World Health Organization

SIXTY-EIGHTH WORLD HEALTH ASSEMBLY **A68/23**
Provisional agenda item 15.4 **15 May 2015**

WHO response in severe, large-scale emergencies

Report of the Director-General

1. Pursuant to the request by the Executive Board in resolution EBSS3.R1, adopted at the special session on Ebola, the Director-General submits this report on all WHO Grade 3 and United Nations Inter-Agency Standing Committee Level 3 emergencies where WHO has taken action between May 2014 and April 2015.

2. During the period under review, WHO responded to 40 emergencies (see Annex) including an unprecedented six concurrent emergencies evaluated as Grade 3, the most severe level based on WHO's Emergency Response Framework. [1] Since May 2014, WHO has declared three new Grade 3 emergencies: the complex humanitarian crisis in Iraq (graded in August 2014), the Ebola virus disease outbreak in West Africa (graded in July 2014) and the earthquake in Nepal (graded in April 2015). The other three Grade 3 emergencies are those in the Syrian Arab Republic, Central African Republic and South Sudan, each of which is an on-going conflict graded in 2013.

3. The six Grade 3 emergencies involve 11 countries, with commensurate scale and complexity of operations. The crisis in the Syrian Arab Republic also affects Jordan, Lebanon and Turkey, and the Ebola virus disease outbreak includes Guinea, Liberia and Sierra Leone.[2] With the exception of the Ebola virus disease outbreak and the Nepal earthquake, all the Grade 3 emergencies are also Inter-Agency Standing Committee system-wide Level 3 emergencies.

4. Although Grade 3 emergencies are the most high profile and demanding, they should not obscure the other serious on-going emergencies. Since 1 May 2014 WHO has responded to 31 acute graded emergencies (including the six at Grade 3), in addition to nine protracted crises (e.g., those in Afghanistan, Democratic Republic of the Congo, Myanmar and Somalia). Some countries have had more than one emergency (e.g., Philippines) and some have experienced both acute and protracted crises during that period (e.g., Pakistan). Health needs are almost always among the most pressing for populations directly impacted by emergencies. Over the past 18 months, for example, communities have ranked health services as their highest priority during assessments in Central African Republic, Philippines and Syrian Arab Republic.

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[1] The Emergency Response Framework outlines three separate grades of emergency that convey the extent of organizational support required for the emergency response: 1, 2, and 3. A Grade 1 emergency requires minimal WHO response; Grade 2 requires moderate WHO response; and Grade 3 requires substantial WHO response. The relevant members of the Organization's Global Emergency Management Team determine the emergency grade after consideration of scale, urgency, complexity and context. Once an emergency is graded, WHO's response is monitored according to well-defined, time-bound performance standards.

[2] Cases of Ebola virus disease were also documented in Mali, Nigeria, Senegal, Spain, the United Kingdom of Great Britain and Northern Ireland and the United States of America. These countries were not covered by the Grade 3 declaration.

5. According to the United Nations Office for the Coordination of Humanitarian Affairs, the global scale of humanitarian need is currently the highest on record. There are 77.9 million people requiring humanitarian assistance worldwide; about 172 million people are affected by conflict. In addition, close to 200 million people are affected annually by natural and technological disasters, resulting in almost 110 000 deaths. As of 20 April 2015, total humanitarian appeals amounted to US$ 18 700 million, of which only 15% was funded (8% within the health sector). The competing demands for humanitarian financial assistance have never been greater.

WHO'S ACTIONS IN EMERGENCY RESPONSE

Syrian Arab Republic

6. The conflict in the Syrian Arab Republic has entered its fifth year, directly affecting 12.2 million people, of whom 7.6 million are internally displaced and 3.8 million are refugees. Five countries (Egypt, Iraq, Jordan, Lebanon and Turkey) have generously absorbed large numbers of refugees, placing huge burdens on their own national social services and local communities.

7. The conflict has had a major impact on access to health care, with the near collapse of the Syrian health system and a significant change in the country's public health profile (increased trauma, outbreaks of poliomyelitis and measles, mental health problems and complications of communicable diseases). Most technical and operational support to the WHO Country Office is delivered through the Emergency Support Team established in Amman, Jordan, in January 2013. The Emergency Support Team works with the affected countries to ensure an approach that covers the whole of the Syrian Arab Republic as well as a coordinated regional health approach.

