



World Health  
Organization

# 2016 WHO Humanitarian Response Plans

Department for  
Emergency Risk Management and  
Humanitarian Response (ERM)

Summary of health priorities  
and WHO projects in  
interagency humanitarian response plans



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### **Contributors to WHO's risk management and humanitarian response work in 2015**

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# Foreword

In 2016 over 125 million people living in crisis-affected countries are in need of humanitarian assistance. The humanitarian community is committed to providing aid to over 87 million of those in need. The risks to health posed by humanitarian emergencies are at an all-time high. Developments such as climate change, urbanization, population growth and worsening civil conflict are increasing the frequency and severity of many types of emergencies. Attacks on health workers and health facilities are also on the rise.

This document describes how WHO and its Health Cluster partners plan to meet health needs in countries, territories and regions facing protracted emergencies in 2016. Collectively, health sector partners are appealing for US\$ 2.2 billion to provide assistance. Of that amount, WHO requires US\$ 524 million. Health interventions under the Humanitarian Response Plans address issues such as the spread of infectious diseases, the lack of medicines and health services and rising rates of acute malnutrition. The number of people affected, and their health needs, are likely to rise throughout the year as new acute crises occur.

In addition to the protracted emergencies featured in this document, the Organization and its partners are responding to sudden onset emergencies such as Cyclone Winston that hit Fiji in February 2016, or epidemics such as the Zika virus in Brazil, the remaining cases of Ebola in West Africa and a severe outbreak of yellow fever in Angola that started in December 2015.

No one organization can respond to a health crisis alone. WHO leads the Health Cluster, with 48 partners at global level and more than 300 in countries. The Health Cluster plays a vital role in reaching people in dire need of humanitarian assistance. Effective coordination among Health Cluster partners means the particular strengths of each partner can be leveraged, resources can be shared, duplications avoided and gaps closed. As a result, more people can be provided with life-saving health assistance.

In the Syrian Arab Republic, for example, health partners aim to help 11.5 million people in need of trauma and mental health care. WHO and partners also seek to assist over 4 million Syrians who have sought refuge in neighbouring countries. WHO is working with partners to vaccinate children against life-threatening childhood illnesses such as measles and polio, and is distributing essential medicines and surgical supplies to health partners working in hard-to-reach areas. In Iraq, WHO is establishing a supply chain to stockpile essential medicines for over 7 million people.

Mothers and children require special attention. In Yemen, despite security concerns, partners aim to reach 10.6 million people with essential health care, including around 3 million people in need of reproductive health care services. In South Sudan, the Health Cluster aims to reach 2.3 million people, with a particular focus on addressing the major causes of death among children under five years old, such as malaria, diarrhoea and pneumonia.

Natural disasters are of particular concern in 2016. The health consequences of El Niño are being felt in countries such as Ethiopia where WHO has identified some 400 000 severely malnourished children who need immediate treatment. As the effects of El Niño worsen, this number is likely to rise.

## **WHO is changing how it operates in emergencies**

In 2015, Member States called on WHO to address all emergency health risks and events in a predictable, capable, flexible and accountable manner. This means addressing all hazards, with one workforce, one budget, one set of rules and processes, one set of benchmarks and one line of authority. To operationalize this approach, in 2016 WHO is building core emergency operational capacity at country level to fulfil the Organization's critical functions of health leadership, coordination, technical assistance and monitoring health standards, and - only as a last resort - implementation. WHO will work to improve its ability to collect, analyse data and provide up-to-date health information to partners on health risks, needs, capacities and response; build partnerships at local, regional and global levels, in order to meet its commitment as Health Cluster lead agency.

We know that when collaboration and partnership thrive, emergency response improves. To fully address these crises, WHO and partners need long-term, sustainable resources. WHO is ready to do its part, now we need your support.



## Health Cluster Objectives

### Objective 1: Provision of effective trauma care and mass casualty management to conflict and natural disaster affected people

Planned outputs:

- 100% of conflict-affected districts with at least one First Aid Trauma post providing specialized trauma care.

### Objective 2: Ensure access of displaced populations, refugees, returnees and people residing in white conflict areas to emergency health services

Planned outputs:

- 1 712 565 conflict-affected people residing in white areas (areas with no access to health services) are served by emergency primary health-care/mobile services.

### Objective 3: Provide immediate lifesaving assistance to those affected by public health outbreaks and natural disasters

Planned outputs:

- 100% of outbreak alarms investigated within 48 hours of notification
- 694 871 people served by lifesaving assistance during public health outbreaks or disasters.

## Beneficiaries targeted by health partners in 2016

Health partners are targeting 3.2 million people in 2016. These include:

- Conflict displaced: 300 000
- Health affected by conflict: 1.7 million
- Natural disaster affected: 200 000
- Public health at risk: 700 000
- Refugees and vulnerable returnees: 300 000

Within the groups described above, there are 49% female, 53% children and 5% elderly.

## Geographical areas targeted by health partners in 2016

The people targeted for health humanitarian assistance in this response plan (according to the status described above) are in the Capital, Central Highland, Eastern, North Eastern, Northern, South Eastern, Southern and Western regions of the country.

## Health Cluster funding requirements for 2016

US\$ 39 562 024 (health partners including WHO)

## WHO funding requirements for 2016

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

Health Cluster projects	Requested funds (US\$)
Health Cluster requirements not yet attributed to specific organizations AFG-16/H/91392	39 562 024





# Burkina Faso

Burkina Faso has faced frequent natural disasters over the past decade, which affect the country's food security. While the number of people affected by the food and nutrition crisis has gradually fallen since 2012, there are still more than 1.6 million people suffering from malnutrition. This number includes nearly 510 000 children under five years old suffering from acute malnutrition; 150 000 with severe acute malnutrition; and 360 000 with moderate acute malnutrition. Around half of those affected, 830 000 people, are targeted to receive humanitarian assistance, mainly in the Sahel, Centre, North and East regions.

Other populations in need of assistance include the majority of the 34 000 refugees from Mali who have sought refuge in Burkina Faso and who require multisectoral support for their food, nutrition, water, hygiene, sanitation, health, education and protection needs; those who need help to strengthen their resilience to shocks to mitigate the deterioration of their living conditions; and those affected by floods. Mechanisms to prevent gender-based violence are in need of strengthening to protect refugee women.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	183/188
Population in urban areas%	2015	29.8
Population using improved water source%	2015	82.3
Population using improved sanitation%	2015	19.7
Life expectancy at birth (years)	2015	58
Infant mortality rate / 1000 <sup>2</sup>	2015	60.9
Under 5 mortality rate / 1000 <sup>2</sup>	2015	88.6
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	371
Measles coverage among one year old's%	2014	88

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Health Sector Situation

Lack of resources has led to a reduction in access for refugees and host populations to health services, with very serious consequences for morbidity and child mortality rates, and for pregnant and lactating women. Approximately 313 000 people are in need of medical assistance.

The plan, in partnership with local stakeholders, aims to improve access to preventive and curative care for children under five years old by strengthening the technical platform of health centres, the management of severe acute malnutrition with complications, and strengthening coordination and supervision.

Basic humanitarian assistance for refugee and host populations in the Sahel region will focus on strengthening the availability of drugs and consumables and capacity-building for health workers and the supply of quality services. Access to basic social services such as health and nutrition will focus on primary and secondary health, reproductive health, the fight against HIV/AIDS, epidemiological surveillance and the continued construction of shelters.

## Health Sector Objectives

**Objective 1: Support health structures with the supply of medication and other inputs for primary health care for refugees**

Planned Outputs:

- Increased access for pregnant women to a clean and safe delivery.
- Improved access of refugees to primary health care.
- Health facilities provided with medicines and secondary healthcare inputs.

**Objective 2: Support to health structures with the supply of medications and other inputs for primary health care for host communities**

Planned outputs:

- Increased access of pregnant women to a clean and safe delivery.

## Acknowledgement

In 2015 WHO did not receive financial contributions to support its humanitarian work in Burkina Faso.

## Funding for 2016

Health partners	US\$	3 253 866
WHO	US\$	395 900



- Improved access of refugees to primary health care.
- Health facilities provided with medicines and secondary health care inputs.

**Objective 3: Providing health care for complications of severe acute malnutrition in the Sahel region for children under five years old**

Planned outputs:

- Increased number of under five year old visits per year.
- Strengthened capacity of priority districts for the management of cases of severe acute malnutrition with complications.

**Beneficiaries targeted by health partners in 2016**

Health partners will be targeting 307 000 people, including:

- 32 000 refugees
- 20 000 host communities
- 254 000 vulnerable people

**Geographical areas targeted by health partners in 2016**

The Humanitarian Response Plan aims to meet the needs of people mainly in the Sahel and Northern regions, which are high-priority areas terms of malnutrition.

**Health partners funding requirements for 2016**

US\$ 3 253 866 (health partners including WHO)

**WHO funding requirements for 2016**

WHO is requesting a total of US\$ 395 900

Health partners projects	Requested funds (US\$)
Support to the health district of Gorom-Gorom for health assistance for the refugee and host population <b>BFA-16/H/86354</b>	395 900



# Cameroon

Cameroon faces three crises which have left 2.7 million people in need. The intensification of violence in Nigeria and in the far north of Cameroon has displaced thousands of people. There are nearly 2.4 million people who are food insecure, including 250 000 acutely malnourished children and 68 000 children with severe acute malnutrition. The conflict in Central African Republic has displaced thousands of refugees in the eastern regions of Cameroon.

The majority of the internally displaced people and approximately 15 000 refugees are residing in host communities (which total 336 000 people) who share their limited resources with the new arrivals. Civilians, especially women and children, affected by the increase in attacks and military operations are vulnerable to serious violations of their rights, their safety and psychosocial well-being. Many who fled the violence have witnessed brutal crimes and the trauma is deep and widespread.

Since July 2015, suicide bombings have caused 118 deaths and more than 384 wounded.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	153/188
Population in urban areas%	2015	54.3
Population using improved water source%	2015	75.6
Population using improved sanitation%	2015	45.8
Life expectancy at birth (years)	2015	54.8
Infant mortality rate / 1000 <sup>2</sup>	2015	57.1
Under 5 mortality rate / 1000 <sup>2</sup>	2015	87.9
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	596
Measles coverage among one year old's%	2014	80

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Health Sector Situation

An estimated 1.1 million people need assistance to meet their basic health needs in 2016 – a 20% rise since 2015. Inadequate health facilities, hygiene and sanitation may fuel the emergence of epidemics including cholera and measles.

Health centres are increasingly under pressure because of the large number of displaced people and the influx of serious injuries resulting from the conflict. In addition, 25 health centres have closed because of conflict, leaving 360 000 people without access to health care. The limited access to water and sanitation is worrying, given the frequent and recent epidemics including cholera, polio, measles, yellow fever and meningitis.

Children and women are most affected by the lack of health care services. Meanwhile new refugees from Nigeria and Central African Republic have increased the risk of epidemics and put pressure on Cameroon's already overwhelmed health services.

The health sector aims to increase access to essential health care particularly for vulnerable populations and to build capacity in high-risk regions to help anticipate and respond to public health emergencies. The planned response will include providing continuous curative care for illnesses, providing quality reproductive health care and improving the availability of medicines and equipment for secondary and tertiary care for burn victims and war casualties. The sector also aims to strengthen early warning systems and preparedness in high-risk areas to stop or reduce the scale of potential outbreaks.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in the Cameroon from the Central Emergency Response Fund.

## Health Sector Objectives

**Objective 1: Vulnerable populations have access to good quality basic health care.**

Planned Outputs:

- Conduct surveys to improve preparedness capacity in areas that provide care during crises.

**Objective 2: Capacity in high-risk regions to anticipate and respond to emergencies is strengthened.**

## Funding for 2016

Health partners	US\$	12 183 767
WHO	US\$	9 774 623

Planned outputs:

- Build capacity in high-risk areas, to anticipate and respond to health emergencies and epidemics ensuring continued supply of curative care for common ailments.
- Support reproductive health care and health care for children (e.g. vaccination).
- Support the availability of drugs and equipment for secondary and tertiary care burn victims and war casualties.
- Prevention and management of HIV.
- Strengthen the early warning system and preparedness in high risk regions to halt or reduce the scope of possible outbreaks.

### Beneficiaries targeted by health partners in 2016

Health partners are targeting 1.1 million people. These include:

- 296 000 refugees
- 93 000 internally displaced people
- 19 000 returnees
- 553 000 people in host communities
- 96 000 other vulnerable people

### Geographical areas targeted by health partners in 2016

Adamaoua, East, North, and Far North regions.

### Health partners funding requirements for 2016

US\$ 12 183 767 (health partners including WHO)

### WHO funding requirements for 2016

WHO is requesting a total of US\$ 9 774 623

<b>WHO projects</b>	<b>Requested funds (US\$)</b>
WHO Cameroon: HRP- Global Project 2016 <b>CMR-16/H/85873/122</b>	8 425 506
WHO Health Project - Multi-sector for refugees in the Far North Region <b>CMR-16/H/85897/122</b>	543 000
WHO Health Project for refugees in East and Adamawa Regions <b>CMR-16/H/85901/122</b>	806 117



## Central African Republic

After more than two years of instability, the magnitude and complexity of the humanitarian crisis in the Central African Republic are unprecedented. A large part of the population remains affected by the crisis, vulnerable and exposed to risks caused by serious human rights violations along with poverty and the lack of basic services.

Efforts to broker peace and meet humanitarian needs succeeded in reducing the level of violence in Central African Republic in 2015. However, occasional peaks of aggression broke the relative stability and cast doubts over hopes for a return to peace. The months of September and October 2015 in particular were marked by inter-community violence in Bangui, Dekoa, Bambari and Kaga Bandoro, leading to several thousand deaths and injuries, and displacing tens of thousands of people. These outbreaks of violence also involved deliberate attacks against humanitarian personnel and property, leading to the evacuation of more than 200 humanitarian workers. More than half of the population, approximately 2.3 million people, require humanitarian assistance.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	187/188
Population in urban areas%	2015	40
Population using improved water source%	2015	68.5
Population using improved sanitation%	2015	21.8
Life expectancy at birth (years)	2015	49.5
Infant mortality rate / 1000 <sup>2</sup>	2015	91.5
Under 5 mortality rate / 1000 <sup>2</sup>	2015	130.1
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	882
Measles coverage among one year old's%	2014	49

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

### Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in the Central African Republic from the Central Emergency Response Fund, Italy and the United Nations Organization for the Coordination of Humanitarian Affairs Common Humanitarian Fund.

### Funding for 2016

Health partners	US\$	42 000 000
WHO	US\$	15 851 400

### Health Sector Situation

Despite the efforts of health partners, access to health care remains difficult in some areas including Ouaka, Vakaga health district, and in the southeastern part of the country; due to persistent clashes between various armed groups. Nationally, 23% of health facilities are no longer fully operational, primarily due to a lack of health professionals and damage to facilities, equipment and supplies. In Ouaka district, approximately 35 000 displaced persons in Ngakobo site and Kouango sub-prefecture are without appropriate health care; the nearest functional hospital (Grimari) is 100 km away. In Vakaga, Nana Gribizi and Ouham districts, most of the hospitals and health centres are left without equipment due to looting, damage and/or obsolescence. Some communities are often unable to access to health care due to inter-communal conflicts.

With the persistence of inter-community conflict and clashes between various armed groups, the health sector is facing frequent movement of internally displaced populations to new sites. Health care services must be arranged for the displaced. At the same time, populations returning to their location of origin often find themselves without homes or adequate basic social services. An increase in cases of rape and of injuries are being registered in hospitals which are not prepared nor equipped to take care of these victims.

According to a Health Resources Availability Mapping System (HeRAMS) survey conducted in 2015, 347 health facilities (34%) are partially or totally destroyed out of 1008. Some 68% health facilities are functional and 50% of functional health facilities are supported by health humanitarian partners. The national health system has been heavily impacted by several crises.

In 2015, 693 cases of rape were registered (within health facilities) in the city of Bangui and its environs (Bimbo and Begoua) and in the city of Kaga Bandoro. These cases are mostly registered 72 hours after incidents and often do not receive proper psycho-social support.

Given the weak immunization coverage of routine Expanded Programme on Immunization (around 40%), the Central African Republic is facing frequent outbreaks of diseases preventable by vaccination, in particular among children under five years old. In 2015, three health regions out of seven have experienced measles outbreaks and 723 cases in total were reported by epidemiological surveillance.

## Health Sector Objectives

- Objective 1:** Provide emergency health care (curative, preventative, promotional) to populations affected by acute humanitarian crisis, including the treatment of chronic diseases, mental health, emergency obstetric and neonatal care, and care for the wounded.
- Objective 2:** Increase access to basic health care services for the crisis-affected population and those facing prolonged displacement, including host populations.
- Objective 3:** Reduce the risk of epidemics in at-risk areas.

