The Central African Republic

Situation highlights
The protracted armed conflict in the Central African Republic has intensified since December, with the Séléka armed coalition overthrowing the capital Bangui and culminating in a coup d’état on 24 March. Due to the insecurity since Séléka took control of the capital, healthcare delivery to the general population of Bangui is heavily affected. Wounded patients cannot access health services. There have been reports of widespread looting of healthcare facilities, warehouses and offices (UN Agencies, including WHO; and NGOs).

An assessment earlier in February reported that, over 1.1 million people were affected by the conflict and estimates that over 173 000 were internally displaced and there were over 25 000 refugees.

Health needs are critical, as emergency care, mainly in Bangui, is hampered by non-functional health facilities according to the initial assessments by health partners (NGOs). WHO has internally classified the situation in the Central African Republic as a Grade 2 emergency due to the consequences of the civil unrest.

The precarious security situation is characterized by:

- Limited access to essential healthcare as health workers fleeing violence have left health facilities unable to provide health care
- Lack of medicines, medical supplies and emergency medical assistance equipment.
- A poor disease surveillance system in a context of poor living conditions and a high prevalence of communicable diseases. Scarcity of drinking water, electricity and basic sanitation is increasing the risk of outbreaks of water-borne diseases.
- Lack of access for humanitarian service providers

Health sector emergency response plan
Includes a three-month phase (initial response) and six month phase (to address health facility needs)

1. An initial rapid assessment (IRA) planned by the Health Cluster as soon as security allows.
2. A rapid operationalization of primary and secondary health care as well as outbreak management services with the main areas of intervention including:
   - Provision of supplies for the continuation of basic care, emergency medical assistance and disease control
   - Strengthening local capacities and improving the infrastructure for primary and secondary healthcare facilities through rehabilitation and the provision of furniture and equipment.
   - Provision of logistical and financial support to humanitarian partners for staff deployment and training health care managers

On-going Health Cluster response

Coordination and exchange of health information:
- A Health Cluster response plan was developed to identify the needs of the sector for the next three and six months (as mentioned above).
- WHO provided technical support to the Ministry of Health for setting up a crisis unit to coordinate the health sector humanitarian response.
- WHO and Health Cluster partners provided medicines and emergency surgical supplies to NGOs for delivery to functioning health facilities.
- UNICEF and WHO prepared an urgent international order for medicines, materials and equipment to facilitate the provision of emergency medical assistance for the next three months
- A joint initial rapid assessment and inventory of the health services (28 hospitals and 236 health centres) has been initiated for the 22 health districts and the city of Bangui.

Emergency medical assistance and disease control
- Support the provision of basic health services through NGO partners in healthcare facilities in accessible areas.
**Mali**

**Situation highlights**

Since mid-January, joint Malian and international military forces’ interventions are ongoing to stop the progression of armed groups that were occupying the northern part of the country. In recent weeks, there has been improved access in the central regions, while in the north humanitarian activities continue to be restricted by the threat of mines, violence and on-going military operations. Figures as of 20 March indicate that there are over 280 000 internally displaced people and over 177 000 Malian refugees registered in neighbouring countries.

A major challenge facing the Malian health system is the disruption of the health and sanitation structure in the north of the country as a consequence of the armed conflict. A joint assessment of health actors at the beginning of the crisis concluded that only 10% of the health structures in the north of the country are functional. Functioning health structures, both in the northern and southern parts of the country are overwhelmed with the increasing health needs of local and displaced populations.

Mali is also facing a nutritional crisis. On 25 February, the 2012 SMART survey conducted in the southern regions of the country reported that the prevalence of acute malnutrition (8.9%) and chronic malnutrition (29.1%) has reached the alert threshold at the national level, according to WHO guidelines. The results reveal that 210 000 children under five years old are at risk of severe acute malnutrition (SAM), and 450 000 are at risk of moderate acute malnutrition (MAM).

