

2015 WHO Humanitarian Response

Department for
Emergency Risk Management and
Humanitarian Response (ERM)

Summary of health priorities and
WHO projects in
interagency strategic response plans
for humanitarian assistance to
protracted emergencies



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Contributors to WHO's risk management and humanitarian response work in 2014

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Australia, Canada, China, Finland, France, Israel, Italy, Japan, Japan Kindergarten, Kuwait, Monaco, New Zealand, Norway, Innovation Norway, the Republic of Korea, the Russian Federation, Saudi Arabia, South Africa, Spain, Sweden, Switzerland, Turkey, United Arab Emirates, the United Kingdom of Great Britain and Northern Ireland, the United States of America, the Central Emergency Response Fund, the European Commission Humanitarian Aid and Civil Protection Office (ECHO), the United Nations Office for the Coordination of Humanitarian Affairs, the United Nations Development Programme Common Humanitarian Fund, and the World Food Program.

Foreword

In 2014, WHO and humanitarian health partners responded to an unprecedented number of concurrent major humanitarian crises. Fuelled by conflict, the crises in the Central African Republic, Iraq, South Sudan and Syrian Arab Republic have threatened the health of tens of millions of people and pushed health services to the limit, in some cases to the point of collapse. Typhoon Haiyan in the Philippines left millions of people without access to basic services and health care in just a few hours. WHO, using the grading system adopted in 2013, declared these emergencies Grade 3, requiring a global response by the Organization.

WHO and health partners have stepped in to fill these widening health care gaps to ensure life-saving and routine care for millions, including displaced persons and host communities. This includes routine immunization programmes against measles, polio and other vaccine-preventable diseases, delivering medical and health services ranging from surgical care to treatment for non-communicable diseases (such as cancers, diabetes, heart and lung diseases), and providing primary health care support to remote and besieged communities.

In responding to five Grade 3 crises, including the Ebola crisis, as well as delivering humanitarian health operations in 26 other countries, WHO has demonstrated the Organization's ability to respond to major health emergencies. But the huge stresses posed by these simultaneous and protracted crises have demonstrated the extent to which the capacity of the humanitarian system is stretched.

Furthermore, the scale of the crises in 2014 has put a significant strain on financial resources within the humanitarian community. Out of a total funding requirements of US\$18 billion in 2014, only 59% of funding was received. The health sector received only 49% of its requirements, and WHO only 40%.

As Health Cluster lead, WHO plays a central role in leading, coordinating, and supporting the health sector response in these countries. The Emergency Response Framework, published in 2013, has resulted in more predictable and effective WHO action in areas such as rapid assessments, coordination mechanisms, reporting, disease surveillance and response systems and health action plans.

WHO continues to find ways to become more effective and efficient. Experience from the response to the Typhoon Haiyan in the Philippines, for example, has led to better coordination of the foreign medical teams that arrive in the aftermath of a sudden-onset disaster. WHO has strengthened its collaboration with members of the Health Cluster and has also engaged a number of stand by partners (CANADEM, iMMAP, Norwegian Refugee Council and RedR Australia) to increase the global surge capacity.

The pressure of delivering in multiple emergency situations has also led to the use of new implementation modalities. In the Central African Republic, WHO facilitated the payment of the salaries of healthcare workers so that they could return to work, and in the Syrian Arab Republic and Iraq, WHO has found ways to deliver medicines and health services in the middle of intense conflict through local NGOs.

Through its in-country presence, technical authority and global leadership, WHO remains well-placed to lead the delivery of health assistance in emergencies. However, to continue to do so effectively, increased international support is necessary. There has never been a time when we are more dependent on the commitment of the international community to assist those most in need of humanitarian health support around the world.

In 2015 WHO and health partners are responding to protracted emergencies in 32 countries. The total number of people targeted for health assistance as of March 2015 is 74.9 million. Funding requirements for health partners appealing through the strategic response plans coordinated by OCHA stand at US\$ 18 billion, out of which WHO requires US\$ 499 million. These funding requirements will increase over the year as additional strategic response plans are published.

This document provides an overview of health priorities and WHO projects in the strategic response plans that have been developed to meet humanitarian needs in protracted emergencies in Afghanistan, the Central African Republic, the Democratic Republic of the Congo, Iraq, Myanmar, occupied Palestinian territory, the Sahel region (Burkina Faso, Cameroon, Chad, Mali, Mauritania, Niger, Nigeria, Senegal and The Gambia) Somalia, South Sudan, Sudan, the Syrian Arab Republic, Ukraine and Yemen in 2015. It also includes support to refugees from the Central African Republic, South Sudan and the Syrian Arab Republic who have fled to neighbouring countries. The Central African Republic refugees in Cameroon, Chad, Congo, and the Democratic Republic of Congo; South Sudan refugees in Ethiopia, Kenya, Sudan and Uganda; and the Syrian Arab Republic refugees in Egypt, Jordan, Iraq, Lebanon and Turkey.



Afghanistan

The scale of humanitarian need in Afghanistan is a result of conflict, chronic under development, poverty, deprivation and protracted crises that span several decades and affect all 34 provinces.

Conflict continued unabated in 2014, expanding and changing in its nature as power struggles between state and non-state armed actors intensified and military power transitioned from international to national control. The number of children and women killed and wounded in the conflict has continued to rise, with 24% more children and 18% more women killed or wounded in 2014 compared to 2013.

In the first nine months of 2014, 105 800 people were displaced by conflict, compared to 90 300 in the same period in 2013, an increase of 17%. An additional 225 000 people fled to Afghanistan following the start of military operations in Pakistan's North Waziristan Agency. Heavy rains and flooding in 2014 necessitated emergency assistance for approximately 120 000 people.

Health Sector Situation

Afghanistan's population suffers from some of the worst health indicators in the world, brought about in part by more than 30 years of war and insecurity. However significant progress has been made since 2003 due to greatly expanded aid flows. Innovative service delivery strategies implemented by the Ministry of Public Health have been introduced to channel external assistance. They include the implementation of the Basic Health Service Package and the Essential Package for Hospital Services.

The Ministry of Public Health estimates that the Basic Health Service Package covers around 65% of the population. The majority of those without coverage live in insecure or hard-to-reach areas. The 2012 National Risk and Vulnerability Assessment estimated that 85% of the population lives within two hours of a health facility. However, the intensified conflict has reduced the ability of rural populations to access health services due to checkpoints, military action and lack of transport. In some provinces, fighting has caused damage to health facilities.

Pneumonia and diarrhoea are the leading causes of death in young children. There are approximately 1.7 million cases of acute watery diarrhoea each year and around 600 000 cases of acute respiratory infections. Both of these conditions can be avoided and treated by appropriate and inexpensive interventions, where access is allowed.

There is a shortage of trained surgeons, anaesthetists and trauma capacity in conflict-affected areas. There are on average only three health workers per 10 000 Afghans, substantially below the minimum standard of 22 health workers per 10 000. Furthermore, conflict-related constraints to health care delivery have contributed to low immunization coverage and increased morbidity and mortality risk, especially for children and pregnant women.

No national resources are allocated for provision of basic health care during emergencies, despite the country suffering from numerous natural disasters and widespread conflict. Hence, reliance on the international community remains essential, especially given existing vulnerabilities including inadequate infrastructure, weak institutional and human resource capacity, weak economic governance, deteriorating security and high population growth.

There are concerns that the end of the international combat mission will

Baseline indicators		Estimate
Human development index ¹	2013	169/187
Population in urban areas%	2012	29
Population using improved water source%	2012	64
Population using improved sanitation%	2012	29
Life expectancy at birth (years)	2012	60
Infant mortality rate / 1000 ²	2013	70
Under 5 mortality rate / 1000 ²	2013	97
Maternal mortality ratio / 100 000 ²	2013	400
Measles coverage among one year old's%	2013	75
Wasting% ³	2004	8.6

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in Afghanistan from the Central Emergency Response Fund, the European Commission Humanitarian Aid and Civil Protection, France, the United Nations Development Program Common Humanitarian Fund, the United Nations Office for the Coordination of Humanitarian Affairs and the United States of America.

WHO funding for 2015

2015 Requirements:	US\$ 10 000 000
2015 Funding:	US\$ 0

reduce the flow of international assistance to Afghanistan, pushing the economy into recession and creating a fiscal gap. If domestic development expenditure is cut the humanitarian community may need to fill gaps in the provision of basic services.

Health Cluster Objectives

Objective 1: To reduce maternal and child mortality and morbidity by facilitating access to critical primary outpatient care, immunization, maternal and new-born services, integrated management of childhood illnesses and referral of complicated cases

Planned Outputs:

- Establish 100 health facilities to provide emergency primary health care and referral services in high and very high priority provinces
- Provide mobile health services in 50 'white areas' and districts cut off in extreme winter
- Mobilize communities to deliver reactive vaccination campaigns to immunize one million people
- Provide emergency obstetric care to 75 340 people in high/very high risk districts
- Identify and report outbreaks of epidemic-prone diseases or conditions of public health concern through 390 existing Disease Early Warning System (DEWS) sites
- Undertake a health facility rationalization survey in 14 high-risk provinces
- Procure 2 300 000 individual supply items and kits

Objective 2: To reduce mortality and disability due to conflict through timely access to effective trauma care focusing on areas of conflict

Planned outputs:

- Establish or maintain 18 existing and seven new first aid trauma posts in high priority districts
- Stabilize and transfer trauma patients from these 25 first aid trauma posts
- Manage 30 000 trauma patients at trauma care units in Helmand and Kabul
- Train 278 health facility staff in stabilization and management of war trauma
- Provide equipment and transfusion kits to blood banks in 12 provinces
- Implement Mass Casualty Management plans in 12 provinces
- Carry out mass casualty management capacity mapping exercises for 180 health facilities in 18 provinces

Objective 3: To initiate timely identification and response to the impact of emergencies on the health of the population

Planned Outputs:

- Pre-position relief stocks and freight and in-country transportation for a target population of 365 000
- Establish 30 health facilities to provide critical, time-bound, lifesaving health services for populations affected by emergencies.
- Carry out emergency repairs to 10 facilities damaged due to natural or societal hazards
- Develop an operational emergency response plan

Beneficiaries targeted by health partners in 2015

Total: 2 723 049, of which 1 388 755 are men and 1 334 294 women

Geographical areas targeted by health partners in 2015

Health partners are targeting 32 provinces in Afghanistan

Health Cluster funding requirements for 2015

US\$ 38 800 000 for 2015 (health partners including WHO)

WHO funding requirements for 2015

WHO is requesting a total of US\$10 000 000 for 2015



Baseline indicators		Estimate
Human development index ¹	2013	185/187
Population in urban areas%	2012	39
Population using improved water source%	2012	68
Population using improved sanitation%	2012	22
Life expectancy at birth (years)	2012	51
Infant mortality rate / 1000 ²	2013	96
Under 5 mortality rate / 1000 ²	2013	139
Maternal mortality ratio / 100 000 ²	2013	880
Measles coverage among one year old's%	2013	25
Wasting% ³	2010/11	7.4

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in the Central African Republic from the Central Emergency Response Fund, Finland, the United States of America, the World Bank, and the World Food Programme.

