Overview

The food security and nutrition crisis in the Sahel is already affecting now more than 18 million people. The current food deficit has provoked a nutritional crisis resulting in significant illness and death from malnutrition and associated diseases especially in children under five years of age.

A number of countries (Burkina Faso, Chad, the Gambia, Mali, Mauritania and the Niger) declared a state of emergency, calling for international assistance. In addition to food insecurity, the Sahel countries experience recurrent outbreaks of cholera, measles, meningitis and polio.

Despite the notable progress made in reducing the number of child deaths during the past 20 years, survival for children in the Sahel, is still a challenge. The Sahel countries are among those with the highest under-five mortality rates, with the majority of deaths due to three main preventable and treatable causes: pneumonia, diarrhoea and malaria. Malnutrition intensifies the severity of these epidemics and disease and, in turn, causes a deterioration in nutritional status.

This crisis is further exacerbated because it is occurring in countries with very fragile health systems and services. In many areas, health facilities are poor and health workers scarce.

Health interventions should urgently be scaled up, mainly in areas not yet covered, to complement on-going nutrition and food interventions.

Work needs to be undertaken on disaster risk management, health system strengthening and integrated community-based interventions to build resilience for the future.

Health situation and health risks

At the beginning of the crisis, health was not considered a priority and it was not included as a component of the overall response strategy. As the crisis has evolved there has been increased awareness of the importance of addressing the health consequences of food insecurity and malnutrition. A clear example is that, out of the over one million children that are at risk of severe acute malnutrition (SAM), at least 205 000 are expected to require medical care in health facilities.

Moreover, malnutrition increases the risk of contracting and dying of common illnesses such as malaria, diarrhoea, cholera, pneumonia, measles and others. For instance the case fatality rate of cholera in Burkina Faso, Senegal, the Niger and Nigeria stands at 2.4% until mid-June (rather than <1%). Cases of measles have continued to increase. Over 36 000 cases have been reported in Cameroon, Mali, Chad, Nigeria, Senegal and Niger, with 260 deaths between January and May 2012.

Epidemics of cholera, meningitis, and measles are already on-going in some areas in the Sahel. The situation is expected to deteriorate with the upcoming rainy season and the population movements caused by the conflict in Mali.

Maternal malnutrition augments the risk of poor pregnancy outcomes, including obstructed
labour, premature or low-birth weight newborns and postpartum haemorrhage.

**Regional Health Strategy**

A Regional Health Strategy has been developed by WHO with the contributions of the main health partners active in the region, including UNICEF, the International Organization for Migration (IOM), Medicines Sans Frontiers and the European Commission (ECHO). The Strategy provides a framework for the implementation of health sector response plans and complements food and nutrition and other relevant response strategies for the Sahel crisis. It aims to address the gaps and needs identified in multi-country assessments conducted by WHO and partners in the Sahel.

With the overall goal of reducing excess morbidity and mortality in the populations affected by the food security and nutrition crisis, the strategy is organized around three strategic objectives:

1. Coordinate the health sector response
2. Accelerate priority lifesaving health services, including:
   a. treatment of medical complications of SAM
   b. interventions to control communicable diseases
3. Manage relevant health information to guide action

**Activities**

Health sector partners are focusing their efforts on the following activities:

- Treatment of medical complications of Severe Acute Malnutrition through training of health staff, provision of medical supplies and supporting free access to health care for children under five and pregnant women
- Prevention and control of communicable diseases through vaccination and strengthening of disease surveillance as well as preparedness to respond promptly to outbreaks
- Coordination, both at regional level, setting up a hub in Dakar and in-country Health Cluster coordination (including with UNHCR for refugees); conducting regular needs assessments and monitoring the performance of the health sector
- Support of basic and referral health services, through the deployment of health workers to vulnerable areas to increase access to health care, supporting mobile clinics to access remote areas; and provision of drugs and supplies.