## Beneficiaries targeted by health partners in 2016

Health partners are targeting 1 million people. These include:

- 200 000 internally displaced people
- 800 000 people in host communities

## Geographical areas targeted by health partners in 2016

The following districts have been prioritized:

The 2nd, 3rd and 5th arrondissement of Bangui, Bimbo, Yaloké, Boda, Amadagaza, Gamboula, Bouar, Baboua, Ngaoundaye, Bocaranga, Kouï, Paoua, Bosangoa, Nangha Bagoula, Markounda, Bouca, Batangafo, Kabo, Nana- Bakassa, KagaBandoro, Mbres, Dekoa, Mala, Ndjokou, Birao, Ouanda Djallhe, Bria, Bakouma, Ouango, Gambo, Kembe, Satema, Mobaye, Alindao, Zangba, Mingala, Kouango, Bambari, Ippy, and Bakala.

## Health Cluster funding requirements for 2016

US\$ 42 000 000 (health partners including WHO)

## WHO funding requirements for 2016

WHO is requesting a total of US\$ 15 851 400

Health Cluster projects	Requested funds (US\$)
Health Cluster requirements not yet attributed to specific organizations CAF-16/H/	42 000 000



# Chad

Chad is facing four humanitarian crises – food insecurity and malnutrition; population movements (resulting from instability and conflict in Sudan, Central African Republic, Nigeria, and military operations in the Lake Chad region); health emergencies; and natural disasters. These crises are directly affecting 3.9 million people and leaving 2.3 million people in need of humanitarian assistance – more than half of these are women.

Food insecurity and malnutrition are affecting more than 3.4 million people, 1.6 million of which are in need of assistance for their nutritional needs. An estimated 400 000 children have moderate acute malnutrition and more than 320 000 children have severe acute malnutrition and require urgent nutritional treatment.

Natural disasters (floods, droughts, crop pests) are increasingly frequent and may affect up to 2.7 million people. Their negative impact on agricultural production and livelihoods limits affected communities’ access to basic services.

Despite these crises, Chad has opened its borders and doors to hundreds of thousands of refugees, returnees and internally displaced people (IDPs). Chad has the 7th largest number of refugees in the world. An estimated 638 000 displaced people are living in camps or with host communities who are also need of humanitarian assistance. Those displaced for less than a year show increased vulnerability and urgent multisectoral needs for shelter, food security, water and sanitation, education, protection, health and nutrition.

Humanitarian access is difficult in the Lake region due to insecurity and logistically limited in northern areas during the rainy season. Despite generous humanitarian assistance in recent years, Chad still faces difficulties from inadequate funding.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	185/188
Population in urban areas%	2015	22.4
Population using improved water source%	2015	50.8
Population using improved sanitation%	2015	12.1
Life expectancy at birth (years)	2015	51.1
Infant mortality rate / 1000 <sup>2</sup>	2015	85
Under 5 mortality rate / 1000 <sup>2</sup>	2015	138.7
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	856
Measles coverage among one year old's%	2014	54

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Chad from the Central Emergency Response Fund.

## Funding for 2016

Health Cluster	US\$	34 366 614
WHO	US\$	10 674 080

## Health Sector Situation

The health situation is characterized by the prevalence of potentially epidemic diseases such as cholera and measles and other diseases like malaria – problems compounded by Chad’s weak health system. In the first half of 2015, nearly 390 000 people were suffering from malaria and measles. Low immunization coverage adds to vulnerability, especially for women, children, nomads and displaced populations. Reproductive health remains a major challenge.

The response to this health emergency will include the provision of emergency medical help for people (including refugees, returnees and IDPs) affected by epidemics (cholera, measles) and who end up in poor sanitary conditions. Special attention will be given to the provision of primary health care for the most vulnerable populations, providing maternal and child health care and treatment, and malaria prevention in areas of high impact. Advocacy will be undertaken to strengthen the epidemiological surveillance system and the integration of nutrition into the health system.

## Health Cluster Objectives

**Objective I: Ensure medical support (including for reproductive health) for vulnerable people.**

Planned outputs:

- 100% of children admitted to hospital with severe acute malnutrition will be supported.

- Support 65 health centres with drugs and other supplies in locations where there are refugees, returnees, IDPs and host populations.
- 600 000 outpatient consultations held in districts affected by population movements.
- 44 000 births attended by skilled personnel in districts supported by cluster members.

**Objective 2: Strengthen the prevention of epidemics in areas particularly prone to epidemics and other serious diseases.**

Planned outputs:

- 446 343 children under five years vaccinated against measles.

**Objective 3: Strengthen community-based monitoring and early warning systems to improve the detection and response to outbreaks.**

Planned outputs:

- 1219 monthly epidemiological reports completed and received at national level.

### Beneficiaries targeted by health partners in 2016

Health partners are targeting 845 000 people in 2016. These include:

- 500 850 refugees
- 100 546 returnees
- 51 387 internally displaced people
- 771 third country nationals
- 191 400 people in host communities

### Geographical areas targeted by health partners in 2016

The Sahel region is particularly affected by the food and nutrition crisis. The Lake region is affected by internal displacement and population movements from Nigeria into Chad. Chad's southern regions are affected by displacement from the Central African Republic and eastern Chad.

### Health Cluster funding requirements for 2016

US\$ 34 366 614 (health partners including WHO)

### WHO funding requirements for 2016

WHO is requesting a total of US\$ 10 674 080

WHO projects	Requested funds (US\$)
Emergency medical intervention for saving lives of severely malnourished children and improving delivery and access to primary health care services for under five children in nomadic population and remote areas in Kanem, Bahr El Ghazal, Lake, Ouaddai, Batha, Guera, Hadjer-Lamis, Salamat, Sila, Wadi Fira and regions affected by food insecurity <b>CHD-16/H/84126/122</b>	1 450 000
Emergency response to control meningitis, cholera, malaria, yellow fever, measles and Ebola outbreaks in Chad <b>CHD-16/H/84244/122</b>	6 399 135
Emergency medical intervention for reduction of morbidity and mortality within the IDPs, returnees and host populations in East, Lake and South regions of Chad <b>CHD-16/H/84251/122</b>	2 116 460
Emergency medical intervention for reduction of morbidity and mortality within the refugees, and host populations in Lake and South of Chad <b>CHD-16/H/84755/122</b>	708 485





## The Democratic Republic of the Congo

Decades of upheaval have intensified humanitarian needs and vulnerability in the Democratic Republic of the Congo, leaving it with a humanitarian crisis of massive proportions – 7.5 million people are in need of humanitarian assistance and protection. Currently 1.6 million people are displaced, about 4.5 million people are food insecure, and nearly half of children under five years old suffer from chronic malnutrition.

In addition, the Democratic Republic of the Congo bears the consequences of political and security dynamics within the Great Lakes Region generally. Population movements within the country and from neighbouring countries aggravate the already high levels of vulnerability of the 250 000 households in the Democratic Republic of the Congo that host displaced people.

The population is set to have a potentially turbulent 2016. The national situation politically and in terms of security developments could see resurgence of intercommunal tensions in different parts of the country.

An influx of refugees, and asylum seekers is expected, particularly in the north and east of the country. This exacerbates problems such as persistent insecurity; epidemic cycles of cholera, measles, malaria and haemorrhagic fevers; and destructive natural events including floods.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	171/188
Population in urban areas%	2015	42.4
Population using improved water source%	2015	52.4
Population using improved sanitation%	2015	28.7
Life expectancy at birth (years)	2015	58.1
Infant mortality rate / 1000 <sup>2</sup>	2015	74.5
Under 5 mortality rate / 1000 <sup>2</sup>	2015	98.3
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	693
Measles coverage among one year old's%	2014	77

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

### Health Sector Situation

According to studies and assessments, 80% of internally displaced persons and/or refugees have limited access to health care.

In this protracted crises, there are recurrent outbreaks of measles, cholera, and malaria. By end of 2015, there were over 50 000 cases of measles with about 560 deaths (primarily in children), and 21 584 cases of cholera with 329 deaths (CFR: 1.5%).

In 2016, the Health Cluster strategy aims to: (i) reduce the vulnerability of affected populations and (ii) enhance the resilience of affected populations; (iii) monitor diseases of epidemic potential and (iv) prevent and respond to epidemics. This multisectoral approach will have a particular emphasis on consultation and coordination.

Internally displaced people, returnees and refugees will require particular attention..

### Health Cluster Objectives

**Objective 1: Provide access to basic health care for vulnerable displaced populations, returnees and host communities.**

**Objective 2: Coverage of health needs of victims of fundamental rights violations.**

**Objective 3: Reducing the impact of epidemics and other humanitarian consequences and mortality through Integrated Management of people affected and at risk.**

### Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in the Democratic Republic of the Congo from the Central Emergency Response Fund.

### Funding for 2016

Health Cluster	US\$	50 000 000
WHO	US\$	15 000 000

## Beneficiaries targeted by health partners in 2016

Health partners are targeting 6 million people in 2016. These include:

- 3.9 million people at risk of cholera
- 670 000 people at risk of measles
- 40 000 people at risk of viral haemorrhagic fever
- 80 000 people at risk of medical complications related to malnutrition
- 1.1 million people without basic health care
- 200 000 refugees and returnees

## Health Cluster funding requirements for 2016

US\$ 50 000 000 (health partners including WHO)

## WHO funding requirements for 2016

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

Health Cluster projects	Requested funds (US\$)
Cluster requirements not yet attributed to specific organizations <b>DRC-16/H/91385/5826</b>	50 000 000



# Djibouti

Recurrent drought conditions induced by climate change over the past two decades have led to a significant deterioration in Djibouti’s humanitarian situation. The El Niño climatic event that is currently affecting the Horn of Africa region and is expected to have severe impact over the coming months may also lead to flash floods and/or increased drought conditions in some parts of the country.

More than 58% of the rural population is food insecure, about 23% live in extreme poverty and 42% of the total population live in absolute poverty. Malnutrition has reached extremely high levels and 35% of the rural population have no access to water.

The increased influx of refugees and migrants has created additional pressure on public infrastructure and further stretched the state’s limited capacity to provide basic services.

The humanitarian situation is also exacerbated by lack of access to safe water and basic sanitation services and health care.

Overall, 282 000 people will require humanitarian assistance in 2016.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	168/188
Population in urban areas%	2015	77.3
Population using improved water source%	2015	90
Population using improved sanitation%	2015	47.4
Life expectancy at birth (years)	2015	61.6
Infant mortality rate / 1000 <sup>2</sup>	2015	54.2
Under 5 mortality rate / 1000 <sup>2</sup>	2015	65.3
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	229
Measles coverage among one year old’s%	2014	71

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Health Sector Situation

An important proportion of people in Djibouti require urgent assistance to maintain or increase access to primary health care. Because of high vulnerability, every year many people die due to preventable and treatable diseases of poverty such as acute pneumonia, diarrhoea, malaria, measles, tuberculosis, HIV and non-communicable diseases. Nearly 300 000 people, about one third of the population, require assistance for primary health care. These include 222 088 of the most vulnerable Djiboutians (extremely poor people living in rural and peri-urban areas with limited or no access to health services; children under five years old and pregnant women), 25 579 projected refugees and asylum seekers as well as 34 750 migrants.

## Health Sector Objectives

- Objective 1: Provide quality life-saving health care services by ensuring availability of essential drugs, supplies and equipment.**
- Objective 2: Ensure availability of high quality of preventive and curative health care for vulnerable people including maternal and child health.**
- Objective 3: Strengthen disease surveillance response, including laboratory capacities and guidance on priority public health issues and threats.**

## Beneficiaries targeted by health partners in 2016

Health partners will target 237 999 people (49% female, 46 % children and 4% elderly) in 2016. These include:

- 25 579 refugees
- 34 750 migrants
- 177 670 host and local communities

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Djibouti from Japan.

## Funding for 2016

Health Cluster	US\$	10 692 563
WHO	US\$	1 937 021

## Health Sector funding requirements for 2016

US\$ 10 692 563 (health partners including WHO)

## WHO funding requirements for 2016

WHO is requesting a total of US\$ 11 937 021

WHO projects	Requested funds (US\$)
Increase access to primary health care for vulnerable population in Djibouti <b>DJI-16/H/89834/122</b>	1 937 021



# Ethiopia

Ethiopia is experiencing one of its worst droughts in decades. Government estimates of people needing food assistance rose from 4.5 million people in August 2015 to 8.2 million in October. Some regions experienced between 50 and 90% crop loss. Lack of rainfall and subsequent drought have caused an increase in humanitarian needs, which are expected to continue through much of 2016.

Lives are at risk due to the lack of food and water and the risk of disease outbreaks. Also, 3.6 million people are in need of emergency health care.

The drought-induced increase in household food insecurity is resulting in record levels of acute malnutrition. In 2015, rates of children's severe acute malnourishment rose, with August numbers being the highest reported in past years – even compared to the Horn of Africa crisis in 2011.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	174/188
Population in urban areas%	2015	19.4
Population using improved water source%	2015	57.3
Population using improved sanitation%	2015	28
Life expectancy at birth (years)	2015	63.1
Infant mortality rate / 1000 <sup>2</sup>	2015	41.4
Under 5 mortality rate / 1000 <sup>2</sup>	2015	59.2
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	353
Measles coverage among one year old's%	2014	66

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Health Sector Situation

Access to emergency health services is needed for approximately 400 000 children projected to be severely acutely malnourished, 1.7 million moderately malnourished pregnant and lactating mothers and 820 000 people predicted to be displaced by drought and flooding during 2016. Health emergency preparedness and response, including the availability of drugs and medical supplies, is relatively limited in relation to the current and anticipated degree of the crisis.

Estimates for 2016 show that poor water availability, lack of sanitation, decreased food availability and displacement will significantly increase the risk of mortality and morbidity resulting from malnutrition and outbreaks of communicable disease. Outbreaks include measles, meningitis, malaria, dengue fever, diarrhoeal disease and acute respiratory infection.

An estimated 80 060 of the expected 400 000 severely malnourished children will develop medical complications that need highly intensive lifesaving medical treatments in hospital-based therapeutic feeding centres.

Malnutrition amongst pregnant women increases the risk of abortion, fetal death and bleeding, contributing to increased maternal and neonatal morbidity and mortality. A minimum initial reproductive health service package is required. Stresses from displacement are also linked with increasing psychosocial and mental health effects. Overburdened national health systems will face increasing difficulties to address emergency health needs.

The Federal Ministry of Health and partners have already taken important steps to address on-going outbreaks of scabies, measles and dengue fever. This includes a three year national vaccination campaign against meningitis A. However, new threats are appearing such as meningitis C in the open camps of Gambella and increases in the number of watery diarrhoea, malaria, dengue and other communicable diseases in drought and/or flood affected areas.

## Health Cluster Objectives

**Objective I: Provide life-saving health services to highly food insecure and displaced people in emergency affected areas.**

Planned Outputs:

- Reach 3.6 million people with emergency and essential health care services including reproductive health for the displaced population.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Ethiopia from Japan.

## Funding for 2016

Health Cluster	US\$	33 600 000
WHO	US\$	8 200 000

- Reach 3.5 million people via mobile health and nutrition team deployment in pastoralist communities – to deliver essential primary health care services and to support surveillance.
- Support 3.2 million people in the most affected regions with temporary health professional deployment (surge capacity).
- Assist 3.6 million people via community engagement and social mobilization.

**Objective 2: Detect and respond to epidemic disease outbreaks in high risk areas.**

Planned Outputs:

- Protect 3.6 million people via communicable disease outbreak investigation, response and control (medical supplies, medications, and lab supplies).
- Reach 3.6 million people with public health surveillance and emergency nutrition screening.

**Beneficiaries targeted by health partners in 2016**

Health partners will target 3.6 million people in 2016. These include people:

- affected by drought
- at risk of flooding and displacement,
- at high risk of malnutrition and disease outbreaks

Highly vulnerable individuals include

- all women of reproductive age
- pregnant and lactating women
- all newborn babies
- children under five years old
- elderly people
- people with disabilities.

**Geographical areas targeted by health partners in 2016**

Partners will target vulnerable woredas in Tigray, Amhara, Afar, Somali, Gambella, Oromia, Dire Dawa City Administration and the Southern Nations, Nationalities and People’s (SNNP) region; and areas of population displacement (Afar, Gambella, Hareri, Oromia, Somali and SNNP).