8. WHO increased its operational capacity in the Syrian Arab Republic to 66 staff, and has a decentralized network of 27 medical focal points across all governorates, including those in remote and opposition-controlled areas. WHO has sub-offices in Aleppo, Hassake and Homs and plans to establish a presence in Daraa. WHO also has active partnerships with 56 local nongovernmental organizations to improve access and establish sustainable modalities for delivery of health services.

9. In 2014, WHO distributed 13.5 million medical treatments in the Syrian Arab Republic, 22% of which were distributed through partner nongovernmental organizations and 32% of which went to hard-to-reach and opposition-controlled areas, including in Aleppo, Daraa, Deir ez-Zor, Hassake, Idleb, Raqqa and Rural Damascus. This figure is more than twice the amount distributed in 2013. In addition, 10 rounds of polio vaccination were administered to 2.9 million children under 5 years old in 2014; 1.1 million children were vaccinated against measles in June 2014. The number of Disease Early Warning System sentinel sites increased from 441 to 650 in 2014, a third of these in opposition-controlled areas.

10. The crisis has also overburdened health systems in neighbouring countries. WHO worked with host governments and health sector partners to assess, monitor and address key public health risks and health sector burden related to the 3.8 million Syrian refugees and affected host communities in Egypt, Iraq, Jordan, Lebanon and Turkey.

11. Despite the expansion of WHO's response, gaps remain owing to increasing health needs, difficulty in accessing services, limited operational capacity of partners and limited funding. The health sectors within the Syrian Arab Republic and in neighbouring countries require a total of US$ 687.2 million (and WHO needs US$ 131.6 million) in 2015 to continue providing life-saving medicines, medical supplies and equipment to a growing number of increasingly vulnerable people;

strengthen trauma management; expand delivery of immunization services; provide mental health and physical rehabilitation services; strengthen overall support to health services in neighbouring countries; and support a regional approach to communicable disease surveillance and response.

Central African Republic

12. The crisis in the Central African Republic has displaced more than one million people since December 2013. Today there are more than 430 000 internally displaced persons and more than 1.47 million people in urgent need of humanitarian health support. About 60% of health care facilities are now functional, but 80% of those depend on support from partners.

13. WHO expanded its country presence by bringing in 55 staff in successive phases and repurposing 31 country office staff members to respond to the crisis. There are currently 69 staff members in Bangui and the three subnational offices (Bambari, Bandoro and Bouar).

14. WHO leads the Health Cluster of 64 health partners to coordinate the provision of emergency health services to people most in need. Free health care was delivered to the most vulnerable and supplies provided to care for 800 000 people; 345 508 children were vaccinated against measles and poliomyelitis; and a disease early warning surveillance and response system was established covering 82% of displaced people. Despite these efforts, health coverage remained limited. Challenges to providing emergency and basic health services remain insecurity and related lack of access and high operational costs, lack of resources, limited number of operational partners and collapse of the national essential medicines supply system.

15. The health cluster requires US$ 63 million in 2015, US$ 15 million of which WHO needs in order to provide urgent support to the affected population. As at 20 April 2015 the funding gap was 100%.

South Sudan

16. The crisis in South Sudan has resulted in 4.1 million people needing humanitarian assistance in 2015, of whom the Health Cluster is targeting 3.4 million, including 706 000 children aged under 5 years and 840 000 women of child-bearing age. There has been major disruption to health care delivery due to attacks on facilities, health workers and patients, shortages of medicines and lack of personnel.

17. Since the start of the crisis, WHO has been operational in all 10 states, and expanded its presence particularly in the five conflict-affected states of Central Equatoria, Jonglei, Lakes, Unity and Upper Nile; 138 staff members have supported the emergency response. WHO leads the Health Cluster with 36 health partners operating in the conflict-affected states.

18. In 2014, WHO delivered life-saving medicines for treatment of 959 000 people, supported emergency primary health care services in the Protection of Civilians sites, supported emergency vaccination campaigns against poliomyelitis and measles, oral cholera vaccination in major sites for internally displaced persons, responded to a cholera epidemic in five states and to outbreaks of hepatitis E, measles and visceral leishmaniasis, deployed surgical teams to manage trauma cases in Bentiu, Bor, Juba and Malakal, and strategically prepositioned essential medicines and life-saving supplies as part of contingency planning.

19. The risk of communicable disease outbreaks remains high in 2015. WHO and its health partners face numerous challenges in sustaining health services owing to insecurity, limited logistic and technical capacities, limited operational partners and lack of funding and staffing.