A measles epidemic has been reported in the Gao and Kidal health districts with 25 suspected cases and one death.

**Health Cluster priorities**

- Improve access to quality basic and referral health services, including reproductive health care and HIV/AIDS treatment, for crisis-affected target populations.
- Strengthen early warning surveillance systems, ensure adequate preparedness and response to diseases with epidemic potential and other disasters.
- Contribute to the rehabilitation of health facilities.
- Strengthen the coordination of emergency health interventions.

**Health Cluster response**

- A subnational health cluster is functioning in Mopti and Segou.
- In response to the measles epidemic, a vaccination campaign reached 16 111 (98% of the target) children from six months to 15 years old. Four stationary teams and 12 mobile vaccination teams conducted these vaccinations.
- From 1 January - 17 March, 28 477 children under 5 were newly admitted for acute malnutrition in nutritional rehabilitation units at the national level (OCHA).
- In partnership with the Ministry of Health, WHO has delivered anti-retrovirals, anti-diabetes medicine and other medicines/supplies to health facilities in Timbuktu that are not yet supported by humanitarian actors.
- There has been a review and reprioritization of needs to avoid shortages of medicines at the national level.
- Humanitarian assistance missions were deployed to the regions of Gao, Timbuktu, Mopti and Segou to strengthen the health system.
- A workshop was held to assess the response capacity of health structures in the district of Bamako.
- A nationwide assessment of the capacity of health facilities, including in conflict affected areas, is in progress with WHO technical support. This will form the basis of the medium-term health sector response plan. See also below: Health Resources Availability Mapping System Mali assessment
- An Inter-Agency Emergency Health Kit which will benefit 10 000 people over a period of three months was sent to a Health Cluster NGO partner in the Mopti region.

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**Statistics**

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<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tr>
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<tr>
<td>Gross national income per capita</td>
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<tr>
<td>Life expectancy at birth m/f (years)</td>
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<td>Probability of dying between 15 and 60 years m/f **</td>
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<td>Total expenditure on health per capita* (2010)</td>
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<td>Total expenditure on health as % of GDP (2010)</td>
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</table>

* Purchasing power parity international $  ** per 1000 population  *** Source: PNUD 2011

Source: WHO/WHO.

**Funding US$ 2013**  

<table>
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<tr>
<th>Health Cluster</th>
<th>WHO</th>
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<tr>
<td>Requested</td>
<td>28 885 768</td>
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<tr>
<td>Received</td>
<td>19 938 962</td>
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WHO received US $1 007 292 in 2012, 12.3% of the funds requested.

Source: OCHA/FTS.

WHO’s emergency activities in 2012 in Mali have been supported by the Central Emergency Response Fund, and the International Fund for Agricultural Development.

**For more information:**

http://www.who.int/hac/crises/mli
**Situation highlights**

It has been two years since the beginning of the Syrian crisis and, in March, the number of refugees surpassed the one million mark. As a result of the conflict, 70 000 individuals have lost their lives and an estimated further 350 000 persons have been injured. The health system has been severely disrupted, along with the health care infrastructure, with the workforce and availability of essential medicines and supplies being most affected. This has had a direct impact on the provision of primary and secondary health care (preventive and curative), including support for chronic diseases, reproductive health, infant and child health, nutrition, mental health services, and support for people with disabilities.

- 36% of hospitals and 7% of health centres are out of service.
- Functioning hospitals are overwhelmed and constrained by shortages of medicines and medical supplies.
- 70 per cent of health workers cannot access their work place in heavily-affected areas of Rural Damascus, Homs and Aleppo.
- Hepatitis A and leishmaniasis cases continue to increase: during 10–23 February, the Early Warning Alert and Response System (EWARS) reported 469 new cases of suspected hepatitis A (mostly in Aleppo, Deir-Ézorz, Ar-Raqqa, and Idlib) and 433 cases of leishmaniasis (mostly in Hamah, Aleppo and Deir-Ézorz).