WHO funding for 2015

2015 Requirements:	US\$	15 000 000
2015 Funding:	US\$	530 223

Central African Republic

The political crisis and ensuing violence that started in 2013 continue to have significant humanitarian consequences in the Central African Republic. There has been a slight improvement in the security situation in Bangui and western areas of the country, but it remains extremely volatile in both rural and urban areas. The number of internally displaced people (IDPs) has reduced since its peak in January 2014 but there are still some 438 538 IDPs (some in new sites) and an increasing number of refugees—424 707—in neighbouring countries.

More than 30% of the population suffer from food insecurity and do not have access to safe water and sanitation facilities. Nearly half of the country's 4.6 million inhabitants depend on humanitarian assistance for one or more of their basic needs. The crisis in the Central African Republic was declared a Grade 3 emergency in December 2013.

Health Sector Situation

Insecurity, funding gaps and the huge scale of humanitarian needs continues to hamper the work of WHO and all other health sector partners. In the first nine months of 2014, access to basic services improved, mainly in Bangui and surrounding districts. But the provision of advanced health services for life threatening conditions is still weak due to the lack of health workers and medical equipment and the looting of supplies. At the end of the same period, 27% of health facilities had been destroyed or seriously damaged. Only 55% of health facilities were functioning, with most of them providing only basic health services and the majority reliant on external support from health partners. At the regional level, 33% of district hospitals were reported to be partially destroyed and not able to provide emergency services. Only 35% of immunization services and 26% of ambulances were operational.

Malaria, respiratory infections, watery diarrhoea and physical trauma are the biggest health problems among the displaced population, including those living near of areas of insecurity and confrontation. In addition, the Central African Republic experiences recurrent measles outbreaks due to poor immunization coverage. These health threats compound an already poor situation. Nearly two in ten children in the Central African Republic do not reach their first birthday. The maternal mortality rate is 580 deaths per 100 000 live births and average life expectancy is 51 years.

Reduced purchasing power and the lack of free health care are barriers to access to care for the most vulnerable populations: children under five, pregnant women, breastfeeding women, victims of sexual violence, people with medical emergencies and people in acute crisis zones. Their main health needs include: strengthening the disease early warning and surveillance systems, the management of the most common diseases in children under five, vaccination of children under one against preventable diseases, maternal and newborn health, the management of all life threatening gynaecological, surgical, and traumatic emergencies, care for the victims of sexual violence and treatment of mental illness.

Health Cluster Objectives

Objective 1: To provide emergency health services (preventative and curative) to people affected by the crisis, including management of chronic illnesses, reproductive health care and trauma care

Objective 2: To increase access to health services for people affected by the crisis and/or protracted displacement, including host families

Objective 3: To prevent outbreaks of epidemic-prone diseases in areas at risk

To support delivery of these objectives, WHO priorities for 2015 are as follows:

- Priority 1: To strengthen health information management to guide the planning and monitoring of the health response to the humanitarian crisis, and also to guide the restoration of services
- Priority 2: To restore basic health and emergency services, including: primary health care: the management of common diseases (malaria, diarrhoea and respiratory infections) and severe malnutrition cases: immunization (Expanded Programme on Immunization, polio and measles); the management of obstetric and surgical emergencies (including trauma and conflict-related injury management); mental health: management of cases of sexual violence: management and non-interruption of treatment for chronic diseases (including non-infectious and infectious diseases such as tuberculosis and HIV/AIDS); and continuity of care
- Priority 3: To establish a disease early warning and response system for epidemic-prone diseases (including measles, cholera, meningitis, polio and yellow fever) and other public health events among the most vulnerable; and gradual strengthening of the Integrated Disease Surveillance and Response System
- Priority 4: To strengthen coordination, including Health Cluster support for reinstating health governance structures (in the most affected districts and regions) to support the resumption of health services and public health activities
- Priority 5: To provide administrative and logistical support for health interventions, including security risk mitigation mechanisms for WHO and health sector partners

Beneficiaries targeted by health partners in 2015

Health partners are targeting a total of 1 472 000 people. This includes:

- All displaced, returned or evacuated persons
- All inhabitants of enclaves
- All children under five in areas of high vulnerability
- All pregnant women in areas of high vulnerability
- All lactating women with a child under 12 months in areas of high vulnerability
- All persons suffering from medical, surgical, obstetrical and gynecological and traumatic emergencies in areas of high vulnerability

Geographical areas targeted by health partners in 2015

Health partners have identified the following sub-prefectures and districts as areas of high vulnerability: Third, fifth and eight arrondissements in Bangui; Alindao, Kembé, Mingala and Satema in the Prefecture of Basse Kotto; Bambouti in the prefecture of Haut Mbomou; Yalinga and Bria in the prefecture of Haute Kotto; Dekoa, Mala and Ndjoukou in the prefecture of Kemo; Bayanga in the prefecture of Sangha; Boda, Boganangone and Boganda in Lobaye prefecture; Gadzi and Amadagaza in the prefecture of Mambéré Kadeï; Abba in the prefecture of Nana Mambéré; Bimbo Boali Bossembélé and Yaloké in Ombella Mpoko prefecture; Bakala, Bambari, Kouango and Ippy in the prefecture of Ouaka; Batangafo Bossangoa Markounda Nana Bakassa, Nangha Boguila, Bouca and Kabo in Ouham prefecture; Bocaranga Bossemtélé, Kouï, Ngaoundaye, Paoua Bozoum in the prefecture of Ouham Pende and Birao in the Vakaga prefecture.

Health Cluster funding requirements for 2015

US\$ 63 200 000 for 2015 (36 health sector partners including WHO)

WHO funding requirements for 2015

WHO is requesting a total of US\$ 15 000 000

Health Cluster projects	Requested funds (US\$)
Cluster requirements not yet attributed to specific organizations CAR-15/H/3991/5826	63 200 000



Central African Republic Regional Refugee Response Plan

More than a year after the onset of conflict and violence in December 2013, the security situation in the Central African Republic remains volatile with sporadic incidents of violence. In 2014, approximately 187 000 refugees fled to neighbouring countries—Cameroon, Chad, Democratic Republic of Congo and Congo—taking the total number of Central African Republic refugees in the region to more than 400 000. This figure is expected to reach 464 000 by the end of 2015.

The number of refugees fleeing to neighbouring countries has steadily decreased since mid-2014, but the Central African Republic remains in the grip of one of the world's largest humanitarian crises. Conflict and insecurity continue to cause internal and external displacement.

Health Sector Situation

The growing number of refugees, both in camps and in host communities, has put significant pressure on health systems in neighbouring countries.

In **Cameroon**, a joint rapid assessment revealed that more than 50% of host villages lack basic health structures and that newly arrived refugees face problems in accessing health and nutrition services. Governmental health facilities face acute drug shortages and a lack of adequately trained staff. Few pregnant women have access to antenatal care and many deliveries occur unassisted and outside of health facilities. The capacity of health-care infrastructure to provide medical services, in particular for HIV/AIDS, reproductive health and mental health, is limited for both the existing refugee population and host communities. Refugees from the Central African Republic are mostly located in the East and Adamaoua regions, where epidemic-prone diseases, including poliomyelitis, measles, and cholera are common.

In **Chad**, although refugees have been able to access camp-based and out-of-camp health facilities, the quality of the services provided has suffered from the volume of people needing care. Government-owned facilities face acute drug shortages and a lack of qualified staff.

In the **Democratic Republic of Congo**, refugees have settled primarily in Equateur and Orientale provinces to the detriment of an already weak and overstretched health system. The region suffers from a serious lack of health and sanitation infrastructures and a deficit of skilled health professionals. Out-of-camp refugees have settled in hard-to-reach areas, resulting in numerous logistical challenges. Epidemic-prone diseases, including diarrhoeal diseases, cholera, typhoid fever and measles are common in these areas.

In **Congo**, the majority of refugees are living in host communities, for whom the latest influx has brought added pressure in terms of food security and access to social services. Conditions in the camps where the remaining refugees are living have deteriorated and require improvement. However in 2014, 96% of refugees received primary health care, with the most serious cases being transferred to referral hospitals.

WHO funding for 2015

2015 Requirements:	US\$	15 996 471
2015 Funding:	US\$	0

Health Sector Objectives

Priorities in the four host countries include:

- To provide primary health care and referral services to refugees, including mental health care
- To support district hospitals to provide basic emergency health care and management of referrals

- To strengthen capacity of health centres with human resources, medical equipment and infrastructures
- To supply essential medicines and medical supplies
- To strengthen the healthcare capacity of communities and volunteers
- To organize, conduct and strengthen immunization campaigns against measles and polio
- To establish mobile health clinics
- To strengthen early warning systems and make timely responses to outbreaks of epidemic-prone diseases
- To strengthen epidemiological and nutritional surveillance
- To strengthen care for chronic diseases, including communicable diseases such as HIV and non-communicable diseases such as diabetes

Beneficiaries targeted by health partners in 2015

Humanitarian partners plan to target a total of 464 414 people in 2015

Cameroon: 243 750

Chad: 102 892

Democratic Republic

of the Congo: 90 000

Congo: 27 772

Health and Nutrition sector funding requirements for 2015

US\$ 62 089 075 for 2015 (health and nutrition sector partners including WHO)

WHO funding requirements for 2015

Cameroon: US\$ 11 859 250

Chad: US\$ 1 251 800

Democratic Republic

of the Congo: US\$ 1 805 112

Congo: US\$ 1 080 309



The Democratic Republic of the Congo

Violence and conflict, epidemics, malnutrition and natural disasters continue to affect some 15 million people—nearly 20% of the total population—in the Democratic Republic of Congo. As well as costing the lives of many people, recurring crises have deprived thousands of their livelihoods, property and basic services. In 2015, 937 000 people were newly displaced, raising the total number of displaced people in the country to 3 359 000.

The humanitarian community has identified four main areas of need for 2015:

- Protection, food security, and access to essential household items and basic services for around 6.5 million people
- Malnutrition among four million children, as well as pregnant and lactating women, and people living with HIV or ill with tuberculosis (TB)
- Access to healthcare, safe water and sanitation services for approximately 12 million people in areas affected by epidemics
- Strengthening capacity to prepare and respond to natural disasters

Health Sector Situation

Violence and armed conflict, particularly in eastern Democratic Republic of the Congo, has caused widespread degradation of basic services. Thousands of people who have been displaced or affected by the crisis have difficulty accessing clean water, sanitation facilities and health care, putting them at high risk of contracting diseases.

Three epidemic-prone diseases pose the greatest humanitarian risk: cholera, measles and viral haemorrhagic fever. The country continues to face recurrent epidemics of cholera and measles. Between January and September 2014 there were 15 591 cases of cholera and 30 223 cases of measles, causing 262 and 341 deaths respectively. Viral haemorrhagic fevers are also of concern. An Ebola epidemic between August and November 2014 in Boende, Equateur province, resulted in 66 cases and 49 deaths.

Low immunization rates in affected areas are a major factor contributing to the presence and spread of epidemics. Insecurity and the difficulty of accessing isolated areas are the main challenges preventing better coverage.

The country is facing a severe malnutrition crisis. Around four million children in the country suffer from malnourishment. One in ten children do not reach their fifth birthday, with malnutrition responsible for 45% of these deaths. Pregnant and lactating women and people living with HIV or TB are particularly affected.

Health Cluster Objectives

Objective 1: To address health concerns in areas affected by armed conflict and violence.

