

Health Action in Crises

**Compendium  
of CAP and Other Appeals:  
Health 2009**



**World Health  
Organization**

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# Table of Contents

<b>Foreword</b> .....	<b>4</b>
<b>Afghanistan</b> .....	<b>6</b>
<b>Central African Republic</b> .....	<b>9</b>
<b>Chad</b> .....	<b>13</b>
<b>Côte d'Ivoire</b> .....	<b>16</b>
<b>Democratic Republic of the Congo</b> .....	<b>18</b>
<b>Iraq and the Region</b> .....	<b>20</b>
Egypt .....	20
Iraq .....	22
Jordan.....	24
Lebanon .....	26
Syria.....	28
<b>Kenya</b> .....	<b>30</b>
<b>Nepal</b> .....	<b>33</b>
<b>occupied Palestinian territory</b> .....	<b>35</b>
<b>Somalia</b> .....	<b>38</b>
<b>Sri Lanka</b> .....	<b>41</b>
<b>Sudan</b> .....	<b>44</b>
<b>Uganda</b> .....	<b>50</b>
<b>West Africa</b> .....	<b>54</b>
<b>Zimbabwe</b> .....	<b>58</b>
<b>List of Acronyms</b> .....	<b>61</b>

# Foreword

The year 2008 witnessed a worsening situation in several ongoing emergencies. Renewed fighting in the eastern Democratic Republic of the Congo left many casualties and forced many to flee their homes. Insecurity in Somalia, Afghanistan, Chad, Kenya and Pakistan caused increased hardship for millions of vulnerable people. A number of major natural disasters also took place: tropical cyclone Nargis in Myanmar, an earthquake in China, drought and floods in the Horn of Africa, floods and landslides in India and Nepal, a devastating hurricane season in the Caribbean and floods in South and Central America. The efforts to control a major cholera outbreak in Zimbabwe are ongoing. Additionally, an old phenomenon with new intensity is affecting access of humanitarian workers to areas affected by crises. In Somalia, Afghanistan, Darfur and the Gaza Strip several aid workers were kidnapped or killed in targeted attacks during 2008. This fact drew the attention to the exceptional role of national staff in delivering humanitarian assistance on one side and the need to strengthen measures to ensure their protection and that of their families on the other.

The overall underfunding of health in the 2008 Consolidated Appeal Process (CAP) was a factor which affected the health situation in CAP countries. The overall funding received by WHO for the CAP 2008 covered 42% of the needs, while in the WHO African Region, it remained at around 37%. For CAP countries in the WHO Eastern Mediterranean Region, it was around 32%, and 96% for the other four WHO Regions (mainly the Region for the Americas and South-East Asia Region, which include a few of the appeals – recovery and transitional appeals for Cuba, the Lao People's Democratic Republic, Nepal, Sri Lanka, Timor-Leste, Tajikistan). Compared to the donor response to the CAP, health components in the flash appeals were funded at a level of around 50%, ranging from 33% to over 100%. Consequently, in many cases the overall objectives of the health sector in the CAP 2008 were only partially achieved.

The year 2008 also witnessed the roll-out of the cluster approach in 27 countries suffering from acute or chronic crises. In many countries, the work is just starting. Substantial resources are needed for the successful roll-out and implementation of the cluster at country level, both to assure the continuity and sustainability of the coordination, the recruitment of dedicated professional staff and the technical and logistic support health to interventions.

The effects of the sharp increase in food prices increased vulnerability within countries, societies and households. Countries will have to spend more resources for covering their food imports. The resulting gap in the governmental budget would be covered by cutting other sectors including health. This may also lead to re-distribution of re-

sources within the health sectors with gaps in the coverage of essential services. At the household level, the poorest households will be more directly affected. Higher prices will translate into an even poorer diet (as families reduce around 0.75% for every 1% increase in food prices) and shift the meagre income spent on other food to purchases of cereals, as well as reducing expenditures for health care.

Within the CAP 2009, the food price crisis was taken into consideration in the majority of countries. Monitoring the impact of the crisis on health and nutrition, nutritional interventions and surveillance were injected to the usual WHO package of interventions which traditionally consists of disease surveillance, communicable disease control, immunization, improving access to essential health services to vulnerable population and filling gaps in public health. All these represent a health safety network to prevent additional excess of morbidity and mortality of most vulnerable due to the food price crisis.

By the end of 2007, an estimated 33.2 million people were living with HIV globally, with an estimated 10 to 15% living in crises-affected countries. Failure to address the HIV-related needs of populations in crises will gravely jeopardize the progress made towards the universal access to HIV prevention, treatment and care for infected and affected communities. In countries like Zimbabwe, HIV/AIDS is one of the three major elements of the humanitarian crisis besides food insecurity and deteriorating services. For 2009, the health component of the CAP is very committed to strengthen the response to HIV in countries affected by humanitarian crises.

The 2009 Humanitarian Appeal culminates a dynamic process in 24 countries, territories and regions across the world and seeks to meet the most pressing needs of million of people in the Central African Republic, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Iraq and the neighbouring countries, the occupied Palestinian territory, Somalia, Sri Lanka, Sudan, Uganda, Zimbabwe as well as the West Africa Region. WHO global needs are around 139 million for 12 Appeals. The total health and nutrition part adds up to \$834 million which is around 11% of the total CAP requirement. Some CAPs included nutrition under food security, and this has not been reflected in this analysis.

The ongoing financial and economic crisis is a great challenge to humanitarian assistance in general and to the health sector in particular. Industrialized and higher income countries have convincingly demonstrated their willingness and capacity to mobilize thousands of billions of dollars to avert and mitigate the effect of the global financial and economic crisis. It is hoped that all these States and actors will demonstrate their political will to provide the necessary resources.

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Health Action in Crises  
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# Afghanistan

## Health Sector Needs Assessment

Afghanistan continues to have some of the most alarming health indicators in the world as a result of years of isolation and conflict. Life expectancy at birth is 43 years, slightly more than half that of the world's wealthiest countries. The infant mortality rate – one of the highest in the world – is 165/1000 live births. The under-five mortality rate is 257/1000 live births and the maternal mortality ratio is 1600/100 000 live births. 52% of the population are under 18 years

of age. The main causes of maternal death – haemorrhage, convulsions, obstructed labour and unsafe abortions – are all preventable with proper emergency obstetric care. Similarly, infant mortality rates could decrease by more than a third with proper care. Three preventable diseases – acute respiratory infections, diarrhoea and measles – are the leading causes of child mortality in the country. Chronic malnutrition, developed at a young age, translates into extraordinarily high prevalence rates of underweight children (40%) and of stunting (54%). Health and nutrition indicators were further exacerbated by a severe food shortage in 2008 due to drought, coupled with sudden and drastic increases in food prices, making food unaffordable for most low-income households.

The country has a high burden of communicable diseases such as TB and malaria. HIV/AIDS, while still at a low level, is a growing threat, the extent of which is not yet known. Lastly, as a direct consequence of the years of conflict, Afghanistan has a large number of people living with disabilities and mental health problems for whom treatment and rehabilitation services need to be developed.

Despite substantial foreign aid and health sector investments and progress made since 2003, the health situation in Afghanistan remains fragile. Most bilateral and multilateral donors give funds to support health sector recovery and development rather than primary health care or emergency response. The health and nutrition sector receives a negligible portion of government resources, accounting for only 3% of the overall operating budget and 5% of the development budget (*Health and Nutrition Sector Strategy 2008-2013*). Financing of the basic package of health services (BPHS), which is considered the cornerstone of the Afghan health system, is based on 2003 costs that



have not been adjusted to reflect changing needs and increased service delivery costs.

In the last two years, health agencies' ability to provide health services is being undermined by increasing insecurity, decreasing humanitarian space and the recurrence of natural disasters, including drought. This challenging environment hampers both the availability of and access to quality health services for vulnerable communities in insecure and under-served areas.

## Health Sector Priorities for 2009

- Maternal and child care at the community and health facility level, including basic emergency obstetric care at community health centres and comprehensive emergency obstetric care in district hospitals;
- Emergency preparedness and response capacity for communicable disease outbreaks and natural disasters;
- Access to emergency hospital care services;
- Access to primary health care in under-served areas (including services for persons living with disabilities);
- Availability of female-friendly health services; including family planning, medical response to gender-based violence and community sensitization of reproductive health needs;
- Advocacy for the equitable distribution of health services, including reproductive health services;
- Strengthen capacity of local stakeholders in health emergency management;
- Monitor quality of drinking water at health facility level;
- Waste product management and vector control at health facilities;
- Increase health seeking behaviours.

## WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Mainstreaming gender in the health system <b>AFG-09/H/23737/122</b>	211 500	MoPH
Ensuring national and provincial preparedness and response to the health crisis in Afghanistan <b>AFG-09/H/23738/122</b>	6 600 000	MoPH/Provincial MoPH
Strengthening the coordination and advocacy capacity of the health cluster at national and regional levels <b>AFG-09/H/23739/122</b>	1 950 000	Health Cluster partners (MoPH, NGOs & UN agencies involved in health)
Leishmaniasis control in Kabul <b>AFG-09/H/23742/122</b>	450 000	NMCLP, MoPH, GLCC

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
TB control activities in refugee camps <b>AFG-09/H/23744/122</b>	223 630	National TB Control programme/MoPH
Improve access of women and children to comprehensive maternal and child health care services in areas of high refugee returns and IDPs <b>AFG-09/H/23762/122</b>	2 412 850	MoPH, NGOs, UN agencies
Building capacity in emergency nutrition response <b>AFG-09/CSS/23789/122</b>	476 685	MoPH, UNICEF, NGOs

\* Amounts given in US dollars.

**Total funds requested: US\$ 12 324 665**

# Central African Republic

## Health Sector Needs Assessment

More than 200 000 Central Africans are still too scared to return to their villages. Concentrated in the northwest, 108 000 people live in internal displacement, most of them now for two or three years. Many others were recently forced to flee their villages because of banditry, renewed conflict between militant groups and government forces or incursions of foreign armed

groups such as the Lord's Resistance Army, which kidnapped at least 55 children in Obo and other places in the south-east in early 2008. Some 101 000 Central Africans continue to live as refugees in Cameroon and Chad. People who have lived through the conflict have experienced a total lack of health services and clean water.

In the conflict areas in the north, many health facilities have been destroyed or looted and many health staff have fled. Access to basic health care, including maternal and infant care, is limited. According to WHO, there were only 137 medical doctors (three for every 100 000 people), 294 state-licensed nurses and 240 midwives working in the entire country in 2006. As a result, the national vaccination coverage rate, which had reached a record level of 84.6% for DTP3,<sup>1</sup> could not be maintained. According to the Ministry of Health's disease surveillance reports, malaria remains the leading cause of morbidity (40% of consultations) and mortality (13.8% of deaths). Less than one family in five owns an impregnated mosquito net and only 15% of children under five sleep under a net.<sup>2</sup> Diarrhoeal diseases, often resulting from dirty water, are widespread in the north and south-east.

All indicators point to the gravity of the situation. Maternal mortality is one of the highest in Africa, at 1355/100 000 live births. The infant mortality rate is 106/1000 live births; under-five mortality is 176/1000.<sup>3</sup> This means that almost one child in five will not live to his or her fifth birthday. More than half of the population dies before their fortieth birthday, often a result of lack of clean drinking water and unhygienic conditions. More than 35% of Central Africans have to resort to unhealthy water sources such as surface water from rivers or ponds, and unprotected wells and springs. Only 26% have access to clean drinking water, and only 27% have adequate sanitation facilities.

HIV/AIDS prevalence is one of the highest in the sub-region: 6.2% of all Central Africans between 15 and 49 years (7.8% of women and 4.3% of men) are infected.<sup>4</sup> In



conflict areas, the vulnerability of adolescents to sexual violence is particularly high, with victims exposed to a heightened risk of sexually transmitted infections, HIV, unwanted pregnancies, unsafe abortions and psychological distress. The deterioration of health services hinders access to information and drugs for prevention, voluntary counselling and testing, and reproductive health services. Moreover, access to psychological care and support is extremely limited.

Health information among health organizations in the humanitarian community in CAR needs to be better coordinated, analysed and disseminated. Better capacity for conducting rapid assessments during emergency situations and identifying and filling gaps will help improve the timely and effective delivery of humanitarian assistance to vulnerable people.

## **Health Sector Priorities for 2009**

To provide an adequate response to urgent health needs generated by the crisis, humanitarian efforts will be concentrated on four areas:

### *1. Assessment*

- Assess humanitarian needs, identify gaps, monitor and prioritize health programmes.

### *2. Coordination*

- Strengthen the coordination of humanitarian activities in the health sector, particularly in emergency situations and with regard to vulnerable people;
- Decentralize coordination mechanisms by empowering regional health directorates;
- Establish a health information system and database;
- Reactivate the health technical sub-group on integrated disease surveillance and response, as well as disaster and crisis management committees at national and district levels.