**Health Cluster funding requirements for 2016**

US\$ 33 600 000 (health partners including WHO)

**WHO funding requirements for 2016**

WHO is requesting a total of US\$ 8 200 000

Health Cluster projects	Requested funds (US\$)
Cluster requirements not yet attributed to specific organizations <b>ETH-16/H/91385/5826</b>	33 600 000



# Gambia

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	175/188
Population in urban areas%	2015	59.3
Population using improved water source%	2015	90.2
Population using improved sanitation%	2015	58.9
Life expectancy at birth (years)	2015	59.8
Infant mortality rate / 1000 <sup>2</sup>	2015	47.9
Under 5 mortality rate / 1000 <sup>2</sup>	2015	68.9
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	706
Measles coverage among one year old's%	2014	96

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

Drought, flooding, wind-storms, pest infestation and disease outbreaks have been undermining food security and decimating livelihoods in Gambia since 2013. An estimated 200 000 people will require humanitarian assistance to meet their basic needs in 2016.

Climate change-related erratic and declining rainfall has destabilized the agriculture sector and food security is a huge challenge. Malnutrition and poor access to basic social services continue to affect large sections of the population. An estimated 699 940 people (33% of the population) are considered food insecure.

Other drivers of inadequate nutrition include poor infant feeding practices and care givers' limited knowledge of essential nutritional and hygiene practices. Less than 40% of the population has access to improved sanitation. Schools lack access to safe drinking water (13%) and basic sanitation (18%).

Crop production levels remain low compared to the last five-year average. Affected households desperately require support to meet immediate food needs, restore livelihoods and enhance resilience to future shocks and disasters.

## Health Sector Situation

In Gambia, basic health services are out of reach for the most vulnerable people due to low income or lack of access. Basic essential drugs and other medical equipment are not readily available most of the time. Gambia's population is exposed to meningitis and malaria, and approximately 65% are at risk from cholera. In 2015 there was an outbreak of measles in the West Coast Region – at least 100 cases were reported in children aged nine months to 15 years. In addition, up to September 2015 there were 79 reported cases and 19 deaths from meningitis.

Malaria is endemic in all regions, but a drastic reduction of malaria among children under five years old was recorded in Upper River and Central River Regions thanks to Seasonal Malaria Chemoprevention.

Malnutrition is affecting children and women the most. An estimated 100 000 children under the age of five years old and pregnant and lactating women are estimated to be at risk of acute malnutrition.

## Health Sector Objectives

- Objective 1: Strengthen institutional capacity in Ebola preparedness and response.**
- Objective 2: Strengthen institutional capacity in disease control and prevention.**
- Objective 3: Strengthening health system capacity in the management of malnutrition.**

## Beneficiaries targeted by health partners in 2016

Health partners are targeting 143 000 people in 2016.

## Acknowledgement

In 2015 WHO did not receive financial contributions to support its humanitarian work in Gambia.

## Funding for 2016

Health partners	US\$	2 927 109
WHO	US\$	2 927 109



## Health partners funding requirements for 2016

US\$ 2 927 109 (health partners including WHO)

## WHO funding requirements for 2016

WHO is requesting a total of US\$ 2 927 109

<b>Health partners project</b>	<b>Requested funds (US\$)</b>
Support the provision of health care services to the Gambia <b>GMB-16/H/87569/122</b>	2 927 109



# Guatemala and Honduras

In Guatemala and Honduras the cumulative effects of two years of drought and the El Niño weather pattern have left 2.8 million people in need of humanitarian assistance in meeting their food, health care and livelihood needs.

Insufficient and erratic rainfall has resulted in the loss of staple grain crops and the death of thousands of cattle. Food security has been severely eroded by high seasonal food prices, limited income opportunities and crop losses. Hardest hit are families who depend on subsistence farming, day labourers and landless farmers. These low-income households have limited access to basic health services and education, and find it hard to afford staple foods.

The Famine Early Warning System predicts that in May 2016, Guatemala and Honduras will experience crisis-level acute food insecurity, where one in five households will face critical food consumption gaps and acute malnutrition.

## Health Sector Situation

In **Guatemala** around 250 000 people suffer from malnutrition and diseases (diarrhoeal and vector-borne diseases) related to the prolonged dry spell and nutrition services are needed to reach 20 000 people who have severe acute malnutrition.

Emergency needs will remain high unless the root causes of malnutrition are addressed, and the resilience of the most vulnerable people is strengthened. In addition to specific nutritional interventions targeting children under five years old and pregnant women, disease control, health services, health promotion and reproductive health care are needed.

In **Honduras**, limited access to water due to the prolonged drought has negatively impacted people's consumption and their hygiene practices, thereby increasing health risks. Health services – especially in rural areas, do not have the capacity to meet the needs of the affected population. For this reason, the health sector is prioritizing action to preserve the health of 50 000 families (250 000 people) who are at high risk, especially 32 500 children under five years old, pregnant women, lactating mothers and elderly people.

Guatemala		Estimate
Baseline indicators		
Human development index <sup>1</sup>	2015	128/188
Population in urban areas%	2015	51.5
Population using improved water source%	2015	92.8
Population using improved sanitation%	2015	63.9
Life expectancy at birth (years)	2015	71.4
Infant mortality rate / 1000 <sup>2</sup>	2015	24.3
Under 5 mortality rate / 1000 <sup>2</sup>	2015	29.1
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	88
Measles coverage among one year old's%	2014	67

Honduras		Estimate
Baseline indicators		
Human development index <sup>1</sup>	2015	131/188
Population in urban areas%	2015	54.7
Population using improved water source%	2015	91.2
Population using improved sanitation%	2015	82.6
Life expectancy at birth (years)	2015	72.8
Infant mortality rate / 1000 <sup>2</sup>	2015	17.4
Under 5 mortality rate / 1000 <sup>2</sup>	2015	20.4
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	129
Measles coverage among one year old's%	2014	88

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Guatemala and Honduras from the Central Emergency Response Fund.

## Funding for 2016

Health partners	US\$	5 580 000
WHO	US\$	2 550 000

## Health Sector Objectives

### Guatemala

**Objective 1: Save the lives of children under five years suffering from acute malnutrition and prevent the appearance of new cases, including other priority groups such as women and elderly people.**

#### Planned Outputs:

- Identify, treat and recover 1500 cases of malnutrition in children under five by the end of June 2016.
- Provide supplementary nutrition for 10 000 cases of malnutrition in pregnant and lactating women by the end of June 2016.

**Objective 2: Prevent, detect and address morbidity that contributes to deteriorating health and nutritional status, mainly in children under five years, pregnant women and women of childbearing age.**

Planned Outputs:

- Identify and treat 3000 cases of food-borne diseases in children under five years old by the end of June 2016.
- Identify and treat 3000 cases of acute respiratory infections in children under five years old by the end June 2016.

**Objective 3: Strengthen epidemiological surveillance of diseases associated with the prolonged dry spell (respiratory, diarrhoeal, and vector-borne) and acute malnutrition in children under five years old.**

Planned Outputs:

- Strengthen 148 health centres, 18 nutritional recovery centres and 13 hospitals with basic supplies, equipment and support personnel to enable them to treat and manage acute malnutrition according to Ministry of Health guidelines by the end of 2016. Ensure timely registration and health system referral in cases of acute malnutrition and diseases under surveillance (food-borne, vector-borne and respiratory diseases) especially for children under five years.

## Honduras

**Objective 1: Provide essential medicines and health supplies to health facilities for the prompt treatment of communicable diseases (diarrhoea, intestinal parasites) affecting vulnerable people.**

Planned Outputs:

- 15% reduction in cases of diarrhoea in selected communities according to surveillance data from health facility units, consolidated at municipal level.
- 100% of health facility units in the intervention area have the supplies needed to improve care for those affected during the current emergency.

**Objective 2: Promote sanitary risk evaluations in households related to water, sanitation and vector control.**

Planned Outputs:

- 100% of municipalities implementing vector-borne disease control measures (eradication and treatment of mosquito breeding).

## Beneficiaries targeted by health partners in 2016

Health partners are targeting 200 000 people in Guatemala and 250 000 people in Honduras in 2016.

## Health partners funding requirements for 2016

US\$ 3 500 000 for Guatemala and US\$ 2 080 000 for Honduras (health partners including WHO)

## WHO funding requirements for 2016

WHO is requesting a total of US\$ 1 150 000 for Guatemala and US\$ 1 400 000 for Honduras

Health partners projects	Requested funds (US\$)
Guatemala Health partners requirements <b>GTM-16/H/91934/5826</b>	3 500 000
Honduras Health partners requirements <b>HND-16/H/91934/5826</b>	2 080 000



# Iraq

The ongoing conflict within Iraq has had profound humanitarian consequences. Nearly one third of Iraq’s population – 10 million people – need help, and almost half (over 4.7 million) are children. Three million Iraqis have fled their homes and 3 million more live in areas no longer under government control.

Many displaced people are unable to return home, and are reliant on diminishing public and personal resources, further exacerbating tensions with host communities. Health service capacity in areas hosting internally displaced people is heavily overburdened by rapidly rising demands.

Throughout Iraq people struggle to find employment, secure housing, health care, food and safe drinking water. Trauma is widespread because of the violence, mass executions, systematic rape and torture used against communities. Depending on the intensity of fighting and scale of violence, the number of Iraqis needing some form of humanitarian assistance could increase to 13 million by the end of 2016. However, access to the most vulnerable people remains a key challenge, limiting the provision of life-saving assistance.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	121/188
Population in urban areas%	2015	69.4
Population using improved water source%	2015	86.6
Population using improved sanitation%	2015	85.6
Life expectancy at birth (years)	2015	69.1
Infant mortality rate / 1000 <sup>2</sup>	2015	26.5
Under 5 mortality rate / 1000 <sup>2</sup>	2015	32
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	50
Measles coverage among one year old's%	2014	57

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Iraq from the European Commission Humanitarian Aid and Civil Protection, Kuwait, the Republic of Korea, the United States of America and the United Nations Organization for the Coordination of Humanitarian Affairs.

## Funding for 2016

Health Cluster	US\$	83 739 344
WHO	US\$	27 300 000

## Health Sector Situation

Iraq’s health system is faltering because of the conflict, displacement and disease outbreaks. National health systems have been disrupted and infrastructure has been destroyed and looted. There is a widespread lack of essential medicines, medical supplies and nutritional supplements.

Hospitals and primary health-care clinics in some areas indicate a 50% increase in people seeking services due to the influx of displaced people. Funding shortages in mid-2015 caused significant and ongoing disruption of health services. Over 8 million people are estimated to be in critical need of essential health-care services in 2016.

Compromised water and sanitation services combined with interrupted immunization programmes have created a high risk of disease. The early warning and disease control system and vaccination services have deteriorated due to diminished public funds. The national immunization coverage for measles is 57%, well below the required threshold of 90% to ensure protection against measles in the community. Since late 2015, Iraq has been experiencing a cholera outbreak and there is also an increased risk of typhoid, acute jaundice syndrome and measles.

Women and children are disproportionately affected by a severe reduction in health services. Pregnant and lactating women continue to face compromised access to reproductive health and referral services, to antenatal care and postnatal care and safe birthing practices.

## Health Cluster Objectives

**First line response:** Save lives through provision of critical life-saving health interventions reaching the most vulnerable people across Iraq.

**Second line response:** Support provision of essential health services through mental health and psychosocial support services; essential reproductive health care; essential nutritional services support to cold chain systems; promotion of routine vaccination; and ensuring a

functional supply chain as well as stockpiling of essential medicines to primary health-care units.

**Full cluster response:** Provide a comprehensive package of emergency health-care services with a focus on transitioning toward support and recovery of the existing health-care system in crisis-affected areas.

### Beneficiaries targeted by health partners in 2016

Health partners are targeting 7.1 million people including:

- 2.9 million internally displaced people
- 2.5 million people in host communities
- 900 000 people in armed opposition group-controlled areas
- 800 000 returnees

### Geographical areas targeted by health partners in 2016

Humanitarian needs are concentrated in the western and northern parts of Iraq.

### Health Cluster funding requirements for 2016

US\$ 83 739 344 (health partners including WHO)

### WHO funding requirements for 2016

WHO is requesting a total of US\$ 27 300 000

WHO projects	Requested funds (US\$)
Support to WHO operations for reducing morbidity and mortality by early detection and response to epidemics of communicable diseases among IDPs, refugees and impacted communities <b>IRQ-16/H/83166</b>	4 300 000
Supporting the provision of primary and secondary health care services to populations affected by the humanitarian emergency in Iraq including IDPs and host communities <b>IRQ-16/H/83196</b>	15 000 000
Ensuring access to lifesaving medicines and medical supplies for IDPs and impacted host communities in most affected governorates <b>IRQ-16/H/83231</b>	8 000 000



# Libya

Five years of armed conflict and political instability have affected almost every part of Libya, claiming thousands of lives and leaving thousands more injured. An estimated 2.44 million people are now in immediate need of protection and some form of humanitarian assistance, including almost 435 000 internally displaced people (IDPs) – many of whom have endured multiple displacements and lost homes, livelihoods and loved ones. Those affected but not displaced by the conflict include an additional 1.75 million people.

Libya is also host to an estimated 250 000 vulnerable refugees, asylum seekers and migrants who have fled violence, economic difficulty and political turmoil in north and Sub-Saharan Africa, and the Middle East. They face discrimination and marginalization, limited access to food and medical care, and poor shelter conditions.

The conflict has affected access to food for over 1.2 million people, particularly IDPs and those living in southern and eastern Libya. Approximately 680 000 people are in need of assistance to ensure access to safe drinking water and sanitation.

More than 30 000 people have suffered injuries, in many cases life-threatening or life-changing. Gender-based violence and forced recruitment increasingly threaten women and children in their communities, while the operating environment for humanitarian actors remains one of the most insecure and hostile in the world.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	94/188
Population in urban areas%	2015	78.5
Population using improved water source%	2012	54
Population using improved sanitation%	2015	96.6
Life expectancy at birth (years)	2015	71.4
Infant mortality rate / 1000 <sup>2</sup>	2015	11.4
Under 5 mortality rate / 1000 <sup>2</sup>	2015	13.4
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	9
Measles coverage among one year old's%	2014	93

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Libya from the European Commission Humanitarian Aid and Civil Protection.

## WHO funding for 2016

Health partners	US\$	38 103 050
WHO	US\$	15 260 000

## Health Sector Situation

Libya's health care system has deteriorated to the point of collapse and struggles to deal with casualties from the conflict. Serious illness and disease are rising. In conflict areas, over 60% of hospitals have been inaccessible or closed in the last six months, especially in the east and south. Hospitals are overcrowded, and their capacities have been severely reduced by a large scale exodus of foreign health workers. There is also a shortage of essential medicines and supplies. An estimated 1.9 million people need assistance to meet their basic health-care needs.

Major health service issues include:

- A debilitated primary health care system, especially in the main cities of Tripoli and Benghazi.
- High dependence on foreign health workers, especially in the southern part of the country.
- A substantial proportion of public health expenditure being used for the treatment of Libyans abroad.
- The neglect of health care provision in southern parts of Libya (Al Kufra, Sabha, Ghat and Awbari).

## Health Sector Objectives

**Objective 1: Improve access to basic life-saving primary and emergency secondary health care services through the provision of essential medicine, medical materials, and technical support for primary health care, disability care, and life-saving emergency care.**

Planned outputs:

- Provide 16 health facilities with access to essential medicines.

- Reach 100 000 people via mobile medical activities.
- Provide rehabilitation services to 10 000 people with disabilities.
- Support 16 health facilities to provide basic obstetric and neonatal care and/or comprehensive obstetric and neonatal care.
- Enable 11 000 people to participate in health and hygiene promotion activities.

**Objective 2: Reduce communicable diseases transmission and outbreak through detection and mitigation measures.**

Planned outputs:

- Increase the coverage of measles vaccination to 95%.
- Verify and respond to 85% of communicable diseases alerts within 48 hours.

**Objective 3: Strengthen the existing health structure to avoid health-system collapse through capacity building measures, referral system strengthening, infrastructure rehabilitation and the strengthening of data collection and information sharing mechanisms.**

Planned outputs:

- Training 3200 health personnel.
- 12 000 people admitted to secondary health facilities following referrals.
- Rehabilitation of five health facilities.

### Beneficiaries targeted by health partners in 2016

Health partners will target 1.2 million people. These include:

- 827 471 people affected (but not displaced) by the crisis
- 320 337 internally displaced people (IDPs)
- 38 500 migrants
- 20 000 refugees

### Geographical areas targeted by health partners in 2016

Partners will target areas most affected by the conflict, particularly Benghazi, Tripoli and Sabha.

