World Health Organization

SIXTY-NINTH WORLD HEALTH ASSEMBLY **A69/26**
Provisional agenda item 14.6 **6 May 2016**

WHO response in severe, large-scale emergencies

Report of the Director-General

1. The present report is submitted pursuant to the request by the Executive Board in resolution EBSS3.R1 (2015), adopted at the Board's Special Session on Ebola. The document provides information on all WHO Grade 3 and United Nations Inter-Agency Standing Committee Level 3 emergencies in which WHO took action between 1 January and 31 December 2015, and reports on the ninth meeting of the Emergency Committee convened on 29 March 2016 by the Director-General under the International Health Regulations (2005) regarding the Ebola virus disease outbreak in West Africa. The Executive Board at its 138th session considered and noted an earlier version of this report.[1]

2. During the period under review, WHO responded to major emergencies in 47 countries, including 32 acute emergencies and 19 protracted emergencies (four countries had both types; see Annex 1). The acute emergencies all received a grade, 1, 2 or 3, according to WHO's Emergency Response Framework, including seven concurrent emergencies evaluated as Grade 3, the most severe level.[2] WHO declared two new Grade 3 emergencies between January and December 2015: the earthquake in Nepal (graded in April, downgraded in June) and the escalating humanitarian crisis in Yemen (upgraded in July). These were in addition to five other 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 conflicts in Central African Republic (graded in December 2013), South Sudan (graded in February 2014) and Syrian Arab Republic (graded in January 2013). These seven Grade 3 emergencies directly involve 11 different countries (the Ebola outbreak in West Africa concerns Guinea, Liberia and Sierra Leone; the crisis in the Syrian Arab Republic includes Jordan, Lebanon and Turkey). Since the report to the Sixty-eighth World Health Assembly, one Grade 3 emergency, the conflict/civil strife in Central African Republic, has been downgraded to a Grade 2 emergency.

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[1] See document EB138/23 and the summary record of the Executive Board at its 138th session, second meeting, section 2 and third meeting, section 1 (document EB138/2016/REC/2).

[2] 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.

3. In 2015, with the exception of the Ebola virus disease outbreak in West Africa and the Nepal earthquake, WHO's grading was aligned with that of the Inter-Agency Standing Committee system. The Standing Committee Level 3 emergency in the Central African Republic was deactivated on 13 May 2015. WHO currently has ongoing responses to five Grade 3 emergencies (see Table).

Table. Summary of WHO's activation of Grade 3 emergencies

Country	Grade 3 activation date	Grade3 deactivation/downgrading date
Central African Republic	13 December 2013	3 June 2015 (to G2)
Iraq	12 August 2014	Ongoing
Nepal	27 April 2015	23 June 2015 (to G1)
South Sudan	12 February 2014	Ongoing
Syrian Arab Republic	3 January 2013	Ongoing
Ebola outbreak in West Africa	26 July 2014	Ongoing
Yemen	1 July 2015	Ongoing

4. In addition to the high-profile Grade 3 emergencies, WHO also responded to the health needs of affected populations in 21 other acute graded emergencies, including 11 Grade 2 and 10 Grade 1 emergencies. These ranged from the earthquake in Afghanistan, flooding in Malawi, Mozambique, Madagascar and Myanmar, cyclone Pam in Vanuatu and Tuvalu, cyclone Maysak in Federated States of Micronesia, the El Niño phenomenon in Ethiopia and typhoon Koppu in the Philippines to conflicts and/or related displacement in Burundi, Cameroon, Libya, Mali, Niger, Nigeria, Philippines, Ukraine, United Republic of Tanzania and Yemen. Some countries have been affected by more than one emergency during the reporting period, related or unrelated to the event that led to the initial WHO emergency declaration, such as the cholera outbreaks that complicated the Grade 3 conflicts in Iraq and South Sudan, floods that complicated the protracted crisis in Myanmar and the response to the Ebola outbreak in Sierra Leone; and the second earthquake that complicated the recovery efforts following the earlier Grade 3 earthquake in Nepal.

5. WHO is also responding to protracted crises in 19 countries, areas and territories: Afghanistan, Democratic Republic of the Congo, Horn of Africa countries (Djibouti, Eritrea and Ethiopia), Myanmar, the Sahel (Burkina Faso, Cameroon, Chad, Gambia, Mali, Mauritania, Niger, Nigeria and Senegal), Pakistan, Somalia, Sudan and the West Bank and Gaza Strip.

6. In all cases, WHO's emergency response was based on WHO's Emergency Response Framework, which sets out performance standards structured around the Organization's four critical functions of leadership/coordination, information management, technical expertise and core services (such as logistics, procurement, human resources and financial management). In Grade 3 emergencies, WHO applied three essential policies: the surge policy ensured that WHO country office staff were repurposed and experienced emergency personnel deployed; the health emergency leader policy allowed for the deployment of senior staff to help the Head of the WHO Country Office lead and coordinate; the no regrets policy aimed to ensure predictable levels of staff and funds at the onset of all emergencies, including access to WHO headquarters' Rapid Response Account and regional emergency funds managed by its regional offices for Africa, the Americas and the Eastern Mediterranean. WHO used its emergency funds on several occasions in 2015 to start operations, as well as for bridging loans to secure the continuity of operations in Mozambique, Nigeria, Sudan and Vanuatu. The newly created WHO Contingency Fund for Emergencies was first used to support operations to scale up the response to the crisis in Ethiopia to the amount of US$ 400 000 in November 2015.