### *3. Gap filling*

- Improve access to primary health care including the management of obstetrical and neonatal emergency care with referral and counter-referral systems, as well as kits, contraceptive and drug supplies;
- Improve access to sexually transmitted infections and HIV prevention services including voluntary counselling and testing, prevention of mother-to-child transmission of HIV and safe blood transfusion in conflict areas;
- Improve the capacity of health facilities to prepare for and respond to crises;
- Provide medical and psychosocial care to survivors of sexual violence, improve initiatives to prevent sexual violence and advocate for the establishment of an effective legal system.

#### 4. Capacity building

- Rehabilitate and revitalize health units by providing kits, equipment, communication systems and ambulances, and revamping communication, supervision and monitoring;
- Strengthen the capacity of health structures for active surveillance of diseases and adequate emergency response during epidemics and disasters;
- Decentralize hospital preparedness and response plans, involving local and national authorities;
- Promote community participation in the prevention of and response to sexually transmitted infections, HIV/AIDS and sexual violence;
- Train health organizations on the management of emergencies.

### WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Strengthening emergency obstetric and neonatal care in conflict affected zones <b>CAF 09/H/20573/122</b>	1 047 530	ACABEF, AMI, ASSOMESCA, IMC, IRC, JUPEDEC, MERLIN, MoH
Supporting the Health Cluster to better coordinate health activities during emergency situations <b>CAF 09/H/20579/122</b>	502 900	MoH, IRC, IMC, CAM, AMI, ASSOMESCA, ACABEF, CARITAS, ACF, MERLIN, CRS, CRCA, ICRC
Prevention and management of childhood illnesses in the conflict affected areas <b>CAF 09/H/20578/122</b>	823 900	ACABEF, ACF, AMI, ASSOMESCA, IMC, IPHD, IRC, JUPEDEC, MERLIN, MoH
Control of vaccine preventable diseases <b>CAF 09/H/20625/122</b>	823 900	AMI, ASSOMESCA, IMC, IRC, JUPEDEC, MERLIN, MoH
Strengthening the response against STIs, HIV and AIDS and sexual violence among uniformed services and adolescents in conflict affected zones <b>CAF 09/H/20570/122</b>	576 730	ACABEF, Assomesca, AMI, Caritas, COOPI, IMC, IRC, JUPEDEC, MoH, MoYouth
Support the national information health system <b>CAF 09/H/20593/122</b>	271 299	MoH
Post traumatic stress disorder and substance abuse management in conflict affected prefectures <b>CAF 09/H/20592/122</b>	329 560	
Prevention of and medical, psychosocial and community based <b>CAF 09/H/20569/122</b>	388 410	ACABEF, ACF, AMI, CAM, CIFAD, IRC, JUPEDEC, MERLIN, NRC

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Strengthening the integrated disease surveillance system for better support to the International Health Regulations in CAR <b>CAF 09/H/20575/122</b>	1 165 230	MoH and NGOs
Decentralize prevention and preparation activities for a prompt response to disasters and crises <b>CAF 09/H/20581/122</b>	775 750	
Preventive chemotherapy for neglected tropical diseases (NTDs) <b>CAF 09/H/21995/122</b>	648 248	

\* Amounts given in US dollars.

**Total funds requested: US\$ 7 353 457**

**Notes:** 1) Diphtheria/tetanus/pertussis vaccine, 3rd dose. 2) WHO (August 2008): *World Malaria Report 2008*. 3) MICS-3 (2006). 4) MICS-3 (2006).

# Chad

## Health Sector Needs Assessment

Chad is regularly hit by various types of emergency including meningitis, cholera and hepatitis E outbreaks, new waves of refugees and internally displaced people (IDPs), conflicts and floods. Most of these emergencies occur in the east and in the south where, apart from refugee camps, access to health care for displaced populations is limited or non-existent. There are no health services in the areas bordering Sudan that are home to hundreds of thousands of IDPs and returnees. Many humanitarian health partners have ceased activities permanently (for mandate reasons) or temporarily (due to insecurity).

Most of the humanitarian agencies that remain in the country are based in Abeche, eastern Chad. However, the size of the country does not allow these agencies to cover humanitarian needs in the southern areas. In eastern Chad, the referral system is beset by security problems and logistic difficulties. There are delays in responding to disease outbreaks: although an early warning system for epidemic-prone diseases has been established, weekly notifications arrive late or not at all. Many health centres are isolated and lack basic amenities such as radios that would allow them to communicate vital health information. Most of the health centres bordering Sudan have been looted and abandoned during repeated attacks and confrontations, with many health care workers among those fleeing the area. With the improvement of security conditions and the return of IDPs, eight health centres (Gongour, Allacha, Borota, Daguessa, Tissi, Tiero, Kawa, Daguessa) need to be urgently refurbished with equipment and essential drugs.

The main cause of morbidity mortality in eastern Chad remains malaria (average 22 to 24%) followed by diarrhoea and acute respiratory infections. WHO and the Ministry of Public Health recommendations on appropriate combination therapies are not implemented due to lack of resources. Drugs to treat tuberculosis are frequently in short supply.

Immunization coverage is below standard, with oral polio vaccine coverage at 66% in 2007 and 40% in the first half of 2008. As a result, previous polio control successes (only two cases in 2005 and one in 2006) have suffered a serious setback, with 21 cases detected in 2007. From January to October 2008, 26 cases were registered, including



one in Bredjiing refugee camp. There is a high risk of the further spread of the polio outbreak, with sub-regional and international implications.

Chad's maternal health indicators remain among the worst in Africa, due to the lack of pre-natal and delivery services and the poor referral system. Vaginal fistulae due to multiple pregnancies and unassisted deliveries frequently remain untreated.

Treatment programmes for HIV/AIDS in eastern and southern Chad are inadequate, despite an estimated HIV prevalence of 3.3% in the east and 10% in the south. There is a serious risk of a further spread of HIV in the country, given the dense population concentrations (Sudanese refugees and displaced persons in the east, Central African refugees to the south), the proliferation of other sexually transmitted infections and the lack of prevention and care programmes.

Moreover, the food price crisis will further aggravate the health and nutrition status of people already affected by the humanitarian situation. The rise in food prices, especially among populations living below the poverty line, will have a direct effect on their access to basic health services, since a large proportion of their health expenditure comes from out-of-pocket expenditures.

The cluster approach has been implemented in the country since 2007. Coordination and strategic planning need to be strengthened in the capital, N'Djamena.

## Health Sector Priorities for 2009

### *1. Access of vulnerable to essential health care*

- Strengthening existing health facilities (especially for referral systems);
- Increasing health coverage in areas not covered, including returnees;
- Providing essential medicines, vaccines and consumables, reproductive health kits, various diagnostic tests and nutritional inputs;
- Strengthening the capacity of health staff and community members for promotion, prevention and care;
- Implementing communication activities in the community;
- Improving the management of chronic and acute malnutrition cases;
- Implementing monitoring/surveillance activities and nutritional surveys;
- Supervision, monitoring.

### *2. Control of endemic and outbreak-prone communicable diseases*

- Capacity building for epidemic control committees;
- Pre-positioning of contingency stocks for emergencies and epidemics;
- Implementing epidemiological early warning and surveillance systems for the rapid detection and confirmation of outbreaks;
- Developing a comprehensive package for HIV control (screening, prevention, care).

### *3. Building the technical and coordination capacity of local and national health actors*

- Strengthening the health information system;

- Ensuring the presence of health coordination focal points in N'djamena and the field (Sarh and Goz Beida).

## WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Nutritional monitoring towards reducing morbidity and mortality <b>CHD-09/H/20479/122</b>	168 650	MoH, UNICEF and ACF
Maintaining existing presence in the east and filling the gaps of Health Cluster functions in N'Djamena and southern Chad <b>CHD-09/H/20481/122</b>	760 342	MoH and all the health partners
Reinforcing disease surveillance and emergency health response in Chad <b>CHD-09/H/20485/122</b>	1 100 966	MoH, health NGOs and Red Cross
Improving access to health care for IDPs and host populations in east Chad <b>CHD-09/H/20488/122</b>	507 870	MoH; IRC; IMC, Red Cross, PSF
Maintaining ongoing emergency HIV health actions in eastern and southern Chad <b>CHD-09/H/20490/122</b>	1 697 752	MoH, UNAIDS, NGOs
Supporting polio surveillance and control programmes among the affected population especially refugees and IDPs <b>CHD-09/H/20494/122</b>	2 500 000	MoH, health NGOs and Red Cross
Monitoring the food price crisis and responding to its impact on health <b>CHD-09/H/20495/122</b>	500 000	MoH, UNICEF, WFP and NGOs

\* Amounts given in US dollars.

**Total funds requested: US\$ 7 235 580**

# Côte d'Ivoire

## Health Sector Needs Assessment

Côte d'Ivoire has experienced at least one major disease outbreak every year for the past five years, including yellow fever (2005, 2006 and 2008), cholera (2005 and 2006) and meningitis (2005, 2006, 2007 and 2008).

A 2006 survey – before the food price crisis – revealed the national prevalence of acute malnutrition in children under five was 7% in 2006, with stunting prevalence rates of 33.9% and wasting prevalence of 14.9% among children 12–23 months old. A more recent survey conducted by WFP indicated a much higher (17%) prevalence

of acute malnutrition in under-five children in the northern regions of the country. Unfortunately, nutrition is not yet included in the national routine disease surveillance system, making it difficult to capture the trend in “real time”. The current food price crisis will certainly lead to increased acute malnutrition rates in under-five children. Therefore, providing health care to children with malnutrition and strengthening nutrition surveillance are sectoral priorities.

According to the 2005 AIDS indicator survey, HIV/AIDS prevalence among the general population is 4.7%, ranking Côte d'Ivoire as the worst affected country in West Africa. Women pay the highest price (6.4% female and 2.9% male prevalence). Besides, UNAIDS estimates there were 420 000 HIV/AIDS orphans in Côte d'Ivoire in 2007.

As the prospects of political progress and stability increase, more and more IDPs will continue to return to their areas of origin. Providing health and other social services to returning IDPs is one of the cornerstones of the peace process. Community sensitization on HIV/AIDS needs to be reinforced, and prevention services made available to the most vulnerable groups, including as teenage girls in IDPs' areas of return.



## Health Sector Priorities for 2009

### 1. Strengthening emergency health coordination

- strengthening coordination among humanitarian partners;
- setting up mechanisms for exchange of health information, concerted strategic planning;

- supporting the coordination capacity of the Ministry of Health.
2. *Improving health sector capacity to provide quality primary health care services*
    - Supporting the country in scaling up effective nutrition actions and improving vaccination coverage;
    - Ensuring access to essential reproductive health services and quality emergency obstetric care and commodities for most vulnerable populations, incorporating HIV/AIDS prevention and response activities.
  3. *Advocate to national authorities the need to improve access and quality of primary health care services for the most vulnerable populations*
    - Sensitizing the community on special needs of vulnerable groups such as people living with HIV/AIDS, pregnant women and lactating poor mothers.
  4. *Improving health information systems*
    - Supporting the improvement of national health and nutrition surveillance systems.
  5. *Regular monitoring and evaluation of the effect of the food price crisis on the health status of the vulnerable populations*
    - Monitoring the health and nutritional status of most vulnerable population groups through existing health and nutrition surveillance systems and in collaboration with partners in other sectors.

## WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Integrated nutrition surveillance for under-five children in western and northern most affected health districts of Côte d'Ivoire: Bangolo, Biankouma, Danane, Man ( <i>Montagnes</i> ); Duekoué, Guiglo, Touleupleu ( <i>Moyen Cavalley</i> ); Boundiali, Ferkessiédougou, Korhogo, Tengrela ( <i>Savanes</i> ) <b>CIV-09/H/22018/122</b>	1 125 683	MoH, UNICEF, UNFPA, NGOs

\* Amounts given in US dollars.

**Total funds requested: US\$ 1 125 683**

# Democratic Republic of the Congo

## Health Sector Needs Assessment

The Democratic Republic of the Congo (DRC) has one of the highest maternal mortality rates (1289/100 000 live births, according to 2007 UNFPA estimates) and infant mortality rates (213/1000 live births) in the world. Maternal mortality in the east is estimated to be double the average for sub-Saharan Africa. The majority of deaths are caused by preventable diseases including acute respiratory infections, malaria, diarrhoea, acute infections and measles, worsened by malnutrition. Malaria accounts for about 45% of infant mortality. Polio eradication efforts have been compromised, with five new cases reported in four provinces in 2008.



The health system has been severely weakened by dilapidated infrastructures, shortages of health care workers and poorly organized health services. The *Humanitarian Plan of Action for the DRC* identifies thresholds for interventions including key indicators such as acute malnutrition and disease outbreaks.

Eastern DRC is particularly affected by conflicts and epidemic diseases. At the end of 2008, North Kivu was the arena of a major conflict between rebels and the Government. Both North and South Kivu have been hit by recent cholera outbreaks (130 new cases and three deaths were reported in North Kivu during the second week of the outbreak, with 320 new cases and one death in South Kivu during the same period).

Kasai Occidental is dealing with its second Ebola outbreak in three years, with 49 suspected cases and 15 deaths (case fatality rate 31%) affecting eight villages in Mweka and Demba health zones.