**Health sector priority actions**

- Coordinate the Health Sector response by working with the Ministry of Health, the Ministry of Higher Education, non-governmental organizations and community based organizations.
- Implement interventions to fill the gaps in health service delivery through local non-governmental organizations and in cooperation with the Ministry of Health.
- Distribute essential medicines and supplies to health facilities and to implementing partners with access to conflict areas.
- Deliver a standardized package of essential quality health care services (preventive and curative) through implementing partners.
- Support the regular supply of essential medicines and supplies through a functioning supply chain with emergency medical stockpiles at the regional level.
- Update information on health needs and service availability through on-going integrated assessment missions with relevant UN partners (WHO, UNICEF, UNFPA, WFP and UNHCR) and in close cooperation with the Ministry of Health.
- Monitor service delivery and remote activities using participating non-governmental organizations and community-based organizations.
- Standardize systems for reporting with implementing partners.

**Health Sector response**

- WHO activities have resulted in the provision of basic health care supplies for over 1.4 million people from Jan 2012 – Feb 2013; 331 000 medical interventions have been performed through the distribution of medical kits and essential medicines. WHO continues to provide medicines and medical supplies to the Directorate of Health in Aleppo. This facilitated 200 surgical interventions (26 February – 11 March). Also, two ventilators, three defibrillators and four reproductive health kits have been supplied.
- From 26 February – 11 March the Jesuit Refugee Service Organization carried out 1100 surgical interventions using kits supplied by WHO.
- Three ventilators and six intensive care unit beds were delivered to the main referral hospital in Damascus (which is under the stewardship of Ministry of Higher Education) to assist with the expansion of the burns department.
- Sixty health care professionals from six governorates were trained to strengthen reporting and monitoring skills for effective disease response and management.
- EWARS sentinel sites have been expanded from 97 to 142.
- WHO and UNICEF will support the Ministry of Health in an upcoming national measles vaccination campaign scheduled for March–April 2013. This campaign will target 1.6 million children and will be conducted primarily in shelters for internally displaced people, schools and health facilities.

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**The Syrian Arab Republic**

**Statistics**

- **Total population**: 20 411 000
- **Gross national income per capita**: 5120
- **Life expectancy at birth m/f (years)**: 71/76
- **Probability of dying between 15 and 60 years m/f**: 159/95
- **Total expenditure on health per capita** (2010): 174
- **Total expenditure on health as % of GDP** (2010): 3.4

* Purchasing power parity international $ per 100 population

**Source**: WHO/GHD.

**Funding US$ 2013**

- **WHO**: Requested 81 905 133
- **WHO**: Received 48 465 000

**WHO received US$ 8 556 692 in 2012, 27.5% of the funds requested.**

**Source**: OCHA/FTS

WHO’s emergency activities in the Syrian Arab Republic in 2012 have been supported by Finland, Ireland, Italy, the League of Arab States, Norway, the United States of America, the Central Emergency Response Fund and the OCHA Emergency Response Fund.

**For more information**: [http://www.who.int/hac/crises/syr](http://www.who.int/hac/crises/syr)
The Sudan

Situation highlights

Tensions between the Sudan and the Republic of South Sudan contributed to growing economic challenges during 2012, which formed a backdrop to significant on-going humanitarian needs in the country that continue to be driven by a cycle of conflict, displacement and vulnerability. Heavy rains also caused considerable flooding and damage to property, infrastructure, crops and livestock, in many parts of the country. In addition to a worsening humanitarian crisis in South Kordofan and Blue Nile State, Darfur remains the Sudan’s largest relief operation.

The health system in the Sudan continues to face several challenges. Many primary health care facilities lack appropriate medical equipment and supplies, have inadequate infrastructure or are understaffed. The percentage of non-functioning primary health care facilities is 14% nationwide and 28% in Darfur.

