**Situation highlights**

As of 18 December 2013, the security situation in the Central African Republic (CAR) was stabilizing somewhat after the rapid deterioration of inter-communal and inter-religious violence that had taken place in previous weeks. The humanitarian situation remains catastrophic, with around 2.3 million of the country’s population of 4.6 million in need of urgent humanitarian assistance. Many people have responded to the widespread human rights violations by fleeing their homes; as of 17 December, OCHA estimated that there were some 639,000 internally displaced people (IDPs) in the country.

The Inter-Agency Standing Committee (IASC) graded the crisis Level 3 on 11 December 2013, and on 16 December the crisis was graded G3 under WHO’s Emergency Response Framework (ERF).

Even before the latest upsurge in violence, the health situation in the country was precarious, with some of the world’s worst health indicators: an infant mortality rate of 173 per 1000 live births, an under-five mortality rate of 159 per 1000 live births, and a maternal mortality ratio of 890 per 100,000 live births.

Health assessments conducted by the Ministry of Health and Health Cluster partners between June and August 2013 showed a drastic reduction of access to health care with shortages of medical supplies due to insecurity affecting supply chains; health workers fleeing insecurity and leaving health facilities non-functional; looting of health facilities by armed groups (more than 50% of health units had been vandalized or looted and lacked essential medicines); and weak disease surveillance in a context of poor living conditions and a high burden of communicable diseases.

In the crisis-affected zones, many nutritional centres had been closed or were not functioning normally, and there were pockets of severe malnutrition such as in Sangha-Mbaéré: Marathe (Global Acute Malnutrition: 13.7%) and in Lobaye: Boda (Global Acute Malnutrition: 10.9%).


As of early November, the Central African Republic was at high risk of Poliovirus reintroduction.

Health priorities

- Improve access to essential primary and secondary health services, including support for treatment and control of infectious diseases, trauma care, child health, reproductive health (especially emergency obstetric care), nutrition services and chronic diseases, such as HIV/AIDS and TB, and mental health. This includes free life-saving assistance provided to targeted populations.
- Ensure a coordinated and comprehensive needs-based response by all health partners, based on the results of objective assessments; standardized monitoring of effectiveness and achievements; strengthen and increase the presence of skilled staff for health coordination at national as well as sub-national levels, including improved logistic support to the health cluster coordinator and co-facilitator.
Health Cluster response

Coordination:
- The national Health Cluster in Bangui has been strengthened with a crisis committee and the arrival in-country of a level 3 capable Health Cluster Coordinator.
- Technical expertise and advice is being provided to the Ministry of Health on assessments, planning, disease surveillance and epidemic response, among other areas.
- WHO is participating in multisectoral coordination meetings and convening health cluster meetings.

Health service delivery:
- Health Cluster partners are carrying out surgical interventions, including obstetric surgery, and are donating medicines and medical supplies to hospitals, health centres and dispensaries, including surgical kits, malaria kits, individual delivery kits, delivery beds, condoms and dignity kits and supplies.
- 34 spontaneous IDP settlements have been mapped and Health Cluster partner support allocated to each one.
- Drugs and equipment for 200,000 people have been provided by Health Cluster partners to the IDP sites and health facilities. WHO is shipping essential medicines for an additional 180,000 people for three months.
- Four ambulances have been deployed to affected zones to support referral of patients.
- Despite ongoing insecurity, humanitarian staff including the ICRC, NGOs and the UN, are operating in Bangui, Bouar, Paoua, Zemio, Kaga Bandoro, Batalimo, Bambari and Bossangoa.

Scaling up WHO operational capacity:
- Following the grading of the crisis as G3, WHO has mobilized organization-wide support for the country. Emergency operations centres across the three levels of the organization have been activated. As per standard practice under WHO’s ERF, the Emergency Support Team is monitoring performance against the Emergency Response Procedures.
- Initial deployments to the Country Office have already commenced to strengthen WHO’s leadership, coordination, assessment, information, logistics, programming and communications capacities; WHO has repurposed its 32 staff in CAR and established an Emergency Response Team (ERT) under the direct supervision of the WHO Country Representative. Approximately 40 additional experienced staff are also being mobilized through the WHO regional and global surge mechanisms, as part of a 3-month initial staffing plan that will be regularly reviewed.
- An Emergency Support Team has been established in AFRO/SHOC in Brazzaville to coordinate WHO technical and operational support, with a backstopping team established at HQ;
- Staff recently withdrawn from Bouar/Bossangoa and Kaga Bandoro will be redeployed as soon as security allows and these hubs strengthened. Additional Health Cluster hubs will be established in Bambari and two other potential sites.
- Rapid Response Funds have been released from the WHO regional Office for Africa and Headquarters.
The Philippines