The quality of health care staff is a critical issue. Government salaries are extremely low, and training programmes are inadequate. Most state hospitals have implemented a system of self-financing that requires patients to pay for treatment and medicine: this severely limits access to government health care for the very poor. The overall rate of use of public health services is around 22%. Other health providers include faith-based or NGOs. Access to health care is very limited or non-existent in some areas.

The Health Cluster has identified 193 out of 515 health zones (37%), located throughout the country as being emergency zones. Around 25.5 million people – more than a third of the population – live in these zones.

## Health Sector Priorities for 2009

Four priority areas of action have been identified by the Health Cluster:

1. *Implementation of essential action for the survival of mothers and children*
  - Reduced risk for maternal mortality and morbidity;
  - Obstetrical and neonatal emergency care;
  - Essential care for newborn children;
  - Evaluation and treatment of paediatric emergencies;
  - Safe blood transfusion;
  - Prevention of mother-to-child transmission of HIV/AIDS;
  - Vaccination in emergency situations.
2. *Preparedness and response to epidemics*
  - Strengthening capacity of epidemic response teams;
  - Pre-positioning of strategic response stocks;
  - Rapid investigation of epidemics and evaluation of public health needs of affected populations;
  - Health promotion and strengthening of social mobilization;
  - Strengthening of epidemiological surveillance.
3. *Strengthening of technical and institutional capacities*
  - Training of health care providers in emergency health care;
  - Training of communities in community-based surveillance and alert;
  - Provision of medical stocks;
  - Minimal rehabilitation of health structures.
4. *Monitoring and evaluation of emergency action*
  - Coordination and partnership as guiding principles for the management of emergencies;
  - Management of information on emergencies (collection and dissemination);
  - Filling gaps;
  - Mobilization of additional resources.

## WHO Proposed Projects in the CAP 2009

The total *Humanitarian Action Plan for the Democratic Republic of the Congo* amounts to US\$ 831 005 696 of which **US\$ 131 535 858** are dedicated to the health sector. WHO needs are estimated to be US\$ 10 million.

# Iraq and the Region

## Egypt

### Health Sector Needs Assessment

Most Iraqi refugees live in Cairo in areas where access to affordable and comprehensive public health care close to their homes is scarce. The majority of those registered with UNHCR use health care services provided by Caritas. Access to specialist psychosocial and mental health services is very limited. Iraqi children of primary and secondary school age who are not able to enrol in public schools in Egypt attend expensive private schools (fees for which range between 1400-5000 EGP).



### Health Sector Priorities for 2009

Agencies participating in the CAP for Egypt (IOM, UNFPA, UNICEF, UNHCR and WHO) have submitted projects in the fields of protection, health, education, support to vulnerable groups and voluntary return, some of which are supported and implemented by partners, including Caritas and the Catholic Relief Services.

In the field of health, activities include improving the capacity of public and other health facilities to provide services to refugees, asylum seekers and nationals alike, including in the fields of reproductive and psychosocial health.

Projects under the CAP will be followed through periodic meetings between participating agencies coordinated by UNHCR.

### WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Strengthening health information for evidence-based decision-making in the health sector IRQ 09/H/20968/122	141 240	MoHP, Caritas

Management of displaced Iraqis with life-threatening diseases (cancers, renal failure, thalassaemia, and coronary insufficiency) <b>IRQ 09/H/20967/122</b>	270 710	MoHP, private tertiary level facilities
<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Improving health awareness among the displaced Iraqi population <b>IRQ 09/H/20966/122</b>	141 240	MoHP and Caritas
Strengthening capacity for the management of chronic diseases at the primary health care level <b>IRQ 09/H/20965/122</b>	400 180	MoHP

\* Amounts given in US dollars.

**Total funds requested: US\$ 953 370**

# Iraq

## Health Sector Needs Assessment

Access to essential health services remains difficult for conflict-affected communities in Iraq. Recent data<sup>1</sup> indicate that 24 out of 114 districts in eight governorates<sup>2</sup> are considered highly vulnerable, with diphtheria, pertussis, tetanus (DPT1) immunization coverage below 80% (first dose). Children and pregnant women are among the most affected, leading to increased risks of morbidity as well as child and maternal mortality. Under-five mortality rates (46/1000)<sup>3</sup> and maternal mortality rates (84/100 000)<sup>4</sup> are high for the region. Eight governorates<sup>5</sup> reported institutional deliveries below the national average of 62.4%.<sup>6</sup> Diarrhoea and acute respiratory infections, further compounded by malnutrition, account for about two thirds of deaths among the under-five population. In the second half of August 2007, cholera outbreaks were reported due to the poor quality of drinking water, poor sanitation and dilapidated infrastructure. As of 17 September 2008, 21 districts across seven governorates had reported a total of 162 lab-confirmed cholera cases, with a fatality rate of 16%. This raises public health concerns regarding case management protocols. The low immunization coverage in the last four years (measles coverage dropped to less than 50% in 26 governorates)<sup>7</sup> has resulted in an increased cumulative number of susceptible cases that led to an ongoing measles outbreak in early 2009 with so far more than 6000 cases.

Although the number of returnees is slowly increasing, the Iraqi health care delivery system is struggling to cope with the extra burden generated by thousands of IDPs. To encourage greater numbers of IDPs to return to their homes, conditions for reconciliation and return must be in place and access to income/employment, health services, food and shelter must improve. In the meantime, the living conditions of displaced, returnees, and other conflict-affected populations continue to deteriorate, especially for vulnerable groups such as women and children.

Although national average indicators for wasting and underweight are relatively low, they remain unacceptably high in eight out of 18 governorates. This is compounded by high rates of low birth weight (14% as per 2006 Multiple Indicator Cluster Survey [MICS] 3), with inadequate infant and young child feeding practices (the exclusive breastfeeding rate for <six months is 25%) and possible micronutrient deficiencies.



Around four million Iraqis suffer from hypertension and one million from diabetes. However, shortages and rationing at primary health care centres prevent treatment of these and other chronic diseases. Despite recent improvements, there is a reported shortage of at least ten out of 32 standard drugs for chronic illnesses. This problem is more severe in the conflict-affected areas because of distribution difficulties. Moreover, an estimated four% of the population suffers from severe mental disorders and another 20% from common mental health problems<sup>8</sup> as a result of the security situation.

## Health Sector Priorities for 2009

- Strengthen the Ministry of Health (central and local level) capacity in humanitarian coordination and health emergency management and response;
- Support the generation of decentralized health information to enable early detection of and response to communicable disease outbreaks;
- Support the delivery of life-sustaining essential services such as maternal, child, reproductive health, emergency obstetric care, community management of malnutrition and psychosocial support, including psychosocial first aid and services, to individuals and groups at risk;
- Provide essential health and nutrition supplies, focusing on vulnerable groups.

## WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Life saving public health intervention package to most vulnerable crisis affected population in Iraq <b>IRQ 09/H/23537/122</b>	6 500 000	MoH/DoH, LNGOs, INGOs, NGOs
Improving access to safe water for schools and most vulnerable communities in Kerbala, Basra, Babil and Baghdad governorates <b>IRQ 09/WS/20248/122</b>	1 920 000	UN-HABITAT, WHO, MMPW, MoH, MoEnv, MoE, DoEs/DoHs Babil, Basrah, Baghdad, Kerbela
Curtailing spread of cholera among most vulnerable rural population in Babil governorate <b>IRQ 09/WS/20236/122</b>	792 000	MoMPW, MoH, MoEnv, NGOs

\* Amounts given in US dollars.

**Total funds requested: US\$ 9 212 000**

**Notes:** 1) MoH-WHO supported routine surveillance data Jan-Jun 2008. 2) Baghdad, Ninawa, Diyala, Anbar, Wassit, Salah Al-Din, Dahuk and Sulaymaniyah. 3) *State of the World's Children Report*, UNICEF 2008. 4) Iraq Family Health Survey, 2007. 5) Baghdad, Basrah, Ninawa, Anbar, Babel, Kerbala, Muthana, Najaf. 6) MoH Statistics 2007. 7) Ref. March 2008 WHO/UNICEF joint reporting. 8) AIMS Report: WHO 2006.

# Jordan

## Health Sector Needs Assessment

Iraqi refugees, with scarce resources and limited employment opportunities, have pressing health needs. Priorities include access to quality health services, including mental health care and treatment for chronic diseases and life-threatening conditions. There is a general lack of health information to guide decision making for health service providers and Iraqi refugees. In addition, an increasing proportion of Iraqi refugees live in peripheral areas which lack health outreach services.

UNICEF and WHO are conducting, together with Johns Hopkins University, a health needs assessment survey (quantitative and qualitative). The national survey covers areas where displaced Iraqis are known to reside, both inside and outside Amman. While smaller-scale studies have been conducted by various partners working in the field of health, this study will provide a comprehensive overview of the situation faced by Iraqi refugees.

Consultations with beneficiaries have highlighted the need for quality services, especially for chronic diseases and mental health, and for health awareness programmes. Some especially vulnerable groups need secondary and tertiary services (i.e. the disabled and people with life-threatening diseases that need programmed interventions).

## Health Sector Priorities for 2009

- Work with the MoH and other national partners to ensure access of Iraqis to quality health services, especially for chronic diseases, mental health, life-threatening diseases, child health and nutrition and reproductive health;
- Develop unified quality treatment protocols and working procedures between different NGOs and Ministry of Health;
- Monitor health card system for extremely vulnerable Iraqis, and evaluate the impact on the level of assistance provided to vulnerable groups;
- Establish harmonized and standardized health information system to improve decision making and monitoring, building upon WHO improvements related to UNDAF-funded activities;



- Strengthen coordination among health partners through health coordination meetings, harmonizing health programmes and activities, avoiding duplication and mobilizing resources;
- Coordinate with the Outreach Working Group to identify available clinical mental health services;
- Conduct training to facilitate better identification of mental health issues by primary health care providers in conjunction with the Psychosocial Working Group;
- Support the Ministry of Health through the bilateral procurement and provision of general and essential drugs;
- Raise awareness of and attain reliable information on reproductive health, including family planning, and STI/HIV/AIDS preventive treatment.

## WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Strengthening health information for evidence-based decision-making in the health sector <b>IRQ 09/H/20465/122</b>	329 560	MoH, Jordan Red Crescent, Caritas Jordan, Jordan Health Aid Society, private sector
Management of displaced Iraqis with life-threatening diseases (cancers, renal failure and thalassaemia) <b>IRQ 09/H/20466/122</b>	3 001 350	King Hussein Cancer Foundation/Centre, JAHT, MoH, private sector
Strengthening mental health care at the primary, secondary and tertiary levels of care <b>IRQ 09/H/20467/122</b>	776 820	MoH
Practical approach to nutritional deficiencies among displaced Iraqi children <b>IRQ 09/H/20468/122</b>	235 400	Noor Al Hussein Foundation: Institute for Family Health
Development of community mental health centre to assist displaced Iraqi children <b>IRQ 09/H/20463/122</b>	423 720	MoH, national and international NGOs
Provision of drugs for chronic diseases <b>IRQ 09/H/20464/122</b>	1 765 000	MoH
Strengthen the stakeholders and their responsibilities to scale up services for displaced Iraqis suffering from mental disorders <b>IRQ 09/H/20441/122</b>	428 000	MoH, IRD, CARE, IMC, ICMC

\* Amounts given in US dollars.

**Total funds requested: US\$ 6 959 850**

# Lebanon

## Health Sector Needs Assessment

While Lebanon is known for the quality of its medical services, these come at a high price. Although primary health care centres are generally found throughout the country, medical care for chronic patients and secondary interventions are expensive and doctors and hospitals normally require a guarantee of payment. As a result, refugees, who normally do not possess any health insurance, must cover most health care costs themselves. The 2007 Danish Refugee Council Survey found that 43% of Iraqi respondents paid for natal care themselves (as opposed to 49% by NGO and charity organizations); 68% paid themselves for chronic health care (27% by NGO and charity organizations); and 68% paid themselves for treatment of acute illness (24% by NGO and charity organizations). These figures suggest that while external assistance is available, refugees continue to shoulder the cost of medical care. Iraqi refugees have even more limited access to mental health care due to its high cost and scarcity of services. In the meantime, there is a significant need for psychosocial care among the Iraqi refugee population, given the level of violence and human rights violations experienced in Iraq. A report prepared by IOM in February 2008 concluded that 34% of Iraqi refugees in Lebanon were exposed to highly traumatizing events.<sup>1</sup>



## Health Sector Priorities for 2009

### Prevention

- Health education for the refugee community in order increase awareness on important topics including child nutrition, immunization, childhood diseases, maternal health care, and personal hygiene;
- Immunization of at least 80% of under-five children (according to the National Vaccination Programme);
- Develop a response mechanism for substance abuse cases;
- Develop awareness of and response to sexually transmitted infections, e.g. HIV/AIDS.

### *Health information system (HIS)*

- Establish a multifunctional committee working with a programmer to develop a HIS;
- Introduce the system to partners and train working staff.

### *Mental health care*

- Provide rehabilitation services for victims of torture, poly-traumatized and people with special needs;
- Strengthen skills for psychological and mental health support among health professionals;
- Raise awareness on Iraqi refugee psychological and social needs among caregivers.