7. WHO supported Governments and led, co-led or supported health cluster sector coordination in 24 countries to ensure the adequate coverage and quality of emergency health services where access permitted. WHO supported primary health and hospital care by operating mobile teams and clinics, procuring medicines and supplies, training health care workers and supporting partners in carrying out mobile clinic services. In addition, outbreak surveillance, preparedness and response were strengthened.

8. According to the United Nations Office for the Coordination of Humanitarian Affairs, the scale of global humanitarian needs is higher than ever. As at December 2015, there were an estimated 125 million people in need of humanitarian assistance worldwide. In the 37 most-affected countries, 89.4 million are targeted for assistance through interagency Humanitarian Response Plans; meeting their needs required an estimated figure of US$ 19.5 thousand million to be spent. In 2015, humanitarian appeals were funded at only 55% (US$ 10.7 billion of US$ 19.3 billion requested). During 2015, WHO was similarly funded at 55% of the total requested (US$ 198 million of US$ 380 million requested). Although several donors have increased their humanitarian funding, the gap between needs and funding continues to widen, severely hampering operations. For example, Iraq is the first Grade 3 emergency where funding shortages have obliged WHO and partners to shut down health care services, affecting almost 3 million people.

9. In early 2016, WHO also responded to major outbreaks of Zika virus disease in the Region of the Americas and in other regions, and of yellow fever in Angola. The response to the outbreaks of the two diseases falls outside the reporting period for this report. However, given the significance of the outbreaks, a summary of their status and of the respective response activities undertaken by WHO since 1 January 2016 is provided in Annex 2.

WHO ACTIONS IN GRADE 3 EMERGENCIES

Central African Republic

10. The crisis in the Central African Republic has displaced more than 1 million people since December 2013. As at 4 December 2015, 2.3 million people needed humanitarian assistance, with most needing access to health care. Almost two thirds of health care facilities depended on external support to remain functional.

11. WHO expanded its country presence by deploying 55 staff in phases and repurposing 31 country office staff to respond to the crisis. There are currently 69 staff members in Bangui and three subnational offices (Bambari, Bandoro and Bouar). WHO plans to establish two more field offices when security allows.

12. WHO leads the Country Health Cluster (comprising 64 health partners), which is working to provide emergency health care services to people most in need. Free health care was delivered to around 1.2 million of the most vulnerable people. A disease early warning and response system was established at the main sites hosting internally displaced persons in Bangui, Bimbo, Begoua, Kaga Bandoro, Bambari and Ngakobo in order to reinforce the national system of surveillance. The early warning and response system covers currently around 60% of sites hosting displaced persons. In 2015, at least 53 585 children aged between 6 months and 15 years were vaccinated against measles during mass vaccination campaigns in Batangafo, Bria, Bakouma and Birao. Despite these efforts, routine

immunization coverage remains weak. Currently only approximately 43% of infants aged 0–11 months have been vaccinated with pentavalent vaccine. In four health districts,[1] fewer than 15% of infants have been vaccinated. The main challenges to providing emergency and basic health services remain lack of access due to insecurity, high operational costs, lack of funds and human resources, the limited number of health partners and the collapse of the national essential medicines supply system.

13. While the security situation remains volatile in several areas, some internally displaced persons are returning to their homes. The Secretariat recently supported the Ministry of Health in developing a health sector transition plan for 2015–2016.

14. The Health Cluster in the Central African Republic requires US$ 63 million in 2015. As of 31 December 2015, the Health Cluster was 47% funded. WHO had received 28% of the funds required.

Ebola virus disease outbreak, West Africa

15. From a peak of over 950 confirmed cases per week at the height of the Ebola outbreak, all known original transmission chains in West Africa were declared interrupted on 28 December 2015, coinciding with the end of the last transmission chain in Guinea. Guinea then entered a period of heightened surveillance, which will continue through to 27 March 2016. Liberia, which had previously declared the end of transmission on 3 September, had documented three new cases on 19 and 20 November, probably due to the re-emergence of the virus through a survivor. Similarly, although Sierra Leone declared the end of transmission on 7 November, it also documented a new case due to re-emergence from contact with a survivor on 14 January 2016.

16. The ninth meeting of the Emergency Committee convened by the Director-General under the International Health Regulations (2005) regarding the Ebola virus disease outbreak in West Africa took place by teleconference on Tuesday, 29 March 2016. Representatives of Guinea, Liberia and Sierra Leone presented information on the epidemiological situation, ongoing work to prevent Ebola re-emergence, and the capacity to detect and respond rapidly to any new clusters of cases in each country. The Committee noted that since its last meeting all three countries have met the criteria for confirming interruption of their original chains of Ebola virus transmission, although as expected, new clusters of Ebola cases continue to occur following reintroduction of the virus as it is cleared from the survivor population. The frequency with which reintroduction occurs is, however, decreasing. The Committee emphasized that to date all of these clusters have been detected and responded to rapidly, limiting transmission to at most two generations of cases in those clusters that have now been stopped. The Committee provided its view that Ebola transmission in West Africa no longer constitutes an extraordinary event, that the risk of international spread is now low, and that countries currently have the capacity to respond rapidly to new virus emergences. The Committee emphasized that there should be no restrictions on travel and trade with Guinea, Liberia and Sierra Leone, and that any such measures should be lifted immediately.