20. About US$ 90 million is required for the Health Cluster emergency response in 2015, of which US$ 16.7 million is required for WHO. WHO's funding gap as at 20 April 2015 was 83.6%.

Iraq

21. The current crisis has led to massive population displacement, with an increase from 1.8 million in late 2014-early 2015 to a total of 2.2 million internally displaced persons as of March 2015. Combined with 250 000 Syrian refugees in the northern governorates and the needs of host communities, the total humanitarian caseload is now 5.2 million people.

22. WHO expanded its humanitarian health response and strengthened its capacity, reaching 81 technical and operational staff including 25 international staff members. WHO established hubs and/or focal points in 10 governorates, and leads the Health Cluster of 45 health partners.

23. WHO provided essential medicines and medical supplies for a total of 1.6 million beneficiaries throughout the country (August 2014–February 2015), and supported the provision of primary health care services (819 546 consultations between August 2014 and January 2015) to internally displaced persons and refugees in Dohuk, Sulaymaniah and Erbil. To improve access to care for both internally displaced persons and host communities, WHO supported Dohuk and Sulaymaniah governorates with 10 mobile medical units each. More than 300 000 people were covered and more than 53 000 people reached with various medical interventions.

24. WHO supported the central Ministry of Health, the Kurdistan Regional Ministry of Health, and Directorates of Health by strengthening planning and management capacity and providing technical expertise in health assessments, disease surveillance and information management.

25. A major challenge to humanitarian response is insecurity, and a significant part of the country is inaccessible with limited or no access to health services. The limited number of operational partners and lack of financial resources are also problematic.

26. In 2015, WHO requires US$ 120.3 million to respond to the health needs of more than five million beneficiaries (2.2 million internally displaced persons and 3.5 million people in host communities). WHO's funding gap as at 20 April 2015 was 100%.

Ebola virus outbreak, West Africa

27. The first confirmed case of Ebola virus disease in West Africa was documented on 21 March 2014 in the Forestière region of Guinea, although cases may have occurred as early as December 2013. Since then the outbreak has spread to involve nine countries, including Guinea, Liberia, Mali, Nigeria, Senegal, Sierra Leone, Spain, the United Kingdom of Great Britain and Northern Ireland and the United States of America. As at 17 April 2015 there have been 25 834 confirmed cases and 10 702 deaths in the three main affected countries of Guinea, Liberia and Sierra Leone.

28. Milestones in emergency response have included WHO's declaration on 25 March 2014 of the outbreak as a Grade 2 emergency; its upgrade to a Grade 3 emergency on 25 July 2014; the declaration

on 8 August 2014 of a Public Health Emergency of International Concern; and the establishment of the United Nations Mission for Ebola Emergency Relief on 17 September 2014.

29. In response to a worsening of the outbreak, the international community expanded its response substantially during the second half of 2014. In support of this, the United Nations Secretary-General established the United Nations Mission for Ebola Emergency Response. Under this unique United Nation's mission, WHO provided technical leadership while working with partners to develop a phased response strategy. The first phase emphasized isolating and treating patients, burying the dead in a safe and dignified manner, and promoting behavioural change. The second phase has emphasized case finding, contact tracing and community engagement.

30. In response to the Ebola virus disease outbreak in West Africa, WHO has established the largest emergency operation in its history. As at 16 April 2015, more than 700 staff members were deployed across more than 60 field sites in the three main affected countries of Guinea, Liberia, and Sierra Leone, with a further 37 in Mali. In total, more than 2100 technical experts have been deployed by WHO, including 678 experts from partners in the Global Outbreak Alert and Response Network. In addition, the United States Centers for Disease Control and Prevention have directly deployed experts in surveillance, contact tracing, data management, laboratory testing and health education, and have supported assessments of Ebola preparedness in non-affected border countries.

31. WHO has worked closely with a wide range of governmental, local and international partners. Key operational partners include the International Organization for Migration and sister United Nations specialized agencies, funds and programmes (e.g., WFP, UNICEF, UNFP and UNDP), the African Union, the Government of Cuba and its medical brigades, nongovernmental organizations (e.g. Médecins Sans Frontières, International Medical Corps, International Rescue Committee and Save the Children) and the International Federation of the Red Cross and Red Crescent Societies.