A more detailed breakdown of activities in each of the affected countries is provided in Annex 1.

**Timeline**

The plan covers a 12 month period. It will be updated as needs evolve.

**Funding required**

According to data from the OCHA Financial Tracking Service (FTS), as of 15 June 2012 the overall funding received for the five countries that have issued a Consolidated Appeal (CAP) – Burkina Faso, Chad, Mauritania, the Niger and Mali – amounts to 58% of the financial requirements. However, the health sector has only received 19% of the funds needed.

In the case of WHO, the low level of funding of its appeals, only 8%, is hampering its capacity to coordinate the health response, sustain progress made and collect and disseminate adequate health information to its partners.

Additional funding is urgently needed to continue the implementation of the Regional Health Strategy for the Sahel.

Details on funding requested and funding received for the whole of the health sector and for WHO can be found in Annexes 2 and 3.

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For more information:

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# Annex 1 – Matrix of activities by country

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<th>On-going Response</th>
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</table>
| Burkina Faso  | - Total Population affected: 2.85 million  
- Food insecure areas about 16 provinces, mainly Yagh, Sëno, Oudalan and Soum  
- Refugees: mainly Oudalan (Idanabo & Gendafabou & Soum (Djibo) provinces  
- Global Acute Malnutrition (GAM): 13.4% in Mouhoun region | - Ongoing meningitis outbreak due to Nm W135 (64%) and S.pneumoniae (22%): decreasing, 5,714 cases, 613 deaths (CFR: 10.72%), week 1-21.  
- Measles: 55,442 cases and 27 deaths (CFR: 0.4%), week 1-21 33.5% of case <5 years and 35% > 15 years.  
- Major causes of morbidity in children under five include: malaria (28%), Acute Respiratory Infection (ARI) (18%), diarrhoea (16%) and measles.  
- Nine hospital beds, 0.6 medical doctors and 21 nurses per 10 000 population. (National average, 2006: WHO World Health report 2011) | - Through CERF for refugees  
- Procuring medical kits and other medical supplies  
- Support the deployment of additional staff in health centres  
- Briefing health workers on management of common diseases, including acute malnutrition with medical complications and psychological stress, based on national guidelines and protocols  
- Strengthening disease surveillance in health districts hosting refugees  
- Supporting immunization campaigns against measles and meningitis  
- Support community sensitization for disease prevention  
- Support immunization campaigns against measles and meningitis | - Scaling up ongoing interventions for local populations suffering from food insecurity: Disease burden  
- Procure drugs (kits) and other medical supplies for health care facilities  
- Support deployment of additional staff in health centres  
Severe acute malnutrition  
- Brief health workers on management of common diseases, including acute malnutrition with medical complications and psychological stress, based on national guidelines and protocols  
Prevent and control disease outbreaks  
- Strengthen disease and nutrition surveillance and EWARN systems in health districts hosting refugees  
- Preposition medical supplies for the control of communicable diseases  
- Support community sensitization for disease prevention  
Mitigating health impact of the crisis  
- Health risk assessment and contingency planning  
- Strengthen health coordination mechanisms with MoH (resources for field visits and eventual presence) |
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<td>Cameroon</td>
<td>• Total population in affected regions (North and Far North): 5,891,785 people (1,184,249 children under five years old and 324,048 pregnant women).&lt;br&gt; • GAM: 12.4% (9.8 to 15.1) in the region of the Far North; 9.6% (6.8 to 12.5) in the North.&lt;br&gt; • Prevalence of malnutrition among women, 15.2% (12.1 to 18.4) in the North; 21.4% (17.4 to 27.5) in the Far North.</td>