Planned Outputs:

- Pre-position health kits and surgical teams at the provincial level and in affected health zones
- Establish a minimum package of primary and secondary health care activities, including emergency reproductive healthcare and treatment for major diseases
- Provide holistic care for victims of sexual violence
- Provide reproductive health services including management of victims of sexual violence and prevention of HIV/AIDS
- Introduce mobile primary healthcare clinics
- Provide free emergency health care

Baseline indicators		Estimate
Human development index ¹	2013	186/187
Population in urban areas%	2012	35
Population using improved water source%	2012	46
Population using improved sanitation%	2012	31
Life expectancy at birth (years)	2012	52
Infant mortality rate / 1000 ²	2013	86
Under 5 mortality rate / 1000 ²	2013	119
Maternal mortality ratio / 100 000 ²	2013	730
Measles coverage among one year old's%	2013	73
Wasting% ³	2010	8.5

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in the Democratic Republic of the Congo from the Central Emergency Response Fund, and the United Nations Development Program Common Humanitarian Fund

WHO funding for 2015

2015 Requirements:	US\$	20 000 000
2015 Funding:	US\$	0

- Reinforce the capacity of individuals, communities and the public sector to provide healthcare using appropriate tools and protocols
- Monitor and respond to epidemic-prone diseases (e.g. measles, cholera and viral haemorrhagic fever)
- Respond to cholera and other diarrheal diseases through integrated services in health facilities and cholera treatment centres
- Vaccinate internally displaced children under 15 years of age against measles
- Monitor the protection of health workers

Objective 2: To respond to epidemics.

Planned Outputs:

- Decrease the incidence of cholera in endemic areas, especially North Kivu, South Kivu and Katanga, by analyzing risk factors, introducing a package of integrated activities for the management of cases and pre-positioning materials, providing the capacity to treat 22 714 cases. The cluster will also consider the benefits of using a cholera vaccine to complement traditional activities
- Provide case management and vaccination against measles for vulnerable people affected by measles outbreaks in health zones with less than 80% vaccination coverage, with the capacity to reach 4.2 million girls and boys
- Respond to viral haemorrhagic fever epidemics through epidemiological surveillance for early case detection, isolation, management, identification and contact tracing. The response will include infection control in supported health facilities and communities, and strengthening community resilience by advocating for behaviour change. The response will cover a total of 800 000 people at risk
- Build capacity among individuals and public sector institutions to prepare for epidemic responses

Objective 3: To respond to nutritional crises

Planned Outputs:

- Ensure adequate care for children with severe acute malnutrition and medical complications, in collaboration with the Nutrition Cluster
- Provide assistance regarding hospital hygiene and the surveillance of disease with epidemic potential in health zones affected by food insecurity and malnutrition

Objective 4: To respond to the health consequences of natural disasters

Planned Outputs:

- Support the health system in emergencies according to national and provincial contingency plans
- Prepare and respond in the event of natural disasters such as volcanic eruptions, floods, landslides
- Provide equitable access to guaranteed emergency care for men, women, girls and boys, according to identified needs
- Strengthen the response capability of individuals and health services

Beneficiaries targeted by health partners in 2015

Health partners are targeting a total of 7 947 354 people

- 4 327 300 people affected by violence and armed conflict
- 315 263 people affected by malnutrition
- 3 256 050 people affected by epidemics (1 275 330 men, 1 381 607 women and 599 113 children)
- 48 741 people affected by natural disasters

Geographical areas targeted by health partners in 2015

Katanga (2 192 697), Nord-Kivu (1 743 988), Sud-Kivu (1 356 854), Maniema (689 657), Orientale (662 976), Kasai Oriental (313 434), Bandundu (275 398), Equateur (274 915), Kinshasa (154 647), Kasai Occidental (52 174), Bas Congo (130 615)

Health Cluster funding requirements for 2015

US\$ 43 800 000 for 2015 (80 health partners including WHO)

WHO funding requirements for 2015

WHO is requesting a total of US\$ 20 000 000

Health Cluster projects	Requested funds (US\$)
Cluster requirements not yet attributed to specific organizations DRC-15/H/75285/5826	43 800 000



Baseline indicators		Estimate
Human development index ¹	2013	120/187
Population in urban areas%	2012	66
Population using improved water source%	2012	85
Population using improved sanitation%	2012	85
Life expectancy at birth (years)	2012	70
Infant mortality rate / 1000 ²	2013	28
Under 5 mortality rate / 1000 ²	2013	34
Maternal mortality ratio / 100 000 ²	2013	67
Measles coverage among one year old's%	2013	63
Wasting% ³	2011	7.4%

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35.

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in Iraq from the Central Emergency Response Fund, Italy, Kuwait, the Republic of Korea, the Kingdom of Saudi Arabia, the United Kingdom of Great Britain and Northern Ireland and the United Nations Organization for the Coordination of Humanitarian Affairs.

WHO funding for 2015

2015 Requirements:	US\$	189 421 986
2015 Funding:	US\$	0

Iraq

Conflict in Iraq has escalated since January 2014 and prompted a protection crisis impacting millions of Iraqis. Four governorates in Iraq's central belt—Anbar, Ninewa, Salah-al Din, and Kirkuk—have experienced the worst violence.

An estimated 5.2 million people are now in urgent need of humanitarian and protection assistance due to ongoing violence and insecurity. This includes approximately 2.2 million people newly displaced since January 2014, 1.5 million individuals in affected host communities, 1.7 million vulnerable Iraqis who are not displaced but remain in areas directly impacted by the conflict, and 215 000 Syrian refugees. Nearly half of all those newly displaced are children and large-scale displacement continues.

Health Sector Situation

Essential public services, including health services, water and sanitation have sharply deteriorated in conflict-affected areas and are overstretched by the rapid influx of internally displaced people (IDPs). More than half of these IDPs are children, who are particularly vulnerable to deteriorating health. Poor living conditions, sanitation conditions and water quality are contributing to increased health problems and a high risk of outbreaks among IDPs.

Attacks on public hospitals have occurred in Anbar, Ninewa, Diyala, Salah al-Din and Kirkuk governorates, damaging facilities already weakened by decades of underinvestment. An estimated 45% of health professionals from these areas are now displaced. In Ninewa, more than half of health facilities are no longer functioning.

The conflict has also severely disrupted the national system for procurement and distribution of medical supplies, preventing essential items from reaching clinics and hospitals. Approximately 5.2 million people are in need of emergency health interventions as a result. However humanitarian access to at least 2.2 million Iraqis in need is severely compromised in areas under the control of armed opposition groups. Conflict is volatile and the liberation of areas may create both opportunities and demands for the provision of health-care services.

After two polio cases were confirmed in Baghdad in early 2014, it was estimated that 5.8 million children in Iraq are vulnerable to contracting polio if adequate vaccination coverage is not implemented. A total of 1040 cases of measles were reported in the first nine months of 2014.

Health Cluster Objectives

Objective 1: To provide, in a timely fashion, a basic package of primary and secondary health care services, including reproductive and mental health services, care for disabled and patients with chronic diseases and nutrition services

Planned outputs:

- Provide a basic package of primary and secondary health care interventions, including those for noncommunicable diseases and mental health and psychosocial support, to all 4 000 000 people targeted by the cluster strategy
- Support 200 referral hospitals and primary health care facilities, including mobile medical services, in providing basic maternal, newborn and child health care including basic and comprehensive emergency obstetric care and newborn care

- Achieve 85% coverage of the Penta2 vaccine by providing routine immunizations services through the Expanded Program on Immunization
- Develop, produce and print information, education and communication materials to raise awareness of health issues including reproductive health, reaching 13 000 families
- Conduct rapid nutrition assessments and establish regular growth monitoring for all children under five. Promote recommended infant and young child feeding practices, with special attention to breast feeding, reaching 80 000 mothers among IDPs and 320 000 mothers in host communities.

Objective 2: To strengthen early detection, investigation and response to outbreaks of communicable diseases for various target populations (IDPs, returnees and impacted communities).

Planned outputs:

- Strengthen disease surveillance, with 85% of sentinel health facilities reporting disease outbreaks in a timely manner
- Provide timely responses to disease outbreaks including vaccination against polio and measles, achieving 90% coverage with measles vaccination campaigns

Beneficiaries targeted by health partners in 2015

Total beneficiaries: 4 000 000

Geographical areas targeted by health partners in 2015

Health partners are targeting all 18 governorates in Iraq:

Health Cluster funding requirements for 2015

US\$ 314 231 723 for 2015 (health partners including WHO)

WHO funding requirements for 2015

WHO is requesting a total of US\$ 189 421 986 for the following projects:

WHO projects	Requested funds (US\$)
Life saving emergency medical and community primary care services for Anbar IRQ-14/H/69876/R/122	900 000
Mental health and psychosocial support services for IDPs in Iraq IRQ-14/H/71032/R/122	2 800 000
Prevention and control of communicable diseases including timely detection and response to outbreaks among IDPs and host communities in Iraq IRQ-14/H/71035/R/122	32 500 000
Supporting the provision of primary and secondary health care services to populations affected by the humanitarian emergency in Iraq including IDPs and host communities in Iraq IRQ-14/H/71036/R/122	107 000 000
Preventing measles and polio outbreaks in security affected areas and among IDPs, refugees and impacted communities in Iraq IRQ-14/H/71037/R	42 350 000
Enhancing detection and health response capacities to manage SAM among IDPs and host communities in Iraq IRQ-14/H/71038/R	2 750 000
Ensuring provision of safe water to IDPs according to Iraqi water quality standards (WASH) IRQ-14/WS/68295/R	1 121 986



Myanmar

The Humanitarian Country Team in Myanmar has identified 536 400 vulnerable people who are in need of humanitarian assistance in 2015 as a result of conflict and inter-communal violence. These people, in the Rakhine, Kachin and northern Shan states, include internally displaced persons (IDPs), people in communities hosting IDPs and non-displaced people who are affected by the crisis.

Many IDPs living in camps are almost entirely dependent on humanitarian assistance to meet basic needs. Displacement is also putting a strain on resources in host communities, where vulnerable groups including women, children, the elderly and people with disabilities are particularly exposed and disadvantaged. In Rakhine, continued inter-communal tensions and restrictions on freedom of movement hinder access to basic and secondary services, as does the lack of a functional referral system. In Kachin and northern Shan states the armed conflict and recent escalation of fighting have made it difficult to find durable solutions for displaced people.

Baseline indicators		Estimate
Human development index ¹	2013	150/187
Population in urban areas%	2012	31.4
Population using improved water source%	2012	86
Population using improved sanitation%	2012	77
Life expectancy at birth (years)	2012	66
Infant mortality rate / 1000 ²	2013	40
Under 5 mortality rate / 1000 ²	2013	51
Maternal mortality ratio / 100 000 ²	2013	200
Measles coverage among one year old's%	2012	86
Wasting% ³	2009/10	7.9%

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35.

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in Myanmar from the Central Emergency Response Fund.

WHO funding for 2015

2015 Requirements:	US\$	1 350 000
2015 Funding:	US\$	0

Health Sector Situation

Improving access to health care proved particularly challenging in 2014. Funding, logistical and security constraints, as well as decreased service capacity from some partners, led to difficulties in providing basic health care services. The availability and willingness of health workers to operate in crisis-affected areas also continued to be a challenge.