32. Drawing on its own expertise, and strong linkages with governments, foreign medical teams, the Global Outbreak Alert and Response Network and other technical networks, such as the Emerging and Dangerous Pathogens Laboratory Network and Global Infection Prevention and Control Network, WHO has played a major role in expanding critical capacities for clinical, public health, infection control and laboratory services across the three main countries. Consistent with its normative role, WHO has provided or produced 45 technical guidance documents, covering a broad range of public health and clinical topics. More than 4000 staff members and consultants have been trained on Ebola virus disease, and a further 1400 people have accessed online training provided by the Organization.

33. WHO has also facilitated the review and consideration of numerous vaccines, medicines, therapies and diagnostic tools for the treatment and detection of Ebola virus disease. Accelerated review procedures have allowed the fast tracking of several of these therapeutics and diagnostics.

34. WHO has undertaken extensive work in all regions to support Member States in preparing for possible cases of Ebola virus disease, including technical support missions to 15 priority countries in the African Region, assistance with operational plans for these countries, monitoring preparedness capacities, and disseminating technical guidance.

35. WHO is playing a leading role in supporting the three main affected countries to reactivate health facilities safely and plan for health system recovery. WHO convened a partner meeting on building resilient health systems in Ebola-affected countries (Geneva, 10–11 December 2014); played a vital role in the Ebola recovery assessments led by the European Union, UNDP and the World Bank; and has contributed to the health system recovery plans that have recently been presented to partners.

36. Although significant progress has been made in recent months, the outbreak has revealed that in many respects WHO's own emergency structures, systems, capacities and culture will need to be addressed during the proposed reform of WHO emergency capacities in order for it to be adequately prepared for a crisis of this scale and complexity.

Nepal

37. On 25 April 2015 an earthquake of magnitude 7.8 struck Nepal, with the epicentre in Lamjung District, 70 kilometres north-west of Kathmandu. As at 28 April 2015, preliminary information indicated 4358 deaths, 8174 injuries and more than eight million people affected. Projections from the Ministry of Health and Population suggested that there may be as many as 10 000 deaths and 60 000 injuries. Thirty nine of 75 districts have been affected, with 11 priority districts requiring the most assistance. Continuing hazards have included aftershocks, avalanches and landslides.

38. Damage to hospitals and health facilities has been variable. In Kathmandu, all five main hospitals remained functional in spite of sustaining some damage, in part owing to retrofitting undertaken as part of national preparedness plans. However, up to 90% of the health facilities in Ramechhap, Nuwakot, Sindhupalchowk and Gorkha have been severely damaged.

39. The urgent response priorities included rescue; recovery; and provision of emergency trauma and medical care, shelter, water and sanitation and food aid. The Government of Nepal has a well-established Strategy for Disaster Risk Reduction Management, with health components, including preparedness planning, developed by the Ministry of Health and Population with support from WHO. In the days following the earthquake, WHO assisted the Ministry in implementing the Strategy, including the activation of a dedicated and equipped Health Emergency Operations Centre. WHO staff members were immediately deployed to assist the Ministry with rapid assessments of the health impact, health needs and impact on health facilities of the earthquake.

40. The Government has requested urgent international medical assistance, and it is essential that such support is well coordinated and, particularly when working in remote districts, largely self-sufficient. WHO is supporting the Government in registering foreign medical teams, classifying them according to their capacities and guiding their field deployment to the areas of greatest need. By the end of April 2015, 63 foreign medial teams had arrived in the country, and another 39 had been asked to refrain from deployment until specifically requested, following on-going needs assessments. The Health Cluster has also been activated, with WHO co-chairing with the health ministry. Members of the Cluster include development partners who have repurposed their programmes to assist the relief effort and the newly arrived foreign medical teams. Cluster Members are required to support the Government's priorities and response plans.

41. Within 72 hours of the earthquake, WHO had brought in 15 staff members from country offices, the Regional Office for South-East Asia and headquarters to support the response. These included experts in emergency management, public health, epidemiology, logistics, water and sanitation, and communications. Over 30 more were on standby, ready for deployment once requested. WHO also immediately mobilized essential medicines and supplies to meet the needs of 120 000 people for three months, surgical supplies to meet the needs of 1200 patients, trauma kits for 500 patients, interagency diarrhoeal disease kits for 2100 cases and nine medical tents.

42. At the time of writing, WHO was continuing to expand its operations and expected to open more field sites in the priority districts. Key activities included conducting assessments, establishing disease surveillance, coordinating partners and providing technical guidance, for example on

management of dead bodies. Crucial disease control measures were being implemented and a public health risk assessment developed. WHO also expected to provide psychosocial and reproductive health support and continuity of care for patients with chronic illness.