17. Based on the advice of the Emergency Committee, and on her own assessment of the situation, the Director-General terminated the Public Health Emergency of International Concern regarding the Ebola virus disease outbreak in West Africa, in accordance with the International Health Regulations (2005). The Director-General also terminated the Temporary Recommendations that she had issued in relation to this event, supported the public health advice provided by the Committee, and reinforced

[1] Vakaga in region 5 and Haut Mbomou, Kembe and Mobaye in region 6.

the importance of States Parties immediately lifting any restrictions on travel and trade with these countries.

18. Although the incidence of Ebola has significantly decreased, the risk of reintroduction due to virus persistence has emerged as a substantive near-term threat to achieving and maintaining zero Ebola in the region. The July 2015 outbreak in Liberia, which was probably the result of virus persistence in a male survivor who had recovered months earlier, reaffirmed the possibility that transmission may resume. While the risk of reintroduction due to virus persistence in some survivors is declining over time, it is significant owing to the high number of people affected in the outbreak. The subsequent cases in Liberia in November 2015 and Sierra Leone in January 2016 further highlighted the significance of this persistent risk.

19. Following the decommissioning of the United Nations Mission on Emergency Ebola Response (at the end of July 2015), responding partners established a successor entity, the Interagency Collaboration on Ebola, with WHO as the lead technical and coordinating agency. In the light of changes in the epidemiology in the region, the Interagency Collaboration on Ebola developed a strategy for Phase 3 of the response. The Collaboration continued to implement the plan until the end of March 2016.

20. Phase 3 builds on the rapid scale-up of treatment beds, safe and dignified burial teams, and behaviour change capacities of Phase 1 (from August to December 2014), and the enhanced capacities for case finding, contact tracing and community engagement during Phase 2 (January to July 2015).[1] To achieve and sustain a "resilient zero", Phase 3 incorporates new knowledge and tools into the ongoing Ebola response and recovery work, from vaccines, diagnostics and response operations to survivor counselling and care. Many of the operational advances were reflected in the latest national Ebola response initiatives, from Operation Northern Push in Sierra Leone to the "cerclage" approach in Guinea and the rapid response operation in Liberia. Phase 3 also recognizes the need for strong linkages across the response, early recovery and longer-term health system-strengthening work outlined in the National Health System Recovery Plans. As in previous phases of the response, all partners have emphasized the critical need for affected communities, households and individuals to be fully engaged in implementation and their concerns well understood. Central to the Phase 3 strategy are measures to manage the residual risk of potential virus re-emergence due to virus persistence in survivors, including strengthened surveillance, survivor care and counselling, and the establishment of rapid response teams across all three countries.

21. Throughout the outbreak, WHO has worked closely with a wide range of governmental, local and international partners. Key operational partners include such United Nations specialized agencies, funds and programmes as UNDP, UNFPA, UNICEF and WFP, the Canadian Centers for Disease Control and Prevention, the Chinese Center for Disease Control and Prevention, the European Centre for Disease Prevention and Control, the United States Centers for Disease Control and Prevention, nongovernmental organizations (such as International Medical Corps, International Rescue Committee, Médecins Sans Frontières and Save the Children), the African Union, the Government of Cuba and its medical brigades, the International Federation of the Red Cross and Red Crescent Societies, the International Organization for Migration and the West African Health Organization.

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[1] A full description of Phase 1 and 2 activities and capacities can be found in the WHO Ebola response roadmap. available at http://www.who.int/csr/resources/publications/ebola/response-roadmap/en/, accessed on 13 April 2016, the Ebola Outbreak Overview of Needs and Requirements, available at https://ebolaresponse.un.org/sites/default/files/onr2015.pdf, accessed on 13 April 2016 and the WHO strategic response plan 2015: West Africa Ebola outbreak, available at http://www.who.int/csr/resources/publications/ebola/ebola-strategic-plan/en/, accessed on 13 April 2016.

22. The emergency operation established by WHO in response to the Ebola outbreak in West Africa is the largest in the Organization's history. Throughout most of 2015, WHO had up to 1200 staff members deployed across more than 70 field sites in the three main affected countries of Guinea, Liberia and Sierra Leone. In total, across all West African countries that experienced active transmission of Ebola, more than 2200 technical experts have been deployed by WHO, including 962 experts from partners in the Global Outbreak Alert and Response Network.

23. Drawing on its own expertise and strong linkages with Governments, the Global Outbreak Alert and Response Network, the Emerging and Dangerous Pathogens Laboratory Network, the Global Infection Prevention and Control Network, foreign medical teams and stand-by partners, WHO has played a major role in expanding critical capacities for clinical, public health, infection control and laboratory services across the three main affected countries. Consistent with its normative role, WHO has provided or produced more than 50 technical guidance documents covering a broad range of public health and clinical topics. In total, more than 8600 people have received training through WHO's programmes and those of its partners using WHO-developed materials and curricula, either in person or online.

