**Situation highlights**

Afghanistan has been in a state of protracted crisis for 30 years caused by on-going conflict, recurrent natural disasters, weak governance and underdevelopment, scarce resources, and unsustainable systems of livelihood.

Despite significant progress since 2000, more than 30% of the population still has no access to, or has difficulty accessing, essential health care. In the south and east where armed conflict is escalating, the situation is worse. Between 50% and 70% of the population have no functional health facilities in their districts. At present there are more than 570 000 internally displaced people (IDP) in the country, mainly as a result of conflict and deterioration of the general security situation. Almost 90 000 people have been displaced during 2013.

Security risks for the humanitarian community remain high, with 104 incidents of violence against humanitarian personnel reported since the beginning of the year. The health cluster reported a 40% increase in security incidents involving health facilities, staff and patients from Logar, Faryab, Daykundi, Paktika, Nuristan, Kunar, Kandahar, Badakhshan, and Balkh. Conflict and road insecurity also led to the temporary suspension of health services and outreach activities in some provinces, with significant access difficulties encountered in the eastern region.

In 2013, over 120 000 people were affected by floods (mainly) and earthquakes. The significant increase in hospitalized and outpatient war victims in Helmand, Kunar, Maidan Wardak and Kabul put an additional burden on health facilities, referral mechanisms, and the weak health system. Health sector and Inter-agency contingency planning and preparedness measures helped to mitigate the humanitarian impact. According to OCHA, the response reflects a recent strengthening in domestic disaster management capacity; the assumption of a lead coordination role by the Afghanistan National Disaster Management Authority and a well-functioning partnership between the Government and the international community. This is a significant step as, in Afghanistan, crises are not caused by the scale or severity of the emergency, but rather by the lack of local capacities and mechanisms to respond.

**Health Cluster priorities**

- Support timely access to emergency health care services with a focus on maternal and child health for communities affected by humanitarian emergencies.
- Support the mass casualty response through better mass casualty management planning, sufficient supplies and human resources capacity building focusing on high risk provinces/regions
- Strengthen the disease early warning mechanism and respond promptly to outbreaks that surpass the local response capacity across the country.
- Establish a water quality control mechanism in emergency situations
- Address the health needs of especially vulnerable groups requiring humanitarian aid (e.g. IDPs, refugees, persons in informal settlements and host communities).

**Health Cluster response**

- In 2013, WHO and the Health Cluster supported the establishment of 62 temporary mobile and static clinics to cover the essential health needs of 708 000 people affected by conflict, including IDPs.
- WHO prepositioned medical supplies to cover the essential health needs and respond to acute watery diarrhoea outbreaks for 180 000 people in high risk provinces. So far, 93% of 102 outbreak alerts have been investigated and response initiated within 24 hours from notification resulting in rapid containment and low case fatality rate (within internationally agreed standard).
- Provided essential medicines to support the functioning of newly established temporary clinics (covering 300 000 people) and trauma supplies in Kabul and Helmand and trained 60 people on rapid water quality testing in emergency situations.
- Translated national guidelines for response to cholera, typhoid and hepatitis outbreaks and trained 120 health managers from central and provincial level. Printed and disseminated 20 000 posters across the country on hand hygiene and infection prevention.

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**Statistics**

- Total population: 31 412 000
- Gross national income per capita*: 1140
- Life expectancy at birth m/f (years): 59/61
- Probability of dying between 15 and 60 years m/f **: 289/245
- Total expenditure on health per capita* (2010): 50
- Total expenditure on health as % of GDP (2010): 9.6

* purchasing power parity international $

** per 1000 population

Source: [WHO/GHO](http://www.who.int).
Mali

**Situation highlights**

As a result of the on-going conflict in Mali, large-scale humanitarian needs persist. According to the latest estimates from 20 June there are 353 455 internally displaced persons (IDP) (Population Movement Commission), and 174 129 refugees in neighbouring countries (UNHCR). OCHA reports that the number of IDPs (298 027) has increased compared to previous reports due to recent assessments updating the number of IDPs in Gao, Kidail and Timbuktu.

Precarious water, sanitation and hygiene conditions pose a serious risk of a rise in the incidence of water-borne diseases. This risk of water-borne diseases and particularly cholera has been compounded by the arrival of the rainy season, and partners are concerned about at potential resurgence in the cholera epidemic. Between July and October 2012, a cholera outbreak erupted in two districts of Gao region: Gao and Ansongo. In May 2013, another cholera outbreak was rapidly contained in Ansongo. As a result, the Health and WASH clusters are advocating additional resources for the prevention of water borne disease and repairs to water distribution systems.

Food insecurity is a major problem as the lean season has begun in the northern regions. According to food security partners, 3.5 million people are experiencing food insecurity. This includes 1.4 million people in need of immediate food assistance.

Even though the security situation in the north is improving and the presence of humanitarian organizations is increasing, health programmes in the three northern regions are limited. The return of health personnel to the north continues gradually and the redeployment of other health personnel is needed for health activities to fully resume.