43. A US$ 75 million flash appeal was launched on 29 April 2015, US$ 6 million of which was for WHO's operations. A United Nations Central Emergency Response Funds allocation of US$ 15 million was also expected, of which WHO requested US$ 2 million.

Other acute/graded emergencies and protracted crises

44. In addition to the six concurrent Grade 3 emergencies, WHO responded to the health needs of affected populations in 25 other acute/graded emergencies and nine protracted crises during the reporting period. Eleven of the acute/graded emergencies occurred between 1 January and 20 April 2015 alone.

45. The acute/graded events included 11 Grade 2 emergencies, due to conflict (Cameroon, Niger, Nigeria, Ukraine and Yemen), outbreaks (Middle East respiratory syndrome in the Middle East and avian influenza (H7N9) in China), floods (Madagascar, Malawi and Mozambique) and a cyclone (Vanuatu); and 13 Grade 1 emergencies. Some countries were affected repeatedly by several separate events.

46. In Grade 1 and Grade 2 emergencies, as in all acute/graded emergencies, WHO's response strategy and deliverables were consistent with its Emergency Response Framework, supporting governments and working with health partners to ensure coverage and quality of emergency health services.

47. Nine countries face protracted emergencies: Afghanistan, Democratic Republic of the Congo, Mali, Myanmar, Pakistan, Philippines, Somalia, Sudan and Yemen. Two have had acute-on-chronic escalations of conflict (Philippines and Yemen).

48. Protracted emergencies require special attention, as they are all associated with persistently high levels of mortality and morbidity, are prone to acute-on-chronic exacerbations (including outbreaks, escalations of conflict and natural disasters), are increasingly difficult to mobilize human and financial resources for, and are all expected to continue for the foreseeable future. Five of these countries are among the 10 with the highest child mortality rates globally. Constraints to WHO's emergency response in these countries include chronic underfunding, lack of human resources, problems of access due to insecurity, limited number of operational partners, logistics difficulties and, in some cases, complicated administrative and clearance processes.

CONCLUSION

49. All six Grade 3 emergencies and the nine protracted crises that WHO is currently responding to will continue to require the Organization to play a major operational role for the foreseeable future. Only the Ebola outbreak is likely to end within the next 12 months. All will eventually require major recovery operations. When considered together with the high number of infectious disease events, natural disasters and new conflicts, it is clear that there is no real "peace time" for WHO and its emergency partners.

50. For each crisis, WHO's emergency response was mounted according to the Organization's Emergency Response Framework, to deliver on performance standards structured around four critical

functions: leadership, information, technical expertise, and core services (e.g., logistics, human resources, resource mobilization and supply distribution). In each of the six Grade 3 emergencies and many of the other crises, WHO has also been required to fill gaps in health services through direct management of health facilities and mobile clinics, subcontracting local nongovernmental organizations, distributing essential medicines and supplies, and recruiting clinical staff for government facilities.

51. In all Grade 3 emergencies, WHO applied three essential policies: *the surge policy* ensured WHO country office staff members were appropriately repurposed and experienced emergency personnel were deployed; the *health emergency leader policy* allowed experts to be deployed to support WHO Representatives in leading the response; and the *no-regrets policy* supported predictable levels of staffing and funds at the onset of all emergencies, including access to WHO's Rapid Response Account.

52. WHO drew on its Rapid Response Account on several occasions in 2014 and 2015, for instance for a bridging loan to secure the continuity of operations in protracted crises. Rapid Response Account reserve funds amount to about US$ 1 million, established with one-off grants from humanitarian donors over the past 10 years. Rapid Response Account loans are disbursed based on a standard operating procedure and are released within a few hours, but need to be refunded by WHO country offices once they receive funding from appeals. Given the number of emergencies and insufficient funding of emergency response, the Rapid Response Account is not always reimbursed and therefore funding from this account is limited to small amounts of between US$ 80 000 and US$ 200 000 (with exceptions on a case-by-case basis) for each new emergency.

53. As at 20 April 2015, WHO funding against appeals for the five Grade 3 emergencies was worryingly low.[1] Major challenges to WHO's emergency response include insufficient core funding and human resource capacity to ensure a predictable response, lack of rapid response funding, insecurity, increasing field costs (due to security, logistics and subnational presence), and inefficient internal administrative, financial and human resource processes. An internal report in December 2014 concluded that WHO needed an estimated 1587 staff globally dedicated to Category 5 emergency operations across all hazards; currently, there are only 530 (i.e., only 33.4% of required human resource capacity).