### Health partners funding requirements for 2016

US\$ 38 103 050 (health partners including WHO)

### WHO funding requirements for 2016

WHO is requesting a total of US\$ 15 260 000

WHO projects	Requested funds (US\$)
Reducing avoidable morbidity and mortality in Libya via improving access to supplies and emergency response <b>LBY-16/H/81484/122</b>	9 720 000
Building the capacity of public and private sector health system for improving health services <b>LBY-16/H/81665</b>	4 040 000
Reduction of avoidable morbidity and mortality in Libya <b>LBY-16/H/81824/122</b>	1 500 000





# Mali

The people of Mali have experienced frequent droughts, floods and epidemics along with chronic poverty. Added to this, there has been armed conflict in the north since 2012, causing population movement and increased vulnerability for the affected population.

The signing of a peace and reconciliation agreement in Mali brought hope for a better future in 2015. Humanitarian actors made advances in providing assistance to the people affected by the protracted crisis. In many areas, people are entirely dependent on humanitarian aid for basic services.

However, limited funding has meant that the humanitarian community was unable to cover all the needs in 2015. The low level of financing had a negative impact on the ability to reach the most vulnerable. The impact of under-funding of vital sectors, such as health care (23%) was felt through consequences such as increased infant mortality and the spread of disease and epidemics.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	171/188
Population in urban areas%	2015	39.9
Population using improved water source%	2015	77
Population using improved sanitation%	2015	24.7
Life expectancy at birth (years)	2015	57.2
Infant mortality rate / 1000 <sup>2</sup>	2015	74.5
Under 5 mortality rate / 1000 <sup>2</sup>	2015	114.7
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	587
Measles coverage among one year old's%	2014	80

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO did not receive financial contributions to support its humanitarian work in Mali.

## Funding for 2016

Health Cluster	US\$	10 143 414
WHO	US\$	1 396 293

## Health Sector Situation

In 2016, the health sector has identified needs related to non-functional health care structures, malnutrition, low immunization coverage rate.

The Health Cluster will focus its efforts on the following: ensuring access to an essential primary health care package (curative, preventive and promotional); strengthening surveillance systems, warning and response to diseases with epidemic potential (measles, cholera, meningitis, malaria, etc.); strengthening the health information system; detecting and supporting the care of severe acute malnutrition at community health centre and reference health centre level; and strengthening coordination mechanisms.

## Health Cluster Objectives

- Objective 1: Strengthen the health information system in 17 health districts.**
- Objective 2: Increase the health care coverage for the populations of 17 health districts.**
- Objective 3: Improve the epidemic and disaster preparation and response system.**

## Beneficiaries targeted by health partners in 2016

The Health Cluster is focusing on supporting 203 health structures and targeting two million people.

The beneficiary population is composed of:

- 54% children (0-17 yrs)
- 43% adults
- 3% elderly

This population is made up of 49.85% women and 50.15 % men.

## Geographical areas targeted by health partners in 2016

The interventions of the cluster will target the regions of Timbuktu, Gao and Kidal and three sanitary districts of Mopti (Douentza, Tenenkou and Youwarou).

## Health Cluster funding requirements for 2016

US\$ 10 143 414 (health partners including WHO)

## WHO funding requirements for 2016

WHO is requesting a total of US\$ 1 396 293

WHO project	Requested funds (US\$)
Increase health care access, support epidemic response and provide reproductive health care in areas affected by the crisis <b>MLI-16/H/84856</b>	1 396 293



# Mauritania

Mauritania continues to suffer from a multidimensional crisis related to food insecurity, high prevalence of malnutrition, the hosting of refugees from Mali and flooding.

Some areas of the country experienced 65% less rainfall than average. Other areas saw increases as high as 35%, causing floods that affected households, infrastructure and livelihoods. Over 140 000 people were affected by the floods.

According to the 2014–2016 Mauritania Humanitarian Needs Overview, 531 000 people (315 200 children) will require assistance, including 141 000 malnourished, 190 000 severely food insecure, 60 000 refugees and 140 000 affected by the floods.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	156/188
Population in urban areas%	2015	59.8
Population using improved water source%	2015	57.9
Population using improved sanitation%	2015	40
Life expectancy at birth (years)	2015	62.7
Infant mortality rate / 1000 <sup>2</sup>	2015	65.1
Under 5 mortality rate / 1000 <sup>2</sup>	2015	84.7
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	602
Measles coverage among one year old's%	2014	84

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Mauritania from the Central Emergency Response Fund.

## Funding for 2016

Health partners	US\$	4 864 521
WHO	US\$	3 916 000

## Health Sector Situation

There is a continuing need for life-saving interventions such as treatment for acute malnutrition (there were over 2120 severe acute malnutrition cases in 2014); measles vaccination; and the provision of clean water.

Only 464 out of 714 health facilities are currently providing integrated management services for acute malnutrition.

## Health Sector Objectives

### Objective 1: Respond to the humanitarian consequences of malnutrition within eight vulnerable areas.

#### Planned outputs:

- Centre de Récupération Nutritionnelle en Interne and Centre de Récupération Nutritionnelle Ambulatoire equipped with medicines and supplies necessary for the management of severe acute malnutrition and moderate acute malnutrition and malnourished pregnant and lactating women.
- Health workers trained.
- Supervision and monitoring provided.
- Children and women immunized.
- Populations informed and sensitized on the prevention of malnutrition.
- Health facilities equipped with medicines for the treatment of common diseases.
- Capacities of health facilities offering obstetric and neonatal emergency care are strengthened.

### Objective 2: Respond to the humanitarian consequences of epidemics (e.g. cholera, malaria, etc.) including Ebola virus disease affecting the sub-region within eight vulnerable areas with the border areas with Senegal, Mali and the wilaya of Nouadhibou.

#### Planned outputs:

- Health facilities equipped with personal protection equipment, disinfectants and medicines for the treatment of epidemics, including Ebola.
- Health workers trained.
- Laboratory equipped for the diagnosis of Ebola epidemics including: Ebola treatment centre equipped and functional; functional border watch sites; epidemiological surveillance for the early detection, enhanced early warning; local health structures supported for collection, processing and analysis of data.

**Objective 3: Respond to the humanitarian consequences of natural disasters (e.g. drought, floods, bushfire, etc.) within eight vulnerable areas.**

Planned outputs:

- Health facilities equipped and drugs for the treatment of cases.
- Trained staff.
- Population sensitized and informed.
- Provide intermittent preventive treatment, supplementation with folic acid, iron and zinc, routine vaccination and enhanced distribution of long lasting insecticide treated nets.
- Drinking water supply structure available.
- Regional coordination supported.

**Beneficiaries targeted by health partners in 2016**

Health partners will target 198 000 people including children under five years old suffering from severe acute malnutrition and malnourished pregnant and lactating women requiring humanitarian assistance.

**Geographical areas targeted by health partners in 2016**

Health partners are targeting health districts (22) in seven regions:

Districts: Amourj, Kobeni, Tichitt, Kankossa, Barkéol, Sélibaby, M'bout, Monguel, Oualata, Ould Yengé, Bababé, Boghé, M 'Bagne, Kaédi, Maghama, Tidjikja, Guerou, Boumdeid, Kiffa, Djigueni, Nema, Moudjeria

**Health partners funding requirements for 2016**

US\$ 4 864 521 (health partners including WHO)

**WHO funding requirements for 2016**

WHO is requesting a total of US\$ 3 916 000

<b>WHO projects</b>	<b>Requested funds (US\$)</b>
Support for children with DSS in the 23 targeted moughataa <b>MRT-16/H/86456</b>	715 000
Support the capacity building in the 23 moughataa health structures targeted for the prevention and control of common diseases associated with malnutrition and maternal and child health <b>MRT-16/H/86465</b>	1 111 000
Support the prevention and response to epidemics and emergencies including Ebola in food insecure regions <b>MRT-16/H/86637</b>	2 090 000



# Myanmar

The number of people in need of humanitarian assistance in Myanmar rose to 1 020 000 following floods that affected 460 000 people in August 2015. The worst effects were felt in Rakhine State, the poorest and least-developed part of Myanmar,

Other groups needing humanitarian assistance include: 240 000 people internally displaced by long-running armed conflicts and inter-communal tension; 192 000 people affected by these crises but not displaced; and 120 000 people in communities struggling to host those displaced by the conflict.

Rakhine, Kachin and Shan States bear the brunt of these crises. In Rakhine State, the situation is most critical for the state's internally displaced people (IDPs). Many IDPs live in overcrowded and temporary accommodation. While some IDPs in Rakhine State are being helped by the government to return home and build new dwellings, humanitarian access to populations in conflict affected areas in Kachin and Shan States remains severely restricted.

An estimated 20 000 people are hosting IDPs across Kachin and northern Shan states alone. Prolonged displacement has put a strain on the displaced and on host communities who have exhausted their resources and require support.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	171/188
Population in urban areas%	2015	26.7
Population using improved water source%	2015	55.3
Population using improved sanitation%	2015	31.9
Life expectancy at birth (years)	2015	69.8
Infant mortality rate / 1000 <sup>2</sup>	2015	66.3
Under 5 mortality rate / 1000 <sup>2</sup>	2015	91.1
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	396
Measles coverage among one year old's%	2014	66

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Myanmar from the Central Emergency Response Fund.

## Funding for 2016

Health Cluster	US\$	22 900 000
WHO	US\$	4 100 000

## Health Sector Situation

Improving equitable access to health care remained a challenge in 2015, with mid-year monitoring indicating that, in Rakhine State, only 60% of the 105 000 targeted IDPs had access to basic health care services. This was largely due to restrictions on freedom of movement, logistical and security constraints, insufficient quality health care services and medical supplies, and limited skilled staff to support health operations.

After several years of displacement, the majority of IDPs in Kachin, Shan and Rakhine States continue to rely on essential health-care services provided by the 19 Health Cluster partners. The primary focus in 2016 is to continue to provide life-saving health interventions through a package of primary health care services, including referrals to secondary care in state-run hospitals.

## 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:

- Provide 537 399 vulnerable people with access to basic health care services.
- Provide 348 000 vulnerable people with access to reproductive, maternal and child health care, including emergency obstetric care.
- Vaccinate 90% of children under the age of two years (33 700) 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 reproductive, maternal, adolescent and child health services through increased attention to children with disabilities.

- Improve systems for hospital referral, including inpatient services, weekend and boat referrals.
- Address the critical shortage of trained health workers through training qualified displaced persons.
- Strengthen disease surveillance, outbreak control and response.
- Support routine immunization.
- Develop protocols and conduct 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 good hygiene and nutrition practices in collaboration with the WASH cluster and the Nutrition sector respectively.
- Increase access to mental health and psychosocial support services, through the provision of additional support to existing vulnerable groups within the caseload and linking with available protection and gender-based violence referral pathways.
- Support the expansion of national health-care service coverage to displaced people to progressively reduce the reliance on health partners.

### Beneficiaries targeted by health partners in 2016

Health partners are targeting 537 772 people in 2016. These include:

- 211 421 internally displaced people (IDPs) in camps, collective centres or self-settled.
- 177 290 people affected by armed conflict, inter-communal tensions or other crises in Rakhine State, but not displaced.
- 28 894 IDPs in host families or other individual accommodation.
- 120 000 crisis-affected people in communities hosting or surrounding IDPs.

### Geographical areas targeted by health partners in 2016

Health partners will continue to target Rakhine State, Kachin State and Shan State.

### Health Cluster funding requirements for 2016

US\$ 22 900 000 (health partners including WHO)

### WHO funding requirements for 2016

WHO is appealing for a total of US\$ 4 100 000

Health Cluster project	Requested funds (US\$)
Health Cluster requirements <b>MM-16/H/91776/R</b>	22 900 000



# Niger

Niger’s humanitarian situation is the result of a complex mix of armed violence, malnutrition, food insecurity, epidemics and floods. Most people affected by these crises need assistance with access to shelter and non-food goods, water, health care and education. Around two million people will need humanitarian assistance in 2016.

The nutritional situation in Niger remains a major challenge, with global acute malnutrition rates of 15%. More than one million children suffering from acute malnutrition are expected in feeding centres in 2016.

The actions of Boko Haram in the Diffa region and in the Lake Chad Islands, and instability along the border with Mali, have forced hundreds of thousands of people to flee violence. Due to its proximity relative with Algeria and Libya, Niger has also become a migration route to Europe for tens of thousands of people. But many are extremely vulnerable as they reach Niger and need to rely on humanitarian assistance.

In August 2015, about 213 000 refugees, returnees and internally displaced people were identified in the Diffa region. They mainly live with host families (an estimated 150 000 people). The state of emergency is still in force in the region, suspending local trade routes and thereby increasing the vulnerability of local populations already faced with lack of basic social services.

To the west of Niger, instability in northern Mali continues to cause displacement of people to the regions of Tillabery and Tahoua. The level of vulnerability of newcomers and the improbability that they will be able to return to Mali in the near future requires a strengthening of humanitarian assistance.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	188/188
Population in urban areas%	2015	18.7
Population using improved water source%	2015	68.5
Population using improved sanitation%	2015	10.9
Life expectancy at birth (years)	2015	60.6
Infant mortality rate / 1000 <sup>2</sup>	2015	57.1
Under 5 mortality rate / 1000 <sup>2</sup>	2015	95.5
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	553
Measles coverage among one year old's%	2014	72

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Niger from Japan and the Central Emergency Response Fund.

## Funding for 2016

Health Cluster	US\$	9 886 604
WHO	US\$	7 220 895

## Health Sector Situation

Niger’s food insecurity and chronic malnutrition exist against a backdrop resurgent epidemics such as cholera, measles and meningitis.

The Health Cluster will focus its priority interventions in high-risk areas of cholera, meningitis, measles, and those receiving the displaced, returnees and refugees. Children under five, pregnant women, the elderly and chronically ill people who have interrupted their treatments following the travel will be targeted. The strategy aims to strengthen the resilience of the health system and communities to epidemics and health-emergency consequences by strengthening coordination.

The main activities are: protection (the clinical management of gender-based violence); nutrition (the management of medical complications of malnutrition); the fight against cholera; preparedness and response to the Ebola virus disease; reproductive health, prevention and management of STIs / HIV / AIDS, the management of chronic diseases and mental health.

## Health Cluster Objectives

**Objective 1: Improve access and quality primary health care, including for reproductive health and HIV/AIDS in vulnerable areas targeted.**

**Objective 2: Achieve prevention, preparedness and appropriate response to epidemic disease potential and other health disasters and emergencies.**

**Objective 3: Reinforce coordination of emergency health interventions.**



## Beneficiaries targeted by health partners in 2016

Health partners are targeting 725 000 people in 2016. These include:

- 100 000 refugees
- 25 000 migrants
- 100 000 internally displaced people
- 50 000 returnees
- 150 000 people in host communities
- 300 000 others

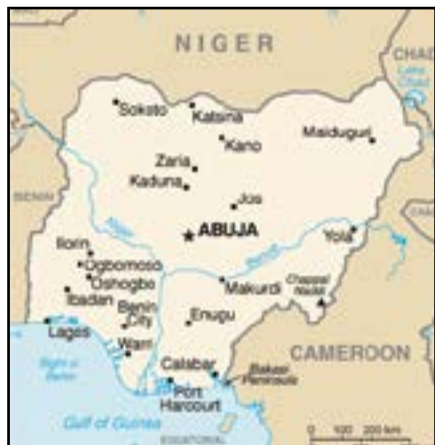
## Health Cluster funding requirements for 2016

US\$ 9 886 604 (health partners including WHO)

## WHO funding requirements for 2016

WHO is appealing for a total of US\$ 7 220 895

Health Cluster projects	Requested funds (US\$)
Preparation and health emergency response to major diseases with epidemic potential in Niger <b>NIG-16/H/85000/122</b>	4 483 193
Réponse d'urgence aux besoins sanitaires des populations des districts sanitaires accueillant les réfugiés nigériens et maliens dans les régions <b>NIG-16/H/86355/122</b>	920 414
Emergency response to the health needs of the populations of the health districts welcoming Nigerian and Malian refugees in regions <b>NIG-16/H/86360/122</b>	823 900
Strengthening of the resilience of the health system of Niger to resist to the negative impacts of outbreaks and other health emergencies <b>NIG-16/H/86365</b>	993 388



# Nigeria

Violent attacks since 2009 on civilians by Boko Haram have caused widespread devastation in north eastern Nigeria, generating a crisis that now affects more than 14.8 million people in Adamawa, Borno, Gombe and Yobe States. More than 2.2 million people have fled their homes and 7 million are estimated to be in need of humanitarian assistance. An estimated 3 million people lived in unknown conditions in inaccessible areas in 2015.

Borno State capital, Maiduguri, has received more than 1 million internally displaced people (IDPs). This has overwhelmed the delivery of basic services and created overcrowding in already inadequate living conditions, posing massive environmental and sanitation risks. More than 1000 people contracted cholera and 17 have died in Maiduguri since September 2015, in an outbreak that started in an IDP camp and spread to nearby areas.