<td>• Measles epidemics affecting 21 of the 43 health districts (43.8% in affected regions) Most of the reported cases were in age group above five years.&lt;br&gt; • There have been 7,801 cases of measles, with 42 deaths (CFR: 0.53%) as of week 1-21 (about 64% of cases in food-insecure areas).&lt;br&gt; • Risk of cholera due to poor access to water; Lassa fever (ongoing in Nigeria) and polio.&lt;br&gt; • Low routine immunization coverage (&lt;70%); deworming (39.1%); and use of ITNs (8.7% in children and 5.7% among women).&lt;br&gt; • Major causes of child morbidity: malaria (19%), ARI (18%), diarrhoea (16%), measles; increasing number of ARI cases related to the dry season.&lt;br&gt; • Fifteen hospital beds, 1.9 medical doctors and 16 nurses per 10,000 population (National average, 2006).&lt;br&gt; • Detection rate of SAM cases is only 47% due to lack of financial resources (medicine, laboratory, X-rays).</td>
<td>• Nutritional status evaluation in the two regions by the Ministry of Public Health&lt;br&gt; • WFP started food distribution in the most affected area (Far North region)&lt;br&gt; • Surveillance system assessed to address gaps&lt;br&gt; • Planning for mass immunization campaign against polio coupled with measles (11-16 April), with partners: UNICEF, MSF, Lions club, Red Cross and Plan Cameroun&lt;br&gt; • Setting up Toll-Free Numbers in affected districts (2 regions) to improve data collection for EWARN and surveillance system.&lt;br&gt; • A network of 835 community workers for malnutrition case detection and referral to nutrition and health facilities&lt;br&gt; • Review of nutrition data collection tools&lt;br&gt; • Nutrition survey planned by MSF during the immunization campaign&lt;br&gt; • Immunization campaign for measles(with contribution from NGO partners): 1,300,026 people immunized (104.85% of the target)</td>
<td>Disease burden&lt;br&gt; • Support for the prevention and management of measles cases and infectious diseases associated or linked to malnutrition (guidelines and medical supplies).&lt;br&gt; Prevent and control disease outbreaks&lt;br&gt; • Strengthen disease and nutrition surveillance and EWARN systems&lt;br&gt; • Preposition medical supplies for the control of communicable diseases.&lt;br&gt; Severe Acute Malnutrition&lt;br&gt; • Strengthen integrated management of SAM cases with medical complications with medical supplies provision staff training and deployment&lt;br&gt; Coordinated health interventions&lt;br&gt; • Strengthen health coordination mechanisms with MoH (resources for field visits and eventual presence)&lt;br&gt; • Preposition medical supplies for the control of communicable diseases</td>
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| Chad    | • Total Population in affected regions: 6,035,253 people  
  • < 5 years: 1,098,416  
  • Pregnant Women: 196,150  
  • Most affected regions: Kanem, Barh El Gazel, Batha, Wadi Fira, Hadjer Lamis, and Salamat  
  • IDPs: 69,000 not resettled  
  • Refugees: 274,640 Sudanese; 67,863 Central African Republic  
  • Returnees: 800 from Nigeria  
  • GAM above 15% (in seven affected regions)  
  • SAM: Batha, 4.6%; Wadi Fira, 4.6%; Sila, 5%;  
  • Expected cases of SAM: 127,300  
  • Expected SAM with medical complications: 25,460 | • Recurrent outbreaks: meningitis, measles and cholera  
  • Ongoing meningitis (NmA) outbreaks: 3,716 cases and 154 deaths: week 1-20 (CFR: 4.1%)  
  • Measles cases: 7,127 cases and 51 deaths (CFR: 0.7%), week 1-20.  
  • GAM cases registered in health facilities: 50,758, week 1-20.  
  • SAM cases registered in health facilities: 24,332, week 1-20.  
  • Major causes of child morbidity: Malaria (24%), diarrhoea (20%), ARI (18%).  
  • Four hospital beds, 0.4 medical doctors and 2.8 nurses per 10,000 population (National average, 2005). | • Health situation monitoring (Ministry of Health with partners support)  