### *Accessibility*

- Capacity-building for health caregivers;
- Providing health care, focusing on maternal healthcare;
- Establishing mobile clinics and providing outreach health services outside cities.

## **WHO Proposed Projects in the CAP 2009**

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Supporting public health functions needs for Iraqi refugees in Lebanon 2009 <b>IRQ 09/H/20954/122</b>	219 220	MoPH, local NGOs

\* Amounts given in US dollars.

**Total funds requested: US\$ 219 220**

**Notes:** 1) *Assessment of psychosocial needs of Iraqi displaced in Lebanon and Jordan*, IOM, February 2008.

# Syria

## Health Sector Needs Assessment

The arrival of large numbers of Iraqis over recent years has placed a severe strain on the Syrian health system, which has provided Iraqis access to the same health care as for Syrians. Consolidated figures reported by the Syrian MoH<sup>1</sup> show that the number of people using primary health care (PHC) centres increased by over 2.7 million between 2004 and June 2008. This increase corresponds to movements of Iraqis into Syria. In addition to PHC centres, more specialized treatments are provided by hospitals or specialist institutions. Data from these institutions indicate that a significant number of Iraqi patients need costly treatments for various types of cancer, heart, renal or chronic diseases.



UNHCR registration, health and morbidity data show that of the total number of registered Iraqis (220 000), 19.2% have medical problems and 2.4% disabilities. The disease profile is dominated by chronic illnesses such as hypertension and diabetes. Registration data also indicate an increasing incidence of acute mental and psychosocial distress, often occurring alongside physical conditions caused by torture and violence. Many Iraqi refugees also require emergency medical interventions.

Reproductive health services and follow-up referral for Iraqi women are needed. The immunization and nutrition status of children is another priority, along with the status of pregnant women. The poor polio immunization rates of Iraqi refugee children could potentially threaten the polio-free status of Syria. Lastly, the population increase with the arrival of Iraqi refugees has affected sanitary conditions in many areas, in particular water and waste disposal, bringing the risk of epidemics and waterborne diseases.

Improving data collection and creating a standard health information system across service providers are also priorities.

## Health Sector Priorities for 2009

- Strengthen the quality of Syrian health care where Iraqis live (including reproductive/child health) and integrate mental health/psychosocial/support services;
- Utilize and consolidate current information and surveillance systems;
- Ensure effective referral mechanisms for secondary and tertiary health services;

- Undertake community mobilization/empowerment/awareness-raising among Iraq refugee families and host communities;
- Standardize the methodology for building the capacity of healthcare providers;
- Facilitate coordinated and integrated government, SARC, private sector, United Nations and NGO health responses for Iraqi refugees;
- Maintain environmental health activities, including waste management and improved access to potable water in vulnerable host communities;
- Provide immunization and coverage measurement support;
- Provide emergency obstetric care.

## WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Improving the quality of mental health services at all health care levels <b>IRQ 09/H/21255/122</b>	588 500	MOH, the Syrian Arab Red Crescent (SARC)
Improving environmental health services in areas where Iraqis are residing <b>IRQ 09/H/21249/122</b>	706 200	MOH, Ministry of Local Administration and Environment
Immunisation against targeted diseases for Iraq refugee children in Syria <b>IRQ 09/H/21045/122</b>	354 000	MOH
Strengthening the health information, surveillance and response systems <b>IRQ 09/H/21251/122</b>	676 775	MoH, SARC
Improving access to and quality of secondary and tertiary health care services <b>IRQ 09/H/21256/122</b>	1 594 835	MoH
Interagency Initiative for Training of Master Trainers in Psychosocial Support and Mental Health to Refugees <b>IRQ 09/H/21209/122</b>	288 400	SARC, MOH, MoE, UNHCR, UNICEF, UNFPA, IMC

\* Amounts given in US dollars.

**Total funds requested: US\$ 4 208 710**

**Notes:** 1) The Ministerial Consultation on the Health Needs of Displaced Iraqis living in Neighbouring Countries, held in Damascus in July 2007, agreed not to create a parallel system for refugees, so Iraqi refugees now use the same health facilities and services as Syrians.

# Kenya

## Health Sector Needs Assessment

Recent natural and human disasters in Kenya include drought, floods, civil strife and mass displacement, disease outbreaks (Rift Valley fever, acute watery diarrhoea, cholera, Kala Azar, acute flaccid paralysis), earth tremors and landslides. The morbidity, mortality, disability and psychosocial trauma caused by these events has placed a severe strain on emergency systems and on basic and primary health care services.

In 2008 there were cholera outbreaks in several areas, with 2166 cases of cholera and 83 deaths reported as of July. A further 174 cases of Kala Azar and nine deaths were also recorded. Kenya's HIV epidemic prevalence rate remains high at 7.8%.

The post-election violence that gripped the country in early 2008 significantly disrupted emergency primary health care structures and services. Rapid assessments conducted by WHO and the Ministry of Health in May 2008 revealed a drop in most emergency health and life-saving indicators. National coverage for the fully immunized dropped from 79% to 65% between March 2007 and March 2008. Surveillance reporting rates fell from 80% in late 2007 to 40% in March 2008. Antenatal care and family planning services offered in health facilities dropped by 17% and 12%, respectively, and TB case notification rates dropped by 12%. Basic emergency systems and primary health care services were affected, and many health care workers were themselves displaced.

Kenya is also affected by the food price crisis. Acute malnutrition has risen significantly, with around 3.8 million people at risk of food insecurity. Up to 95 000 children under-five and pregnant and lactating women are receiving food supplementation. Surveys conducted in eight districts between March and April 2008 indicated nutritional levels of between 20 and 29.8% global acute malnutrition while severe acute malnutrition was between 1.2% and 3.5%. The capacity of partners and the Ministry of Health to diagnose malnutrition is poor, and many health care providers have not been trained to handle severe malnutrition cases. Given Kenya's poor health infrastructure and its location in an epidemic zone, the risk for concurrent disease outbreaks in 2009 is extremely high.



Kenya is hosting over 217 000 refugees in Dadaab and another 50 000 in Kakuma. With the deteriorating political situation and insecurity in Somalia, more refugees are expected to arrive in 2009. The fragile health infrastructure in the camps and in host communities may collapse if resources are not made available.

Cross-border emergency health issues in the Horn of Africa, particularly Kenya, have become a serious concern. All major disease outbreaks such as cholera, Rift Valley fever, poliomyelitis and Kala Azar occur concurrently along Kenya's bordering neighbouring areas. Somalia, southern Ethiopia, northern Uganda and southern Sudan all have poor health infrastructures, and pose serious public health challenges for cross-border cooperation and emergency health response.

## Health Sector Priorities for 2009

- Establish emergency early warning systems for disease, malnutrition and water quality surveillance;
- Support 30 provincial and district teams for prompt diagnosis, disease outbreak investigation including laboratory kits and case management;
- Hire short-term local staff for disease outbreak response;
- Procure personal protection equipment for haemorrhagic fevers;
- Procure disinfectants for cholera treatment units and other isolation wards;
- Train and equip district and provincial emergency health response teams in 30 districts hosting IDPs, refugees and in the Arid and Semi-arid Land (ASAL) and semi-arid areas on emergency preparedness and contingency planning;
- Conduct joint rapid health and nutrition assessments and emergency activities monitoring the vulnerable populations;
- Train health workers in the provision of psychosocial support to affected populations;
- Provide basic health care services (drugs, emergency health kits) for identified vulnerable populations;
- Provide essential secondary health care drugs, kits and services for especially vulnerable groups such as HIV and TB cases, patients requiring psychological support, etc.;
- Facilitate coordination and health information management in IDP and refugee camps and ASAL and semi-arid areas.

## WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Addressing psychosocial and community health needs of mobile, host and vulnerable populations in Rift Valley (Uasin Gishu & Lugari Districts) <b>KEN-09/H/20875/122</b>	345 000	MoH (MMS & MPHS), WHO, Provincial/District teams, provisional and district hospitals

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Essential integrated health services for marginalised and vulnerable populations in Kenya <b>KEN-09/H/20367/122</b>	535 000	MoH, Merlin, IMC, KRC, AMREF, Catholic Secretariat, CHAK, CBOs, OCHA/WFP, UNHCR, WW, KEMRI, UoN
Emergency health response to vulnerable populations in Kenya <b>KEN-09/H/20487/122</b>	3 103 000	Provincial/District Health teams, GTZ, IRC, MERLIN, HENNET, FBOs, CBOs
Emergency health response for refugees in Kenya <b>KEN-09/H/20723/122</b>	609 900	Provincial/District Health teams, GTZ, IRC
Emergency health response for severe and complicated (medical) malnourished children in 12 district hospitals in most affected areas in Kenya <b>KEN-09/H/20826/122</b>	556 400	Provincial/District hospitals

\* Amounts given in US dollars.

**Total funds requested: US\$ 5 149 300**

# Nepal

## Health Sector Needs Assessment

Major floods in 2008 and continued unrest in Central and Eastern Terai regions reconfirm the necessity to strengthen health sector emergency preparedness and response in Nepal. The combined impact of the internal conflict and natural disasters has led to increased health needs, while the overall capacity of the health care system has declined. The health system has been particularly affected in the mid and far western regions in Nepal. Health infrastructures have been damaged; security constraints have restricted movement; supply chains are inadequate; and health staff are poorly trained and have a high turnover rate, especially in peripheral health facilities.

The impact of the Koshi River flooding will continue to be felt in 2009. Access to, and quality of, public health services, including reproductive health services, remains inadequate, with the presence of acute diarrhoea, cholera, acute respiratory infections and measles.

Counselling services for trauma cases are insufficient, and there is virtually no patient referral system. Children under five and women of reproductive age remain most vulnerable in emergencies, as illustrated by maternal, infant and child mortality rates. Recent population-based estimates reveal that one in every ten women of reproductive age is suffering from uterine prolapse,<sup>1</sup> a curable reproductive health condition which severely impedes the lives of women. Civil unrest and different armed groups in Nepal are also associated with increased sexual violence and transmission of sexually transmitted infections including HIV/AIDS.<sup>2</sup> Physical and psycho-social care for survivors of sexual violence remains largely unaddressed.

In addition, the recent global food price crisis has further aggravated the health and nutritional status of people already affected by the conflicts and natural disasters. Higher food prices have led to the reduced use of health care services, as families use their scarce income to buy food and have no resources to pay for health care. A WFP vulnerability assessment indicated that 31% of surveyed households reported a serious illness in the family over the past twelve months.

As Nepal goes through an important political transition, peace building, recovery and reconstruction are a priority for all sectors including health. The Ministry of



Health and Population is under great pressure to reactivate health care facilities and increase the delivery of effective and equitable health services.

## Health Sector Priorities for 2009

- Expand delivery of essential HIV services to affected populations in emergency and transitional settings;
- Ensure health coordination between humanitarian and development partners during disaster response and recovery operations, including strengthening referral services;
- Ensure coordination between hospitals for timely health care services;
- Support the delivery of essential health care services, especially with regard to reproductive health, newborn care and HIV/AIDS prevention and treatment to reduce excess mortality and morbidity;
- Provide and pre-position essential emergency medicines, equipment and health kits;
- Improve access to physical rehabilitation services for disabled people affected by the conflict;
- Intensify the disease surveillance and reporting system.

## WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Emergency Health Preparedness and Response <b>NEP-09/H/H/23646/122</b>	1 942 050	MoHP, Nepal Red Cross Society, UN agencies, NGOs

\* Amounts given in US dollars.

**Total funds requested: US\$ 1 942 050**

**Notes:** 1) Uterine prolapse is a downward displacement of uterus from its normal location inside the pelvis. It ranges from first to third degree prolapse, when the uterus extends outside of the body. 2) In Nepal, there is considerable increase in the number of HIV infection since 1996 when conflict started. YOUANDAIDS (2005). Nepal at a glance: HIV Situation. <http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/Nepal/index.asp#>. Scenario cited in *HIV and conflict in Nepal: Relation and strategy for response*, Karkee R, Shrestha DB, School of Public Health, BP Koirala Institute of Health Sciences, Dharan, Nepal Kathmandu University Medical Journal (2006), Vol. 4, No. 3, Issue 15, 363-367.

# occupied Palestinian territory

## Health Sector Needs Assessment

The general health situation in the occupied Palestinian territory (oPt) shows that growing difficulties for the Ministry of Health and its partners in ensuring the provision of and access to quality health services have increased the need for humanitarian assistance in health in the whole of the oPt. There is a need to address the gaps in essential service delivery, specifically in areas with severe access restrictions, as well as to strengthen communities' capacities to deal with health emergencies. Effective information sharing and coordination at all levels need to be maintained and strengthened to ensure that emergency health needs are identified and addressed in an effective and efficient manner. The promotion of health as a human right remains of the utmost importance and calls for advocacy focusing on improvements in access and other essential health issues.