24. 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 vaccines and diagnostics, which has allowed for successful vaccine and diagnostic trials to take place in Guinea and Sierra Leone. As at 31 December, most progress had been made with a WHO-sponsored trial using the rVSV-ZEBOV vaccine. The trial used a "ring vaccination" strategy, based on the approach used to eradicate smallpox. The trial had two main objectives: to assess the protection the vaccine provides to individuals and to assess whether vaccination impacts the overall transmission of Ebola virus disease in the ring. Interim results were published in *The Lancet* in late July.[1] The results suggest that the efficacy of the rVSV vaccine might be as high as 100%. WHO also supported the successful development of an automated polymerase chain reaction diagnostic test and has been evaluating several rapid diagnostic tests.

25. 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.

26. WHO has supported each of the three affected countries in developing national recovery and resilience plans outlining strategies for the safe reactivation of essential health services and longer-term health system functions. Each of the three national plans identified infection prevention and control as a high priority area for early recovery. These plans were part of the foundational documents for the Secretary-General's International Ebola Recovery Conference, held in New York on 9 and 10 July 2015. WHO and the international community continue to support national authorities in implementing these recovery plans.

27. Although significant progress has been made in recent months, the outbreak has revealed that, in many respects, WHO's emergency structures, systems, capacities and culture require reform to become fit for purpose. In that regard, and further to resolution EBSS3.R1, adopted by the Executive Board at its Special Session on Ebola, and to decision WHA68(10) (2015), WHO is undertaking a

[1] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)61117-5/abstract (accessed 13 April 2016).

considered and thorough review and reform of its capacities in emergency risk management and response to emergencies with health and humanitarian consequences. This reform is guided by the Director-General's Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies with Health and Humanitarian Consequences, established on 9 July 2015 and chaired by Dr David Nabarro, the Special Envoy of the Secretary-General on Ebola, and the Report of the Ebola Interim Assessment Panel, requested in resolution EBSS3.R1 and issued on 7 July 2015.

Iraq

28. Over the past 18 months, the humanitarian crisis in Iraq has caused four successive massive waves of displacement and placed more than 8.6 million people, including 3 million internally displaced persons, in need of humanitarian assistance. Almost 7.8 million people are in need of health assistance. Health facilities are overloaded and medicines and supplies running short. In four of the most severely affected areas in the country, 14 hospitals and more than 170 health facilities have been damaged or destroyed. Health, protection, food and water and sanitation are priority needs, as violence and displacement continue to exacerbate the dire humanitarian situation across the country.

29. WHO and its Health Cluster partners supported the Ministry of Health of Iraq in its response to a country-wide cholera outbreak. WHO brought in cholera experts, epidemiologists and specialists in water, sanitation and hygiene, case management and laboratory from headquarters, regional offices, partners from the Global Outbreak and Alert Response Network (United States Centers for Disease Control and Prevention and International Centres for Diahorreal Disease Control and Research, Bangladesh) to support the Ministry of Health. An operational cholera task force was established to coordinate activities. WHO provided 15 inter-agency diarrhoeal diseases kits (enough to treat 10 500 cholera cases) and 600 000 chlorine tablets, and supported early warning surveillance and case management at health facilities in affected governorates and districts. Cholera-prevention messages were circulated widely. In an effort to prevent further spread of cholera in the region, the Secretariat and WHO partners supported the Ministry of Health to implement an oral cholera vaccination mass campaign. The campaign involved two rounds of vaccination (in October and December 2015) conducted in 62 camps for internally displaced persons and refugees covering 13 governorates. More than 510 000 vaccine doses were provided, enough to protect 255 000 people in high-risk populations (internally displaced persons and refugees) across the country. By the end of October, the outbreak had begun to decrease.

30. WHO has scaled up its field presence, establishing hubs in Baghdad, Erbil and Basrah and sub-hubs in Dahuk and Sulaymaniyah, and deploying 81 surge staff. A network of national focal points operates in 15 governorates. WHO leads and coordinates the Health Cluster, comprising 48 partners.

31. WHO and Health Cluster partners, working with the Ministry of Health of Iraq, supported the delivery of life-saving health services for 3.2 million people by deploying 27 mobile clinics and 30 ambulances, training 1250 local health care workers on different aspects of public health emergencies, procuring and distributing more than US$ 17.5 million worth of medicines, vaccines and supplies to replenish emergency stocks in approximately 1400 health care facilities around the country, and monitoring the quality of water in internally displaced persons camps and other locations. Between January and June 2015, up to 3.4 million people received health care, especially in the northern and central governorates hosting large numbers of internally displaced persons, as well as the conflict-affected Anbar governorate. More than 300 000 patients were referred to secondary and tertiary level care. Moreover, 3.4 million children aged from 9 to 59 months were vaccinated against measles and 5.3 million children were vaccinated against polio. Disease outbreak surveillance has

been significantly strengthened: the number of reporting sites tripled from 18 in May 2014 to 54 in August 2015.

32. Funding gaps and access are key challenges. Delivering essential medical supplies to large parts of Iraq remains difficult as the situation is extremely volatile. A severe funding shortfall in August 2015 led to the closure of 84% of health programmes supported by humanitarian partners, largely in northern governorates, leaving almost 3 million people without access to urgently needed heath care services. Accelerated resource mobilization and advocacy efforts have resulted in donor commitment and saving about 100 health projects. However, the funding gaps are still significant. The Iraq Humanitarian Response Plan 2015 appealed for US$ 60.9 million for the Health Cluster, of which only US$ 28.9 million (48%) had been received by the end of 2015. WHO appealed for US$ 22.5 million, but had received only US$ 16 million (72%) as at 31 December 2015.