Communicable disease outbreaks continue to challenge the health system. The Lassa fever outbreak currently ongoing is an example of the difficulties to detect and follow up on suspected cases when access to communities remain restricted and health workers face shortages on basic equipment and drugs to implement appropriate case management.

For more than one year, already-poor host communities have been sharing resources with one of the largest IDP populations in the world.– with little support. This is exhausting household and community resources and beginning to cause tension between displaced and host communities, potentially leading to secondary displacement of IDPs.

Poor rains and lack of access to agricultural lands have negatively affected food production, helping push the number of people in need of food assistance to 3.3 million. The impact of the crisis has spread to neighbouring countries with Nigerians seeking refuge in Cameroon, Niger and Chad.

With front lines shifting in the conflict, people are returning to their place of origin only to find that basic infrastructures, including health, have been destroyed. Providing services to returnees must be a priority.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	152/188
Population in urban areas%	2015	47.7
Population using improved water source%	2015	68.5
Population using improved sanitation%	2015	29
Life expectancy at birth (years)	2015	52.2
Infant mortality rate / 1000 <sup>2</sup>	2015	69.4
Under 5 mortality rate / 1000 <sup>2</sup>	2015	108.8
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	814
Measles coverage among one year old's%	2014	51

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Nigeria from Japan.

## Funding for 2016

Health partners	US\$	24 748 290
WHO	US\$	5 031 200

## Health Sector Situation

Health facilities have been targeted during the conflict, restricting access to basic services and deterring health care professionals from working in areas where they are most needed. Since the conflict started, 72% of health centres have been damaged or destroyed in Yobe and 60% in Borno.

Reliable health data from the region is a challenge, mainly due to inaccessibility of most conflict areas. A combination of secondary review of available data from the pre-conflict period, individual agency assessments, surveillance data and expert opinion were used to determine the needs for 2016.

The maternal mortality ratio in Borno and Yobe are as high as 1500 – 2000 per 100 000 live births compared to the national average of 576 per 100 000 live births. Under-five mortality is 192 in Borno and 240 in Yobe, which are above the national average of 157.

There is an urgent need to provide integrated basic health services including reproductive health services in Adamawa, Borno, Gombe and Yobe to prevent further deterioration of the health situation and prevent increasing mortality and morbidity.

Young children and the elderly are particularly vulnerable and require life-saving maternal and child health interventions, along with management for chronic non-communicable disease to decrease morbidity and mortality.

## Health Partners Objectives

### Objective 1: Deliver coordinated and integrated emergency life-saving health intervention to the population affected by the crisis.

Planned outputs:

- Provide life-saving integrated basic primary health care services in relation to immunization, integrated management of childhood illnesses maternal, child and neonatal health, referral, HIV services and management of common conditions including non-communicable diseases for IDPs and host communities.
- Deliver psychosocial and mental health services.
- Provide care for conflict-related trauma.

### Objective 2: Continual monitoring of health risks and vulnerabilities of the affected population and integrate findings to improve the health response.

Planned outputs:

- Conduct joint health sector assessment and continuous monitoring to provide evidence for sector response.

### Objective 3: Strengthen existing health system capacity to respond to health emergencies and foster early recovery and resilience.

Planned outputs:

- Rehabilitate destroyed or damaged health facilities in the north-east to ensure equitable access to health services where applicable.
- Strengthen and expand early warning alert and response system (EWARS) for epidemic prone diseases.
- Strengthen capacity of health authorities' at all three government levels for health emergency response.

## Beneficiaries targeted by health partners in 2016

Health partners will target 2.6 million people including:

- 1 776 645 million vulnerable host community members
- 832 232 internally displaced people

## Geographical areas targeted by health partners in 2016

Health partners will focus their response on the states particularly affected by Boko Haram-related violence and its aftermath – Borno, Adamawa, Yobe and Gombe.

## Health partners funding requirements for 2016

US\$ 24 748 290 (health partners including WHO)

## WHO funding requirements for 2016

WHO is appealing for a total of US\$ 5 031 200

Health partners projects	Requested funds (US\$)
Strengthening capacity of frontline healthcare providers to save maternal and new-born lives around the perinatal period at primary health care facilities in IDPs camp and host communities <b>NGA-16/H/84873/122</b>	695 000
Strengthening information and accountability for women's and children's health in Adamawa, Borno, Yobe and Gombe states <b>NGA-16/H/84904/122</b>	686 000
Provision of Mental Health in Emergencies Services in IDP Camps and Host Communities in Borno, Yobe, Adamawa and Gombe States <b>NGA-16/H/85580/122</b>	990 200
Provision of coordinated, lifesaving basic primary health care services and Early Warning Alert and Response System for the affected communities in the north east <b>NGA-16/H/85729</b>	2 660 000



## occupied Palestinian territory

The protracted crisis in the occupied Palestinian territory is now approaching its 50th year and continues to be characterized by conflict, lack of access to basic services and frequent outbreaks of violence. In October 2015 the conflict, including violent clashes between Palestinian civilians and Israeli forces, escalated and spread out from East Jerusalem. In the Gaza Strip, basic infrastructure and services have deteriorated due to years of blockade and outbreaks of hostilities.

Across the occupied Palestinian territory there is 26% food insecurity and 25% poverty. OCHA estimates that 2.3 million people need humanitarian assistance, including 1.2 million refugees.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	113/188
Population in urban areas%	2014	74
Population using improved water source%	2015	58.4
Population using improved sanitation%	2015	92.3
Life expectancy at birth (years)	2015	72.6
Infant mortality rate / 1000 <sup>2</sup>	2014	18
Under 5 mortality rate / 1000 <sup>2</sup>	2014	21
Maternal mortality ratio / 100 000 <sup>2</sup>	2013	47
Measles coverage among one year old's%	2014	99

Source (unless otherwise indicated by a footnote): WHOEMRO Regional Health Observatory. References on page 62.

### Acknowledgement

In 2015 WHO did not receive financial contributions to support its humanitarian work in the occupied Palestinian territory.

### Funding for 2016

Health and Nutrition Cluster	US\$	25 765 842
WHO	US\$	3 556 728

### Health Sector Situation

The protracted occupation and blockade has had a direct impact on the health of Palestinians, for example, from violence-related deaths, traumas and injuries, and mental health disorders. There are also indirect impacts as a result of obstacles to the essential health and nutrition services, which represent a violation of the right to health. The internal Palestinian divide has also affected the quality and availability of health care in Gaza.

### Health Cluster Objectives

**Objective 1: Providing access to quality and affordable primary health care and nutrition services in the West Bank, namely in Area C, in East Jerusalem and in the Gaza Strip in areas or to groups where access is lacking.**

Planned outputs:

- Vulnerable communities in the Gaza Strip and the West Bank are ensured access to quality and affordable health services, and referral of victims of violence to protection organizations.

**Objective 2: Providing access to emergency services, particularly during crises in the West Bank and the Gaza Strip.**

Planned outputs:

- Vulnerable communities in the West Bank and Gaza are better prepared to cope with the impact of current and potential new man-made and natural disasters.

**Objective 3: Strengthening emergency preparedness, coping capacity and the resilience of communities to potential future conflicts in the occupied Palestinian territory.**

Planned outputs:

- Vulnerable communities in the West Bank and Gaza are better prepared to cope with the impact of current and potential new man-made and natural disasters.

### Beneficiaries targeted by health partners in 2016

The Health and Nutrition Cluster is planning to target over one million people (Gaza: 809 641 West Bank: 210 257).

Prioritized vulnerable groups include neonates, those injured with long term impairment and disabilities, children under five, people with chronic diseases, pregnant and lactating women and survivors of conflict and gender based violence.

## Geographical areas targeted by health partners in 2016

The targeted population includes those living in the catchment of totally destroyed primary health care centres and in the ARA in Gaza, people in Area C and East Jerusalem and refugees living outside camps..

## Health and Nutrition Cluster funding requirements for 2016

US\$ 25 765 842 (health partners including WHO)

## WHO funding requirements for 2016

WHO is appealing for a total of US\$ 3 556 728

<b>WHO projects</b>	<b>Requested funds (US\$)</b>
Protecting Right to Health in the occupied Palestinian territory through advocacy <b>OPT-16/H/86589</b>	214 000
Strengthening health information and coordination in emergency for more effective humanitarian health action in the occupied Palestinian territory <b>OPT-16/H/87376/122</b>	535 000
Procurement of essential pharmaceuticals to leukaemia and haemophilia patients in Gaza <b>OPT-16/H/87849/122</b>	2 272 728
Support robust and coordinated emergency response mechanisms for East Jerusalem Hospitals <b>OPT-16/H/87856/122</b>	535 000



## Sahel Regional Response Plan

Africa's fastest growing displacement crisis is unfolding in the Lake Chad Basin, where the lives and livelihoods of some 30 million people in the poorest parts of Cameroon, Chad, Niger and Nigeria are threatened by Boko Haram.

Life-saving humanitarian assistance is needed to help millions of people in the Sahel region because of the triple crises of food insecurity and malnutrition, conflict, and epidemics. At least 6 million people across nine countries (Burkina Faso, Chad, Cameroon, Gambia, Mali, Mauritania, Niger, Nigeria and Senegal) face severe food insecurity and require urgent assistance. More than 4.5 million people have been displaced from their homes, lost livelihoods or are hosted in already highly vulnerable communities.

Malnutrition remains high, with 7.2 million children under five years old and pregnant and lactating women in need of assistance in 2016 – an estimated 5.9 million of them are projected to suffer from global acute malnutrition, and 1.9 million estimated to need treatment for severe acute malnutrition.

Women and girls kidnapped by Boko Haram have been subjected to physical and psychological abuse. Boys have been forcibly enrolled as combatants. As of December 2015, an estimated 9.1 million people need urgent assistance and protection.

The situation in Mali continues to be of concern with persisting insecurity and around 200 000 Malians displaced. In addition, an anarchic Libya, a deteriorating situation in Darfur, and the return to civil war in the Central African Republic continue to compound the region's chronic difficulties.

### Health Sector Situation

Shortages of essential medicines and vaccines remain an enduring weakness of many health systems throughout the Sahel region, with particularly concerning situations in conflict-affected areas where access to health services is often severely constrained. Humanitarian health needs fall primarily in the category of prevention and treatment of infectious diseases, including epidemic-prone illnesses such as cholera, Ebola virus disease, measles and meningitis – the risk of which continues to threaten communities across the region.

Recent cholera outbreaks in internally displaced people's camps in Nigeria are a cause for concern. Between January and September 2015, 4639 cholera cases, including 184 deaths, were reported Nigeria, Cameroon and Niger – 97% of these were reported from Nigeria. As of September 2015, a total of 21 936 suspected cases of meningitis were reported in the nine countries, resulting in 1611 deaths, while Lassa fever and yellow fever remain serious risks. In addition, in 2015 there were more than 40 000 cases of measles.

While the worst-ever Ebola outbreak that ravaged West Africa saw only a small number of cases in Sahel countries, strengthening health systems, surveillance and prevention remains critical to keep Ebola and other epidemic diseases at bay. Avian influenza further threatens livelihoods, particularly in Burkina Faso and parts of Nigeria.

### Health Sector Objectives

Priority areas for health sector partners in the Sahel for 2016 include:

**Priority 1: Track and analyse risk and vulnerability, integrating findings into humanitarian and development programming.**

**Priority 2: Support vulnerable populations to better cope with shocks by responding earlier to warning signals, by reducing post-crisis recovery times and by building capacity of national actors.**

**Priority 3: Deliver coordinated and integrated life-saving assistance to people affected by emergencies.**

Planned outcomes include:

- 114 951 births assisted by a skilled attendant in districts supported by cluster members.
- 2520 epidemiological reports completed and received at a central level.
- 2.6 million outpatient consultations in districts supported by cluster members.
- 293 791 children under five years old vaccinated against measles in districts supported by cluster members.

### **Beneficiaries targeted by health partners in 2016**

Health partners are targeting a total of 6.9 million people.

### **Geographical areas targeted by health partners in 2016**

The nine countries included in this regional response plan are Burkina Faso, Chad, Cameroon, Gambia, Mali, Mauritania, Niger, Nigeria and Senegal

### **Health sector funding requirements for 2016**

Health partners, including WHO, are appealing for a total of US\$ 116 600 000 for 2016

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





# Somalia

The humanitarian crisis in Somalia is one of the most complex protracted emergencies in the world. Resurgent conflict across the country and endemic environmental hazards have left the majority of Somalia’s 12.3 million people chronically or acutely vulnerable. About 4.9 million people were in need of humanitarian assistance as of September 2015.

Malnutrition rates remain high with about 308 000 children under five years old acutely malnourished and 56 000 children severely malnourished, while the overall burden of acute malnutrition in 2016 is estimated at be more than 800 000 cases. Health conditions remain worrying, with frequent outbreaks of acute watery diarrhoea and measles.

Internally displaced people are particularly vulnerable and make up more than 58% of those food insecure. Over 1.1 million remain in an ongoing internal displacement situation with no adequate access to basic services and livelihoods. Refugees and returnees fleeing the Yemen crisis continue to arrive in Somalia, and as of late November 2015 close to 30 000 had arrived in Puntland, Somaliland, and southern and central Somalia.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	NA
Population in urban areas%	2015	39.5
Population using improved water source%	2010	31
Population using improved sanitation%	2010	23
Life expectancy at birth (years)	2015	54.8
Infant mortality rate / 1000 <sup>2</sup>	2015	85
Under 5 mortality rate / 1000 <sup>2</sup>	2015	136.8
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	732
Measles coverage among one year old's%	2014	46

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Somalia from the Central Emergency Response Fund and the United Nations Development Program Common Humanitarian Fund.

## Funding for 2016

Health Cluster	US\$	71 180 216
WHO	US\$	14 050 727

## Health Sector Situation

Essential and life-saving medical services are insufficient and overstretched, including critical public health, nutrition and water services, which increases the risk of outbreaks. Delivery of life-saving medicines and medical equipment has been irregular because of insecurity, road inaccessibility, and electricity and fuel shortages. Access to essential health services is an immediate need for around 3.3 million people, with health capacities severely overburdened, stocks diminished and services disrupted, especially in conflict, drought and flood-affected areas.

Child-focused interventions will include emergency immunization against measles and polio, and addressing major causes of newborn and childhood morbidity and mortality.

With low immunity levels, overcrowding in camps and shelters and continued displacement, there is a high risk of communicable disease outbreaks of measles, cholera, meningitis, acute jaundice syndrome and leishmaniasis. Timely identification, treatment, and case management for communicable diseases and response to outbreaks will be managed through a functional early warning system and increased availability of stocks of medicines, vaccines and medical supplies.

Health Cluster partners plan to reach about 1.9 million people, or 56% of the people in need of assistance with health care. This assistance will be through the provision of primary and secondary health care services, focusing on displaced people, host communities, underserved rural and urban areas (including newly recovered areas), and people affected by drought and the El Niño weather pattern.

## Health Cluster Objectives

**Objective I: Improved access to essential life-saving health services (quality primary and secondary health care) for crisis-affected populations aimed at reducing avoidable morbidity and mortality.**

Planned outputs:

- 57% of health facilities providing minimum basic package of primary health care services (treatment of common diseases, immunization, antenatal care, provision of essential drugs, nutrition).
- 57% of population covered by functioning health facility.
- 28 members of the health workforce (doctor, nurse, midwife) per 10 000 people.
- One secondary health care facility/hospital providing comprehensive emergency obstetric care per 500 000 people in crises-affected areas.

**Objective 2: To contribute to the reduction of maternal and child morbidity and mortality.**

Planned outputs:

- 8 health facilities with basic emergency obstetric care per 500 000 people.
- 85% of children below one year receiving Penta 3 vaccine.
- 90% of children under one year receiving measles vaccine.
- 70% of births assisted by skilled birth attendant.

**Objective 3: Strengthened and expanded early warning disease detection to mitigate, detect and respond to disease outbreaks in a timely manner.**

Planned outputs:

- 1% case fatality rate in relation to acute watery diarrhoea and cholera outbreaks.

## Beneficiaries targeted by health partners in 2016

Health partners are targeting 1.9 million people in 2016.