Between 27 December 2008 and 18 January 2009, Israeli forces conducted a major military operation in the Gaza Strip, resulting in extensive casualties and destruction of homes, livelihoods and infrastructures, and further weakening the health system. According to the Palestinian Ministry of Health, 1326 Palestinians were killed during this period, including an estimated 430 children and 110 women, and 5450 were injured, including 1855 children and 795 women. Sixteen out of 27 hospitals and 38 primary health care clinics in the Strip were damaged during the hostilities. Health personnel were themselves victims of the conflict, with 16 killed and 22 injured while on duty. A Flash Appeal for Gaza was issued on 2 February 2009. It includes detailed information on the health sector situation, the specific needs, the health sector response strategy and planned projects in Gaza.

## Health Sector Priorities for 2009

### *Access to essential health services*

Ensure that people living in these areas have access to essential health services:

- The Gaza Strip 's Khan Younis East villages and the eight refugee camps;
- Southern West Bank Area C: communities near settlements and military zones, H2 in Hebron City;



- Central West Bank, East Jerusalem, Biddu area, Al Jib area, An Nabi Samwil, Khalili, Beit Iksa, Area C Jerusalem District;
- Jordan Valley e.g. Jiftlik, Bardala, E.Beidah, Jahaleen;
- West and northwest villages of Ramallah e.g. Ni'lin, Bilin, Rantis, Qibya;
- South East Nablus–B.Furiq, Asirah Qibliyah; South East Nablus–Azmout, Salim, Madama and areas near settlements;
- Qalqilya, Salfi, Jenin and Tulkhareh: communities surrounded by the Barrier and close to the Barrier as well as in proximity to Israeli infrastructure;
- Tukarem: villages close to the Israeli industrial zone.

Specific targets include vulnerable groups such as neonates, children and women, pregnant women at high risk, the elderly, disabled and chronically sick, Bedouin, herders and people with mental health problems. Existing services will be strengthened and mobile clinics made available. Assistance with transportation of patients to secondary and tertiary care will also be provided.

#### *Health as a human right*

Advocacy is essential to highlight and address obstacles to access and improved health care. Priority will be given to increasing awareness of the right to health and the most flagrant violations of that right. Access difficulties will be documented. Activities include the formulation of a joint advocacy strategy with the Ministry of Health and other agencies, media campaigns, workshops and dialogue with the Israeli authorities.

#### *Information and coordination*

Coordination mechanisms at central and district levels will be strengthened to improve identification of emergency health needs and the delivery of appropriate assistance. A health-facility database (currently being updated by WHO and the Ministry of Health) will be used to review priorities. Data will be consolidated for more effective joint planning. A joint monitoring framework will be developed and implemented by the Ministry of Health.

#### *Community empowerment*

There will be greater emphasis on empowering communities to reduce health risks, promoting community risk mapping, healthier life-styles and behaviours, and identifying how basic health needs can be more effectively met.

### WHO Proposed Projects in the CAP 2009

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Advocacy for access to health as a fundamental human right (Early Recovery) <b>OPT 09/H/20574</b>	226 305	MOH, UNICEF, UN-RWA, Care, MSF, MAP, HI, Merci, Merlin, SC
Strengthen emergency preparedness and response of the health sector in the oPt (Early Recovery) <b>OPT 09/H/20576</b>	187 000	

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Improved access of patient and staff to East Jerusalem hospitals (Humanitarian) <b>OPT 09/H/20584</b>	502 900	EJH association, PRCS
Procurement of pharmaceuticals for MoH strategic buffer stock in Gaza (Humanitarian) <b>OPT 09/H/20585</b>	2 824 965	MoH, ECHO, Norway, Italy, OCHA
Monitoring health trends in emergency (Early Recovery) <b>OPT 09/H/20586</b>	52 650	MoH
Nutrition surveillance system (Early Recovery) <b>OPT 09/H/20587</b>	204 750	MoH, UNICEF, UNRWA, Care, MSF, MAP, HI, Merci, Merlin, SC
Protection of Palestinian localities in Nablus, Salfit and Qalqiya from environmental health hazards caused by settlements' waste water. (Early Recovery) <b>OPT 09/WS/20577/122</b>	162 640	MoH
Strengthen humanitarian Health Cluster coordination and operational capacities <b>OPT 09/CSS/23973/122</b>	1 500 000	MoH, ERCS, PRCS
Restoring critical hospital services in the Gaza Strip <b>OPT-09/H/23886/122</b>	5 061 100	MoH, IOM, CARE, other cluster partners
Joint nutrition assessment of children under five, adolescents and pregnant women in the Gaza Strip <b>OPT-09/H/24007/122</b>	50 000	MOH, UNRWA, WHO, UNICEF, MAP-UK, SC-US
Identifying and addressing environmental health risks <b>OPT-09/H/24030/122</b>	250 000	MoH, local/international NGOs, water authority
Strengthening disease surveillance, early warning and outbreak response <b>OPT-09/H/24032/122</b>	200 000	MoH, UNICEF, NGOs
Restoring and strengthening quality of PHC services <b>OPT-09/H/24033/122</b>	300 000	MoH, National NGOs (PMRS), other health partners
Strengthening nutrition surveillance in Gaza <b>OPT-09/H/24034</b>	200 000	MoH, local NGOs, UNICEF
Mental health – psychosocial response to Gaza Crisis <b>OPT-09/H/24052</b>	750 000	Palestinian general population, MoH mental health professionals and PHC staff, MoE (supervisors & counselors), local NGOs

\* Amounts given in US dollars.

**Total funds requested: US\$ 12 472 310**



## Health Sector Priorities for 2009

The response plan targets the 3.2 million estimated people to be in need of humanitarian assistance in 2009, with priority given to women and children. South/Central Somalia remains the focus of the health response, while targeted coordination, response and preparedness activities will continue in Puntland and Somaliland.

Training and capacity building is an integral part of the 2009 CAP, with a clearly identified activity/budget item on all project sheets. Expanding and sustaining secondary curative health services will be critical to sustaining capacity and developing and delivering services. Plans to better manage remote control operations, including innovative monitoring and evaluation strategies, are being considered. Preventive initiatives such as immunization programmes and child survival interventions are essential, as are the continuing disease surveillance, epidemic preparedness and response activities. Close collaboration with the Water and Sanitation Cluster on safe drinking water and environmental sanitation is anticipated, while health education and hygiene promotion has been identified as one of the key activities under the Health Cluster response. The Health Cluster will also focus on reproductive health interventions including sexually transmitted infections, sexual and gender-based violence and blood safety.

Continuous improvements in disease surveillance, outbreak response and disease prevention activities throughout Somalia are anticipated. While maintaining the same level of access to quality health services in South/Central and Puntland, improvements are expected in Somaliland. The focus of this response plan is on improving the quality rather than the coverage of health services. Emphasis will be given to emergency preparedness in Somaliland and Puntland and response planning in South/Central. Health Cluster coordination and response will be increasingly decentralized in 2009. All Health Cluster projects are expected to waive user fees for the beneficiaries.

## WHO Proposed Projects in the CAP 2009

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Facility based delivery of essential health care and life saving services to vulnerable population and host communities <b>SOM 09/H/22307/122</b>	2 483 470	UN agencies, INGOs, CBOs, Somali Red Crescent, Regional/ local authorities, MoH, local NGOs
Reaching children under five years of age with high impact life-saving services (Child Health Days - CHDs) <b>SOM 09/H/22308/122</b>	5 743 225	UN agencies, INGOs, CBOs, Somali Red Crescent, regional/ local authorities, local NGOs
Polio Eradication Initiative in Somalia 2009 <b>SOM 09/H/22309/122</b>	723 350	TFG, MoHL Somaliland, MoH Puntland, international & national NGOs

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Reducing HIV infection, improving universal precaution, reducing maternal deaths and disabilities in emergency obstetric care services through comprehensive blood safety in Somalia <b>SOM 09/H/22310/122</b>	470 800	Somali Red Crescent Society, IMC, COOPI
Reducing maternal and neonatal deaths and disabilities through provision of quality emergency obstetric care and essential reproductive health including ending obstetric fistula care services in Somalia <b>SOM 09/H/22311/122</b>	867 566	Galkayo Medical Center, Islamic Relief, World Vision, MoH
Health Cluster coordination and emergency preparedness in Puntland <b>SOM 09/H/22312/122</b>	439 963	MoH, Health cluster partners, LNGOs
Establishment of Early Warning Alert and Response System (EWARS) for control of communicable diseases <b>SOM 09/H/22313/122</b>	3 057 493	
Health Cluster coordination and emergency preparedness in Somaliland <b>SOM 09/H/22314/122</b>	336 976	
Health Cluster coordination and emergency preparedness in South Central Somalia <b>SOM 09/H/23318/122</b>	1 504 441	

\* Amounts given in US dollars.

**Total funds requested: US\$ 15 627 284**

**Notes:** 1) UNICEF MICS 2006.

# Sri Lanka

## Health Sector Needs Assessment

In the north, the continuing conflict and its recent intensification have resulted not only in unmet health care needs of the IDP population, but have also diminished access to quality health services in host communities. Access to health services has been reduced due to critical understaffing of health posts, combined with poorly maintained and inadequately equipped health facilities. Five health facilities have closed or relocated in Kilinochchi due to security concerns, with remaining medical capacities and health personnel overextended.

Urgent referrals are hampered as a result of insecurity, frequent displacement and inaccessibility to district health teams. Women who have difficulties during labour are unable to access emergency services, resulting in higher numbers of maternal deaths. Unwanted and teenage pregnancies are rising. Against a national average of 7.7%, the teenage pregnancy rate in Killinochchi is 11.7% and 16.1%<sup>1</sup> in Batticaloa. The disruption of family planning supplies for women in conflict areas in the North is also of concern, particularly in light of Ministry of Health statistics indicating the overall contraceptive prevalence in Sri Lanka of 70%.

As the conflict intensifies, setbacks to maintaining high immunization coverages can be expected. Patients, often those who are elderly and suffer from non-communicable diseases such as diabetes, cardiovascular diseases and cancer, find it increasingly difficult to obtain specialised treatment due to lack of diagnostic facilities and specialists.

An assessment of the IDP population in the northern conflict areas highlighted immediate problems of nutrition, water and sanitation along with limited access to healthcare. Living conditions of IDPs in temporary shelters are sub-standard: water, sanitation and garbage disposal management are seriously inadequate, increasing the risk of both vector and waterborne diseases. IDPs in Killinochchi are in temporary, mainly spontaneously organized shelters located on paddy lands prone to flooding during the rainy season. Family and community support systems have been seriously compromised: as a result, preventative measures that communities traditionally undertake to protect themselves from illness and disease have been reduced. Prolonged periods in poor and overcrowded living conditions are also increasing women's and girls' vulner-



ability to sexual and physical abuse, including exposure to sexually transmitted infections and HIV/AIDS. The conflict has also caused significant psychological and social suffering in affected populations, resulting in increased rates of post-traumatic stress disorders and chronic mental health problems.

In the resettlement areas of Batticaloa District, assessments indicate significant gaps in healthcare coverage. Recommended responses include rehabilitating, refurbishing and equipping primary health care centres and recruiting additional doctors.

## **Health Sector Priorities for 2009**

- Conduct rapid health assessments and strengthen disease surveillance;
- Build the Ministry of Health and Regional Director of Health Services capacities to coordinate health interventions in affected areas;
- Support the Ministry of Health to provide essential health services including pre-natal care, post-natal care, family planning services, treatment for non-communicable diseases, protection from sexually transmitted infections and HIV/AIDS, counselling, psychosocial support, and legal aid for victims of sexual and gender-based violence, treatment of sexually transmitted infections and respiratory tract infections (mobile clinics) to IDPs and host families in remote locations;
- Conduct health education campaigns, e.g. HIV/AIDS, communication for behavioural impact, personal hygiene;
- Ensure emergency preparedness through pre-positioning and provision of emergency supplies (infant kits, expectant mothers kits, family mosquito nets, emergency health kits), preparation of emergency preparedness plans at district level and capacity building for emergency preparedness;
- Support the deployment of auxiliary health workers to address human resource gaps;
- Strengthen ongoing activities for the prevention and treatment of communicable diseases (malaria, dengue, chikungunya, diarrhoea, pneumonia) awareness raising and provision of impregnated mosquito nets;
- Provide essential medical supplies such as emergency health kits, first aid kits, clean delivery kits, emergency obstetric care, newborn care equipment and personal hygiene packs for women;
- Provide transport and comprehensive emergency obstetric care for pregnant women;
- Support routine immunization of children under five in conflict-affected areas;
- Prevent and support management of gender-based violence consequences;
- Provide psychosocial support and mental healthcare, including for individuals in host communities;
- Train health service providers and community level health promoters.

## WHO Proposed Projects in the CAP 2009

Project titles	Requested funds *	Implementing partners
Health interventions in conflict-affected areas <b>SRL 09/H/23411/122</b>	4 131 270	MoH, UNFPA, UNICEF, Sewa Lanka, MTI, IRD, Comité d'Aide Médical, Medicare, IFRC, SLRC
Building capacity of local and community health workers in emergency nutrition <b>SRL 09/H/23579/122</b>	400 180	MoH, North & Eastern Provincial Directorates of Health

\* Amounts given in US dollars.