  • Support to MoH for the meningitis and measles outbreaks: medical and laboratory supplies prepositioned in 15 Districts; immunization in Bedjondo and Goundi Districts  
  • Mass immunization campaign against measles and polio (target: children six to 59 months), in January 2012  
  • Strengthened integrated disease and nutrition surveillance in affected districts  
  • Provision of medicines and other medical supplies to health facilities to districts at high risk for cholera  
  • Two mobile clinics for remote areas not covered by health centers (Kanem and Bahr El Ghazal regions)  
  • Support to nutrition surveillance in 10 regions of the Sahel Belt  
  • Support to reactive mass campaigns for meningitis (1,170,000 doses MenA mobilized by WHO and health partners for campaigns in 8 Districts)  
  • NGOS supporting meningitis case management | Disease burden  
  • Support the deployment of mobile teams  
  • Support the deployment of health workers to increase access to health care  
  Prevent and control disease outbreaks  
  • Strengthen disease and nutrition surveillance and EWARN systems (10 regions of Sahel belt)  
  • Respond to the meningitis and measles outbreak  
  • Preposition medical supplies for the control of communicable diseases  
  Severe Acute Malnutrition  
  • Provision of medical supplies to manage malnutrition and related illnesses in 22 health facilities  
  • Training health staff in the management of medical complications of acute malnutrition and IMCI (five regions)  
  • Recruitment of one Medical Nutrition Expert to support MoH  
  Coordinated health interventions  
  • Strengthen health coordination mechanisms with MoH (resources for field visit and eventual field presence) |
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<tr>
<td>Gambia (the)</td>
<td>• Vulnerable population: 605,000 children under five: 102,800</td>
<td>• Major causes of child morbidity: Malaria (22%), ARI (16%), Diarrhea (14%).</td>
<td>• Response plan developed and CERF allocated</td>
<td>Disease burden</td>
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<td>• Most affected: 428,000</td>
<td>• 11 Hospital beds, 0.4 medical doctors and 5.7 nurses per 10,000 population (national, 2009).</td>
<td>• Support to disease surveillance</td>
<td>• Support the deployment of health workers to increase access to health care</td>
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<td>• Vulnerable districts: 25</td>
<td>• Meningitis outbreaks in Fulladu West District (past epidemic threshold): 165 cases/9 deaths (CFR: 5.5%) as of week 20.</td>
<td>• Support to integrated management</td>
<td>• Provision of essential medicine (kits)</td>
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<td>• 19 most affected districts in the affected regions</td>
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<td>Prevent and control disease outbreaks</td>
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<td></td>
<td>• Strengthening disease surveillance and EWARN (19 most affected districts)</td>
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<td>• Support response to the meningitis outbreak.</td>
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<td>• Preposition medical supplies for outbreak response</td>
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<td>Severe Acute Malnutrition</td>
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<td>• Provision of medical supplies to manage malnutrition and related illnesses</td>
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<td>• Training health staff in the management of medical complications of acute malnutrition and IMCI</td>
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<td>• Strengthen health coordination mechanisms with MoH (resources for field visits and eventual field presence)</td>
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<tr>
<td>Mali</td>