Situation highlights: Typhoon Haiyan

A month has passed since super typhoon Haiyan struck the Philippines, causing widespread flooding and damage to infrastructure; 44 provinces out of a total of 81 have been affected, with Regions VI, VII and VIII accounting for 90% of the total affected population. The most severely affected areas were Tacloban City, Leyte, Northern Iloilo and Eastern Samar.

As of 13 December 2013, the National Disaster Risk Reduction Management Council reported 6009 deaths, 27 022 injured and 1 779 missing. More than 16 million people have been affected with 3 927 827 people displaced, of whom 101 646 are currently living in 383 evacuation centres. Rapid health assessments suggest that more than 2258 health facilities are no longer fully functioning.

Damaged roads, fallen trees and debris continue to hamper the humanitarian relief operations and delivery of medical services.

The Government, which is operating under a state of national calamity, is leading the Health Cluster, with WHO as co-lead.

Data from emergency disease surveillance reports continue to indicate that the most common reasons people are seeking medical help are: acute respiratory infections, fever, diarrhoea, high blood pressure, skin disease and wounds. Wounds include both new injuries from cleaning debris and follow-up care for those injured in the typhoon.

Health priorities: identified by the Department of Health (28 November)

Child health

- Expanded Program on Immunization (polio and measles vaccine, including syringes, freezers, cold box, vaccine carriers, ice packs and thermometers)
- Vitamin A and micronutrient supplementation
- Oral rehydration salts and zinc syrup

Maternal health

- Emergency delivery kits
- Iron supplementation for pregnant and post-partum women

Communicable diseases

- Insecticide for mosquitoes to prevent dengue, malaria and other vector-borne diseases
- Doxycycline

Noncommunicable diseases

- Maintenance medications for hypertension, heart diseases and diabetes

Health Cluster response

- The emergency is categorized as Grade 3 – the highest internal emergency category under WHO’s Emergency Response Framework (ERF). WHO has mobilized organization-wide support for the country. Emergency operations centres across the three levels of the organization have been activated. The Global Health Cluster and the Global Outbreak Alert and Response Network (GOARN) have also been activated to mobilize support.

- Following the ERF procedures, and to fulfil WHO’s core functions in emergencies, staff from the Western Pacific Regional Office, Headquarters and other regional offices have been repurposed and deployed to support the WHO Country Office (as of 2 December, 95% of surge positions had been filled, with 87 staff repurposed and deployed against 92 positions). To date, 130 staff have been deployed and repurposed from HQ, six Regional Offices, the Global Outbreak Alert and Response network, NGOs and stand-by partners.

- As of Day 22 of the crisis response, WHO had met 81% of the Performance Standards for emergency response on time; a further 19% had been met within a
Emergency Risk Management and Humanitarian Response

Health emergency highlights

- Daily Health Cluster meetings are held in Manila and sub-national clusters are active in Cebu, Ormoc, Roxas, Tacloban and Samar.
- At national level, five technical sub-working groups have been set up on reproductive health, mental health, vaccination and cold chain, health services planning, and communicable disease surveillance.
- Assessments, tracking and mapping will continue to: estimate the amount of damage and health service availability; better define affected populations and needs; evaluate resources available and what will be required; and refine understanding of the location and activities of health partners.
- A package of global and national guidelines in specific public health areas has been distributed to partners on the ground. As of 6 December, 58 registered Foreign Medical Teams are operational in the affected areas, composed of more than 918 medical staff. There are a further 12 medical teams that have not yet registered. An additional 117 national and local medical teams have also been deployed to the affected areas.
- WHO, in support of the DOH, is developing a logistics tracking and monitoring mechanism to identify gaps in supplies of essential drugs and supplies. Emergency medical supplies for one month for 303 000 beneficiaries have been delivered, including 2000 doses of tetanus immunoglobin.
- As of 3 December vaccinations in Tacloban have been expanded to other communities in Samar and Leyte. Around 10 000 children have been vaccinated against measles and polio in Tacloban and neighbouring communities. Further mass vaccination campaigns will begin next week in and around Ormoc and in earthquake affected Bohol.
- Maternal and child health programmes are being scaled up in evacuation centres. Breastfeeding promotion is being conducted at the vaccination posts.
- Dead body management under the leadership of the DOH, and involving WHO and other partners, is being undertaken on the basis of WHO guidelines.
Two decades of conflict have devastated Somalia’s health sector, leaving the country with some of the worst health and nutrition indicators in the world. An estimated 18 children out of every 100 die before their fifth birthday, which amounts to 70,000 deaths a year. The main causes of death are pneumonia, diarrhoea and measles, as well as infections and other problems in the first month of life. Poor hygiene and sanitation, and a high rate of malnutrition among children have a direct correlation with high child mortality and morbidity in the country. In addition, every two hours a Somali woman loses her life due to pregnancy-related complications.