Nepal

33. On 25 April 2015, a 7.8 magnitude earthquake struck Nepal, with the epicentre in Gorkha District, approximately 140 kilometres northwest of Kathmandu. It was followed by dozens of strong aftershocks, including a 7.3 magnitude earthquake on 12 May 2015, with the epicentre in Sindhupalchowk District, approximately 72 kilometres north-east of Kathmandu, which caused additional injuries and damage. According to the Government of Nepal, 8960 people were killed, 22 322 people were injured[1] and more than 5.6 million people were affected. Just over half the country's 75 districts were affected, 14 of which required priority assistance. Twenty-six hospitals and over 1100 health facilities were damaged and 90% of health facilities outside the main towns rendered non-functional. In Kathmandu, all five main hospitals remained functional despite sustaining damage, in part owing to retrofitting undertaken as part of a WHO-supported national preparedness plan and safe hospitals programme. The immediate priorities were to manage the injured, ensure emergency medical, obstetric and surgical care for other priority conditions, and provide rehabilitation support to those discharged from hospitals and psychosocial support to the affected population.

34. The health sector was able to mobilize quickly, largely thanks to the extensive preparedness work carried out over the past 10 years by the Government of Nepal with the support of WHO. The Government's strategy for disaster risk management, including health components and preparedness planning, was developed by the Ministry of Health and Population with support from WHO.

35. The Government of Nepal requested urgent international medical assistance and activated its Health Emergency Operation Centre. WHO staff were deployed to assist the Ministry of Health and Population with rapid assessments. WHO coordinated the international reception and onward deployment of over 150 Foreign Medical Teams (primarily Government entities providing emergency medical and surgical care) to meet needs in different locations. WHO co-chaired the 148-partner Health Cluster that provided primary health care and other priority public health interventions. WHO released US$ 675 000 in internal funds to scale up operations and immediately mobilized the essential medicines and supplies required to meet the needs of 100 000 people for three months as well as 539 tents, surgical supplies for 1200 patients, trauma kits for 500 patients, interagency diarrhoeal disease kits for 2100 patients and 9 medical tents. As at September 2015, WHO had deployed a total of 50 medical camp kits and 48 tons of supplies and medicines to treat more than 4 million people in the 14 worst-affected districts, where 85% of health facilities had been damaged.

[1] Information available at http://drrportal.gov.np/ (accessed 13 April 2016).

36. WHO organized the rapid redeployment of 34 staff members from country and regional offices and headquarters to support the response. WHO staff members were present in the 14 most-affected districts, where they supported district health authorities in coordinating partners and provided technical support on public health issues such as mass injury management, mental health and obstetric care and strengthening disease surveillance.

37. An inter-agency appeal was launched following the earthquake. By the end of 2015, the health sector had received less than half (47%) of the US$ 41.8 million required. WHO received just 44% of the US$ 12.1 million requested on its own behalf.

South Sudan

38. Since the escalation of the conflict in December 2013, the overall humanitarian situation has continued to deteriorate. As at December 2015, over 2.3 million people had been displaced and another 4.6 million people were in urgent need of humanitarian assistance. Health care services were severely disrupted due to attacks on facilities, health workers and patients, compounded by shortages of medicines and personnel. The risk of communicable disease outbreaks and rapidly worsening malnutrition remained high, especially in places such as the Bentiu and Malakal protection-of-civilians sites, due to poor sanitation and hygiene conditions. The estimated number of people facing severe food insecurity had almost doubled since the beginning of 2015 to 4.6 million, including 250 000 severely malnourished children – the highest numbers since the war began.

39. WHO maintains its presence in Bentiu, Unity State, Bor, Jonglei State, and Mingkaman, Upper Nile State. WHO has a total of 121 staff working in South Sudan, with focal points in all 10 states. While surge rotations have decreased in the past nine months, short-term rotations are still required. WHO leads the Health Cluster and supports the coordination of 60 health sector partners.

40. The Secretariat supports the Ministry of Health at central and subnational levels in strengthening health services to deliver effective, safe, quality interventions to those in need. The Secretariat and WHO's health partners helped the Ministry of Health update mass casualty plans for Bentiu, Malakal and Melut as well as train state and county rapid response teams to investigate and respond to emerging disease outbreaks. South Sudan has a total of 47 country rapid response teams, comprising 298 team members.

41. Although the Health Cluster has increased its efforts to respond to malaria, acute respiratory infections and acute watery diarrhoea, more needs to be done to halt the rise in cases and save the lives of those infected. From January to August 2015, WHO and health partners delivered life-saving medicines and supplies for more than 950 000 people; provided additional supplies to support surgical interventions in 11 facilities; immunized more than 2.4 million children aged under 5 years in the seven stable states with oral polio vaccine, and vaccinated over 37 000 internally displaced persons with oral cholera vaccine.

42. About US$ 93 million is required for the Health Cluster emergency response in 2015, of which US$ 16.7 million is required for WHO. As at December 2015, WHO had received only 51% of the funds required.