In Rakhine, the majority of IDPs continue to rely on essential health care services provided by Health Cluster partners. Township hospitals close to the camps remain inaccessible to the majority of displaced people due to continued tensions and movement restrictions. The situation compromises access to life-saving services and presents a significant barrier to implementing a functioning referral system. Currently, only two hospitals in Rakhine receive referral patients from IDP camps with Muslim populations, increasing the burden on these already understaffed and underfunded facilities.

In northern Rakhine, access to health facilities, especially secondary health, remains restricted for the local population. This already chronic situation worsened following the violence in 2012 and further deteriorated in 2014 due to restricted access for nongovernmental organizations (NGOs).

In Kachin, the majority of displaced persons have limited access to health services. Referral systems remain a major concern and are currently reliant on facilities in China. Different approaches and the varying availability of human and material resources in areas beyond government control make the provision of primary health care services challenging.

Some progress in addressing basic health needs has been achieved. In Rakhine, immunization activities continued without interruption in 2014. MSF-Holland, the largest NGO healthcare provider in the state was allowed to re-start service provision activities in Northern Rakhine and a major measles/rubella catch-up campaign is scheduled for 2015.

Health Cluster Objectives

Objective I: To improve affected people's access to health care services in Rakhine and Kachin/Shan including those newly affected by disasters and other emergencies

Planned outputs:

- Reach 184 337 IDPs with access to basic health care services
- Provide 45 577 IDPs with access to reproductive, maternal and child health care including emergency obstetric care
- Vaccinate 95% of children in the target population aged 9 months to 15 years against measles

Cross-cutting activities to support the Health Cluster's objective include:

- Provide primary health care services to conflict and disaster-affected people including host communities
- Strengthen maternal and child health services
- Improve the hospital referral system for the entire population
- Address the shortage of trained health care workers by training qualified displaced persons
- Strengthen disease surveillance and control
- Develop protocols and training on the clinical management of gender-based and sexual violence cases
- Strengthen health education in particular for prevention of communicable diseases
- Coordinate the promotion of hygiene practices in collaboration with the WASH Cluster
- Increase access to mental health and psychosocial support services, through additional support to existing vulnerable groups

Beneficiaries targeted by health partners in 2015

Health partners are targeting 536 401 people in 2015. These include:

- 202 569 IDPs in camps or camp-like situations (116 183 in Rakhine State and 86 386 in Kachin and northern Shan states)
- 14 969 IDPs in their own villages in Rakhine State
- 20 842 IDPs in host families or other individual accommodation (8158 in Rakhine State and 12 684 in Kachin and northern Shan states)
- 120 000 crisis-affected people in communities hosting or surrounding IDPs (100 000 in Rakhine State and 20 000 in Kachin and northern Shan states)
- 177 290 non-displaced crisis-affected people in Rakhine State
- 731 resettled IDPs in Kachin State

Geographical areas targeted by health partners in 2015

Health partners are targeting Rakhine, Kachin and northern Shan states.

Health Cluster funding requirements for 2015

US\$ 22 700 000 (14 partners including WHO)

WHO funding requirements for 2015

WHO is appealing for a total of US\$ 1 350 000

Health Cluster projects	Requested funds (US\$)
Health response in Rakhine MM-15/H/75358/6491	17 009 882
Health response in Kachin MM-15/H/75359/6491	5 735 306



occupied Palestinian territory

The occupied Palestinian territory remains in a protracted protection crisis, with some 1.9 million people out of a population of 4.5 million estimated to be in need of humanitarian assistance. The seven weeks of violence in Gaza during July and August 2014 resulted in the death of 2260 people, nearly a third of them children, and around 10 625 people were injured. The destruction of homes has displaced more than 100 000 people and left them inadequately protected during the winter storms. Explosive remnants of war are spread across Gaza and pose a continuing threat to the life of Palestinians and humanitarian workers. Access to already insufficient basic services has been further undermined by the damage or destruction of a number of health facilities.

Health Sector Situation

Access to essential health services and the referral of patients for specialized health care remains especially limited in Gaza, and in many areas of the West Bank, particularly for males aged 18-40. Women particularly feel the impact of these limitations due to their reproductive health needs and their responsibilities for the health of children and care for elderly or disabled family members.

The Joint Health Sector Assessment of the Health and Nutrition Cluster highlighted the severe impact of the recent conflict in Gaza on the health and wellbeing of the population. The conflict resulted in the loss of life, creation of disabilities, the deterioration of the health of people with chronic illnesses and a severe negative effect on the mental wellbeing of the population.

Security issues and the destruction of vital health infrastructure remain the main contributors to the reduced availability of health services. Although steps have been taken by authorities to alleviate the situation, shortages of medicines and medical supplies, limitations in tertiary care capacity, fuel shortages and complicated mechanisms for the referral of severe cases abroad have exacerbated an already acute humanitarian situation.

In the West Bank, insufficient access to primary health care persists as a result of insecurity, restrictions on the freedom of movement of patients, health staff and medical students, a shortage of medicines and other medical supplies and shortage of health care workers. Access to primary health care is particularly difficult for women, the elderly and people with disabilities in Area C of the West Bank due to restrictions on movement and limited public transportation. Health partners are therefore running mobile clinic services offering essential primary health care services, including reproductive and child health, laboratory tests and health education.

The occupied Palestinian territory is also highly vulnerable to a variety of natural and manmade hazards, including earthquakes, floods, landslides, droughts and desertification. The Health Cluster will therefore address the need to build the capacity of cluster partners and communities in emergency preparedness and strengthen contingency planning.

Health Cluster Objectives

Objective 1: To provide vulnerable communities in the Gaza Strip and the West Bank with access to quality and affordable health services, refer victims of violence to protection organizations and carry out advocacy activities disasters and other emergencies

Baseline indicators		Estimate
Human development index ¹	2013	107/187
Population in urban areas%	2012	73.8
Population using improved water source%	2012	89.1
Population using improved sanitation%	2012	98.7
Life expectancy at birth (years)	2012	72.5
Infant mortality rate / 1000 ²	2012	19.2
Under 5 mortality rate / 1000 ²	2012	22.6
Maternal mortality ratio / 100 000 ²	2011	28
Measles coverage among one year old's%	2012	98.8
Wasting% ³	2007	1.8%

Source: WHO EMRO Regional Health Observatory unless indicated otherwise by a footnote. References on page 35

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in the occupied Palestinian territories from the Central Emergency Response Fund, Italy, Norway, South Africa, Turkey and the United Nations Office for the Coordination of Humanitarian Affairs.

WHO funding for 2015

2015 Requirements:	US\$	3 382 750
2015 Funding:	US\$	

Planned outputs:

- Provide access to high quality and affordable essential health services for 1.6 million vulnerable people in the West Bank and Gaza, including maternal and child health, reproductive health, mental health and rehabilitation services for people with disabilities
- Refer 100 survivors of violence to protection organizations
- Issue 15 publications, including press releases, with information on restricted access to primary health care.

Objective 2: To support vulnerable communities in the West Bank and Gaza to be better prepared to cope with the impact of current and potential man-made and natural disasters

Planned outputs:

- Train 650 primary health care providers, members of grass roots organizations and community leaders in the principles of managing mass casualties, rescue and first aid and referral to higher levels of health care
- Carry out health awareness sessions in Gaza focusing on nutrition, reproductive and emergency health care at the community level for 40 000 participants

Beneficiaries targeted by health partners in 2015

Health partners are targeting a total of 1.6 million people in 2015, of which 730 280 are women, 490 062 are children and 370 570 are men.

Geographical areas targeted by health partners in 2015

Health partners are targeting 1.3 million people in Gaza and 300 000 people in the West Bank.

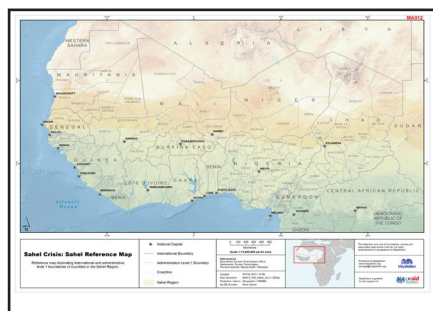
Health and Nutrition Cluster funding requirements for 2015

US\$ 21 000 000 for 2015 (health partners including WHO)

WHO funding requirements for 2015

WHO is appealing for a total of US\$ 3 382 660

WHO projects	Requested funds (US\$)
Strengthening emergency health information and coordination for more effective humanitarian health action in the occupied Palestinian territory OPT-15/H73454/122	529 560
Procurement of essential pharmaceuticals to leukaemia and haemophilia patients in Gaza OPT-15/H73458/122	2 500 000
Protecting Right to Health in the occupied Palestinian territories through advocacy OPT-15/H73466/122	353 100



Sahel Regional Response Plan

There are nine countries in need of humanitarian aid in the Sahel region: Burkina Faso, Cameroon, Chad, Mauritania, Mali, Niger, Nigeria, Senegal and The Gambia. The heavy burden of chronic food insecurity, malnutrition and epidemic risk, compounded by conflict, insecurity and natural threats such as flooding, remain the key drivers of humanitarian need in the region. An estimated 20.4 million people remain food insecure at the start of 2015. Some 1.2 million children under five die each year in the Sahel, with 570 000 of these deaths associated with malnutrition and related diseases, despite efforts made by countries to address these challenges.

Violent conflict in and around the Sahel region has led to a surge in population displacement. The region began 2015 with some 2.8 million people displaced, around a million more than in early 2014.

Health Sector Situation

Recurrent epidemics of diseases such as cholera, malaria, meningitis, measles and yellow fever affect thousands of households across the Sahel. The spread of epidemics and high case fatality rates are driven by a lack of safe water, poor access to prevention and treatment services and low quality of care. Conflict and poor governance exacerbate difficulties in the functioning of an already fragile health system. Inadequate access to reproductive health and emergency care, partially due to a lack of healthcare workers, is also responsible for some of the highest maternal mortality rates in the world.

By November 2014, at least 40 820 cases of cholera had been registered in Niger, Nigeria, Cameroon and Chad, with a case fatality rate of 2.4 per cent. Access to improved sanitation facilities and safe water is very limited in most countries. Niger, for example, has only 11% coverage for improved sanitation facilities.

In spite of mass vaccination campaigns in five out of nine Sahel countries, 2014 saw an 80% increase in meningitis cases across the region, rising from 3551 cases in 2013 to 6416 cases in 2014.

By October 2014, around 32 000 cases of measles had been reported in the Sahel countries, roughly half the number reported in 2013. However, children in the region are still vulnerable to epidemics due to low measles vaccine coverage.

Malaria accounts for 25 to 45 percent of all outpatient clinic visits, and between 20 and 45 per cent of all hospital admissions in the Sahel. Malaria is responsible for an estimated 17 per cent of deaths among children under five. In Burkina Faso, malaria is a matter of public health concern as it is the primary cause of hospital admission and leading cause of death in the country.

There are signs of improvement in the region. Nigeria and Cameroon, for example, did not report any cases of Wild Polio Virus for a period of more than eight months. Internally displaced persons and refugees remain the most vulnerable populations. Of the nine cases of Polio that Cameroon has reported since October 2013, the majority was among the refugee population.

Nigeria, Mali and Senegal reported cases of Ebola in 2014. These three countries have now been declared Ebola-free, however Ebola continues to pose a risk to the Sahel necessitating investment in vigilance and preparedness measures.