**Total funds requested: US\$ 4 531 450**

**Notes:** 1) MoH, FHB 2007.

# Sudan

## Health Sector Needs Assessment

The health situation across Sudan remains fragile, with high risks of disease, low access to drinking water, poor sanitation and low literacy rates. Environmental factors (e.g. floods and drought) contribute to the spread of water and vector-borne diseases such as diarrhoea, dysentery, typhoid, hepatitis, malaria and dengue fever. Health and nutrition rates are below averages for Middle East and North Africa, and there are significant urban/rural, regional, gender and socioeconomic disparities in the country. The health infrastructure, poor to begin with in many regions, has been abandoned or destroyed by decades of conflict. In Southern Sudan there are just 220 doctors for a population estimated at between 7 and 10 million. The nationwide ratio is better – 17.8 general practitioners and 57 nurses/100 000 people – but regional disparities are staggering.



Government expenditure on health has risen in the last two years, but at around \$5.5 per capita in 2003, is still well below the global recommendation of \$37. Southern Sudan has one of the highest maternal mortality rates in the world with more than 2054 out of every 100 000 live births. Across the country the rate remains extremely high at 1107/100 000 live births. Despite efforts to train midwives, skilled attendance at births has actually decreased in recent years.

Disease outbreaks will remain the major challenge in 2009. Sudan's epidemiological profile is dominated by common, preventable communicable diseases. Every two to five years there are outbreaks of meningococcal meningitis and acute watery diarrhoea. Poor sanitation and drinking water, especially after flooding, leave open the potential for serious outbreaks during the rainy season. An outbreak of Rift Valley fever that started in late 2007 and lasted through January 2008 killed 230 people. There were around 300 cases of epidemic meningitis, including 12 deaths, and outbreaks of hepatitis E and dengue fever in Red Sea state led to more than 500 cases and 38 deaths. Malaria is a big risk, and tuberculosis is on the rise. The risk of polio transmission increases with cross-border population movements.

The nutrition situation in Sudan is characterized by high levels of chronic malnutrition and persistently high levels of acute malnutrition. Nationally, a third of children under five are moderately or severely underweight. The level of global acute malnutri-

tion (14.7%) is just below standards internationally recognized as a nutrition emergency. Global increases in food prices will deepen existing vulnerabilities, and women and children will be hardest hit.

## **Health Sector Priorities for 2009**

### *Abyei*

Fighting in May 2008 damaged much of the town's health infrastructure, and medical supplies were looted. In the months following the crisis, the displaced population received only emergency health assistance. They were exposed to all kinds of health risks associated with overcrowding and the rainy season. The health and nutrition sector will focus in 2009 on the establishing the ministry of health, reconstructing basic and advanced health facilities and expanding quality health care into rural areas. A key challenge is finding qualified health care workers.

### *Blue Nile*

The State Ministry of Health provides health care in Damazin, Roseires, Geissan and Baw. In Kurmuk 70% of health care is provided by international NGOs. Health services are centred in urban areas; this, combined with the lack of an efficient referral system covering the peripheries, results in urban services being overcrowded and remote communities un-served. In the whole state there are just 173 functional health facilities, most of which are basic units and dispensaries. Only 22.8% of health facilities report regularly on communicable disease surveillance due to a lack of communications and phone coverage in several locations.

Health indices reflect the poor access to health care. The infant mortality rate is 126/1000 live births, and the maternal mortality rate 526/100 000 live births. In Kurmuk, the crude mortality rate and under five mortality rates are 0.87 and 2.05/1000 people respectively, slightly under the Sphere emergency threshold. Malaria is endemic, as are leishmaniasis, bilharzia, leprosy and tuberculosis. In 2008, national tuberculosis and leprosy programmes were launched in Kurmuk. Poor hygiene standards due to lack of water chlorination, drainage systems and waste disposal increase the health risks.

In 2008, cooperation between the state ministry, the UN and NGOs saw support provided to IDPs, host communities and refugees in terms of increased access to health care, better communicable disease surveillance and control, building the capacity of health personnel and raising awareness of HIV/AIDS. The sector also responded to the flooding. In 2009, partners will focus on improving access to care, improving primary health care services, strengthening disease control and prevention, improving mother and child services, improving information management systems and expanding supplementary and therapeutic feeding programmes.

### *Darfur*

The health situation in Darfur is expected to remain fragile in 2009, with continuing reliance on humanitarian support for basic services. The health system and infrastruc-

ture are weak; in accessible areas the health situation is stable, but in rural areas few health and nutrition services are available. Primary health care coverage across Darfur is about 60%. Some health partners have pulled out for security reasons, leading to increasing gaps in service delivery. Mortality levels are below the emergency threshold, but most children under five who die are killed by easily treatable diseases such as acute respiratory illness, diarrhoea, malnutrition and malaria. Funding is a common problem, and there have been problems with delays in clearing imported drugs and medical supplies. Reproductive health services are inadequate in some areas, and there is low awareness of HIV/AIDS and the prevention and management of gender-based violence. The health information system remains weak despite efforts to strengthen it. Human resources in key departments of the state MoH remain a critical issue, both in terms of capacity and staff retention. Monitoring and supervising programmes in remote areas is difficult due to the volatile situation on the ground. Lack of safe water puts vulnerable people at risk of diseases of epidemic potential. All three states continue to see low trends of health-seeking behaviour.

Recent nutritional surveys in North Darfur suggest improvement within camps but deterioration in rural and inaccessible areas. In Abu Shok and Alsalam camps, for example, nutritional surveys showed a drop in global acute malnutrition to 17.9% in June 2008, from 30.4% at the same time the year before. The emergency threshold, however, is 15% so levels are still unacceptably high. In South Darfur, nutrition depends on geography and seasonality. Global acute malnutrition appears to be above the emergency threshold. Coverage is low, however, and concentrated in specific areas. In West Darfur, the situation is getting worse, and coverage is generally low. Global acute malnutrition, according to emergency food security and nutrition assessments, rose to 12.3% in 2007 from 6.2% in 2005.

### *Eastern States*

Although the planning region has 46 hospitals, 406 primary health care facilities and 316 dispensaries, the UN and NGO partners provide primary health care and nutrition services to refugees through seven facilities in the camps. In 2008, Kassala had an outbreak of meningitis, while Red Sea state had an outbreak of hepatitis E and dengue haemorrhagic fever. There were also cases of acute watery diarrhoea in Gedaref. Other challenges include high maternal and child mortality and morbidity, tuberculosis, HIV/AIDS, leishmaniasis and bilharzia. Routine immunization coverage is lower than targeted. There is a high prevalence of global acute malnutrition, ranging from 19.7% in rural Port Sudan to 30.8% in Sinkat. In 2009, the region's nutrition activities will focus on community-based malnutrition programmes. Vitamin A coverage is already high in children, and will need to be maintained. Coverage for micronutrients includes post-partum vitamin A, iron and folic acid to pregnant women, deworming to children under five and fortification initiatives such as iodized salt. The essential nutrition service package, including infant feeding, HIV/AIDS context and prevention, child growth monitoring and maternal nutrition and low birth rate prevention will be integrated into 56 health centres and hospitals.

### *Southern Kordofan*

The health care system in Southern Kordofan, like other social services, was poor before Sudan's north/south conflict and has been devastated since. Now that the state is undergoing an integration process, the health system is being revamped, decreasing the morbidity and mortality rates, and targeting the most vulnerable, such as women, children, and those living in inaccessible areas. In 2009, the sector will focus on providing essential services and strengthening the system, by identifying gaps such as the lack of skilled manpower, by mitigating disasters and consolidating recent gains. Projects will contribute to restoring essential structural and functional capacities of priority health facilities in the state, increasing access to essential preventive and curative health services and reducing maternal and neonatal morbidity and mortality by providing secondary care that includes general surgeries and emergency obstetrics care. The sector will also coordinate with the water and sanitation sector to provide clean water and sanitation and promote personal hygiene, and to increase health literacy across target communities.

### *Southern Sudan*

Health facilities in Southern Sudan were limited before the war; now, infrastructure and basic health services are still virtually non-existent outside of main towns. In 2006, the Sudan Household Survey estimated that only 25% of the population had access to adequate health services. The enormous post-conflict challenges include limited funding, poor or absent infrastructure and equipment, inadequate sanitation and access to safe drinking water, a high prevalence of communicable disease and a scarcity of qualified staff. The ever-increasing numbers of returnees place an additional strain on already stretched facilities. A 2007 survey by the Christian Health Association of Sudan reported there were 646 operational health care facilities across the region, and only 1500 hospital beds.

The main challenge is the lack of trained staff. According to a survey carried out in July 2006, there were only 220 medical doctors in Southern Sudan for a population estimated at between seven and 10 million. The limited number of health workers is unevenly spread, with two thirds of the workforce deployed in three out of ten states, with a heavy urban bias. Midwifery, pharmacy and radiology are particularly understaffed.

Estimates suggest there are just 1005 midwives across the region, some without recognized training. Infant and under-five mortality rates are 150 and 250/1000 live births respectively. For women of childbearing age, complications of pregnancy and delivery are the leading causes of death and ill health. Communicable diseases also remain a major concern. The main causes of morbidity and mortality are infectious and parasitic diseases including cholera, acute watery diarrhoea, meningitis, tuberculosis, malaria, measles, acute respiratory infections and HIV/AIDS. Neglected tropical diseases are endemic in certain areas. These include Guinea worm (80% of the global burden), sleeping sickness, onchocerciasis, filariasis, schistosomiasis and leishmaniasis.

Preventing the further spread of HIV is one of the greatest challenges of post-war Southern Sudan. Estimates of HIV prevalence vary greatly according to the source. A

conservative estimate by UNAIDS in 2003 put the HIV rate among the general population at 2.3%, while other small-scale studies indicate rates of up to 8%. Although reliable data is not available, it is clear that Southern Sudan needs urgent prevention and response to HIV.

Fifty NGOs, of which 40 are international, provide an estimated 86% of health care in Southern Sudan, but many have ceased operations or are likely to, due to shrinking funding or corporate mandates that limit their scope to emergencies. The state Ministry of Health is carrying out a head count of health workers for planning and payroll purposes.

## WHO Proposed Projects in the CAP 2009

<b>Project titles</b>	<b>Requested funds *</b>
<b>National Programmes</b>	
Strengthening national preparedness and response capacity to reduce morbidity and mortality due to infectious disease outbreaks in Northern Sudan <b>WHO - SUD-09/HN200</b>	1 476 115
<b>Blue Nile</b>	
Improve access to quality health care services for affected population and host community <b>WHO - SUD-09/HN112</b>	770 400
Increase coverage of quality health care services for affected population and host communities <b>WHO - SUD-09/HN113</b>	380 000
<b>Darfur</b>	
Improve access to quality health care services for vulnerable and conflict-affected population in the three Darfur states <b>WHO - SUD-09/HN194</b>	8 500 000
Improve access to quality health care services and strengthen the local capacity to manage health risks that include outbreak control <b>WHO - SUD-09/HN195</b>	14 500 000
Contribute towards universal access to HIV and AIDS prevention treatment and care for populations of humanitarian in concern in Darfur states <b>WHO - SUD-09/HN196</b>	1 104 240
Strengthen standard precautions for HIV/AIDS and blood safety for the hospitals and PHCCs in the Greater Darfur <b>WHO - SUD-09/HN197</b>	211 900
Promotion of water/environmental health services delivery to pre-empt and/or control water/environmental health related disease incidences prevalent in Darfur <b>WHO - SUD-09/WS111</b>	930 356
Promotion of water/environmental health services delivery to pre-empt and/or control water/environmental health related disease incidences prevalent in Darfur <b>WHO - SUD-09/WS112</b>	162 355

<b>Eastern States</b>	
Strengthen and sustain access to and delivery of health care services to the local population including the vulnerable groups of host communities, returnees and IDPs <b>WHO - SUD-09/HN91</b>	451 000
Increase provision of health care services to the local population including the vulnerable groups of host communities and returnees <b>WHO - SUD-09/HN90</b>	1 000 000
<b>Khartoum and other northern states</b>	
Strengthen the health care delivery system including surveillance and communicable diseases outbreak response <b>WHO - SUD-09/HN139</b>	750 000
Strengthening surveillance system for communicable disease outbreaks and early detection among the high-risk groups <b>WHO - SUD-09/HN138</b>	400 000
<b>Southern Sudan</b>	
Health sector coordination, emergency preparedness and humanitarian action <b>WHO - SUD-09/HN36</b>	878 000
Scaling up HIV/AIDS services for populations of humanitarian concern in Southern Sudan <b>WHO - SUD-09/HN38</b>	650 000
Reduction of excess morbidity and mortality due to malaria during an outbreak in flood-affected states <b>WHO - SUD-09/HN41</b>	420 000
Capacity building on integrated management of childhood illness (IMCI) or integrated essential child health care (IECHC) for health workers in Southern Sudan <b>WHO - SUD-09/HN43</b>	200 000
Construction of a WHO store for emergency medicines and medical supplies in Rumbek, Lakes State <b>WHO - SUD-09/HN50</b>	550 000
Improvement of surveillance, diagnosis and treatment of selected neglected tropical diseases (NTDs) <b>WHO - SUD-09/HN51</b>	330 000
Basic curative services for returnees in Southern Sudan <b>WHO - SUD-09/HN52</b>	300 000
Improving maternal health in Southern Sudan <b>WHO - SUD-09/HN57</b>	635 384
Tuberculosis control in Southern Sudan <b>WHO - SUD-09/HN66</b>	14 000 000
Epidemic preparedness and response <b>WHO - SUD-09/HN68</b>	2 000 000

\* Amounts given in US dollars.