Syrian Arab Republic

43. Since the start of the conflict in March 2011, the number of people in need of humanitarian assistance has increased from 1 million to a staggering 13.5 million. More than 1.2 million people

have been injured and approximately 6.5 million internally displaced. Five neighbouring countries (Egypt, Iraq, Jordan, Lebanon and Turkey) have absorbed large numbers of refugees, placing huge burdens on national social services and local communities. The number of registered refugees has reached 4.59 million – the largest refugee population from a single conflict in over a quarter of a century. This includes 2.2 million Syrians registered by the Office of the United Nations High Commissioner for Refugees in Egypt, Iraq, Jordan, Lebanon and North Africa, and 2.2 million Syrians registered by the Government of Turkey. There are over 1 million Syrian refugees in Lebanon, comprising 30% of the population and representing the highest concentration of refugees in the world. The number of people living in areas that are difficult or impossible for aid agencies to reach has almost doubled over the past two years (from 2.5 million in 2013 to 4.56 million by 2015). At present, United Nations agencies and partners are reaching only one third of the more than 4 million people in need in hard-to-reach and more than 400 000 people in besieged areas. Half the population in the country lacks regular access to clean water.

44. Within the Syrian Arab Republic, the conflict has had a major impact on access to health care, as the Syrian health system has deteriorated and the country's public health profile has experienced a significant change (increased number of patients with traumatic injuries, outbreaks of measles, mental health problems and complications from untreated noncommunicable diseases).

45. WHO has increased its operational capacity in the Syrian Arab Republic to more than 90 staff, 90% of whom are nationals, complemented by a decentralized network of 59 medical focal points across all 14 governorates, including in remote and opposition-controlled areas. WHO has sub-offices in Aleppo, Hassake Homs, and Lattakia. WHO has active partnerships with more than 67 nongovernmental organizations to improve access and establish sustainable modalities for delivering health care services. In addition, teams from WHO's hubs in Gaziantep, Turkey, and Amman, Jordan, support cross-border operations under the "Whole of Syria" approach, to expand the delivery of health care services in hard-to-reach and besieged areas.[1]

46. Throughout 2015, WHO distributed 17.2 million medical treatments in the Syrian Arab Republic, compared with 13.8 million between January and December 2014. Thirty-four mobile clinics were donated to nongovernmental organizations to support provision of basic health care services for populations in hard-to-reach and besieged areas across Syria. WHO has supported a total of 14 rounds of national polio vaccination campaigns and three subnational campaigns since 2013. The first national campaigns in 2013 reached 2 432 751 children aged under 5 years, while the last two campaigns reached only 80% of the 2.9 million children targeted. Efforts to conduct the last two campaigns were hampered by the fact that security problems and the blocking of immunization activities by Daesh[2] caused implementation to be suspended in Ar-Raqqa and Deir-ez-Zor governorates, and in Palmyra District in Homs governorate. A total of 1.6 million children were also vaccinated against measles in April 2015. The number of sentinel sites reporting to the Early Warning Alert and Response System increased from 104 in 2012 to 995 in 2015; 30% of these are in hard-to-reach areas. WHO conducted "Whole of Syria" contingency planning and pre-positioning for cholera with partners in the light of the outbreak in Iraq.

47. The crisis has severely overburdened health systems in neighbouring countries hosting refugees. WHO is working with host governments and health sector partners to assess, monitor and address key public health risks and health sector burden related to the significant increase in outpatient and

[1] As per United Nations Security Council resolutions 2139 (2014), 2165 (2014) and 2191 (2014).

[2] Also known as the Islamic State in Iraq and the Levant, ISIL.

hospital loads and increased needs in medicines, especially those to treat noncommunicable diseases. Other challenges include the need to train staff and address mental health, tuberculosis, leishmaniasis and other public health issues specific to the refugee population. WHO has teams in all neighbouring countries as well as a coordinating team in Amman to support all countries affected by the crisis.

48. While much has been accomplished, humanitarian needs continue to grow. Gaps remain due to: increasing health needs; lack of access to populations in need as a result of insecurity and bureaucratic constraints imposed by authorities; and partners' limited operational capacity and funding. In 2015, the health sectors within the Syrian Arab Republic and in neighbouring countries appealed for a total of US$ 687.2 million, of which the WHO country office in the Syrian Republic needs US$ 131.6 million, 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. As at 31 December 2015, the WHO country office in the Syrian Arab Republic had received only 56% of the funds requested.

Yemen

49. Since the uprising in March 2015, violence in Yemen has sharply escalated, leading to a dramatic increase in humanitarian needs. Civilian infrastructure has suffered widespread damage and destruction. Restrictions on commercial imports have caused severe shortages in, and sharp price increases for, basic commodities such as fuel, food and medicines. Most health facilities in security-compromised governorates have either ceased to function or function only partially. At least 160 health facilities across the country have closed due to a lack of medicines, supplies, equipment and fuel to run the generators, as electricity supplies have become increasingly erratic. The departure of health professionals fleeing the violence has led to shortages of qualified health workers, creating a gap in the provision of primary health care, trauma, surgical and obstetric care in areas of ongoing violence. A total of 2.6 million children aged under 15 years are at risk of measles; a further 2.5 million children aged under 5 years are at risk of diarrhoeal disease and 1.3 million are at risk of acute respiratory infections.

50. More than 1.4 million people have been forced out of their homes in addition to the 250 000 internally displaced persons currently living in the country. These numbers are still rising as the conflict continues. As a result, 15.2 million people are in urgent need of humanitarian assistance, 10.3 million of them targeted for health interventions. The ongoing fighting makes the delivery of life-saving assistance extremely difficult and risky.