Somalia experiences recurrent outbreaks of communicable diseases, particularly polio, cholera, measles, malaria, dengue fever, whooping cough and diphtheria. As of 18 November there had been 183 cases of polio in the country in 2013.

The quality of health, nutrition, education and water and sanitation services remains extremely poor as a result of the conflict, weak governance, lack of access, insufficient numbers of skilled staff, as well as low and irregular salaries.

Violence in southern Somalia, particularly in Mogadishu, Kismayo and Beletweyne, increases displacement of civilians, limiting their access to health care, amplifying the risk of outbreaks of communicable diseases and hampering vaccination campaigns.

On 14 August, MSF announced its withdrawal from Somalia after 22 years of continuous support. The Health Cluster estimates that approximately 1.5 million people may lack access to health services as a result.

**Health priorities**

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

**Health Cluster response**

- The Somali Health Cluster works with over 140 Health Cluster partners, including NGOs, communities, health authorities, other clusters (in particular Nutrition, WASH and Protection), UN agencies and others to provide emergency and recovery health services.
- The Somali health authorities, along with three UN agencies and development partners, have signed a five-year Joint Health and Nutrition Programme 2012–2016 to scale up the delivery of essential reproductive, maternal, newborn and child health and nutrition services for women, children and girls, in particular.
- WHO continues to support hospitals and health service providers in remote areas of south and central Somalia. Emergency trauma surgery, obstetric care and health services are provided for the most vulnerable groups, such as women, children, and displaced persons.
- Between January and October 2013, over 3800 wounded civilians were treated at four major hospitals supported by WHO in Mogadishu. Another 1100 civilians were treated at the main hospital in Kismayo.
- A country-wide polio vaccination campaign carried out in October and November
targeted Somalia’s entire population, including adults. Further campaigns are planned for December, and response planning will continue into 2014.

- Following the withdrawal of MSF from Somalia, the Health Cluster is working with all stakeholders to ensure the handover of MSF-supported health facilities to partners with the capacity to provide quality service to the Somali population. The current funding received will allow health partners to support the most vital services until April 2014. The Health Cluster reports that an additional US$ 7 million will be required to run and maintain the most essential 12 of the 14 health facilities vacated by MSF (Oct 2013).
- The health authorities stepped up to support the staff working in the TB centres previously supported by MSF, while WHO and partners will provide anti-TB medicines, laboratory supplies, technical assistance and monitoring of the patients. Sufficient anti-TB drugs are available until June 2014 in the 68 TB centres in Somalia.
- Mass screening against malaria (for 200 000 people) and strengthening of Comprehensive Emergency Obstetric Care activities (15 000 women assisted in facilities supported by WHO) have continued in 2013.
- In September 2013, WHO and the health authorities in Puntland conducted a training workshop for 19 participants (lab technicians and blood bank staff) on basic laboratory and blood safety procedures.
- In August, WHO provided 15 health workers (including doctors, nurses and lab technicians) with training on screening, diagnosing, management and referral of malaria cases.
- Training for 45 Lady Health Workers began in Mogadishu in August, aimed at improving access of the rural population to basic essential reproductive maternal and child health services. This is part of a larger programme that is being rolled out across Somalia, involving 200 Lady Health Workers and 40 maternal and child health centres.
- In November 2013, WHO started a baseline survey on child and maternal health issues in three regions of central and southern Somalia to support evidence-based decision-making and improve resource allocation for an equitable delivery of health services.
Situation highlights