**Health Cluster priorities**

- Provide emergency healthcare to people affected by violence by providing medicines and medical supplies, deploying trained staff and organizing emergency services.
- Restore essential health services in accessible areas in the north.
- Sustain health service delivery to IDPs and other people affected by the crisis in all parts of the country through medical supply provision and using mobile clinics to fill health service gaps.
- Continuously monitor health service availability and essential needs for recovery and build resilience.
- Monitor communities’ health status through disease surveillance and response system.
- Strengthen health coordination to ensure an efficient health response based on joint priority setting related to the evolving situation.
- Mobilize financial resources to support the implementation of the health recovery plan.

**Health Cluster response**

- Following the WHO measles risk assessment that identified 26 vulnerable district a national measles response plan was developed.
- A measles vaccination campaign was organized in three districts of Bamako (I, II and IV) following confirmation of cases in Bamako in May. Nearly 74,000 children between six months and five years were vaccinated.
- From 5-11 July a multi-antigen immunization campaign targeting 600,000 children in the North will be funded and supervised by WHO in collaboration with the Health Cluster members and MoH. From 26-29 May, National Immunization Days were funded by WHO. A total of 6 691 625 children were immunized against polio for a target of 6 291 873 in 47 districts. 5 630 394 children received vitamin A and 5 039 405 children from 12 - 59 months received Albendazole.
- With financial support from Finland, WHO has facilitated the return of 116 health workers in the north in May.
- WHO is finalizing the analysis of the Malian health system for the entire country. This critical information will lay the basis for the reconstruction of the health system in Mali.
- WHO supported the Mali Medical Council to provide emergency health care in northern regions; more than 10,000 people received health care in three outreach missions.

**Statistics**

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<thead>
<tr>
<th>Health Cluster</th>
<th>WHO</th>
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**Funding US$ 2013**

- 19 938 962

Source: OCHA/FTS.

WHO’s emergency activities in 2013 in Mali have been supported by the Central Emergency Response Fund and Finland.

For more information: http://www.who.int/hac/crises/mli
WHO participation in the IASC-led emergency simulation exercise

Following months of inter-agency preparations, WHO participated in a 2-part IASC-led emergency simulation exercise this month. The objective was to enhance the collective response capacity of IASC members, deepen awareness of agency mandates and operational procedures, and create a culture of trust and common purpose. The first component from 18-21 June tested the procedures of the IASC and individual agencies in the initial 72 hours following the reporting of an event (an earthquake in a fictitious country in central Asia). During this component, WHO tested its ability to deliver on the its initial requirements as per the Emergency Response Framework (assessment of the situation, first situation report, internal grading) and its obligations to the IASC (participation in the Emergency Directors Group meeting, contributions to the Preliminary Scenario Definition, and participation of the Director General in the ad hoc IASC Principals meeting to determine the classification of the emergency, the leadership model, the activation or not of the Inter-Agency Rapid Response Mechanism (agency/cluster surge teams) and joint key messages on the emergency from the IASC. The second component of the simulation ran from 24-28 June and tested the requirements of individual agencies and cluster lead agencies during the first 5 days following deployment of the IARRM surge teams including the development of a 4W (who is doing what where and when), the health sector strategy and the health sector appeal. While many lessons were learned on how to improve on the application of WHO’s procedures and obligations under its ERF and the IASC, the simulation demonstrated the effectiveness of WHO’s reforms in emergency response as well as those of the IASC’s Transformative Agenda.

June 2013 Health Cluster Coordinator meeting

With the aim to strengthen the linkages between the GHC and country Health Clusters, and to ensure the effectiveness of country clusters, the GHC secretariat hosted the annual Health Cluster Forum in Hammamet, Tunisia from 17-19 June 2013. Through peer sharing, focus group discussions, and interaction with experienced speakers, the overall purpose of the Health Cluster Forum was to steer the country Health Clusters towards fulfilling their roles as efficient and effective coordination mechanisms at country level, achieving the core cluster functions, meeting the needs of constituent members, and supporting the delivery of health services to populations affected by humanitarian emergencies.

The Forum was a key opportunity to document lessons learned and good practices from experienced Health Cluster Coordinators, agree on measures for improving the Health Cluster performance at country level, and identify steps for operationalizing the IASC transformative agenda TA in country Health Clusters.

The Health Cluster Forum meeting brought together 48 participants:

- 28 professionals representing 24 Country Health Clusters/Sectors (9 AFRO, 12 EMRO, 1 EURO, 2 SEARO, 2 WPRO, 2 AMRO/PAHO);
- 4 WHO regional office representatives (2 AFRO, 1 WPRO and 1 AMRO/PAHO);
- 6 WHO Headquarters representatives;
- 4 Country Health Cluster partners (2 Merlin, 2 IMC and 1 from MoH Afghanistan);
- 3 GHC Core Group partners (Care, IMC, Merlin);
- 1 Ex Health Cluster Coordinator (S. Sudan).

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