Health Sector Objectives

Priority areas for health sector partners in the Sahel for 2015 include:

- Infectious diseases, including Ebola, cholera, malaria, measles and meningitis
- Pneumonia, diarrhea and malaria in children under five
- Reproductive health for pregnant women
- Medicine and vaccine shortages
- Service delivery to the most vulnerable and deprived groups, especially in rural and remote areas
- Severe acute malnutrition

Key indicators include:

- 8.1 million births assisted by a skilled attendant in districts supported by health cluster members
- 1057 completed monthly epidemiological reports received at the central level
- 2.5 million outpatient consultations in districts supported by health cluster members
- 6.2 million children under five children vaccinated against measles in districts supported by cluster members

Beneficiaries targeted by health partners in 2015

Health partners are targeting a total of 9.3 million people. Children: 2 14 600

Geographical areas targeted by health partners in 2015

The humanitarian situation in the nine Sahel countries is intertwined and whether climate or conflict-induced, national crises frequently have a regional dimension. For this reason, the Sahel Response Plan provides a framework to ensure regional coherence across the Strategic Response Plans of Burkina Faso, Cameroon, Chad, Mali, Mauritania, Niger, Nigeria, Senegal and The Gambia.

Health sector funding requirements for 2014

Health partners, including WHO, are appealing for a total of US\$ 134.5 million for 2015, across Sahel countries.

The details of funding requirements and projects for each of the health sector partners has not yet been published.



Baseline indicators		Estimate
Human development index ¹	2012	-
Population in urban areas%	2010	37.3
Population using improved water source%	2012	31
Population using improved sanitation%	2012	23
Life expectancy at birth (years)	2012	53
Infant mortality rate / 1000 ²	2013	90
Under 5 mortality rate / 1000 ²	2013	146
Maternal mortality ratio / 100 000 ²	2013	850
Measles coverage among one year old's%	2013	46
Wasting% ³	2006	13.2

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35.

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in Somalia from the Central Emergency Response Fund, Kuwait and the United Nations Development Program Common Humanitarian Fund.

WHO funding for 2015

2015 Requirements:	US\$	13 957 344
2015 Funding:	US\$	0

Somalia

After two years of fragile improvements, a mix of drought, soaring food prices, conflict, access constraints and under-funding has led to a serious deterioration of the humanitarian situation in Somalia.

In 2014, the number of people unable to meet their food needs increased by 20% to more than one million (up from 857 000). This is the first time the number of people in need of life-saving assistance has increased since the end of the 2011 famine. Military operations in southern and central Somalia led to the pre-emptive displacement of more than 80 000 people, of whom at least 70 to 80 percent are women and children.

Somalia's human development indicators remain extremely low and continue to aggravate the humanitarian situation. Coverage and quality of basic social services in the country is low, mainly due to a lack of infrastructure.

Health Sector Situation

Health indicators in Somalia are among the lowest in the world. The immunization coverage rate for measles is 46% countrywide and even lower in hard to reach areas. Only one in three Somalis has access to safe water; one in every nine Somali children dies before their first birthday; and the maternal mortality ratio is 850 deaths per 100 000 live births.

The health care system in Somalia remains weak, poorly resourced and inequitably distributed. Health expenditure remains very low and there is a critical shortage of health workers. As a result, around 3.2 million women and men in Somalia are in need of emergency health services.

An estimated 1.1 million displaced people live in sub-standard conditions. There is a high risk of measles outbreaks due to crowded settlements and a high risk of acute watery diarrhoea (AWD)/cholera outbreaks due to limited access to basic sanitation and hygiene services. The most affected areas include settlements for displaced people in Mogadishu.

Around 3800 cases of AWD/cholera were recorded in the first nine months of 2014, with 74% of cases among children under five years of age. Measles outbreaks occurred in several regions of Somalia in 2014. Around 9000 suspected measles cases were reported between January and November; more than twice the number of cases in the same period in 2013.

Polio continues to threaten the lives of Somali children. A well-coordinated vaccination campaign reached more than four million people across the country in 2014. As a result, only five polio cases were confirmed up to November; compared to 194 cases in 2013. However, there are an estimated 420 000 children in insecure areas not under government control, who have not been reached by polio vaccination programme since 2009.

Health Cluster Objectives

Objective I: To prevent (including through immunization) and control epidemic-prone and communicable diseases.

Planned outputs:

- Reduce the case fatality rate of AWD/cholera outbreaks to 1%, from a baseline of 2%.
- Increase the percentage of outbreak rumours investigated and responded to within 96 hours to 85%, from a baseline of 75%.

Objective 2: To ensure crisis-affected people have access to primary and secondary health care

Planned outputs:

- Provide 60% of crisis-affected people with adequate access to primary health care, from a baseline of 39%
- Increase the percentage of health facilities in crisis-affected areas that are fully functioning from a baseline of 39% to 69%
- Increase the number of secondary health care facilities/hospitals providing Comprehensive Emergency Obstetric Care in crises-affected areas from 0.7 per 500 000 people to 1 per 500 000 people

The Health Cluster will focus on four priority activities which will contribute to the Health Cluster objectives:

- Pre-position emergency supplies in high-risk-areas prone to natural disasters and epidemics and settlements where displaced people reside. Provide medical supplies to primary and secondary health care facilities
- Investigate, survey and respond to disease outbreaks
- Support the establishment of health care facilities to cover gaps and provide quality primary health care services to the most vulnerable people, including women and children
- Increase the number of fixed sites providing routine immunization (including measles and polio) to children under five years of age and mothers

Beneficiaries targeted by health partners in 2015

Total: 1 870 000, of which 890 000 men and 980 000 women

Geographical areas targeted by health partners in 2015

Health partners are targeting beneficiaries in all 18 of Somalia's regions

Health Cluster funding requirements for 2015

US\$ 71 400 000 for 2015 (health partners including WHO)

WHO funding requirements for 2015

WHO is appealing for a total of US\$ 13 957 344 for the following projects:

WHO projects	Requested funds (US\$)
Provision of primary and basic secondary health services with a focus on maternal, newborn and child health care for vulnerable populations in Afgooye and Walna Weyn districts in Lower Shabelle and Banadir regions of south central Somalia SOM-15/H/71877/122	2 692 120
Access to emergency primary and secondary health care and life-saving services, including emergency surgical procedures, safe blood transfusions, strengthened referral networks and increased capacity of facilities and work force. SOM-15/H/791901/122	5 295 000
Early detection, response and control of communicable diseases including Leprosy, Leishmaniasis and Schistosomiasis, and non-communicable diseases including diabetes mellitus and hypertension in Somalia SOM-15/H/71928/122	3 737 500
Promotion of Mental Health and prevention, treatment and rehabilitation of MNS disorders, with respect for human rights and social protection, for people affected by conflicts and crisis in Somalia. SOM-15/H/71999/122	568 724
Provision of a coordinated response for the delivery of essential health services to the most vulnerable population in order to reduce morbidity and mortality in Somalia SOM-15/H/72041/122	1 664 000



South Sudan

The conflict that began in December 2013 continues to affect the lives of millions of people in South Sudan. It has been marked by brutal violence against civilians and deepening suffering across the country. Insecurity and active hostilities constrain civilians' freedom of movement. The major humanitarian consequences include widespread displacement, high death rates, disease and injuries, severe food insecurity and a malnutrition crisis.

The people in need of emergency assistance include an anticipated 1.95 million internally displaced people and a projected 293 000 refugees.

Baseline indicators*		Estimate
Human development index ¹	2012	-
Population in urban areas	2013	18
Population using improved water source	2012	57
Population using improved sanitation	2012	9
Life expectancy at birth (years)	2012	55
Infant mortality rate / 1000 ²	2013	64
Under 5 mortality rate / 1000 ²	2013	99
Maternal mortality ratio / 100 000 ³	2013	730
Measles coverage among one year old's%	2013	30
Wasting ³	2006	24.6%

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35

Health Sector Situation

The conflict in South Sudan has caused a major public health crisis disrupting essential primary and secondary health care services. As of July 2014 only 41% of health facilities in Unity State, 57% in Upper Nile and 68% in Jonglei were functioning. Overall, 184 of 425 health facilities in conflict-affected states are not functioning.

Vaccination programmes, malnutrition screening and antenatal care have all been disrupted. Surgery and referral services are limited or non-existent, as are services to manage HIV/AIDS, tuberculosis and mental health. Frequent ruptures in drug supplies and a lack of qualified health workers further aggravate the situation.

Trauma cases due to gunshot wounds have been reported since the beginning of the crisis. From 15 December 2013 until the end of 2014, more than 7000 people have been treated for gunshot wounds across 40 facilities. Of these people, more than 400 have been evacuated to appropriate facilities for surgical attention. The Health Cluster estimates that more than 18 000 wounded people will access health care services in 2015.

Communicable diseases are a concern throughout the country due to poor sanitation, a shortage of water, lack of shelter, food insecurity, crowded living conditions—particularly in displacement sites—malnutrition and poor immunity, with young children and pregnant women particularly vulnerable. The situation is compounded by gaps in disease surveillance coverage and low routine vaccine coverage. Outbreaks of cholera, measles and kala-azar have affected some 6100, 2678 and 7204 people respectively as of December 2014.

Other common health threats include acute respiratory infections, acute watery diarrhoea, malaria, malnutrition and measles. The country is in the meningitis belt of Africa and the dry season may see outbreaks of meningococcal meningitis. Malaria remains a major concern throughout the country.

Reproductive health services coverage is very low. Before the crisis, the maternal mortality ratio was estimated to be 2054 deaths per 100 000 live births, one of the highest in the world. There are gaps in the availability of emergency obstetrical and neonatal care. The 2013 Emergency Obstetric and Neonatal Care assessment found that only 24 Emergency Obstetric and Neonatal Care facilities are functional out of the targeted 109. Only 15% of deliveries are attended by a skilled birth attendant according to national estimates.

Reports show that sexual and gender-based violence and exploitation have increased since the start of the crisis. There is a lack of appropriate health services for survivors, especially outside major displacement sites.

The outbreak of conflict has also had a devastating impact on the HIV response. The majority of people living with HIV and AIDS in the conflict-affected states who were receiving anti-retroviral treatment before December 2013 saw their treatment interrupted. Medical facilities offering HIV services were

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in the Republic of South Sudan from the Central Emergency Response Fund, the European Commission Humanitarian Aid and Civil Protection, Finland, the United Nations Development Programme Common Humanitarian Fund and the United States of America.

WHO funding for 2015

2015 Requirements:	US\$	16 760 000
2015 Funding:	US\$	1 100 000

closed or destroyed and community-based support networks dissolved as people were displaced. UNAIDS estimates that 25 000 people with HIV/ AIDS have been directly affected by the crisis and are in need of treatment, care and support services.

Health Cluster Priorities

Objective 1: To improve access to, and responsiveness of, essential and emergency health care, including emergency obstetric care services.

Planned outputs:

- Provide 1 590 358 outpatient consultations in conflict-affected and other vulnerable states, from a baseline of 1 239 696, and increase the number of functional health facilities in these states to 425, from a baseline of 241
- Provide essential preventative care, ensuring that 134 423 children receive three doses of the penta-valent vaccine
- Establish 35 Emergency Obstetrics and Neonatal Care centres
- Procure and preposition emergency drug supplies for 1 800 000 direct beneficiaries
- Increase the number of key surgical facilities able to handle trauma from 7 to 10
- Reach 750 000 people with appropriate health education and promotion message

Objective 2: To enhance existing systems to prevent, detect and respond to disease outbreaks.