51. WHO has a main office in Sana'a and two sub-offices, in Aden and Hodeida, as well as a liaison office in Amman, Jordan, and a logistics base in Djibouti, with 75 national and 17 international staff (10 of the latter are inside Yemen). All United Nations international staff members are based in Sana'a, or provide remote support from bases in Amman and Djibouti. Due to the intense fighting, the United Nations has had to postpone plans to scale up its presence to six humanitarian hubs (Sana'a, Aden, Hodeida, Saada, Taiz and Hadramout).

52. WHO co-leads the Health Cluster of 20 partners with the Ministry of Public Health and Population. Despite the deteriorating security situation, restricted humanitarian access and the limited availability of external funding, WHO and partners have been responding to the increasing health needs of the population by ensuring the functionality of major health care facilities, the reopening of

closed health facilities and the maintenance of the supply chain for medicines and cold chain for vaccines.

53. Since March 2015, WHO has supported the Ministry of Public Health and Population in procuring and delivering over 181 tons of medicines, medical supplies and vaccines, training and deploying 50 mobile and 20 fixed medical teams in 11 governorates, staffing 18 hospitals in 7 of the most affected governorates and providing 780 190 litres of fuel to keep ambulances, cold chain systems and health care facilities (including 51 hospitals, 7 major centres, 6 vaccine depots and 8 renal dialysis centres) functioning. Together with health partners, WHO supported the treatment of an estimated 1.2 million patients in addition to 24 641 patients requiring trauma care and surgery. WHO has provided safe drinking water, hygiene supplies and cleaning materials to internally displaced persons in all affected governorates. A total of 5.4 million of the targeted 5.7 million children aged under 5 years (95%) were vaccinated against polio and over 1.5 million out of the targeted 1.8 million children aged from 6 months to 15 years (83%) were vaccinated against measles in high-risk areas. Since the start of 2015, 2082 disease alerts were generated and investigated through the surveillance system and support was provided to the Ministry of Public Health and Population to develop and roll out dengue fever and cholera control plans.

54. Lack of funding and access constraints are hampering response efforts to fill critical gaps in delivering health care for the affected population. In 2015, the Health Cluster appealed for US$ 152 million, including US$ 70 million for WHO, to respond to the health needs of 10.3 million beneficiaries including 1.4 million internally displaced persons. WHO's funding gap as at 31 December 2015 was 45%.

ACTION BY THE HEALTH ASSEMBLY

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

ANNEX 1

LIST OF ACUTE/GRADED AND PROTRACTED EMERGENCIES IN THE REPORTING PERIOD (1 JANUARY–31 DECEMBER 2015)

Country, territory or area/emergency	Type of crisis	Date of initial emergency grading	Date of revision of grading	Current grade*
Afghanistan	earthquake	29/10/2015		1
Burundi	conflict/civil strife	18/05/2015		1
Cameroon	conflict/civil strife	01/04/2015		2
Central African Republic	conflict/civil strife	13/12/2013 (grade 3)	25/05/2015	2
Ethiopia	food insecurity, El Niño	18/11/2015		2
Guinea	Ebola outbreak	26/07/2014		3
Iraq	conflict/civil strife	12/08/2014		3
Jordan	refugee displacement – conflict in the Syrian Arab Republic	03/01/2013		3
Lebanon	refugee displacement – conflict in the Syrian Arab Republic	03/01/2013		3
Liberia	Ebola outbreak	26/07/2014		3
Libya	conflict/civil strife	28/08/2014		1
Madagascar	floods	09/03/2015 (grade 2)	19/03/2015	1
Malawi	floods	20/01/2015		2
Mali	conflict/civil strife	16/10/2015		1
Micronesia (Federated States of)	Cyclone Maysak	02/04/2015		1
Mozambique	floods	28/01/2015		2
Myanmar	floods	12/08/2015		2
Nepal	earthquake	27/04/2015 (grade 3)	23/06/2015	1
Niger	conflict/civil strife	01/04/2015		2
Nigeria	conflict/civil strife	01/04/2015		2
Philippines	Typhoon Koppu	22/10/2015		1
	conflict/civil strife	10/03/2015		1
Sierra Leone	Ebola outbreak	26/07/2014		3
South Sudan	conflict/civil strife	12/02/2014		3
Syrian Arab Republic	conflict/civil strife	03/01/2013		3
Turkey	refugee displacement – conflict in the Syrian Arab Republic	03/01/2013		3
Tuvalu	Cyclone Pam	16/03/2015		1
Ukraine	conflict/civil strife	20/02/2014		2
United Republic of Tanzania	refugee displacement	18/05/2015		1
	conflict/civil strife	15/12/2015		2
Vanuatu	Cyclone Pam	16/03/2015		2

Country, territory or area/emergency	**Type of crisis**	**Date of initial emergency grading**	**Date of revision of grading**	**Current grade***
Yemen	armed conflict	04/04/2015 (grade 2)	01/07/2015	3
Afghanistan	protracted	N/A		N/A
Burkina Faso	protracted	N/A		N/A
Cameroon	protracted	N/A		N/A
Chad	protracted	N/A		N/A
Democratic Republic of the Congo	protracted	N/A		N/A
Djibouti	protracted	N/A		N/A
Eritrea	protracted	N/A		N/A
Ethiopia	protracted	N/A		N/A
Gambia	protracted	N/A		N/A
Mali	protracted	N/A		N/A
Mauritania	protracted	N/A		N/A
Myanmar	protracted	N/A		N/A
Niger	protracted	N/A		N/A
Nigeria	protracted	N/A		N/A
Pakistan	protracted	N/A		N/A
Senegal	protracted	N/A		N/A
Somalia	protracted	N/A		N/A
Sudan	protracted	N/A		N/A
West Bank and Gaza Strip	protracted	N/A		N/A