Health information systems, particularly in Darfur, South Kordofan, Blue Nile and Abyei, are challenged by fragmentation, a lack of adequately trained staff as well as advanced tools and technologies needed for data collection, compilation and analysis. Furthermore, the organization of the health system and its management are weak at all levels. While the Ministry of Health has developed numerous health policies and strategies, it lacks the capacity to implement them.

Access to maternal and child health services remains low. Only 42% of health facilities provide basic emergency obstetric care and the proportion of births attended by a trained attendant is 46%. Only 18% of women benefit from postnatal care services, with security concerns often limiting access to these services. The maternal mortality ratio is disproportionately higher in conflict and disaster-prone areas, such as Darfur, South Kordofan, Blue Nile and Abyei. The percentage of children fully immunized is as low as 39.3%.

- There is inadequate and insufficient access to primary health care and referral services for 5.75 million internally displaced people, returnees, refugees and people from affected host communities in Darfur, South Kordofan, Blue Nile and Abyei and East Sudan.
- Communicable and vaccine-preventable diseases are the cause of high morbidity and mortality, particularly in conflict-affected regions.
- A low health workforce density, particularly in rural areas, with 1.2 health professionals per 1000 people in Sudan and 0.4 and 0.6 per 1000 people in Darfur and the border areas (the WHO benchmark is 2.3 per 1000 people).
- A yellow fever outbreak that started in September 2012 has affected 35 localities in Central, South, West, North, and East Darfur, and is the worst seen in 20 years. At the end of January, the total number of suspected cases reached 849, including 171 deaths.

Health priorities

- Increase utilization and strengthen quality of primary and first-referral health care services by improving equity in health service coverage and outcomes.
- Improve emergency preparedness, risk reduction, disease surveillance, and prevention and control of epidemic-prone and communicable diseases.
- Build the capacity of the health workforce to achieve sufficient numbers of trained personnel with the right mix of skills to respond to the health needs of vulnerable populations.
- Mainstream cross-cutting themes such as gender, environment, early recovery and HIV/AIDS into all health programmes.

WHO response

- More than five million people were vaccinated against yellow fever during a three-phase vaccination campaign from November 2012 to January 2013.
- Emergency medicines and essential supplies were prepositioned in health facilities located in targeted high risk areas prior to the disease seasons of meningitis and acute watery diarrhoea.
- From January to March, 95 health staff and volunteers were trained to address identified gaps in water quality monitoring, environmental health and sanitation.
WHO's internal grading process for emergencies

WHO continually monitors events happening worldwide to determine their potential impact on public health and whether an emergency response is required. Such events happen suddenly (sudden-onset) or develop progressively over time (slow-onset).

Within 24 hours of the completion of a risk assessment for a sudden-onset event, and within five days of an updated risk assessment for a slow-onset event, the WHO Global Emergency Management Team (GEMT) will convene a teleconference to grade the emergency.

WHO grading is based on the four criteria of **scale** and **urgency** of the event with respect to current or future public health consequences, as well as **complexity** and **context**.

Grading is an internal WHO process that is conducted to:

- a. inform the Organization of the extent, complexity and duration of organizational and or external support required;
- b. prompt all WHO offices at all levels to be ready to repurpose resources in order to provide support;
- c. ensure that the Organization acts with appropriate urgency and mobilizes the appropriate resources in support of the response of the affected Member State, partners and the WHO country office;
- d. trigger WHO’s Emergency Response Procedures and emergency policies;
- e. remind the Head of the WHO country office (HWCO) to apply WHO’s Standard Operating Procedures (SOPs) as per the Director General’s memorandum of 15 January 2008; and
- f. expedite clearance and dissemination of internal and external communications.

**Ungraded**: an event that is being assessed, tracked or monitored by WHO but that requires no WHO response at the time.