Planned outputs:

- Investigate and respond to 90% of disease outbreaks within 48 hours
- Preposition outbreak investigation and response materials in 10 states
- Strengthen national and state rapid response teams for prompt outbreak verification and response
- Train 1200 outbreak surveillance and emergency response team members
- Immunize 705 196 children under five in emergency or returnee situations with measles vaccine
- Reach 360 000 people with health education and promotion messages before and during outbreaks

Objective 3: To improve availability, access and demand for gender based violence (GBV) and mental health and psycho-social support (MHPSS) services, targeting highly vulnerable people.

Planned outputs:

- Strengthen the capacity of 10 health facilities to provide a basic GBV package
- Increase the number of facilities in emergency IDP sites providing comprehensive HIV/AIDS services from two to six
- Train 50 key health personnel on community-based MHPSS in IDP settings

Beneficiaries targeted by health partners in 2015

In 2015 the Health Cluster will target 3 358 076 people, including 1 645 457 women and 1 712 619 men. This target includes 1 950 000 people who are internally displaced, approximately 839 519 women of reproductive age, 1 578 296 children under 15 and 705 196 children under five.

Geographical areas targeted by health partners in 2015

In addition to the three conflict-affected states of Jonglei, Unity and Upper Nile, the Health Cluster will target the most vulnerable counties in the other seven states based on the presence of displaced persons, the status of basic services, vulnerability to disease outbreaks and high malnutrition or severe food insecurity. These counties include Western and Northern Bahr El Ghazal, Warrap, Lakes and Eastern Equatoria.

Health Cluster funding requirements for 2015

US\$ 90 000 000 (30 partners including WHO)

WHO funding requirements for 2015

WHO is appealing for a total of US\$ 16 760 000 to implement the following projects:

WHO projects	Requested funds (US\$)
Delivery of essential life-saving health care services (communicable disease control, life-saving surgery and other health-related emergencies) to affected populations SSD-15/H/73136/I22	12 645 000
Responding to the health-related emergencies in the affected populations in South Sudan SSD-15/H/73137/I22	4 115 000



South Sudan Regional Refugee Response Plan

Since fighting broke out in South Sudan in December 2013, civilians have borne the brunt of the conflict. Conflict and fear of conflict have disrupted livelihoods and reduced food production. As a result, thousands of people have sought refuge in the neighbouring countries of Ethiopia, Kenya, Sudan and Uganda.

By mid-November 2014 these refugees totalled some 475 000 people. This figure is estimated to reach 821 000 by the end of 2015 if current trends persist. There are a disproportionate number of women and children among the new arrivals in all host countries, with children accounting for up to 70% of refugees.

Health Sector Situation

In **Ethiopia**, a nutrition survey conducted in July 2014 showed critical levels of acute malnutrition in newly established refugee camps. Endemic diseases and those with epidemic potential including measles and hepatitis continue to pose a major risk. The demand for primary health care, comprehensive emergency obstetrics care, referral services and care for chronic illnesses risks putting increased pressure on the local health system.

In **Kenya**, refugees' health status remained stable in 2014 due to effective medical screening at border points, the provision of appropriate health care and disease outbreak control measures. However, there is a shortage of qualified medical staff, health resources are overstretched and health infrastructure is weak, especially in the main hospital serving the refugee camp.

In **Sudan** health partners provided 100 000 South Sudanese refugees and members of host communities with free access to primary health care in 2014, among other services. However, there remains a need to strengthen health service delivery systems, both at relocation sites and also at referral health facilities, which would also benefit host communities. The limited capacity of health care infrastructures will require constant support not only to maintain access to health care for the existing refugee population, but also to respond to the needs of new arrivals.

In **Uganda** malaria is the leading cause of death among refugees. Community health interventions have lowered the malaria incidence rate, but the coverage of long-lasting insecticide treated nets is still low (38% in March 2014). Inadequate health infrastructure, a lack of health care workers and a lack of medical supplies and medicines remain a challenge. The number of community health workers is still inadequate and there is a need to build capacity among partners on the use of health information systems. Cholera is endemic to the districts hosting refugees and there have been frequent outbreaks of cholera and other water-borne diseases. The host districts of Arua and Ajumani reported outbreaks of measles in March 2014.

WHO funding for 2015

2015 Requirements:	US\$	9 687 200
2015 Funding:	US\$	0

Health Sector Objectives

The Health sector objectives defined in the Strategic Response Plan are to:

- To provide primary health care services for refugees
- To maintain, reinforce and rehabilitate health facilities
- To provide screening, case management and vaccination services for new arrivals at entry points
- To control the spread of communicable diseases and provide immunization services for disease include measles and polio
- To provide essential and emergency reproductive health care services.

- To provide essential drugs, medical supplies and equipment to health centres
- To support malaria prevention with the distribution of long-lasting insecticide treated nets
- To train health workers
- To provide mental health services and referrals for refugees
- To enhance disease surveillance systems and laboratory investigation capacity for timely detection of epidemics.
- To establish clear and strong referral mechanisms for treatment of endemic diseases and chronic diseases, including tuberculosis and HIV/AIDS

Beneficiaries targeted by health partners in 2015

The 2015 South Sudan Refugee Response Plan is based on a total beneficiary population that is estimated to reach 821 000 by the end of 2015.

Ethiopia:	340 000
Kenya:	75 000
Sudan:	196 000
Uganda:	210 000

Geographical areas targeted by health partners in 2015

Health sector partners are focusing their efforts on the major entry points and settlement sites for refugees from South Sudan.

Health Sector funding requirements for 2015

US\$ 121 320 195 for 2015 (Health and Nutrition Cluster partners including WHO)

WHO funding requirements for 2015

WHO is appealing for a total of US\$ 16 863 349 to implement the following projects:

WHO projects	Requested funds (US\$)
Ethiopia-South Sudan refugee response SSDRRP-15/MS/77309/122	1 450 000
Kenya - South Sudan refugee response SSDRRP-15/MS/77332/122	1 860 000
Sudan - South Sudan refugee response SSDRRP-15/MS/77332/122	7 176 149
Uganda - South Sudan refugee response SSDRRP-15/MS/77344/122	6 377 200



Baseline indicators*		Estimate
Human development index ¹	2013	118/187
Population in urban areas%	2012	56
Population using improved water source%	2012	90
Population using improved sanitation%	2012	96
Life expectancy at birth (years)	2012	68
Infant mortality rate / 1000 ²	2013	12
Under 5 mortality rate / 1000 ²	2013	15
Maternal mortality ratio / 100 000 ²	2013	49
Measles coverage among one year old's%	2013	61
Wasting% ³	2009	11.5

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in the Syrian Arab Republic from Canada, the European Commission Humanitarian Aid and Civil Protection, Finland, Kuwait, Norway, the United Arab Emirates, the United Kingdom of Great Britain and Northern Ireland, the United States of America and the United Nations Organization for the Coordination of Humanitarian Affairs.

WHO funding for 2015

2015 Requirements:	US\$	131 600 669
2015 Funding:	US\$	23 300 446

The Syrian Arab Republic

The Syrian Arab Republic has been affected by almost four years of conflict, resulting in a deterioration of the health situation. More than 200 000 people have been killed and more than 1 million have been injured. Humanitarian needs have reached a record high, with 12.2 million people in need of humanitarian assistance, including 7.6 million internally displaced persons (IDPs) and 2 million children under the age of five.

A United Nations resolution (UNSC resolution 2165) in July 2014 provided the mandate for the UN and its partners to deliver cross-border humanitarian aid through a 'whole of Syria' approach. There are now three hubs—in the Syrian Arab Republic, Jordan and Turkey—which are able to reach populations across the Syrian Arab Republic. Joint planning and needs assessments resulted in the 2015 Syrian Arabic Republic Strategic Response Plan. Each hub has specific priorities and outputs that complement those of other hubs and contribute to the overall objectives of the Health Cluster.

Health Sector Situation

Since the inception of the crisis, primary, secondary, and tertiary health-care services in Syria have deteriorated due to damaged health facilities, power outages, shortages of medical supplies and a lack of qualified healthcare professionals.

Fifty-five percent of public hospitals are reported to be partially functioning or completely out of service, while 63% of public basic emergency obstetric care centres are not functioning. The limited availability of health services in some parts of the country requires patients to travel up to 160 km to reach the nearest hospital, while referral services are frequently non-functional. The private sector, which provided medical services to more than 50% of the population prior to the crisis, has been severely affected by the displacement or departure of the majority of private health service professionals.

All these factors have contributed to increased morbidity and mortality, outbreaks of communicable and vaccine-preventable diseases, and increased risk of complications due to the shortage in chronic disease medicines, in addition to a high number of people suffering from or being vulnerable to mental illness and psychosocial distress. As water and sanitation systems and services have deteriorated, the incidence of waterborne diseases has also increased.

Children less than five years of age are among the most vulnerable groups, especially in rural areas, followed by the elderly and children aged between 5 and 12. Other particularly vulnerable population groups include the chronically ill, people with disabilities and child-headed households. Women are in need of reproductive health services, including antenatal, delivery and postpartum care, while men are in acute need of access to trauma care and mental health services.

Health Sector Objectives

Using the whole of Syria approach, the health sector's interventions target the most affected people based on the results of analyses and multiple needs assessments, taking into consideration the need to provide equitable and needs-based support to all individuals affected by the crisis.

Syrian Arab Republic (Damascus hub)

Objective 1: To strengthen trauma care management

Strengthen the level of preparedness for and management of trauma, including referral mechanisms, for a projected increase in the number of injuries across the country

Objective 2: To enhance primary health care services

Improve access to comprehensive primary health care services

Objective 3: To support delivery of secondary and tertiary health care services

Improve access to secondary health care services and limited tertiary health care services

Objective 4: To enhance and expand the disease surveillance and response system

Prevent, detect early and respond to epidemic-prone diseases and contain the current polio epidemic and its spread to other countries and regions

Objective 5: To scale up mental health services

Strengthen mental health service delivery across the Syrian Arab Republic

Objective 6: To small-scale rehabilitation of damaged health facilities

Support public and private health infrastructure and services affected by the crisis and enhance revitalization of health services and restoration of health facilities in affected areas

Objective 7: To strengthen emergency health information systems

Strengthen health information systems for emergencies using the Health Resources and Services Availability Mapping System for regular, timely and accurate collection and dissemination of data

Objective 8: To coordinate effectively humanitarian interventions in the health sector

Strengthen health sector coordination to address the needs of vulnerable people, provide improved access to quality healthcare services and allow for adequate preparation and response capacities for ongoing and new emergencies

Jordan (Amman hub)

Objective: To enhance the provision of life-saving and life sustaining health services

Planned outputs:

- Support trauma and injuries care through the procurement and shipment of 24 surgical kits to support local health facilities in Dara and Quinetra
- Provide technical support for routine immunization services, achieving 90% coverage for diphtheria-pertussis-tetanus vaccination
- Provide technical support for the implementation of polio immunization campaigns, achieving more than 95% coverage

Objective: To improve coordination for effective health response

Planned outputs:

- Recruit a Health and Nutrition Sector Coordinator
- Conduct a joint health assessment with the Turkey and Syria Health Sector Working Groups
- Conduct interagency health assessments at the Jordan Hub level in Dara and Quinetra
- Recruit an Information Management Officer
- Train health staff in Dara and Quinetra on the Health Resources Availability Mapping System tool
- Train health focal points in Dara and Quinetra on surveillance and early warning and response systems

Objective: To strengthen health preparedness and response capacities for health care providers, and communities

Planned outputs:

- Train health staff in Dara and Quinetra on emergency response
- Pre-position five surgical kits in local warehouses in Dara and Quinetra for year-round availability
- Support local health authorities in Dara and Quinetra to develop a mass casualty management plan
- Support the establishment of a mass casualty management system

Turkey (Gaziantep hub)

Objective: To enhance the provision of life-saving and life-sustaining health services

Planned outputs:

- Provide technical support for the implementation of polio immunization campaigns, achieving more than 92% coverage
- Provide technical support for the implementation of immunization campaigns for measles, achieving more than 92% coverage
- Set-up functional routine immunization services in 50 health facilities
- Establish 8 functional referral labs for case investigation in northern Syria
- Train 100 health staff in targeted chronic disease protocols
- Supply 50 health facilities with equipment, consumables and medicines for targeted chronic diseases
- Train 250 health staff in mental health care

Objective: To improve coordination for effective health response

Planned outputs:

- Recruit technical and coordination staff
- Conduct a joint health assessment with the Jordan and Syria Health Sector Working Groups
- Conduct at least two Health Resources Availability Mapping System assessments in northern Syria
- Conduct 24 Health Working Group/Health Cluster meetings
- Support the establishment of a mass casualty management system

WHO Emergency Support Team for the Syria Crisis (overall coordination)

Objective: To improve coordination for effective health response

Planned outputs:

- Recruit a Whole of Syria Health Sector Focal Point
- Recruit a Whole of Syria Health Sector Information Management Officer

Beneficiaries targeted by health partners in 2015

Health partners are targeting 12.2 million people in 2015.

Geographical areas targeted by health partners in 2015

Health partners are addressing large-scale humanitarian needs throughout all 14 governorates

Health sector funding requirements for 2015

US\$ 318 000 000 (including WHO)

WHO funding requirements for 2015

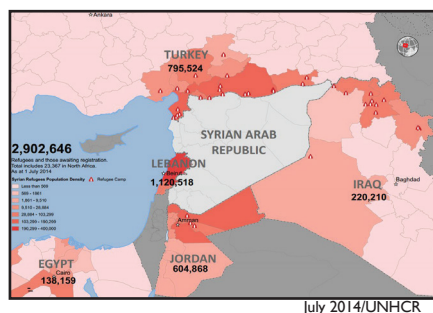
Jordan country office: US\$ 1 820 000

Turkey country office: US\$ 6 227 669

Emergency Support Team: US\$ 500 000

Syrian Arab Republic Country Office: US\$ 116 377 945 for the following projects:

WHO projects	Requested funds (US\$)
Reduce excess morbidity and mortality due to malnutrition SYR-15/H/75326/122	1 551 500
Strengthening trauma care management SYR-15/H/75337/122	27 071 000
Support delivery of secondary and tertiary health care services SYR-15/H/75344/122	32 468 080
Enhancement and expansion of the disease surveillance and response system SYR-15/H/75342/122	5 136 000
Scaling up mental health services SYR-15/H/75346/122	6 152 500
Support the immunization programme SYR-15/H/75348/122	6 955 000
Enhanced primary health care delivered services SYR-15/H/75354/122	33 304 636
Enhancing service delivery and capacity for emergency response in Southern Syria SYR-15/H/78254/122	1 820 000
Enhancing the EWARN and supporting improved vaccination coverage of measles and polio among under five year old children SYR-15/H/78307/122	1 447 646
Integration of non-communicable diseases in primary health care in selected governorates of Syria SYR-15/H/78310/122	1 540 000
Improving the quality of psychosocial support and of mental health management, referral and documentation at the primary health care level in selected governorates SYR-15/H/78315/122	1 011 000
Strengthening health sector coordination SYR-15/H/78316/122	1 296 224
Effective health sector coordination SYR-15/H/75369/122	2 262 390



July 2014/UNHCR

Syria Regional Refugee and Resilience plan

The Syrian Arab Republic crisis, now entering its fifth year, continues to force people from their homes and drive a stream of refugees into neighbouring countries. By November 2014, 3.3 million Syrians, including 1.7 million children, had sought refuge in Egypt, Iraq, Jordan, Lebanon and Turkey, up from 2.4 million at the end of 2013. The total number of Syrian refugees is expected to reach 4.3 million by the end of 2015.

As the crisis continues, refugees are exhausting their savings and resources, becoming more vulnerable. Millions remain in need of lifesaving humanitarian assistance and international protection. The crisis has had unprecedented social and economic impacts on host countries in the region, affecting their stability and reversing years of development gains and overstretching basic social services such as health, water, sanitation and education.

Health Sector Situation

Throughout the region, national health services provide significant health care to Syrian refugees. The increasing demands, however, are stretching local health systems and affecting their ability to deliver to local communities.

Vulnerable populations are at an increased risk of communicable diseases due to unfavourable environmental conditions, including limited access to safe water and sub-standard housing, and limited access to basic health services, such as child immunization. Outbreaks of polio in northern Syria and Iraq triggered mass immunization campaigns in affected and high-risk areas in Egypt, Iraq, Jordan, Lebanon, Syria and Turkey throughout 2014. Other diseases are also increasingly prevalent, such as acute respiratory infections and diarrhoea among children in Iraq.

The management of noncommunicable diseases (NCDs) is a significant challenge. Nearly 30% of refugees in Jordan, for example, suffer from NCDs such as hypertension or diabetes. Extra care and support are needed for survivors of torture and violence who are suffering from post-traumatic stress disorder (PTSD), anxiety or depression, as well as for those with other mental health conditions. A comprehensive care approach at the primary, secondary and tertiary levels, including referrals to wider psychosocial services, is required.

Access to adequate and appropriate reproductive health care is a continuing need. It is necessary to improve capacities for basic and comprehensive emergency obstetric and neonatal care at primary, secondary and tertiary health care locations. In most areas, there is limited access to and availability of clinical management of rape services and wider gender-based violence services.

Given the diverse mechanisms of health support across the region, the regional response plan emphasizes the need to increase access to quality and equitable health care for refugees and impacted local populations both through direct interventions and through bolstering national systems and capacities. Improvements will be directed towards strengthening routine immunization and campaigns, especially for polio and measles, which continue to threaten the region. Newborn and child health will be addressed through capacity building and delivery of integrated packages at health facility and community level. Mechanisms to address communicable disease outbreaks through early warning, alert and response systems, and to increase capacity of health information systems, will be improved. Access to reproductive health care, including clinical management of rape services and referral mechanisms to psychosocial services will remain a priority. NCD management and mental health care across the service levels require significantly greater support both through direct service delivery and increasing technical capacity of national systems.

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in the countries in the Syria Regional Response Plan from Kuwait, Norway, the United Kingdom of Great Britain and Northern Ireland, the United States of America, and the United Nations Organization for the Coordination of Humanitarian Affairs.

WHO funding for 2015

2015 Requirements:	US\$	40 917 100
2015 Funding:	US\$	10 087 994

Health Sector Objectives

The health sector strategy seeks to establish a balance between delivering services to refugees and strengthening health systems in host countries.

Cross-cutting priorities for the sector across host countries include:

- To improve access to primary health care for Syrian refugees and impacted communities
- To optimize life-saving assistance through essential secondary and tertiary health care
- To support access to mental health services
- To support and strengthen the capacity of national health care systems to provide services, including those related to noncommunicable diseases to Syrian refugees and members of impacted communities
- To improve surveillance and the response to communicable diseases and provide routine vaccination and vaccination campaigns to reduce the risk of communicable disease outbreak among refugees

Detailed health sector priorities for each of the four host countries are available in the country plans at:

<http://www.3rpsyriacrisis.org>

Outputs targets include

- Support 439 health facilities
- Train 13 000 health care staff

Beneficiaries targeted by health partners in 2015

The target population includes:

Camp: 460 000

Non-camp: 2 050 000

Host community and others: 955 000

Health sector funding requirements for 2015

US\$ 369.3 million (including WHO)

Egypt: US\$ 28 776 181

Iraq: US\$ 34 294 959

Jordan: US\$ 72 694 443

Lebanon: US\$ 204 549 080

Turkey: US\$ 28 941 000

WHO funding requirements for 2015

WHO is appealing for a total of US\$ 33.6 million for 2015 for the following projects:

Egypt: US\$ 8 440,000

Iraq: US\$ 10 570,000

Jordan: US\$ 4 200 000

Lebanon: US\$ 8 335 000

Turkey: US\$ 2 050 000

WHO projects	Requested funds (US\$)
Egypt - Syria 3RP SRRP-I5/MS/76597	8 440 000
Iraq - Syria 3RP SRRP-I5/MS/76629	10 570 000
Jordan - Syria 3RP SRRP-I5/MS/76685	4 200 000
Lebanon - Syria 3RP SRRP-I5/MS/76755	8 335 000
Turkey - Syria 3RP SRRP-I5/MS/76768	2 050 000



Ukraine

The humanitarian situation in parts of eastern Ukraine remains volatile and is continuing to deteriorate. As a result of ongoing hostilities between armed groups and government forces, as well as the events that occurred in the Autonomous Republic of Crimea in March 2014, Ukrainians have fled their homes and become increasingly vulnerable. Since the start of hostilities in April 2014, more than one million people have been displaced within Ukraine or in other countries.

Those remaining in conflict-affected areas, particularly in densely populated urban areas, face continued security threats due to military activities. Basic life-saving services have been disrupted, access to financial services is limited and food and provisions are increasingly rare and expensive.

Health Sector Situation

The health system in Ukraine, already weak, has been severely affected by the crisis. While the overall budget for health care has increased in the Ukraine over the last six years, it is still comparatively low at around 3.2% of GDP. WHO recommends at least 5%. This, compounded with the ongoing devaluation of the local currency, means that Ukraine's 2015 health budget will only cover approximately 30% of needs.

There are no budgetary resources allocated to health services for IDPs, requiring these people to make out-of-pocket payments for health care, despite many of them no longer having an income. The absence of a unified and centralized IDP registration system is also limiting access to services as public health care is usually provided to citizens in their location where they are registered.

In total, WHO estimates that 4.5 million people, including IDPs, host communities and those remaining in conflict zones are in need of assistance. Vulnerable populations, especially children, women, the elderly and disabled people are particularly at risk. There is limited emergency primary and specialized health-care (including care for chronic non-communicable diseases, maternal and newborn care and mental health care) to cater for these populations.

There is a lack of medical supplies and medicines in Ukraine. Hospitals are running out of stocks, with some medical staff reporting that they have not received funding for several months. Timely procurement is hampered by lengthy legal procedures and there have been failures in the tendering process for the supply of medical supplies, notably for vaccines, tuberculosis (TB) and HIV/AIDS treatments and medications for hypertensive and cardiovascular conditions. Areas of particular concern include:

Maternal health: A lack of access to reproductive health services was reported in three areas: Sloviansk, Sviatohirsk and Popasnyaya.