54. In the past 12 months, WHO and its partners have been called upon to provide assistance in a range of demanding and often insecure environments. The six on-going Grade 3 emergencies have been especially challenging, given their scale, complexity and operational difficulties. WHO's own performance in recent emergencies – like that of many of its partners – has been mixed. WHO staff members have frequently performed beyond expectations, but each of these emergencies has demonstrated deficiencies in WHO's emergency structures, systems, capacities and culture. These issues should be addressed to ensure that WHO can effectively provide the global leadership, support to Member States' capacity-building, technical guidance, and predictable, timely and effective response to emergencies that the world expects.

[1] Central African Republic: 0% of US$ 15 million; Iraq 0% of US$ 120.3 million; South Sudan: 16.4% of US$ 16.8 million; Syrian Arab Republic: 11.1% of US$ 131.6 million; and the Ebola virus disease outbreak: 63.6% of US$ 349.7 million. A United Nations flash appeal in response to the Nepal earthquake was due to be launched on 29 April 2015.

55. But response is only part of the answer. WHO, through building Members States' capacity under the International Health Regulations (2005) and emergency risk management programmes, has the duty to support countries in preventing and mitigating the health consequences of emergencies. The Organization also has a responsibility to lead – through policy development and technical guidance, coordination of partnerships such the Global Outbreak Alert and Response Network and the Global Health Cluster, advocacy, and provision of health intelligence and analysis to guide emergency programmes. It is these interconnected areas of building capacities of Member States, delivering effective response, and leading the emergency health community that should form the basis of a holistic emergency programme for the Organization in the future.

ACTION BY THE HEALTH ASSEMBLY

56. The Health Assembly is invited to note this report.

ANNEX

LIST OF ACUTE/GRADED AND PROTRACTED EMERGENCIES IN THE REPORTING PERIOD (MAY 2014–APRIL 2015)

Country, territory or area/emergency	Date of recent grading	Type of crisis	Grade
Bosnia and Herzegovina	21/05/2014	Floods	1
Cabo Verde	02/12/2014	Volcanic eruption	1
Cameroon	01/04/2015	Conflict/civil strife	2
Central African Republic	13/12/2013	Conflict/civil strife	3
Croatia	21/05/2014	Floods	1
Global (Middle East Respiratory Syndrome)	02/05/2013	Public health event	2
Global (Avian influenza (H7N9))	?	Public health event	2
Iraq	12/08/2014	Conflict/civil strife	3
Libya	04/12/2014	Conflict/civil strife	1
Madagascar	19/03/2015	Floods	1
Malawi	20/01/2015	Floods	2
Mali	04/02/2015	Conflict/civil strife	2
Micronesia (Federated States of)	02/04/2015	Storm	1
Mozambique	28/01/2015	Floods	2
Nepal	27/04/2015	Earthquake	3
Niger	01/04/2015	Conflict/civil strife	2
Nigeria	01/04/2015	Conflict/civil strife	2
Occupied Palestinian territory	10/11/2014	Conflict/civil strife	1
Pakistan	20/06/2014	Displacement	1
Pakistan	11/09/2014	Floods	1
Philippines	08/12/2014	Storm (Typhoon Hagupit (Ruby))	1
Philippines	10/03/2015	Conflict/civil strife	1

Country, territory or area/emergency	Date of recent grading	Type of crisis	Grade
Serbia	21/05/2014	Floods	1
South Sudan	12/02/2015	Conflict/civil strife	3
Syrian Arab Republic (Egypt, Jordan, Lebanon, Turkey)	03/01/2015	Conflict/civil strife	3
Tuvalu	16/03/2015	Storm	1
Ukraine	12/02/2015	Conflict/civil strife	2
Vanuatu	16/03/2015	Storm	2
Ebola virus disease (Guinea, Liberia, Sierra Leone)	26/07/2014	Public health event	3
West Bank and Gaza Strip	10/11/2014	Conflict/civil strife	1
Yemen	02/04/2015	Conflict/civil strife	2
Afghanistan	N/A	Protracted	N/A
Democratic Republic of the Congo	N/A	Protracted	N/A
Mali	N/A	Protracted	N/A
Myanmar	N/A	Protracted	N/A
Pakistan	N/A	Protracted	N/A
Philippines	N/A	Protracted	N/A
Somalia	N/A	Protracted	N/A
Sudan	N/A	Protracted	N/A
Yemen	N/A	Protracted	N/A

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