## Health Cluster funding requirements for 2016

US\$ 71 180 216 (health partners including WHO)

## WHO funding requirements for 2016

WHO is appealing for a total of US\$ 14 050 727

WHO projects	Requested funds (US\$)
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 <b>SOM-16/H/85026/122</b>	1 414 400
Provision of life saving child health services to vulnerable population, through integrated measles campaign <b>SOM-16/H/85813/122</b>	3 092 120
Disease surveillance/Early Warning and Outbreak Response including first responder kits and public health events of international concern <b>SOM-16/H/85835/122</b>	1 840 000
Establishing and strengthening functioning health facilities for primary and essential health services post- disasters including referral <b>SOM-16/H/86723/122</b>	2 010 250
Saving lives in Somalia through Integrated Management of Emergency Surgery and Comprehensive Emergency Obstetric Care <b>SOM-16/H/86763/122</b>	2 830 500
Strengthening routine expanded programme on immunization services in 37 priority districts of Somalia <b>SOM-16/H/87049/122</b>	1 038 507
Vector-borne diseases control among IDPs/refugees, vulnerable communities affected by conflict and disasters <b>SOM-16/H/88295/122</b>	1 824 950



# South Sudan

As 2015 ended, South Sudan's people faced multiple threats, including the armed conflict that began in 2013, inter-communal violence, disease and climatic shocks. More than 2.3 million people (20% of the population) have fled their homes since 2013. There are now 1.66 million internally displaced people (IDPs), with 50% estimated to be children.

Hunger is widespread. By September 2015 there were 3.9 million people severely food insecure. An estimated 30 000 people face a level of 'catastrophic food insecurity' that can lead to starvation, death and destitution.

More than 686 200 children under the age of five years old are estimated to be acutely malnourished, including more than 231 300 severely malnourished. Mortality has been exacerbated by acute malnutrition and disease. Malaria the biggest recorded killer, with more than 1 100 deaths reported in health facilities between January and October 2015. Sexual and gender-based violence is also pervasive.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	169/188
Population in urban areas%	2015	18.8
Population using improved water source%	2015	58.7
Population using improved sanitation%	2015	6.7
Life expectancy at birth (years)	2015	55
Infant mortality rate / 1000 <sup>2</sup>	2015	60.3
Under 5 mortality rate / 1000 <sup>2</sup>	2015	92.6
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	789
Measles coverage among one year old's%	2014	22

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Health Sector Situation

An estimated 4.42 million people are in need of emergency health care, including people with no access to health care due to the combination of conflict, economic downturn, drug shortages, lack of funding for health infrastructure and health workers, and inadequate vaccination coverage. In addition, some 304 000 refugees are expected to need health assistance in 2016. Displacement has caused a severe shortage of skilled human resources to respond to frontline health needs – there is only one doctor per 65 000 patients.

Health facilities have been attacked, damaged and looted. As of September 2015, some 55% of the health facilities in Unity State, Upper Nile State and Jonglei were no longer functioning. In Unity, there is only one county hospital for more than one million people.

Displaced people face the greatest challenges accessing health care, particularly in Unity, Upper Nile, Jonglei, Warrap and Western Bahr Ghazal states. Reproductive health and psychosocial services are limited. Women are at risk of dying during childbirth. There are only 12 trained midwives, one anaesthetist and one obstetrician/gynaecologist per 200 000 people in South Sudan. There are no paediatricians in South Sudan.

Vaccination, malnutrition screening and antenatal care have been interrupted, while surgery and referral services are limited or non-existent, as are services to manage HIV, TB and mental health. Essential medicine shortages are likely to exacerbate the already critical situation. Communicable diseases are a concern throughout the country due to poor sanitation, lack of access to safe water and crowded living conditions. There has been a notable upsurge in the scale and frequency of outbreaks of epidemic prone diseases, especially in displacement sites where malnutrition and poor immunity makes young children and pregnant women particularly vulnerable.

## Acknowledgement

In 2015 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, Japan, the United Nations Organization for the Coordination of Humanitarian Affairs Common Humanitarian Fund and Emergency Response Fund and the United States of America.

## Funding for 2016

Health Cluster	US\$	110 000 000
WHO	US\$	17 573 457

## Health Cluster Objectives

**Objective 1: Improve access, and scale-up responsiveness to, essential emergency health care, including addressing the major causes of mortality among children under five years old (malaria, diarrhoea and pneumonia), emergency obstetric care and neonate services in conflict affected and vulnerable populations.**

**Objective 2: Prevent, detect and respond to epidemic prone disease outbreaks in conflict affected and vulnerable populations.**

**Objective 3: Improve access to psychosocial support and mental health services for the vulnerable population, including those services related to the sexual and gender-based violence response.**

In order to maximize impact, the Health Cluster will focus on integrated health and nutrition life-saving packages to support life-saving referral mechanisms and rapid response modalities.

Planned outcomes include:

- Support the scale-up of disease surveillance, prevention and response at facility and community level, including through expanded immunization coverage in high-risk areas with lowest coverage.
- Provide support for basic restoration of closed or damaged health facilities in conflict-affected states.
- Address the specific needs of highly vulnerable groups, including severely malnourished children, those affected by sexual and gender-based violence (particularly through increasing access to clinical management of rape), people with psychosocial distress, the elderly and people with HIV/AIDS and TB.
- Strengthening reporting mechanisms to monitor community-level mortality data.

### Beneficiaries targeted by health partners in 2016

Health partners will target 2 355 799 people (811 470 IDPs; 118 093 refugees; 1 426 236 people in host communities)

### Health Cluster funding requirements for 2016

US\$ 110 000 000 (health partners including WHO)

### WHO funding requirements for 2016

WHO is appealing for a total of US\$ 17 573 457

WHO projects	Requested funds (US\$)
Measles follow-up/mass campaign for the three conflict affected states (Jonglei, Upper Nile and Unity) in South Sudan <b>SSD-16/H/89641/122</b>	2 373 457
Provision of quality life saving health services and responding to health related emergencies (core pipeline supplies, enhancing outbreak preparedness and response, trauma management), affecting the vulnerable populations of South Sudan <b>SSD-16/H/89661</b>	15 200 000



## South Sudan Regional Refugee Response Plan

Despite the Resolution of the Conflict in the Republic of South Sudan, signed by the warring parties in August 2015, the volatile situation in the country with violations of the ceasefire and the vulnerability of its population, continues to prompt South Sudanese to keep seek refuge in neighbouring countries. While over 1.6 million people are displaced inside South Sudan, more than 700 000 sought asylum in the neighbouring countries of Ethiopia, Kenya, Sudan and Uganda since the current conflict broke out. Additionally, another 121 000 South Sudanese who were already refugees before December 2013 find themselves trapped in countries of asylum, without the possibility of returning home. The total number of South Sudanese refugees could exceed 938 000 by the end of 2016.

### ETHIOPIA

#### Health and nutrition situation

Ethiopia hosts over 326 000 South Sudanese refugees. Despite the improvements in access to health services, the number of available health facilities is insufficient to cater for the needs of the increasing refugee population. Currently, one health facility serves an average of 15 000 refugees, as opposed to the standard of one facility per 10 000. Malaria is a major disease among the refugee population with crude incidence rates ranged between 9.4 in Jewi and 55.5 in Kule at the end of September 2015.

Hepatitis E outbreaks were reported from refugee sites in Gambella, particularly in Kule camp, affecting 1082 individuals between March 2014 and September 2015. HIV/AIDS prevalence among pregnant women is higher in the Gambella refugee camps as compared to other camps in Ethiopia. Okugo refugee camp has seen an increased infection rate of new HIV cases. In combination with high rates of other sexually-transmitted infections, broader interventions are needed to prevent transmission. Given the severe drought, household food consumption is expected to decrease, and acute malnutrition is expected to increase across the camps in Gambella.

#### Health and Nutrition Sector partners planned activities

**Health services:** Implement primary health care service package focusing on curative, preventive and promotion of health care; upgrade primary health facilities at camp level to semi-permanent structures; provide medical equipment and supplies (including ambulances); establish additional health centres/health posts to reach the standard of one health centre/10 000 refugees; procure essential drugs; provide HIV/AIDS and tuberculosis prevention, care and treatment services; support referral to secondary and tertiary health care facilities; provide prosthetic, orthotic, and mobility aid services.

**Immunization and preventative care:** Maintain outbreak response preparedness and immunization services for new arrivals and provide vitamin A supplements and deworming to children 1-5 years; enhance community-based preventive health services by involving health workers in the refugee population for effective communication and health services support.

**Nutrition:** Triage and management of acute malnutrition in the outpatient therapeutic programs, stabilization centre programmes, targeted supplementary feeding programmes for about 6900 severe acute malnutrition and 15 700

#### Funding for 2016

Health and nutrition partners US\$ 83 295 985  
 WHO US\$ 14 124 600

moderate acute malnutrition cases; promote, protect and support optimal infant and young child nutrition at entry points and in the camps for 13 500 pregnant and lactating women; procure and provide 187 000 kilograms of ready to use therapeutic foods; F100 milk, F75 milk and Plumpy-nut to all malnourished children; provide blanket supplementary feeding programmes at entry points and in camps and micronutrient supplements for children 6-59 months and pregnant and lactating women; conduct community outreach activities including malnutrition screening systematic Mid Upper Arm Circumference (MUAC) to monitor acute malnutrition trends and provision of nutrition messages; conduct annual refugees Standardised Expanded Nutrition Survey.

### **Health and Nutrition Sector partners**

ACF, ADRA, Concern Worldwide, DCA, DICAC, DRC, ERCS, GOAL, HelpAge, IMC, IOM, IRC, LWF, MCMDO, NCA/DCA/DASSC, NRC, NRDEP, Oxfam, Plan International, RaDO, SCI, UNHCR, UNICEF, WFP, WVI, ZOA International.

### **Health and Nutrition partners funding requirements for 2016**

US\$ 34 242 764

## **KENYA**

### **Health and nutrition situation**

Kenya hosts over 102 000 refugees from South Sudan, out of which 48 000 arrived as a result of the 2013 conflict. Most of them reside in Kakuma refugee camp, in north-western Kenya. The arrival of new South Sudanese refugees in Kakuma has overstretched the health system beyond its capacity, since they access the same services provided to the old refugee population. As a result, consultations per clinician remains high at 92 consultations per clinician per day compared with UNHCR standard of 50 consultations per clinician per day and the bed occupancy is above 100%, implying that patients have to share beds. The situation is further worsened by increased incidence of communicable diseases such as watery diarrhoea and respiratory tract infections due to overcrowding and increased competition for water. In the nutrition sector, the operation normally records a high number of children who are malnourished or at risk of malnutrition. The high numbers of children in the feeding programmes overstretches the staffing and facilities compromising the quality of services, more so in monitoring the growth of children from birth to five years of age. High numbers have been recorded in the blanket supplementary feeding programme (BSFP) for children aged 6-23 months.

The health and nutritional status of the refugees is relatively stable as evidenced by indicators, which are within Sphere standards. The crude mortality is 0.2/1000/month and under five mortality rate is 0.6/1000/month against standards of 1.5/1000/month and 3/1000/month respectively. The operation is planning to construct two clinics at Kalobeyei before end of the year. The rate of global acute malnutrition for new arrivals was 9% and severe acute malnutrition was 0.4%.

### **Health and Nutrition Sector Partners planned activities**

Health services: Construct one maternity ward at the Kalobeyei settlement site and equip it with modern medical equipment to ensure fast and accurate diagnosis as well as high quality curative services; recruit additional staff to ensure consultations per qualified clinician ratio is maintained within standards of 50/clinician per day; provide adequate facilities at the new site to include stores and nutrition distribution waiting bays for the outpatient therapeutic program as well as the supplementary feeding program for malnourished children and those at risk of malnutrition respectively; construct and equip a stabilization ward for the treatment of malnourished children with medical complication; hire additional technical nutrition staff as well as supportive staff to ensure effective implementation of planned activities.

Nutrition: Implement and strengthen the Infant and Young Child Feeding friendly framework; conduct an annual camp nutrition survey; carry out systematic MUAC screening to monitoring acute malnutrition trends; provide micronutrients supplementation and deworming for children 1-5 years old.



## Health and Nutrition Sector Partners

Danish Refugee Council, Film Aid International, Lutheran World Federation, Norwegian Refugee Council, Peace Winds Japan, UNHCR, UNICEF, WFP.

## Health and Nutrition Partners funding requirements for 2016

US\$ 4 056 969

## SUDAN

Sudan continued to face a steady influx of South Sudanese refugees throughout 2015. By the end of October, over 197 000 South Sudanese had sought safety in Sudan. Including the previous caseload, Sudan hosts a total of 270 375 refugees. The majority of the arrivals, around 84%, are women and children. Children alone represent over 63% of the refugee population. Reception arrangements upon arrival include medical screenings and provision of hygiene kits for females.

Gaps in health-care delivery and nutrition services still exist, a direct result of the heightened burden of the refugees on the already-weak health system in the affected states, and a nutrition assessment across all sites in White Nile State will be carried out in 2016 to accurately assess the malnutrition rates. There is a pressing need to establish more long-term health-care and nutrition facilities, with support to facilities like blood banks, reference laboratories, delivery rooms equipped with comprehensive emergency obstetric care, and theatres for surgeries. The referral system needs to be strengthened with proper ambulances assigned to clinics and major hospitals ensuring 24-hour referral capacity. Referral hospitals need to be supported to be able to respond to the needs of South Sudanese refugees, as well as vulnerable Sudanese host community members.

## Health and Nutrition Sector partners planned activities

**Health facilities:** Maintain and reinforce existing health facilities to ensure free access to primary health care including reproductive health, maternal, neonatal and child care for refugees and host communities; establish new health outposts/ centres at new locations.

**Health services:** Support integrated management of childhood illnesses; support health facilities with basic and comprehensive emergency obstetric care; support health promotion and health awareness activities; strengthening of medical referral systems; facilitate better availability and access to secondary-level health care; support mental health counselling and care at community level and health facilities.

**Medicines and medical supplies:** Procure and distribute drugs, reagents, kits (diarrhoeal disease kits, rapid response kits, primary health care kits, and reproductive health kits, integrated management of childhood illnesses, clean delivery and hygiene kits), emergency obstetric care equipment and medical supplies to all health facilities; strengthening the capacity of blood donation units by provision of basic and comprehensive supplies, and equipment in support of comprehensive emergency obstetric and newborn care services.

**Disease prevention:** Weekly collection of epidemiological data and enhanced detection of communicable diseases outbreaks; support malaria prevention with long-lasting insecticide treated nets distribution; immunization coverage against measles, polio and other antigens above 90% for targeted children.

## Health and Nutrition Partners

Almanar, Assist, FAO, IOM, Pancare, SCI, SRCS, UNFPA, UNHCR, UNICEF, UPO, WFP.

## Health and Nutrition Sector partners funding requirements for 2016

US\$ 24 000 653

## WHO funding requirements for 2016

US\$ 10 200 000



## UGANDA

### Health and nutrition situation

Uganda now hosts some 495 000 refugees. The largest groups originate from the Democratic Republic of the Congo, South Sudan, Somalia and Burundi. There are a total of 238 855 refugees from South Sudan. The Government has made refugee-hosting areas a priority through the inclusion of the Settlement Transformative Agenda in the National Development Plan (NDP II), which will also be supported through the Refugee and Host Population Empowerment (ReHoPE) approach endorsed by the UN Country Team. ReHoPE focuses on progressively enhancing social service delivery in refugee-hosting areas, with a view to integrating services with local government systems, and on economic empowerment of refugee hosting areas.

With an increasing number of refugees arriving, new settlement areas will need to be opened, requiring a high initial investment in basic services infrastructure and/or strengthening existing public services. The existing settlements will need to be stabilized with a focus on capacity building for local government authorities and community self-management structures, including host communities. Primary health care services risk being overwhelmed by the increasing population. The existing health centres are operating beyond capacity thereby stretching their limited resources.

### Health and Nutrition partners planned activities

Health services: Health services fully integrated with the national health system with a minimum health service package (including vaccinations) provided to new refugees; build health staff capacity through training, including refresher courses and support supervision; support access to both preventative and curative health services to persons of concern; access to reproductive health and nutrition services; strengthened health outreach services through the village health teams system; access to special medicine facilitated for chronically sick patients; facilitate access to specialized care through medical referral system; additional medicine and health supplies purchased with a focus on vital and essential medicine and supplies; provision of vaccinations for new arrivals and old caseloads; strengthen infant, young child and mother feeding practices.

Nutrition: Support the management of severe and moderate acute malnutrition and prevention of micronutrient deficiencies, including anaemia; deworming for children aged 1-5 years old and provision of vitamin A supplementation for children aged 6-59 months; expand existing supplementary feeding programmes for malnourished children.

### Health and Nutrition Sector partners

ACF, ACORD, AIRD, DRC, FAO, International Aid Services, IOM, IRC, LWF, Malteser International, NRC, Oxfam, Plan international, TPO, UNFPA, UNHCR, UNICEF, WCC, Welthungerhilfe, WFP, WVI.