<td>• Most affected regions are Kidal, Gao, Tombouctou, Mopti and Ségou (5 693 261 people).&lt;br&gt;• IDPs: Kidal, Tombouctou, Gao; 93 000 people&lt;br&gt;• Situation deteriorating in regions affected by food insecurity and population movement: Tombouctou and Gao&lt;br&gt;• 35 health districts affected by food insecurity&lt;br&gt;• Food insecurity: Kayes (Under 5 GAM: 13%; SAM: 2.9%); Koulikoro (GAM: 13.2%, SAM: 2.8%); Tombouctou (GAM: 16%, SAM: 3.4%); Gao (GAM: 15.2 %, SAM: 2.9%) (MoH, 2011)</td>
<td>• Recurrent outbreaks: meningitis, measles, cholera.&lt;br&gt;• Risk of yellow fever (case in 2010)&lt;br&gt;• 2011: Anthrax in Tombouctou, 25 cases/6 deaths; cholera in five regions, 1303 cases/55 deaths.&lt;br&gt;• 2012: Meningitis cases (Nm W135): week 1-21: 520 cases 6 deaths (CFR: 1.15%); measles: 315 cumulative cases and 5 deaths (week 1-21).&lt;br&gt;• Measles vaccination coverage: 63%; DTP3: 76% (national)&lt;br&gt;• Major causes of child morbidity in general: diarrhoea (22%), ARI (21%), malaria (16%).&lt;br&gt;• MOH survey in 2010 showed malaria prevalence in children between 6-59 months of age was 37.5%. In rural areas, the prevalence was even higher with 44.6%.&lt;br&gt;• There are six hospital beds, 0.5 medical doctors and three nurses per 10 000 population (National average, 2008)</td>
<td>• Health cluster activated and Health Cluster Coordinator deployed&lt;br&gt;• Support to health care for IDPs (NGOs)&lt;br&gt;• Rapid assessment planned in Tombouctou&lt;br&gt;• Medical supplies provision in process (WHO)&lt;br&gt;• Strengthening disease surveillance</td>
<td>Disease burden&lt;br&gt;• Support the deployment of health workers to increase access to health care (in IDP areas)&lt;br&gt;• Provision of essential medicine (kits)&lt;br&gt;Prevent and control disease outbreaks&lt;br&gt;• Strengthening disease surveillance and EWARN&lt;br&gt;• Support response to the meningitis outbreak.&lt;br&gt;• Preposition medical supplies for outbreak response&lt;br&gt;Severe Acute Malnutrition&lt;br&gt;• Provision of medical supplies to manage malnutrition and related illnesses&lt;br&gt;• Training health staff in the management of medical complications of acute malnutrition and IMCI&lt;br&gt;Coordinated health interventions&lt;br&gt;• Strengthen health coordination mechanisms with MoH (resources for field visits and eventual field presence)</td>
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| Mauritania | • 700 000 people in food insecure areas with 520 000 in need of assistance  
• 39 489 refugees: Hodh El Chargu region (Fassala, Mbérra, Kobeni and Tenaha)  
• GAM >15% in four regions Assaba (15.3%), Gorgol (15.7%), Brakna (18%), Guidimakha (15%). In the December SMART survey prevalence showed lower prevalence except in Bakna (12.5%) and Gorgol (11%). However, the worsening food security situation may increase GAM as usual during the lean season.  
• GAM > 14% in 3 regions and GAM> 10% in the remaining 5 regions (SMART July 2011) | • Access to health services: 67% of the population in affected regions  
• Measles vaccination coverage: 66% and DTC3: 79% in refugees’ region;  
• Immunization coverage low in Malian refugees leaving in remote areas of Mali  
• Recurrent risk of outbreaks of meningitis, measles, cholera, Rift Valley Fever, Congo Crimean Haemorrhagic Fever  
• Meningitis: 37 cases (W135) in 4 regions (including refugee area), week 1-21.  
• Major causes of general morbidity at refugee health screening centre: ARI (21.4%), malaria (20.9%), diarrhoea (10.4%), anaemia (4.2%).  
• Major causes of child morbidity in general: ARI (23%), diarrhoea (19%), malaria 6%  
• There are four hospital beds, 1.3 medical doctors and 6.7 nurses per 10 000 population (national, 2006)  
• One medical doctor for 43 000 people in the referral district hospital in the refugees’ area (field assessment report)  
• Birth attended by skilled professionals: 34% in refugees’ areas  
• Critical water and sanitation gaps that could trigger disease outbreaks. Main cause of consultation for refugees is diarrhoea (assessment report) | • Support to initial health assessment in refugees’ area  