Communicable diseases: Winter weather increases health risks, particularly for those without adequate shelter or heating. Low immunization rates among children further exacerbate the risk of infection. The prevalence of HIV/AIDS and poor nutrition among the IDP and returnee population makes them more vulnerable to developing active TB.

Mental health: Very limited psychosocial support is offered to IDPs. The majority of IDPs with mental disorders and psychological distress do not receive any form of treatment.

Health Sector Objectives

Objective 1: To fill gaps and enhance access to quality preventive and curative health services, including medication and health technology

Baseline indicators		Estimate
Human development index ¹	2013	83/187
Population in urban areas%	2010	68.7
Population using improved water source%	2012	98
Population using improved sanitation%	2012	94
Life expectancy at birth (years)	2012	71
Infant mortality rate / 1000 ²	2013	9
Under 5 mortality rate / 1000 ²	2013	10
Maternal mortality ratio / 100 000 ²	2013	23
Measles coverage among one year old's%	2013	79
Wasting ³	2000	8.2%

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35.

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in Ukraine from Canada, the Central Emergency Response Fund, the European Commission for Humanitarian Aid and Civil Protection, Estonia, Israel and the United Nations Organization for the Coordination of Humanitarian Affairs.

WHO funding for 2015

2015 Requirements:	US\$	15 000 000
2015 Funding:	US\$	590 087

Planned outputs:

- Improve access to comprehensive primary health care services and care at secondary and tertiary levels
- Support to HIV-exposed and affected persons lacking treatment due to the emergency
- Support delivery of emergency reproductive health-care to vulnerable women.,
- Direct support to hospitals with surge personnel and supplies
- Support in improving quality of emergency care provision for children through implementing Integrated Management of Childhood Illnesses
- Improve identification, referral and access to mental health care support
- Improve identification, referral and access to medical care for gender-based violence, with 15% of health facilities providing clinical management of rape survival services
- Strengthen the preparedness for and management of trauma care
- Promote an enabled working environment for volunteers, and provide specialized training according to needs

Objective 2: To provide reliable health information for evidence-based emergency response, monitoring and policy decision-making

Planned outputs:

- Conduct joint assessments related to safe and equal access to primary health care services among the most affected populations, including women, children and people with disabilities
- Strengthen the health information management system for emergency and regular health-care, with all mobile emergency primary healthcare units and emergency primary care posts reporting at least 10 times over a 12-month period
- Strengthen the Health Cluster and sub-cluster nutrition coordination to address the protection needs of the crisis affected and displaced people
- support selected health services and infrastructure affected by the crisis, in line with the health system reform, and enhance revitalization and restoration of health services and health facilities in affected areas
- Development of health communication activities to the general population and to health personnel

Objective 3: To strengthen disease surveillance and response, including laboratory capacities and technical guidance on priority public health issues and threats

Planned outputs:

- Strengthen syndromic surveillance, disease monitoring and early warning systems, assessing the vaccination status of 85% of children
- Prevent, detect and respond to epidemic-prone diseases (including polio and measles), with 100% of alerts responded to within 48 hours
- Pre-position emergency medical supplies and materials to ensure a timely response to epidemic-prone diseases outbreaks, with 20 emergency health hospitals receiving Interagency Diarrheal Diseases Kits

Beneficiaries targeted by health partners in 2015

The cluster is targeting 3.17 million people, out of a total of 4.5 million estimated to be in need. In the total number of people in need: 7% are children under 59 months of age; 15% are adolescents; 3% are pregnant or lactating women; 20% are elderly; and 10% are disabled; 16% have communicable or non-communicable diseases.

Geographical areas targeted by health partners in 2015

The Health Cluster will carry out activities in Kharkiv, Dnipropetrovsk, Zaporizhzhia, Luhansk and Donetsk regions, with support provided across Ukraine to selected health services and infrastructure affected by the crisis.

Health sector funding requirements for 2015

US\$ 50 000 000 (including WHO)

WHO funding requirements for 2015

WHO is appealing for a total of US\$ 15 000 000

WHO projects	Requested funds (US\$)
Health activities UKR-15/H/78293/R/122	15 000 000



Baseline indicators		Estimate
Human development index ¹	2013	154/187
Population in urban areas%	2012	33
Population using improved water source%	2012	55
Population using improved sanitation%	2012	53
Life expectancy at birth (years)	2012	64
Infant mortality rate / 1000 ²	2013	40
Under 5 mortality rate / 1000 ²	2013	51
Maternal mortality ratio / 100 000 ²	2013	270
Measles coverage among one year old's%	2013	78
Wasting ³	2011	13.3%

Source: WHO Global Health Observatory unless indicated otherwise by a footnote. References on page 35

Acknowledgement

In 2014 WHO received financial contributions to support its humanitarian work in Yemen from Japan, the United States of America, the Central Emergency Response Fund, and the United Nations Organization for the Coordination of Humanitarian Affairs.

WHO funding for 2015

2015 Requirements:	US\$	25 297 538
2015 Funding:	US\$	1 791 472

Yemen

Despite growing levels of humanitarian assistance over the past three years, Yemen continues to face one of the world's largest humanitarian crises. Political instability and conflict has led to the near collapse of basic services, making increasing numbers of vulnerable people reliant on external assistance for their basic needs. In 2015, an estimated 15.9 million people—61% of the population—will require some kind of humanitarian assistance, mainly in the food, water and health sectors. This is an 8% increase from 2014. Localized conflicts displaced about 80 000 people in Yemen in 2014. Most returned home shortly after conflict ended. However, some 335 000 Yemenis remain in protracted displacement, mainly in the north of the country.

Health Sector Situation

An estimated 8.4 million Yemenis lack adequate access to health care. This figure is largely unchanged from 2014, however geographic concentrations have shifted following the evolution of localized conflict. The number of people in need has fallen dramatically in Abyan and Lahj governorates, while new concentrations of need have emerged in areas more recently affected by conflict, such as Sana'a City, Shabwah and Hadramaut.

Political instability and expanding conflict has increased the need for mass casualty management services and there is a continuing need for health services for new and previously displaced people. In areas where security has improved, health facilities require rehabilitation and support.

An increase in the cross-border movements of refugees and migrants has resulted in a higher risk of outbreaks of communicable diseases, including Ebola and Middle Eastern Respiratory Syndrome. Greater capacity for disease surveillance and outbreak containment is therefore required.

All of these needs exist against a general backdrop of endemic poverty, eroding basic services (including immunization), poor nutrition and sanitation and low community awareness of health issues. Specialized services for women, including reproductive health care, are not always available and health facilities often lack sufficient privacy measures for female patients and staff. Living in camps for protracted periods also exposes women and children to sexual abuse, which may result in physical and psychological trauma or sexually transmitted diseases.

Health Cluster Priorities

Objective I: To ensure access to an essential package of quality life-saving health care services for the vulnerable groups in priority districts, aimed at avoiding preventable morbidity and mortality, through a focused approach on health system strengthening

Planned outputs:

- Support hospitals with Comprehensive Emergency Obstetric and Newborn Care services
- Support health facilities with Basic Emergency Obstetric and Newborn Care services
- Supporting life-saving primary health care/emergency medical services for the most vulnerable population
- Immunization campaigns against measles and polio

Objective 2: To strengthen local capacity to predict, prepare for, respond to, and manage public health risks with a focus on communicable diseases and seasonal emergencies in priority districts

Planned outputs:

- Train health workers in Integrated Management of Child Illness (IMCI) and Minimum Initial Services Package (MISP) in emergencies ensuring participation of both male and female health workers
- Provide essential drugs, medical supplies/equipment and basic repairs to partially functional health facilities
- Strengthen and expand the Disease Early Warning System in affected governorates

Beneficiaries targeted by health partners in 2015

Health partners are targeting 4.4 million people in 2014-2015

Geographical areas targeted by health partners in 2015

Health partners are targeting Abyan, Aden, Al Dhale'e Lahj, Al Hudaydah, Hajjah, Al Jawf, Amran, Hadramaut, Ibb, Sa'ada, Sana'a, Shabwah and Taizz governorates. Measles and polio campaigns will be national with a particular focus on the priority governorates of Abyan, Aden, Al Bayda, Al Dhale's, Al Hudaydah, Al Jawf, Al Maharah, Amran, Hadramaut, Hajjah, Marib, Sana'a, Shabwah and Taizz

Health Cluster funding requirements for 2015

US\$ 61 870 411 (including WHO)

WHO funding requirements for 2015

WHO is appealing for a total of US\$ 25 297 538

WHO projects	Requested funds (US\$)
Health related activities YEM-15/H/78646R/122	25 297 538

Summary Table of Funding Requirements

Country/Region	Health Sector Funding Requested (US\$)	WHO Funding Requested (US\$)
Afghanistan	38 800 000	10 000 000
Central African Republic	63 200 000	15 000 000
Central African Republic Regional Refugee Response Plan	62 089 075	15 996 471
The Democratic Republic of the Congo	43 800 000	20 000 000
Iraq	314 231 723	189 421 986
Myanmar	22 700 000	1 350 000
occupied Palestinian territory	21 000 000	3 382 750
Sahel Regional Response Plan	134 500 000	not yet published
Somalia	71 400 000	13 957 344
South Sudan	90 000 000	16 760 000
South Sudan Regional Refugee Response Plan	121 320 195	16 863 349
The Syrian Arab Republic	318 000 000	131 600 669
Syria Regional Refugee and Resilience Plan	369 300 000	33 595 000
Ukraine	50 000 000	15 000 000
Yemen	61 870 411	25 297 538

The requested funding figures listed above will change over the year as these Strategic Response Plans are modified to reflect conditions within the country and as additional country Strategic Response Plans are published.

List of acronyms

ARI	Acute respiratory tract infection
BEmOC	Basic Emergency Obstetrical and Care
CERF	Central Emergency Response Fund
ECHO	European Commission Humanitarian Aid and Civil Protection
EWARS	Early Warning and Response System
HIV	Human Immune-Deficiency Virus
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immuno-Deficiency Syndrome
IDPs	Internally displaced people
IMCI	Integrated Management of Childhood Illness
IOM	International Organization for Migration
NGO	Nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
UN	United Nations
UNAIDS	UN Joint Programme on HIV/AIDS
UNCT	UN Country Team
UNFPA	UN Population Fund
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
UNRWA	UN Relief and Works Agency for Palestine Refugees in the Near East
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WHO/PEC	World Health Organization/Polio and Emergencies

References

Baseline indicators	Estimate
Human development index ¹	2013
Population in urban areas%	2012
Population using improved water source%	2012
Population using improved sanitation%	2012
Life expectancy at birth (years)	2012
Infant mortality rate / 1000 ²	2013
Under 5 mortality rate / 1000 ²	2013
Maternal mortality ratio / 100 000 ²	2013
Measles coverage among one year old's%	2013
Wasting ³	2003

Source: WHO Global Health Observatory (05/02/2015)

¹ Source: <http://hdr.undp.org> (05/02/2015)

² live births

³ Weight-for-Height <-2 z-scores of WHO Growth Standards, among children 0-59 months.
Source: WHO Global Database on Child Growth and Malnutrition (<http://www.who.int/nutgrowthdb/database/countries/en>)

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Regional Office for Africa

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Regional Office for the Eastern Mediterranean

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World Health Organization

Department for Emergency Risk Management and
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www.who.int/disasters