**Grade 1**: a single or multiple country event with minimal public health consequences that requires a minimal WHO country office (WCO) response or a minimal international WHO response. Organizational and/or external support required by the WCO is minimal. The provision of support to the WCO is coordinated by a focal point in the regional office.

**Grade 2**: a single or multiple country event with moderate public health consequences that requires a moderate WCO response and/or moderate international WHO response. Organizational and/or external support required by the WCO is moderate. An Emergency Support Team, run out of the regional office, coordinates the provision of support to the WCO.

**Grade 3**: a single or multiple country event with substantial public health consequences that requires a substantial WCO response and/or substantial international WHO response. Organizational and/or external support required by the WCO is substantial. An Emergency Support Team, run out of the regional office, coordinates the provision of support to the WCO.

For further details on the grading process please see the WHO Emergency Response Framework [http://www.who.int/hac/about/erf_.pdf](http://www.who.int/hac/about/erf_.pdf)

**WHO country grading status (as of 28 March)**

<table>
<thead>
<tr>
<th>Country</th>
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<th>Latest grading</th>
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<td>The Central African Republic</td>
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<td>March 2013</td>
</tr>
<tr>
<td>The Syrian Arab Republic</td>
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<td>January 2013</td>
</tr>
<tr>
<td>The Philippines</td>
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<tr>
<td>Nigeria</td>
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<td>The Democratic Republic of the Congo</td>
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<td>July 2012</td>
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<td>Pakistan</td>
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</tr>
<tr>
<td>Mali</td>
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</tbody>
</table>
Cluster Performance Monitoring process (CPMp)

Monitoring coordination performance at national and sub-national level in both sudden onset and protracted crises is necessary to ensure that clusters are efficient and effective coordination mechanisms, fulfilling the core cluster functions, meeting the needs of constituent members, and supporting the delivery of health services to affected populations.

The Global Health Cluster plays a prominent role in supporting the launching of the process at country level by; i) providing technical support to the country cluster teams; ii) providing a technical platform for the implementation of the online questionnaires to be completed by cluster partners and cluster coordinators; iii) overseeing the generation of an automatized report after the completion of the surveys. The Global Health Cluster also supports the process by advocating for partners’ active participation in the CPMp by responding to the questionnaire in a timely manner and also ensuring representation at relevant senior level in the final meeting to discuss the results and formulate recommendations for cluster improvement.

After the completion of the CPMp in Somalia (December 2012 – February 2013), a synergized roll-out of the coordination performance monitoring process across all clusters in a number of countries (the occupied Palestinian territory, the Republic of South Sudan, Afghanistan, The pacific/Fiji and the Philippines) is underway. During the week of March 11th the process was launched in the occupied Palestinian territory and in the Republic of South Sudan with the participation of the Health Sector/Cluster. In line with the Global Health Cluster workplan for 2013, the Global Health Cluster plans to support the process in at least 10 countries including the countries where the Inter-agency Standing Committee is planning a joint roll out of the process.

Health Resources Availability Mapping System Mali assessment

At the request of the WHO Mali Country Office, WHO is performing an exhaustive assessment of the availability and readiness of country’s health services, both public and private, including primary, secondary and tertiary health care. The assessment is an adaptation of the Health Resources Availability Mapping System (HeRAMS).

The framework for the assessment was established during the second half of February and data collection began mid-March. An on-line data collection tool was developed to facilitate the assessment. The expectation is that data collection will be finished by mid-April and the data analysis will be completed by the end of April. The data analysis will be performed at headquarters level with tables, graphs and maps to describe the findings. The final report, provided by the WHO Mali Country Office is expected in May.

There has been a request from the WHO Regional Office for Africa to use the same methodology to assess the availability and readiness of the health services in the Central African Republic. Each assessment will be adapted to the specific country.

This monthly report, which is not exhaustive, is designed for operational use and does not reflect any official position of the WHO Secretariat. The designations employed and the presentation of the material do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.