\*\* Implementing partners are not listed in the Workplan 2009

**Total funds requested: US\$ 50 599 750**

# Uganda

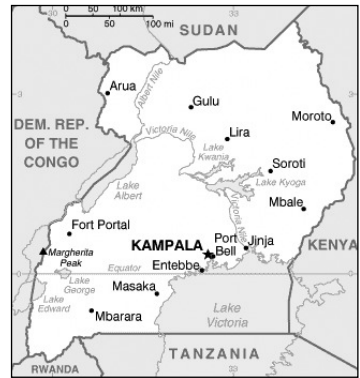
## Health Sector Needs Assessment

The reduced funding requests under the 2008 CAP,<sup>1</sup> combined with rapid population movements to areas where health care systems remain weak, have compromised the delivery of good quality health services. The factors affecting health care delivery across northern Uganda and Karamoja include: a shortage of health workers; poorly trained staff; absenteeism; weak supply chain management that results in frequent shortages of essential drugs; poor infrastructure; lack of medical equipment and poor supervision. Other constraints include poor nutritional capacity at the district level that challenges the sustainability of emergency nutrition programmes, particularly in Karamoja. Pockets of increased malnutrition were also recorded in parts of the Acholi region. Poor water and sanitation in many IDP camps and return areas, meanwhile, has fuelled a protracted outbreak of hepatitis E<sup>2</sup> in the Acholi sub-region, primarily in Kitgum District.

In 2009, the humanitarian community is planning to expand humanitarian assistance and protection to IDPs, extremely vulnerable individuals and vulnerable host communities in Karamoja. It will also assist those affected by natural hazards and external shocks in the Teso region, and will continue to assist IDPs and the most vulnerable individuals and groups in the Acholi region. Large segments of the population remain in critical need of additional recovery and development assistance if they are not to fall back into a state of humanitarian emergency provoked by food insecurity, lack of livelihood and inadequate access to basic social services. In addition to the 1 611 560 people living in Acholi sub-region, Teso sub-region and Karamoja, around 146 000 refugees in Uganda also require humanitarian assistance.

On the basis of the most likely scenario, the humanitarian community has agreed to plan for the following caseload:

- In the Acholi sub-region, an estimated 605 000 people will require continuing humanitarian assistance, including IDPs remaining in the camps, parts of the population living in return sites and villages of origin, and extremely vulnerable individuals in all locations;



- In the Teso sub-region, an estimated 60 160 people will require humanitarian assistance, as above;
- In Karamoja, up to 800 000 people will require humanitarian assistance, particularly to stabilize their food and nutritional security;
- Additionally, some 146 400 refugees living in Uganda will require humanitarian assistance and support for the achievement of a voluntary, durable solution to their situation.

## Health Sector Priorities for 2009

At this pivotal point in the transition from a humanitarian to a recovery and development oriented response, the 2009 Consolidated Appeal focuses on remaining humanitarian needs. The portfolio of projects covers operations in northern Uganda (Acholi and the two IDP-hosting districts of Teso) and urgent needs in Karamoja and other disaster-affected and refugee-hosting areas. A narrower definition of humanitarian action has been jointly elaborated to guide the construction of the 2009 CAP. In all districts in which there are humanitarian operations, the dominant programming requirement is actually that of full recovery. Nonetheless there remain specific humanitarian concerns that require a distinct humanitarian response.

The CAP reflects the long multidisciplinary dialogue undertaken in Uganda as to the scope of genuine humanitarian needs. The more narrow definition and portfolio of projects is presented. Since the signing of the original Cessation of Hostilities between the Government and the LRA more than two years ago, enormous tangible gains have accrued to the people of northern Uganda. Consolidation of these gains is required to sustain a measured peace dividend.

This humanitarian strategy and portfolio of projects should be read in conjunction with the forthcoming *Peace-building and Recovery Support Strategy* in order to gain a full appraisal of the range of needs of the people of LRA-affected northern Uganda and Karamoja, in terms of both humanitarian and recovery engagements.

The following operational definition for humanitarian action in Uganda in 2009 represents the common guide by which the humanitarian community has honed the scope of its proposed action in Uganda in 2009 in each of the regions and/or thematic areas covered by the CAP.

Humanitarian action in Uganda targets at-risk communities in areas prone to and/or recovering from conflict and natural disasters by:

- saving lives by reducing immediate mortality and morbidity through ensuring an effective and rapid emergency response – including a protection response – in all areas where lives are at risk due to conflicts, epidemics or natural disasters;
- supplementing the provision of basic services and livelihoods to ensure conditions for the three durable solutions;
- protecting crisis-prone communities by reducing the impact of potential natural and man-made hazards and strengthening disaster preparedness.

## WHO Proposed Projects in the CAP 2009

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Health, nutrition and HIV/AIDS response coordination <b>UGA-09/CSS/21748</b>	1 071 070	MoH, DHO, Office of the Prime Minister
Health, nutrition and HIV/AIDS response coordination <b>UGA-09/H/CSS/ 21753</b>	647 350	
Nutrition response in Karamoja sub-region <b>UGA-09/H/21390</b>	176 550	MoH, DHOs, UNICEF, WFP, NGOs
Scaling up comprehensive HIV/AIDS care and treatment services in the Karamoja region <b>UGA-09/H/21510</b>	253 055	MoH, DHOs
Integrated emergency health, nutrition and HIV/AIDS services delivery <b>UGA-09/H/21536</b>	682 660	MoH, DHOs, NGOs
Support the scale up of malaria control in Karamoja sub-region <b>UGA-09/H/21542</b>	341 330	
Support the scale-up of malaria control in the Acholi sub-region <b>UGA-09/H/21759</b>	341 300	
Scaling up comprehensive HIV/AIDS care and treatment services in the Acholi region <b>UGA-09/H/21772</b>	323 675	MoH, DHOs
Provision of mental health and psychosocial support <b>UGA-09/H/21789</b>	306 020	MoH, Butabika Psychiatric Hospital, Gulu Teaching Hospital, TPO
Scaling up comprehensive HIV/AIDS care and treatment services in the Teso region <b>UGA-09/H/21796</b>	247 170	MoH, DHOs
Support the Scale Up of Malaria Control in Teso sub region <b>UGA-09/H/21806</b>	294 250	MoH, DHOs, NGOs
Integrated emergency health and HIV/AIDS services delivery in Acholi sub-region <b>UGA-09/H/21813</b>	494 340	MoH, DHOs, UNICEF
Strengthening and consolidation of comprehensive SRH services for conflict affected populations in Acholi region <b>UGA-09/H/21818</b>	341 330	MoH, DHOs, UNFPA, NGOs and CBOs
Strengthening and consolidation of comprehensive SRH services for conflict affected populations in Amuria and Katakwi districts <b>UGA-09/H/21830</b>	437 844	MoH, DHOs, UNFPA, NGOs, CBOs

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Strengthening and consolidation of comprehensive SRH services for conflict affected populations in Karamoja sub-region <b>UGA-09/H/21836</b>	317 790	MoH, DHOs, UNFPA, NGOs, CBOs
Child health (Acholi sub-region) <b>UGA-09/H/22024/1</b>	494 340	MoH, DHOs, UNICEF
Nutrition Response among IDPs and extremely vulnerable population in Acholi sub-region <b>UGA-09/H/22029</b>	235 400	MoH, DHOs, UNICEF, WFP, NGOs
Child health (Teso sub-region) <b>UGA-09/H/22030/1</b>	129 470	MoH, DHOs, UNICEF
Health emergency preparedness and response (EPR) and epidemic disease surveillance in Teso sub-region <b>UGA-09/H/22031</b>	506 110	
Nutrition response among IDPs and extremely vulnerable populations in Teso sub-region <b>UGA-09/H/22032/1</b>	129 470	MoH, DHOs, UNICEF, WFP, NGOs
Health emergency preparedness and response (EPR) and epidemic disease surveillance in Karamoja <b>UGA-09/H/22033</b>	423 720	MoH, DHOs, UNICEF
Child health (Karamoja) <b>UGA-09/H/22034/1</b>	506 110	
Health emergency preparedness and response (EPR) and epidemic disease surveillance in Acholi sub-region <b>UGA-09/H/22043</b>	725 032	
Preventing and responding to gender-based violence in Karamoja region <b>UGA-09/P-HR-RL/21783</b>	105 930	MoH, DHOs, MoGLSD, UNFPA
Preventing and responding to gender-based violence in Acholi region <b>UGA-09/P-HR-RL/21811</b>	105 930	

\* Amounts given in US dollars.

**Total funds requested: US\$ 9 637 246**

**Notes:** 1) Down by US\$2 million compared to 2007, particularly for recovery activities. 2) According to the latest malnutrition surveys, conducted in various districts between June and August 2008 by UNICEF, WFP and ACF, global acute malnutrition (GAM) rates have shown some increase across several Acholi districts. A primary cause for this increase must be seen as the impact of population movement to less serviced parts of the districts (as previously seen in the Lango sub-region in 2007). Well-targeted food and nutritional recovery interventions are clearly needed to stabilize the nutritional situation.

# West Africa

## Benin, Burkina Faso, Côte d'Ivoire, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Senegal, Sierra Leone and Togo

### Health Sector Needs Assessment

West Africa is characterized by high rates of infectious diseases which account for more than half of disease morbidity across the region. Communicable diseases include malaria, vaccine-preventable diseases, and diarrhoeal diseases including Shigellosis and cholera. West Africa is regularly affected by outbreaks of meningococcal meningitis, typhoid and yellow fever. HIV/AIDS, sexually transmitted infections and tuberculosis are a rising concern. The cyclical Lassa fever outbreaks in Sierra Leone and in the border areas of the Mano River Union (Guinea, Liberia and Sierra Leone) are dangerous for the entire region: in 2004, the Ministries of Health of these three countries agreed to coordinate their efforts to control the disease.



The Meningitis Belt extends from Senegal to Ethiopia, where large epidemics of meningococcal meningitis occur. These epidemics, in varying patterns, used to occur in waves of three to four years during the dry season in a cycle of 10 to 12 years. Epidemiological data indicate that the magnitude and the frequency of the MM epidemics are changing and the intervals between epidemics are growing shorter. Moreover, data from recent studies suggest that meningitis epidemics may be extending south of the Sahel, which is consistent with environmental changes in the region.

The 2008 meningitis epidemic, though less severe than that of 2007, led to a reported total of 28 946 cases and 2712 deaths. Previous vaccinations and early detection and management of cases were not enough to limit the epidemic. This calls for strengthening regional and national reference laboratories as well as some sentinel laboratories, and better response and clinical diagnostic capacity in the most severely affected countries such as Burkina Faso, Nigeria, Mali and Niger.

HIV/AIDS remains a major concern. HIV/AIDS prevalence rates are over 10% in Côte d'Ivoire, 8.2% in Liberia, around 7% in Sierra Leone, 5% in Burkina Faso, 2.8% in Guinea and 2% in Mali. The presence of uniformed forces (including peacekeepers)

in some countries and the associated increase in commercial sex work may further aggravate the situation.

In most countries of West Africa the health status of the population remains well below minimum standards, and some have the worst health and socio-economic indicators in the world. Health systems are characterized by limited financial and human resources, weak planning and poor managerial capacities. Weak health systems tend to shrink around the centres, leaving large areas of the country – particularly border areas – with little or no access to health care. Lack of access and incomplete coverage by surveillance systems opens the way to wild and new pathogens. An example of this is Lassa fever in border areas between Guinea, Sierra Leone and Liberia.

The effects of the food price crisis are also being felt. Countries have had to shift resources from other sectors, including basic social services such as health, to food expenditures. Families have had to adapt their expenditures to meet the rising costs of food, decreasing the quantity and quality of their food intake and leading to the following health consequences:

- reduced accessibility to basic health services by the population and subsequent increase in morbidity and mortality (less financial resources available for the public health sector);
- less access to preventive and curative services by households due to lack of financial resources needed to purchase these services as a result of cost recovery by governments, including reproductive health;
- deterioration of public health programmes because of re-allocation of government expenditure to other sectors, resulting in a rise in communicable diseases across the region and increased morbidity and mortality to endemic diseases and outbreaks;
- deterioration in the health status of patients with special dietary needs such as people living with HIV/AIDS, diabetics, and pregnant and lactating mothers;
- increased domestic violence, sexual exploitation of women, and sexual violence against women.

