities, as well as the training of village workers in order to be able to assess, classify and treat the under five population on dehydration, pneumonia and malaria.