### Health and Nutrition Sector partners funding requirements for 2016

US\$ 20 995 599

### WHO funding requirements for 2016

US\$ 3 924 600



# Sudan

Armed conflicts, natural disasters, disease, epidemics and chronic underdevelopment have all contributed to the humanitarian crisis in the Sudan. The ongoing violence in Darfur, the Kordofan states, Blue Nile and Abyei has forced people to flee their homes. There are 1.6 million displaced people registered in camps and an additional 600 000 internally displaced people living outside camps. Children represent about 60% of people displaced in camps.

Since 15 December 2013, more than 195 000 South Sudanese have fled the war in South Sudan and sought refuge in the Sudan, with more than 70% estimated to be children. More refugees arrive every day, particularly to White Nile. The areas of Jebel Marra (Darfur), the Nuba Mountains (South Kordofan) and parts of Blue Nile have remained inaccessible to humanitarian actors for years.

The humanitarian needs in Sudan are also exacerbated by environmental factors, which further drive displacement and food insecurity. El Niño brought reduced rainfall in key agricultural areas, reducing yields and the regeneration of pasturelands.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	167/188
Population in urban areas%	2015	33.8
Population using improved water source%	2015	55
Population using improved sanitation%	2015	24
Life expectancy at birth (years)	2015	63
Infant mortality rate / 1000 <sup>2</sup>	2015	47.6
Under 5 mortality rate / 1000 <sup>2</sup>	2015	70.1
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	311
Measles coverage among one year old's%	2014	86

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Health Sector Situation

People have difficulty accessing health services which increases their vulnerability to malnutrition and disease. Some 2 million children under 5 years old are suffering from malnutrition, with global acute malnutrition (GAM) and severe acute malnutrition (SAM) rates above emergency thresholds.

A prolonged measles outbreak in 2015 demonstrated Sudan's continuing vulnerability to public health emergencies. During 2015, humanitarian health partners in Sudan reached more than 4 million people with health services.

The primary aim of the health sector is to ensure better health for conflict and disaster-affected populations. This can be achieved by providing sustained access to primary care, especially for mothers and children, strengthening the referral system and taking appropriate measures for preparing, detecting and responding to public health risks.

The priority health needs of displaced people are life-saving primary health care, including treatment for injury and trauma care, maternal and child health care, training and expansion of the health workforce, strengthening the health information system and ensuring effective and efficient coordination among health partners.

The health sector will also focus on preparedness activities including maintaining core medicine pipelines in order to respond effectively to natural disasters.

## Health Cluster Objectives

- Objective 1:** Provide primary health care services including referral services for vulnerable populations affected by natural and man-made emergencies
- Objective 2:** Strengthen the capacities to prepare, detect and respond promptly to public health risks or events at federal, state and local level
- Objective 3:** Ensure maternal and child health services for the reduction of maternal and child morbidity and mortality among vulnerable populations

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Sudan from the Central Emergency Response Fund, the Government of Sudan, the United Nations Organization for the Coordination of Humanitarian Affairs Common Humanitarian Fund and the United States of America.

## Funding for 2016

Health Cluster	US\$	60 000 000
WHO	US\$	25 994 000

## Beneficiaries targeted by health partners in 2016

Health partners will target 3.6 million people in 2016.

## Geographical areas targeted by health partners in 2016

Health partners are addressing humanitarian needs throughout South Darfur, North Darfur, South Kordofan, Central Darfur, Blue Nile, West Darfur, East Darfur, North Kordofan, West Kordofan, Kassala, Khartoum, Red Sea, White Nile and Abyei states.

## Health Cluster funding requirements for 2016

US\$ 60 million (health partners including WHO)

## WHO funding requirements for 2016

WHO is appealing for a total of US\$ 25 994 000

<b>WHO projects</b>	<b>Requested funds (US\$)</b>
Health <b>SUD-16/H/93732</b>	14 980 000
Nutrition <b>SUD-16/H/93443</b>	2 675 000
Refugee multi-sector <b>SUD-16/MS/93706</b>	3 670 100
Water, sanitation and hygiene <b>SUD-16/WS/93204</b>	4 668 900



# The Syrian Arab Republic

After five years of conflict, the Syrian Arab Republic’s humanitarian situation continued to deteriorate during 2015. An estimated 13.5 million people (including 6 million children) are in need of humanitarian assistance. Of these, 11.5 million people require urgent health care and 8.7 million are food insecure. Seventy per cent of the population have no regular access to safe drinking water.

To date the conflict is estimated to have killed over 250 000 people, injured more than 1.2 million, and left extensive contamination from explosives. Over half of the population has been displaced, including 1.2 million people in 2015. Many people have been displaced for the third or fourth time. Over 4.2 million Syrians are now refugees. Since the onset of the crisis, the average life expectancy in the Syrian Arab Republic’s has fallen by 20 years.

The humanitarian response in the Syrian Arab Republic is a complex operation with humanitarian assistance and protection services delivered mainly from multiple UN hubs within the Syrian Arab Republic, as well as from Turkey, Jordan, Lebanon and Iraq (see Syrian Regional Refugee and Resilience Plan, on the following pages).

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	134/188
Population in urban areas%	2015	57.6
Population using improved water source%	2015	90.1
Population using improved sanitation%	2015	95.7
Life expectancy at birth (years)	2015	69.5
Infant mortality rate / 1000 <sup>2</sup>	2015	11.1
Under 5 mortality rate / 1000 <sup>2</sup>	2015	12.9
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	68
Measles coverage among one year old’s%	2014	54

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Health Sector Situation

The conflict has left two-thirds of the public hospitals destroyed or only partly functioning, while the shortage of specialised medical staff, ambulances, equipment and medical supplies has increased the number of preventable deaths. Over 3.1 million children under the age of five years old and pregnant and lactating women are at risk of malnutrition. One in three children cannot be reached with vaccines. There are 4.5 million people in need in hard-to-reach and besieged areas.

Lack of basic utility services including electricity, fuel, safe drinking water and basic sanitation services have increased the vulnerability to disease outbreaks such as diarrhoeal diseases, typhoid, hepatitis A, as well as other vaccine-preventable diseases. Essential health services have been further disrupted by the exodus of qualified health-care workers, a 60% drop in local production of pharmaceuticals, and a 50% increase in prices of locally produced pharmaceuticals. At least 640 health care workers have been killed since the crisis started, and medical facilities continue to be attacked.

People with life-threatening chronic diseases such as diabetes, kidney failure, asthma, epilepsy, cancer and cardiovascular illness are at an increased risk of dying or developing complications as access to life-saving medications and care is becoming more difficult. A severe shortage in skilled-birth attendants, including obstetricians, means that there are major obstacles to providing care to an estimated 300 000 women who are pregnant and need targeted support. Only 10% of primary health care centres provide basic mental health services. The number of people seeking mental health care is increasing – current estimates indicate 600 000 people are living with severe mental illness in the Syrian Arab Republic.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in the Syrian Arab Republic from the Central Emergency Response Fund, the European Commission Humanitarian Aid and Civil Protection, Finland, 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 Emergency Response Fund.

## Funding for 2016

Health partners	US\$	437 208 904
WHO	US\$	155 271 474

## Health Sector Objectives

**Objective 1: To provide life-saving and life-sustaining humanitarian health assistance to affected people.**

Planned outputs:

- Provide primary health care services, including child and maternal health.
- Strengthen trauma and injuries care.
- Provide essential medicines and supplies.
- Strengthen of the provision of physical rehabilitation services at the facility level.
- Support immunization services.
- Strengthen and expanding the communicable disease surveillance system.
- Provide Emergency Obstetric and Newborn Care services at health facilities.
- Support mental health services at facility level.
- Strengthen management of non-communicable disease treatment and prevention.
- Strengthen referral system.

**Objective 2: To strengthen health sector coordination and health information systems to improve the life-saving health response for people in need, with an emphasis on enhancing protection and increasing access to health services.**

Planned outputs:

- Coordination meetings held regularly at hub and Whole of Syria (WoS) level to eliminate overlap, identify gaps and consolidate efforts between the five hubs to increase access to hard-to-reach areas listed in UNSCR 2139, 2165, 2191.
- Mainstream protection efforts throughout health programming through coordination fora and training/workshops with health partners.
- Roll out health information systems (HIS) at the cluster/working group level.
- Joint contingency and preparedness planning across the five hubs.
- Flash assessment of emergency situations and design of rapid response.

**Objective 3: To support community resilience, institutional and response capacity by empowering communities and national actors.**

Planned outputs:

- Training, retaining and increasing the capacity of health care providers
- Training community health-care workers.
- Rehabilitating and reinforcing health facilities, including physical structure, equipment/ supplies to provide safe and secure environments for health service delivery.
- Capacity building of national NGOs and health institutions to support Syrian leadership of the health sector.
- Promote mobile medical units for emergency response.

## Beneficiaries targeted by health partners in 2016

Health partners will target 11.5 million people in 2016 (4.5 million internally displaced people and 7 million people in host communities), including over 3.1 million children under the age of five years old and pregnant and lactating women.

## Geographical areas targeted by health partners in 2016

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

## Health partners funding requirements for 2016

US\$ 437 208 904 (health partners including WHO)

## WHO funding requirements for 2016

Syrian Arab Republic: US\$ 141 385 094

Turkey: 11 620 000

Jordan: 651 000

A total of US\$ 155 271 474 for the projects listed on the following pages.

<b>WHO projects</b>		<b>Requested funds (US\$)</b>
Strengthening Trauma Care Management, Surgical Care and Physical Rehabilitation in Syria <b>SYR-16/H/88472/122</b>	Syrian Arab Republic	36 305 000
	Turkey	6 290 000
	<b>Total</b>	<b>44 210 380</b>
Enhancing access to secondary health care, comprehensive obstetric care and referral services across the country <b>SYR-16/H/88477/122</b>	Syrian Arab Republic	33 831 820
	Turkey	1 150 000
	<b>Total</b>	<b>34 981 820</b>
Enhancing Primary Health Care (PHC) delivered services to the affected populations across Syria <b>SYR-16/H/88486/122</b>	Syrian Arab Republic	30 135 000
	Turkey	1 794 000
	<b>Total</b>	<b>31 929 000</b>
Enhancing Mental Health and Psychosocial Support Services across Syria <b>SYR-16/H/88489/122</b>	Syrian Arab Republic	8 806 000
	Turkey	434 000
	Jordan	50 000
	<b>Total</b>	<b>9 290 000</b>
Strengthening Health Information Systems for Emergency Response and Resilience <b>SYR-16/H/88493/122</b>	Syrian Arab Republic	749 324
	Jordan	30 000
	<b>Total</b>	<b>779 324</b>
Strengthening and expanding the established early warning alert and response systems/networks for the early detection, prevention and control of potential epidemic prone diseases in Syria <b>SYR-16/H/88539/122</b>	Syrian Arab Republic	16 331 000
	Turkey	921 000
	<b>Total</b>	<b>17 252 000</b>
Supporting the Immunization Programme in Syria <b>SYR-16/H/88654/122</b>	Syrian Arab Republic	5 865 000
	Turkey	512 000
	<b>Total</b>	<b>6 377 000</b>
Strengthening health coordination countrywide <b>SYR-16/H/88658/122</b>	Syrian Arab Republic	2 466 350
	Turkey	519 000
	Jordan	571 000
	<b>Total</b>	<b>3 556 350</b>

Scaling up prevention and early detection of malnutrition in children under 5, referral and the treatment of complicated cases of severe acute malnutrition <b>SYR-16/H/88672/I22</b>	Syrian Arab Republic	1 805 600
	<b>Total</b>	<b>1 805 600</b>
Establishing sustainable water supply and integrated medical waste management systems in healthcare facilities <b>SYR-16/WS/87077/I22</b>	Syrian Arab Republic	5 090 000
	<b>Total</b>	<b>5 090 000</b>





July 2014/UNHCR

## Syria Regional Refugee and Resilience Plan

The humanitarian and development situation continued to deteriorate or remain under threat both inside the Syrian Arab Republic and in neighbouring countries during 2015. By the end of 2015 the number of Syrian refugees registered in Egypt, Iraq, Jordan, Lebanon and Turkey had risen by more than one million, bringing the overall total to almost 4.3 million. Based on the most recent trends in displacement and population growth – and with access to safety in some countries becoming increasingly managed – it is expected that some 4.7 million Syrian refugees will be registered in the region by the end of 2016. The crisis continues to have an enormous social and economic impact on host countries, with services such as health, education and water under severe strain. Impacted host communities (which total just under 4 million people) report deteriorating wages and working conditions because of increased competition for low- and unskilled jobs.

### Health Sector Situation

Ministries of Health, United Nations agencies and NGOs are providing much-needed health care for Syrian refugees in Egypt, Iraq, Jordan, Lebanon and Turkey. The sheer demand for health services places enormous strain on public health infrastructure, resulting in overwhelming patient caseloads, overworked health staff and shortages of medicines and equipment. Vulnerable populations are at heightened risk of communicable diseases due to overcrowding, sub-standard housing, limited access to safe water and sanitation and varying degrees of access to primary health-care services.

Acute respiratory infections and diarrhoea continue to be prevalent among vulnerable communities. Lebanon saw a notable increase in cases of hepatitis A, mumps and measles over the past two years. Cholera was a major concern following an outbreak in Iraq in September 2015, with neighbouring countries fearing cross-border transmission. Management of noncommunicable diseases is also a major challenge. High prevalence of hypertension, diabetes and cardiovascular diseases among Syrian refugees, in addition to significant caseloads of chronic obstructive pulmonary disease and cancer, continues to drive demand for early diagnostic services and medicines. The huge need for emergency care remains, with surgical trauma and intensive care for severely injured patients from conflict areas requiring considerable human, financial and material resources.

Ensuring the provision of adequate and appropriate emergency obstetric and neonatal care services at primary, secondary and tertiary levels, and family planning services, is also essential, as is the need for a comprehensive approach to mental health care in the face of a shortage of mental health specialists.

In Turkey, where the Ministry of Health has ensured that emergency health care is provided to both registered and unregistered Syrians, WHO and the University of Gaziantep have developed a training curriculum for Syrian doctors and nurses help them provide health services to Syrian refugees in the Turkish health system by addressing the language barrier for Syrian patients.

And a project successfully piloted and rolled out in Jordan using mobile technology to help collect and report public health data is being expanded to other countries. Measures to expand the existing health information system to register and record data on Syrian refugees and to enable better planning is a priority in Turkey where SMS texts will be used, and a hotline established to strengthen information outreach to Syrians.

### Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in the countries in the Syria Regional Refugee and Resilience Plan from the Central Emergency Response Fund, Kuwait, Norway, the United States of America, and the European Commission Humanitarian Aid and Civil Protection.

### Funding for 2016

Health Partners	US\$	540 764 219
WHO	US\$	14 370 000

## Health Sector Objectives

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

- Boosting routine immunization coverage for measles, polio and other vaccine-preventable diseases; strengthening disease early warning and surveillance systems.
- Building more robust health information systems to inform health response action.
- Prioritizing the management of noncommunicable diseases and mental health cases at the primary level and the continuity of care.
- Improve access to reproductive health care services for refugees, which includes clinical management of rape services and referral mechanisms for sexual and gender-based violence psychosocial services.

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:

- 4 977 700 consultations for target population in primary health-care services.
- 377 300 referrals of target population to secondary or tertiary health-care services.
- 650 health facilities supported.
- 14 600 health care staff trained.
- 17 892 800 children (Syrian refugees and in host communities) receiving polio vaccination.

## Beneficiaries targeted by health partners in 2016

4.7 million Syrian refugees (projected by end of 2016) and 4 million members of impacted host communities

## Health partner funding requirements for 2016

US\$ 540 764 219 (health partners including WHO)

Egypt: US\$ 17 101 975

Iraq: US\$ 20 169 948

Jordan: US\$ 183 354 762

Lebanon: US\$ 290 931 134

Turkey: US\$ 29 206 400

## WHO funding requirements for 2016

WHO is appealing for a total of US\$ 14 370 000

WHO projects	Requested funds (US\$)
Egypt - Syria 3RP <b>SRRP-16/MS/91608</b>	2 180 000
Iraq - Syria 3RP <b>SRRP-16/MS/91651</b>	3 550 000
Jordan - Syria 3RP <b>SRRP-16/MS/91707</b>	1 715 000
Regional - Syria 3RP <b>SRRP-16/MS/91726</b>	1 500 000
Turkey - Syria 3RP <b>SRRP-16/MS/91721</b>	5 425 000



# Ukraine

There are an estimated 3.7 million people in need of humanitarian assistance in eastern Ukraine – the consequence of civil unrest that started in April 2014. This includes 2.3 million people (unemployed, elderly, children, internally displaced people (IDPs) and disabled people) in need of life-saving assistance along the ‘contact line’ (between non-government and government forces) and in non-government controlled areas.