## **Health Sector Priorities for 2009**

- Recruit and assign international staff in the region (Dakar) to support and reinforce health information management and provide strategic guidance;
- Set in place mechanisms for exchange of information, strategic planning and standardization of tools and protocols;
- Support ministries of health with weak capacities in countries at high risk from the food crisis;
- Contribute to the joint assessment of the current trend of main causes of ill health such as malnutrition, lassa fever, yellow fever, cholera, meningitis, malaria;
- Health system response to the food price crisis;
- Contribute to the assessment of the gap in health resources to meet the health needs of vulnerable groups – women, children, elderly, etc.;

- Subcontract local and international NGOs working in remote border districts to deliver essential and specific health packages for mental health, SGBV, HIV/AIDS, TB and malaria;
- Support national health services to strengthen existing services or establish emergency services on obstetric care;
- Support national authorities in the training of key health workers in primary health care;
- Support and contribute to the multi-antigen catch-up campaigns in the region and monitoring vaccination activities;
- Undertake continuous monitoring and joint missions at field level;
- Carry out studies and surveys at field level to evaluate the impact of humanitarian actions.

## WHO Proposed Projects in the CAP 2009

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Coordinated health actions and health information management across West Africa <b>WA-09//CSS/21933/122</b>	915 350	MoHs, UNCTs, national and international NGOs and regional health entities
Nutrition for child survival in Togo <b>WA-09/H/21194/122</b>	200 000	NGOs, Togolese Red Cross, 3ASC, SAR Afrique, GAAIN
Response to cerebrospinal meningitis epidemic in Burkina Faso <b>WA-09/H/21839/122</b>	3 602 378	MoH, UNICEF, MSF, UNFPA, Red Cross, NGOs
Cholera outbreaks prevention and response among vulnerable populations in floods-affected areas in Burkina Faso <b>WA-09/H/21841/122</b>	989 292	MoH, MoSA, UNICEF, WFP, MSF, Red Cross
Emergency preparedness for vulnerable populations affected by commodity prices, cholera and meningitis epidemics in Niger <b>WA-09/H/21894/122</b>	1 885 000	MoPH, DHT, NGOs
Surveillance of nutritional status and reinforcement of case management of severe under-nutrition in Niger <b>WA-09/H/21902/122</b>	576 730	MoPH, WFP, UNICEF, NGOs
Improved accessibility of vulnerable populations to basic health services in Agadez region, Niger <b>WA-09/H/21908/122</b>	623 810	MoPH, NGOs
Integrated response to natural disasters in disaster-prone districts (Koinadugu, Pujehun, Bonthe and Western area) of Sierra Leone <b>WA-09/H/21909/122</b>	794 475	MoH, UNICEF and NGOs

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Reinforcing capacities of health structures to better respond to potential new crises victims afflux in Guinea <b>WA-09/H/21919/122</b>	588 500	MoPH, Guinean Red Cross, Hammer Forum, ASWAR
Timely response to cholera epidemics in Guinea Bissau <b>WA-09/H/21921/122</b>	669 713	MoH, UNICEF, IFRC, Guinean Red Cross, UNHCR
Improving hospital case management of acute severe malnutrition among under-five children in Haute Guinea and in Guinée forestière <b>WA-09/H/21922/122</b>	497 871	MoH, Guinean Red crest, Hammar Forum, local NGOs
Prevention and control of cholera and diarrheal diseases in Togo <b>WA-09/H/21926/122</b>	913 900	MoH, NGOs
Prevention and control of diseases outbreaks in flood affected areas in Liberia <b>WA-09/H/21927/122</b>	500 000	MoH, UNICEF, NGOs
Guinea Bissau. Improve cholera emergency preparedness for vulnerable populations affected by the prices crises <b>WA-09/WS/21202/122</b>	513 000	UNICEF, WHO, Red Cross, CREPA, MDM
Prevention and preparedness of cholera in communities most at risk and affected by commodity price increases in Guinea <b>WA-09/WS/21241/122</b>	481 000	Red Cross
Prevention and preparedness of cholera in populations most at risk and affected by commodity price increases in Senegal <b>WA-09/H/WS21252/122</b>	181 000	

\* Amounts given in US dollars.

**Total funds requested: US\$ 13 932 019**

# Zimbabwe

## Health Sector Needs Assessment

Despite many efforts by the Government and partners, universal access to basic health services has been compromised due to deteriorating infrastructures and the lack of material, human and financial resources. All health facilities lack essential medicines due to the inability of local manufacturers to produce these items. In spite of procurement efforts by different partners, in 2008 the gap was estimated to be 70% of requirements.

The country has been faced with frequent diarrhoeal disease outbreaks in rural and urban areas in the past ten years. The frequency of cholera outbreaks has gone from once a decade (in the 1980s) to annually as of the new millennium and has spread from rural to urban areas, with case fatality rates of more than 10%.

A major cholera outbreak that began in August 2008 had yet to be brought under control in February 2009. The total cumulative as of 18 February 2009 was 78 882 cases with 3712 deaths (CFR 4.7%). In the 2009 revised CAP, WHO has requested an additional US\$ 16 887 500 for cholera control, on top of the US\$ 3 094 039 originally requested for health activities.

Dealing with emerging infectious conditions (anthrax, avian influenza and viral haemorrhagic fevers) in the country calls for adequate resources, knowledge and skills. Lack of transport has hampered the movement of supplies and field visits. Surveillance and early warning systems, which depend on weekly epidemiological reporting, receive only 30% of the necessary data.

Although HIV prevalence has dropped significantly (from 24.6% to 15.6%) among adults between 15 and 49 years old, the number of deaths attributable to AIDS remains very high. Around 1.3 million people living with HIV/AIDS live in the country. Only 110 000 of the 480 000 patients who need antiretroviral therapy are receiving the necessary drugs. Tuberculosis remains one of the leading causes of morbidity and mortality, with a notification rate of 434 out of 100 000. The case detection rate for sputum positive cases and treatment completion rates in 2007 stood at 42% and 66% against WHO standards of 70% and 85% respectively. There is a serious need to improve diagnostic facilities.



Around half the country's population lives in malaria-prone areas. Transmission of malaria is unstable, leaving all age groups at risk of malaria, with children under five and pregnant women at greatest risk. Measures to reduce the incidence of malaria include the provision of drugs to high-burden districts, implementation of indoor residual spraying and promotion of insecticide-treated nets.

The maternal mortality ratio remains high at 555/100 000 live births (2006). Emergency obstetric and neonatal care services are not easily available or accessible. Interventions to improve maternal care, including training birth attendants, enhancing the referral system and improving emergency obstetric care, need to be addressed.

The sentinel nutrition surveillance study conducted by UNICEF found a significant link between the incidence of diarrhoea, the inappropriate management of diarrhoeal diseases at home and by health workers, and poor maternal health conditions and severe malnutrition. The findings further corroborate the need to address essential child and maternal health services including the appropriate management of diarrhoea. Nutritional and mortality surveillance should be integrated into the routine health service system.

The 2005/2006 Demographic Health Survey reported a drop in the number of fully immunized children from 67% in 1999 to 53% in 2005/2006. Reactivating vaccination programmes will require significant resources in the form of vaccines, cold chain equipment, injection safety materials, liquid petroleum gas, and support for supplementary immunization activities including child health days.

## **Health Sector Priorities for 2009**

- controlling cholera, diarrhoeal diseases and other emerging infectious conditions;
- procuring and distributing cholera emergency response equipment and supplies;
- compiling the 2008 national health profile;
- integrating nutritional and mortality surveillance into the Integrated Disease Surveillance and Response system, including strengthening communication and the referral and early warning and surveillance systems;
- improving coordination of health activities;
- procuring and distributing essential drugs, vaccine, equipment and supplies;
- integrating the management of survivors of sexual assault at district level;
- catering for basic health services for mobile and vulnerable populations;
- improving basic health services, including upgrading clinical skills of health workers and diagnostic/laboratory services at district level;
- mainstreaming HIV/AIDS into all health interventions and supporting the continuum of prevention, care, treatment and support for people living with HIV/AIDS;
- implementing selected, high-impact maternal and child health interventions.

## WHO Proposed Projects in the CAP 2009

<b>Project titles</b>	<b>Requested funds *</b>	<b>Implementing partners</b>
Strengthen response and management of cholera, other diarrhoeal disease and emerging infectious diseases <b>ZIM-09/H/20937/122</b>	11 233 999	MoCHCW, UNICEF Local authorities
Integrated facility and community based management of acute malnutrition <b>ZIM-09/H/21827/122</b>	612 040	MoHCW
Health Cluster coordination, disease surveillance and health information management in the health sector <b>ZIM-09/H/21864/122</b>	4 148 000	MoHCW, WHO, UNICEF, local EPI partners
Infection control and water and sanitation interventions in the cholera treatment facilities <b>ZIM-09/WS/23888/122</b>	3 987 500	MoHCW, UN agencies and NGOs

\* Amounts given in US dollars.

**Total funds requested: US\$ 19 981 539**

# List of Acronyms

<b>3ASC</b>	<i>Association d'appui aux activités de santé communautaire/Support association for community health activities</i>
<b>ACABEF</b>	<i>Association centrafricaine pour le bien-être familial/Central African Association for Family Welfare</i>
<b>ACF</b>	<i>Action contre la Faim/Action against Hunger</i>
<b>AMI</b>	<i>Aide Médicale Internationale/International Medical Aid</i>
<b>ASSOMESCA</b>	<i>Association des Œuvres Médicales des Eglises pour la Santé en Centrafrique/ Association of Churches Medical Programmes for Health in the Central African Republic</i>
<b>CAM</b>	<i>Comité d'Aide Médicale/Medical Aid Committee</i>
<b>CAP</b>	Consolidated Appeals Process
<b>CAR</b>	Central African Republic
<b>CARE</b>	Cooperative for Assistance and Relief Everywhere, Inc
<b>CBOs</b>	Community-Based Organizations
<b>CERF</b>	Central Emergency Response Fund
<b>CIFAD</b>	Collectif International des Femmes Africaines pour le Développement/International Group of African Women for Development
<b>COOPI</b>	Cooperazione Internazionale/International Cooperation
<b>DHT</b>	District health team
<b>DRC</b>	Democratic Republic of the Congo
<b>ECHO</b>	Humanitarian Aid Office of the European Commission
<b>EPI</b>	Expanded Programme on Immunization
<b>ERCS</b>	Egyptian Red Crescent Society
<b>FMoH</b>	Federal Ministry of Health
<b>HI</b>	Health Inforum
<b>HIV</b>	Human Immune-Deficiency Virus
<b>HIV/AIDS</b>	Human Immune Deficiency Virus/Acquired Immuno-Deficiency Syndrome
<b>ICRC</b>	International Committee of the Red Cross
<b>IDPs</b>	Internally displaced persons
<b>IFRC</b>	International Federation of the Red Cross and Red Crescent Societies
<b>IMC</b>	International Medical Corps
<b>IOM</b>	International Organization for Migration
<b>IPHD</b>	International Partnership for Human Development
<b>IRC</b>	International Rescue Committee
<b>JUPEDEC</b>	<i>Jeunesse Unie pour la Protection de l'Environnement et le Développement Communautaire/ United Youth for the Protection of the Environment and Community Development</i>
<b>KEMRI</b>	Kenya Medical Research Institute
<b>MAP/MAP-UK</b>	Medical Aid for Palestinians
<b>MDM</b>	Médicos do Mundo/Doctors of the World
<b>MoE</b>	Ministry of Education
<b>MoH</b>	Ministry of Health
<b>MoHL</b>	Ministry of Health and Labour

<b>MoPH</b>	Ministry of Public Health (and Population/and Hygiene)
<b>MoGLSD</b>	Ministry of Gender, Labour and Social Development (Uganda)
<b>MoSA</b>	Ministry of Social Affairs
<b>MSF</b>	Médecins Sans Frontières/Doctors without Borders
<b>NGO</b>	Nongovernmental organization
<b>NRC</b>	Norwegian Refugee Council
<b>OCHA</b>	United Nations Office for the Coordination of Humanitarian Affairs
<b>oPt</b>	occupied Palestinian territory
<b>PRCS</b>	Palestine Red Crescent Society
<b>SC/SC-US</b>	Save the Children/Save the Children US
<b>SAR Afrique</b>	<i>Santé rurale en Afrique</i> /Rural Health in Africa
<b>SGBV</b>	Sexual and Gender-Based Violence
<b>SRH</b>	Sexual and reproductive health
<b>STI</b>	Sexually Transmitted Infections
<b>TFG</b>	Transitional Federal Government
<b>TPO</b>	Transcultural Psychosocial Organization
<b>UN</b>	United Nations
<b>UNAIDS</b>	UN Joint Programme on HIV/AIDS
<b>UNCT</b>	UN Country Team
<b>UNFPA</b>	UN Population Fund
<b>UNHCR</b>	UN High Commissioner for Refugees
<b>UNICEF</b>	UN Children's Fund
<b>UNRWA</b>	UN Relief and Works Agency for Palestine Refugees in the Near East
<b>UoN</b>	University of Nairobi
<b>WFP</b>	World Food Programme
<b>WHO</b>	World Health Organization
<b>WHO/HAC</b>	World Health Organization/Health Action in Crises
<b>WV</b>	World Vision