ANNEX 2

ZIKA VIRUS OUTBREAK IN THE REGION OF THE AMERICAS

1. In May 2015 Brazil became the first country in the Region of the Americas to confirm mosquito-borne Zika virus circulation. Since then the virus has spread rapidly throughout the Americas and more recently to other regions. As at 27 April, 2016, 55 countries reported ongoing mosquito-borne transmission. *Aedes aegypti* mosquito is the primary disease vector. The vast majority of affected countries (35) are in the Region, but countries in Africa, southern Asia and the Pacific islands have also reported mosquito-borne circulation of the virus. On 1 February 2016 WHO declared the outbreak a Public Health Emergency of International Concern (internal Grade 2), on the basis of mounting evidence that Zika virus infection in pregnant women is linked to an increased incidence of a rare birth defect, microcephaly, and other associated neurological disorders. There was also strong evidence to suggest that Zika virus infection is associated with an increased incidence of Guillain–Barré syndrome – a rare and severe neurological complication that affects adults. Based on a growing body of preliminary research, there is now scientific consensus that Zika virus is a cause of microcephaly and Guillain–Barré syndrome. As at 27 April 2016, eight countries had reported over 1100 confirmed cases of microcephaly potentially associated with Zika. The vast majority of cases have been reported from Brazil. Eight countries have reported an abnormally high incidence of Guillain–Barré syndrome potentially associated with Zika virus infection.

2. In response to this outbreak, WHO’s Regional Office for the Americas has been working closely with the countries affected since May 2015, and has deployed over 16 technical cooperation missions to affected and at-risk countries since February 2016. Following the declaration of a Public Health Emergency of International Concern, WHO activated a global incident management system and on 14 February launched a global Strategic Response Framework and Joint Operations Plan to guide the international response to the spread of Zika virus infection and associated complications. The Organization’s approach focus on mobilizing and coordinating partners to assist affected and at-risk countries across three core areas: surveillance, response, and research. WHO’s global response to the outbreak is coordinated from WHO headquarters in Geneva, and was enabled initially by the rapid disbursement of US$ 3.8 million from the WHO Contingency Fund for Emergencies.

3. Although the rapid disbursement of contingency funds was adequate to enable the initial stages of WHO’s response, the continuity of this response is threatened by a funding gap amounting to over US$ 21 million of the US$ 25 million requested by WHO and PAHO for the implementation of the Strategic Response Framework for six months from January to June 2016. In order to support the mobilization of resources for partner activities, WHO is working closely with the Officer of the United Nations Secretary General to establish a Multi Partner Trust Fund for Zika.

4. In the coming months, WHO and its partners will place increased emphasis on accelerating the development of new diagnostic tests for women, ensuring effective communication of the risks posed to affected and at-risk communities, providing support to pregnant women, strengthening mosquito-control activities, and accelerating the development of a safe and effective vaccine.

Yellow fever outbreak in Angola

5. A yellow fever outbreak was detected in Angola late in December 2015 and a rapid increase observed in the number of suspected cases. The event was declared a WHO Grade 2 emergency on 12 February 2016. As at 24 April, a total of 2023 suspected cases with 258 deaths had been reported in

Angola. The Democratic Republic of the Congo officially declared a Yellow Fever outbreak on 23 April 2016, and as at 26 April, 37 cases of the disease had been reported. China confirmed 11 cases, Kenya confirmed two cases and Mauritania one case.

6. In Uganda, as at 27 April 2016, 39 yellow fever cases had been reported in seven districts. These clusters do not seem to be epidemiologically linked to the Angola chain according to existing information.

7. The exportation of yellow fever cases to other countries (China, Democratic Republic of the Congo, Kenya and Mauritania) increases the risk of outbreaks arising in multiple countries. Of further concern is the limited availability of vaccines globally, coupled with the fact that response capacities are limited. The risk of outbreaks depends on the immunity of the population and the density of Aedes vectors. This risk is particularly high in urban areas where the population has no immunity and where the vector density is high.

8. All the countries bordering Angola (Congo, Democratic Republic of the Congo, Namibia and Zambia) as well as all countries in which people travel frequently to and from Angola, have been advised by WHO to institute robust point-of-entry surveillance for yellow fever and yellow fever vaccination status, and to enhance surveillance activities in line with the Integrated Disease Surveillance and Response system and the International Health Regulations (2005).

9. WHO deployed a field investigation team to Angola at the end of January 2016 to assess the yellow fever situation. An incident management team was set up for the response. WHO, in collaboration with the Governments of Angola and the Democratic Republic of the Congo, has developed response strategies at country, regional and global levels in order to enable resources to be mobilized quickly for the rapid containment of the outbreak and to deal with the risk of exportation. Vaccination campaigns in Huambo and Benguela had reached more than 59% and 70% of the target population respectively by 27 April 2016. The rate of administering vaccinations needs to be increased in order to interrupt virus circulation.

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