Inter-communal violence in Rakhine State in 2012 resulted in the displacement of 143,000 people. Many of these IDPs have been housed since then in 76 camps and camp-like settings – 91,000 people, including over 53,000 in areas beyond the Government’s control. The violence has continued sporadically, causing further displacement and severely hampering the ability of humanitarian agencies to deliver emergency assistance, especially in Myebon. While the majority of the affected people have access to primary care, and limited access to other health services, major gaps remain. Over 7,000 affected people in inaccessible areas have only intermittent access to services. The majority of IDPs lack access to hospitals. An inter-agency assessment mission in October found that there are substantial needs among the IDPs in terms of food, livelihoods, education, health, water, sanitation and hygiene, shelter, non-food items and protection.

In May, the impact of Cyclone Mahasen, along with flooding in July and September, led to the displacement of tens of thousands of people in various parts of the country, although many were able to return home once the floodwaters subsided.

Health priorities

- Support the dialogue in Rakhine State aimed at guaranteeing unimpeded access for affected people to health services.
- Strengthen health-care services for affected communities in Rakhine State, in particular routine immunization, maternal and child health, referral systems, disease surveillance, mental health and psychosocial support, gender-based violence case management, and health education, including through training of health personnel.
- Target host communities and isolated settlements in Rakhine State, as well as IDPs previously cut off from available services, to provide access to health services.

Health Cluster response

- Core primary care services have been established for people affected by inter-communal violence in Rakhine State. These primary care services include: mobile clinics delivering primary health care to most camps (including in Myebon); essential medicines and supplies for the mobile clinics; referral services for acutely ill patients, high-risk pregnant women and specialist consultations; provision of emergency obstetric care and maternal health care, including access to contraceptives and reproductive health kits; mental health and psychosocial support; treatment of TB and AIDS patients.
- WHO and partners are supporting the Government in prevention, control and surveillance of communicable diseases in Rakhine State through the establishment of an Early Warning and Response System, collection, compilation, and analysis of surveillance data and delivery of samples to the National Health Laboratory in Yangon in case of disease outbreaks, and through health education.
- In September, the International Drug Purchasing Facility (UNITAID), WHO and the Stop TB Partnership made the largest rollout to date a state-of-the-art test for TB that shortens the time to diagnose drug-resistant strains to only a few hours.
- In response to cyclone Mahasen and flooding in various parts of the country the Government, with the support of WHO, organized health sector coordination meetings, supplies and logistics and established mobile health teams. The Ministry of Health and health sector partners deployed 10 mobile teams to Sittwe. WHO provided emergency health supplies, organized mobile clinics, distributed technical guidelines, and provided operational support, by deploying staff to affected areas. WHO South-East Asia Office provided US$ 175,000 from the regional emergency fund for emergency and early recovery interventions.

In May 2013, WHO Member States decided to establish a Financing Dialogue to open discussions on how to fully fund the WHO Programme Budget. On 25-26 November 2013, the Director-General convened the second session of the Financing Dialogue in which 266 participants from 92 Member States and 14 non-State partner organizations participated in person or via webcast.

The Financing Dialogue aims to ensure a match between WHO’s results and deliverables as agreed in the Member-State approved Programme Budget, and the resources available to finance them, with the ultimate objective of enhancing the quality and effectiveness of WHO’s work. It is designed to improve the alignment, predictability, flexibility and transparency of WHO’s funding and to reduce its vulnerability.

In order to ensure that all components of WHO’s programme for 2014–2015 are sufficiently financed and that donors and Member States obtain information about the progress made in achieving results, WHO has developed a web portal that describes each area of work and provides answers to the following questions: 1) What do we want to achieve? 2) What do we do? 3) What resources do we need? 4) How are we financed?

The area of work of Emergency Risk and Crisis Management (ERCM) is located under the Category Five ‘Preparedness, Surveillance and Response’.

The budget for ERCM for 2014–2015 amounts to US$ 88 million for all levels of the Organization. Detailed information on objectives, activities and expected outcomes is available at the following website: https://extranet.who.int/programmebudget/Programme/Overview/28.

Do not hesitate to contact us should you have any questions about contributing to WHO’s work for Emergency Risk and Crisis Management.

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