The decline and interruption of essential water supply and sanitation service provision, particularly in areas connected to centralized systems, is a major consequence of the conflict. Infrastructure related to these large-scale systems on both sides of the ‘contact line’ has frequently sustained damage, halting service delivery over extended periods of time.

An estimated 553 000 people will need food assistance. The most vulnerable are food-insecure people living along the ‘contact line’ and in non-government controlled areas, followed by the vulnerable IDPs and the most vulnerable in IDP-hosting communities. Assessments indicate women, elderly and disabled people are most impacted by the crisis and in need of services. The conflict has also had a devastating impact on the psycho-social well-being of children.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	81/188
Population in urban areas%	2015	69.6
Population using improved water source%	2015	96.2
Population using improved sanitation%	2015	95.9
Life expectancy at birth (years)	2015	70.7
Infant mortality rate / 1000 <sup>2</sup>	2015	7.7
Under 5 mortality rate / 1000 <sup>2</sup>	2015	9
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	24
Measles coverage among one year old's%	2014	79

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

## Health Sector Situation

Access to quality essential health and nutrition services is an immediate need for some 2.3 million people as health services are disrupted in parts of conflict-affected Donetsk and Luhansk. More than 120 health facilities are reported damaged – some critically.

Women and children (more than 60%) are disproportionately affected by a severe reduction in health services. Pregnant and lactating women continue to face compromised access to reproductive health and referral services, antenatal and post-natal care and safe birthing practices. This exposes pregnant women to a high risk of pregnancy related morbidity and mortality. The demand of complementary foods assistance for infants and young children aged 0–23 months remains and nutritional needs of the elderly and pregnant and lactating women residing in non-government controlled areas and areas near the conflict zone are of special concern.

Current emergency mechanisms for providing HIV and TB prevention, treatment, care and support are extremely fragile. Lifesaving Opioid Substitution Therapy services to people in the war zone are completely unsupported, despite the efforts of WHO and other actors. Health concerns have been raised by NGOs for women living in highly militarized areas, as they are exposed to sexual violence, transactional sex, and unhealthy and unsafe sexual practices.

Vaccine-preventable diseases, including polio (there have been two confirmed cases reported in Ukraine) are a major public health concern. Insufficient vaccine supply and the conflict have contributed to low levels of coverage.

## Health Sector Objectives

**Objective 1: Fill critical gaps in health services delivery for conflict affected population and enhance access to essential quality health care services.**

Planned outputs:

- Provide quality essential primary health care and nutrition services and referral services.
- Provide prevention, treatment and referral to TB, HIV/AIDS and STIs.

## Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Ukraine from Canada, Estonia, Finland, the Central Emergency Response Fund, the European Commission for Humanitarian Aid and Civil Protection, and the United Kingdom of Great Britain and Northern Ireland.

## Funding for 2016

Health and Nutrition Cluster	US\$	33 321 635
WHO	US\$	18 500 000

- Support delivery of emergency reproductive healthcare services.
- Provide support to improve quality of emergency care provision for new born and children through implementing Integrated Management of Childhood Illnesses.
- Deliver psychosocial support and community based mental health care services.
- Provide essential medicines and supplies.
- Support trauma care through treatment and capacity building.

**Objective 2: Strengthen and expand disease surveillance and response, including enhance laboratory capacities and technical guidance on priority public health issues and risks.**

**Planned outputs:**

- Expand early warning system for disease surveillance and outbreak response.
- Monitor water quality for control of waterborne diseases.
- Improve diagnostic capacities through provision of lab reagents, supplies and training.
- Preposition emergency medical supplies and material ensuring timely response to epidemic-prone diseases outbreaks.

**Objective 3: Prevent excessive nutrition-related morbidity and mortality of vulnerable groups including acutely malnourished children, pregnant and lactating women, and the elderly.**

**Planned outputs:**

- Support capacity building on nutrition, including provision of equipment and supplies in emergencies.
- Strengthen the epidemiological and nutritional monitoring/surveillance system.
- Ensure adequate coverage with appropriate food supplies to the vulnerable groups.

**Objective 4: Provide technical support through targeted interventions for revitalization of disrupted health services and basic rehabilitation/restoration of health facilities in the affected areas.**

**Planned outputs:**

- Conduct joint assessments related to safe and equal access to primary healthcare services by the most affected populations.
- Strengthen the Health Information Management System for evidence based information and linking the relief to recovery.
- Rehabilitate selected health services and infrastructure affected by the crisis, in line with the health system reforms, and enhance restoration of health services.
- Implement strategic communication, awareness, social mobilization and advocacy in health and nutrition activities (health and hygiene, safe drinking water, vaccination mother and child health, nutrition and mental health, etc.).

## Beneficiaries targeted by health partners in 2016

Health partners will target 2.3 million people in 2016. These include:

- 500 000 people living along the contact line
- 1.6 million people in non-government controlled areas
- 200 000 internally displaced people

## Geographical areas targeted by health partners in 2016

Non-government controlled areas, contact line areas and government-controlled areas where there are IDPs.

## Health and Nutrition Cluster funding requirements for 2016

US\$ 33 321 635 (health and nutrition partners including WHO)

## WHO funding requirements for 2016

WHO is appealing for a total of US\$ 18 500 000

WHO project	Requested funds (US\$)
Provide support through integrated quality emergency health and nutrition services delivery to the crisis affected population in Ukraine <b>UKR-16/H/88257/122</b>	18 500 000



## Yemen

Nearly a year of brutal and complex factional conflict in Yemen has taken a severe toll on civilians. Already mired in a humanitarian crisis when violence escalated in mid-March 2015, Yemen now counts 21.2 million people in need of some form of humanitarian assistance, including: 14.4 million people unable to meet their food needs (of whom 7.6 million are severely food insecure), 19.4 million who lack clean water and sanitation (of whom 9.8 million lost access to water due to conflict), 14.1 million without adequate health care, and at least 2.7 million who have fled their homes within Yemen or to neighbouring countries.

With no camps for internally displaced people (IDPs), displacement has led to a dispersed population that is difficult to assess for vulnerability or specific needs. Many IDPs live with host families – placing additional strain on scarce resources. Displacement and hosting IDPs are significant drivers of food, water and other basic needs assistance – particularly shelter, healthcare, education and essential household items.

Verified reports of human rights violations by all parties have soared, with an average of 41 reports daily as of January 2016. From January to November 2015, there were 747 verified incidents of children being killed and 1120 cases of their being maimed. There are an estimated 2 million acutely malnourished children and pregnant or lactating women in need of treatment, and an additional 1 million children requiring preventive services. About 320 000 children are currently suffering from severe acute malnutrition.

Baseline indicators		Estimate
Human development index <sup>1</sup>	2015	160/188
Population in urban areas%	2010	34.6
Population using improved water source%	2012	55
Population using improved sanitation%	2012	53
Life expectancy at birth (years)	2015	63.5
Infant mortality rate / 1000 <sup>2</sup>	2015	33.8
Under 5 mortality rate / 1000 <sup>2</sup>	2015	41.9
Maternal mortality ratio / 100 000 <sup>2</sup>	2015	385
Measles coverage among one year old's%	2014	75

Source (unless otherwise indicated by a footnote): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015. References on page 62.

### Health Sector Situation

As of November 2015, almost 600 health facilities had closed due to damage, shortages of critical supplies or lack of health workers, including nearly 220 facilities providing treatment for acute malnutrition. Other health facilities are operating at much reduced capacity for the same reasons.

Medical supplies for mass casualty management and essential medicine for chronic diseases are in increasingly short supply. Girls and women – especially pregnant women and women in rural areas – are particularly disadvantaged by a lack of female health service providers. More than 520 000 pregnant women lack access to reproductive health services.

As of late January 2016, health facilities had reported more than 35 000 casualties linked to the conflict, including more than 6100 deaths since mid-March 2015 – an average of 113 casualties per day. Many are believed to be civilians. Casualty estimates understate true figures as they rely on health facility data, and many people face extreme difficulty accessing health facilities. Although the operational plan retains a strong focus on mass casualty management, the main emphasis has shifted to support availability of life-saving essential health care in affected areas, including maintenance of the supply chain. This shift reflects the accelerating collapse of health services across Yemen.

Global activities include environmental health, procurement and distribution of basic medicine and supplies, immunization, vector control, and reproductive and maternal health services through fixed facilities, mobile units and community outreach. Wherever needed and feasible, HIV/AIDS concerns will be incorporated into activities, including provision of minimum HIV services in an emergency setting. Partners are also maintaining support for basic disease surveillance and information management so as to rapidly contain potential public health risks or outbreaks.

### Acknowledgement

In 2015 WHO received financial contributions to support its humanitarian work in Yemen from the Central Emergency Response Fund, Japan, Finland, the United States of America, the Kingdom of Saudi Arabia and the United Nations Organization for the Coordination of Humanitarian Affairs Emergency Response Fund.

### Funding for 2016

Health Cluster	US\$	182 300 000
WHO	US\$	120 000 000

## Health Cluster Objectives

### Objective 1: Ensure availability of a range of integrated primary health-care services in priority districts.

Planned outputs:

- 10 546 101 people targeted benefiting from the procurement and distribution of medicines and supplies for primary, secondary health-care activities, and the maintenance of an uninterrupted supply chain management system.
- 7 082 356 children vaccinated through increased coverage of routine immunization.
- 608 472 trauma kits procured and distributed.
- 600 mobile health units and outreach services made operational, providing reproductive, maternal, newborn and child health, including antenatal, delivery and postnatal care for mothers; routine immunization, screening and treatment.
- 3 106 916 people supported with reproductive health services, including emergency obstetric and sexual and gender-based violence care.

### Objective 2: Improve information management, planning, coordination, monitoring and evaluation of all programmes.

Planned outputs:

- 50 NGO partners supported to fill gaps in health cluster activities, including assessments and reproductive health working group support, and monitoring and evaluation support.

### Objective 3: Rehabilitate health services and build capacity to strengthen resilience and early recovery.

Planned outputs:

- 750 health facilities receiving basic repairs or being upgraded and provided with equipment and supplies.
- Identification of the risk of different types of outbreak-prone diseases prevalent in the affected area pre-event; surveillance system (re)established for early detection and response to disease outbreaks in all locations including those hosting displaced populations.

## Beneficiaries targeted by health partners in 2016

Health partners are targeting 10.6 million people including 6.9 million migrants and refugees.

## Geographical areas targeted by health partners in 2016

Activities are primarily prioritized in the most conflict-affected governorates: Abyan, Aden, Al Bayda, Al Dhale'e, Al Hudaydah, Al Jawf, Amanat Al Asimah, Amran, Hajjah, Lahj, Marib, Sana'a, Shabwah, Sa'ada and Taizz.

Partners are committed to field-based implementation that will see humanitarian staff safely deployed to field locations as close as possible to people with the most immediate needs. Active field presence has grown considerably since June 2015. In 2016, partners will continue working to establish operational field hubs to facilitate implementation and monitoring of activities. As of January 2016, four hubs (Sana'a, Hudaydah, Sa'ada and Ibb) were already functioning. In areas where a permanent field presence may prove more difficult due to insecurity or other constraints, partners will rely on established networks of trusted local partners and long experience – even before the current crisis – of effective remote management.

## Health Cluster funding requirements for 2016

US\$ 182 300 000 (health partners including WHO)

## WHO funding requirements for 2016

WHO is appealing for a total of US\$ 120 000 000

Health Cluster project	Requested funds (US\$)
Health Cluster requirements YEM-16/H/92035/7183	182 300 000



## Summary Table of Funding Requirements

Country/Region	Health Sector Funding Requested (US\$)	WHO Funding Requested (US\$)
Afghanistan	39 562 024	10 000 000
Burkina Faso	3 253 866	395 900
Cameroon	12 183 767	9 774 623
Central African Republic	42 100 000	15 851 400
Chad	34 366 614	10 674 080
Democratic Republic of the Congo	50 000 000	15 000 000
Djibouti	3 407 021	1 937 021
Ethiopia	33 600 000	8 200 000
Gambia	2 927 109	2 927 109
Guatemala	3 500 000	1 150 000
Honduras	2 080 000	1 400 000
Iraq	83 739 344	27 300 000
Libya	38 103 050	15 260 000
Mali	10 143 414	1 396 293
Mauritania	4 864 521	3 916 000
Myanmar	22 900 000	4 100 000
Niger	9 886 604	7 220 895
Nigeria	24 748 290	5 031 200
occupied Palestinian territory	*25 765 842	3 556 728
Sahel Regional Response Plan	116 600 000	
Somalia	71 180 216	14 050 727
South Sudan	110 000 000	17 573 457
South Sudan Regional Refugee Response Plan	*83 295 985	14 124 600
Sudan	60 000 000	25 994 000
Syrian Arab Republic	437 208 904	155 271 474
Syria Regional Refugee and Resilience Plan	540 764 219	14 370 000
Ukraine	*33 321 635	18 500 000
Yemen	182 300 000	120 000 000
<b>Total</b>	<b>2 181 802 425</b>	<b>524 975 507</b>

\* Health and Nutrition

Figures as of 1 March 2016 (FTS): The requested funding figures listed above will change over the year as these Humanitarian Response Plans are modified to reflect conditions within the country and as additional country Humanitarian Response Plans/appeals are published.



## List of acronyms

<b>ACF</b>	Action Contre La Faim
<b>ACORD</b>	Agency for Cooperation and Research in Development
<b>ADRA</b>	Adventist Development and Relief Agency
<b>AIRD</b>	African Initiatives for Relief and Development
<b>ARI</b>	Acute respiratory tract infection
<b>CERF</b>	Central Emergency Response Fund
<b>DCA</b>	DanChurch Aid
<b>DICAC</b>	Ethiopian Orthodox Church - Development and Inter-Church Aid Commission
<b>DRC</b>	Danish Refugee Council
<b>ECHO</b>	European Commission Humanitarian Aid and Civil Protection
<b>ERCS</b>	Ethiopian Red Cross Society
<b>EWARS</b>	Early Warning and Response System
<b>FAO</b>	Food and Agriculture Organization
<b>HIV</b>	Human Immune-Deficiency Virus
<b>HIV/AIDS</b>	Human Immune Deficiency Virus/Acquired Immuno-Deficiency Syndrome
<b>IDPs</b>	Internally displaced people
<b>IMC</b>	International Medical Corps
<b>IOM</b>	International Organization for Migration
<b>IRC</b>	International Rescue Committee
<b>LWF</b>	Lutheran World Federation
<b>NCA</b>	Norwegian Church Aid
<b>NGO</b>	Nongovernmental organization
<b>NRC</b>	Norwegian Refugee Council
<b>MCMDO</b>	Mothers and Children Multisectoral Development Organization
<b>OCHA</b>	United Nations Office for the Coordination of Humanitarian Affairs
<b>RaDO</b>	Rehabilitation and Development Organization
<b>SRCS</b>	Sudanese Red Crescent Society
<b>STI</b>	Sexually transmitted infection
<b>TPO</b>	Transcultural Psychosocial Organisation
<b>UN</b>	United Nations
<b>UNAIDS</b>	UN Joint Programme on HIV/AIDS
<b>UNCT</b>	UN Country Team
<b>UNFPA</b>	UN Population Fund
<b>UNHCR</b>	UN High Commissioner for Refugees
<b>UNICEF</b>	UN Children's Fund
<b>UNRWA</b>	UN Relief and Works Agency for Palestine Refugees in the Near East
<b>UNSCR</b>	UN Security Council Resolution
<b>WASH</b>	Water, sanitation and hygiene
<b>WCC</b>	World Council of Churches
<b>WFP</b>	World Food Programme
<b>WHO</b>	World Health Organization
<b>WVI</b>	World Vision International

## References

Baseline indicators	Estimate
Human development index <sup>1</sup>	2015
Population in urban areas%	2015
Population using improved water source%	2015
Population using improved sanitation%	2015
Life expectancy at birth (years)	2015
Infant mortality rate / 1000 <sup>2</sup>	2015
Under 5 mortality rate / 1000 <sup>2</sup>	2015
Maternal mortality ratio / 100 000 <sup>2</sup>	2015
Measles coverage among one year old's%	2014

Source: (unless otherwise specified): UN Department of Economic and Social Affairs, Population Division (2015) World Mortality Report 2015

<sup>1</sup> Source: Human Development Report 2015

<sup>2</sup> WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation (04/04/2016)

<sup>3</sup> live births

<sup>4</sup> WHO Global Health Observatory (04/04/2016)

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