• Technical support to MoH for disease surveillance, immunization activities and health promotion activities in refugees’ area  
• Immunization campaign against measles and polio 19/05 to 25/5/2012 in refugee camps and host population in Bassiknou District: For the Camps Polio Vaccine: 19,093 kids/ with 10,933 refugees (coverage 89.4%); Measles vaccine: 32,255 kids with 23,390 among refugees (Coverage 83.3%). For the all district of Bassiknou: Polio vaccine coverage reached: 102.6% Measles vaccine: 96.5%.  
• Support to health staff deployment  
• Provision of drugs, medical supplies and cold chain equipment to the MoH  
• Support to coordination (UNCT and health coordination)  
• Immunization campaign : polio with EPI  
• NGOs involved in the health response with UNHCR | Disease burden  
• Improve access to essential health care for refugees (referral level) and local population: medical supplies and equipment (including lab), staff deployment and support to ambulance service in refugees’ areas: Hodh El Chargu (Fassala, Mbérra, Kobeni and Tenaha)  
Prevent and control disease outbreaks  
• Strengthen prevention: vaccination coverage (immunization of all refugees) with coming polio campaign); health and hygiene promotion with WASH partners: water quality control and improvement of access to potable water and sanitation facilities.  
• Strengthen disease and nutrition surveillance: integrating hospital based screening data to disease surveillance  
Severe Acute Malnutrition  
• Strengthen SAM case management in therapeutic centres (CREN, CRENAS) in the Assaba, Gorgol, Brakna and Guidimakha  
Coordinated health interventions  
• Support for continuous situation monitoring  
• Strengthen health coordination mechanisms with MoH (resources for field visit and eventual presence) |
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| Niger (the) | • Six million people affected by the food crisis.  
• Tillabéri region the most affected: highest food insecurity and global acute malnutrition prevalence. This region is also hosting Malian refugees and facing a cholera outbreak for the past year  
• Refugees in three health districts (DS) and in four main sites:  
  • DS Tillabéri (Ayorou: 3940),  
  • DS Ouallam (Sinegodar: 13 005, Mangaize: 2998),  
  • DS Filingue (Abala: 8915).  
• Influx of returnees and refugees from Côte d'Ivoire, Libya and Mali  
• Tillaberi with 14.8% GAM, 35.4% of households with food insecurity;  
• A total of 122 335 SAM cases in children under five with 100 related deaths reported by health facilities from week 1 - 11  
• Expected cases in 2012: 614 116 cases of GAM; 393 737 cases of SAM; 65 600 cases of SAM with medical complications | • Ongoing cholera outbreaks: 1,054 cases and 27 deaths (CFR: 2.6%), week1-21; initially in Tilaberi region and has spread to Niamey and Dosso regions.  
• Increasing measles cases: 1,336 cases/5 deaths (CFR: 0.4%), week 1-21.  
• Meningitis: 220 cases and 36 deaths (CFR:16.3%), at week1-20 versus 1,131 cases and 126 deaths in 2011.  
• Guinea worm prevalent in areas where refugees are coming from (Gao region: 12 of the 30 worldwide cases in 2011).  
• Communicable diseases: malaria.  
• GAM cases in health facilities: 16,955 cases at week 21 compared to 19,489 cases at week 20; cumulative case on 293,298 cases/7212 deaths, with 100,124 of SAM, week1-21.  
• Major causes of child morbidity: malaria (21%); ARI (20%); diarrhea (19%).  
• Three hospital beds, 0.2 medical doctors and 1.4 Nurse per 10 000 population (national, 2005) | • Supporting coordination (Health cluster)  
• Joint needs assessment completed in crisis affected areas  
• Support to cholera outbreak control interventions: epidemic crisis committee coordination, medical and laboratory supplies, health promotion  
• Provision of emergency kits for refugees  
• Strengthening disease surveillance  
• WHO, MoH and NGOs supporting health care in Sinegodar and Mangaize district. UNHCR also supporting refugee health care in Ouallam | Disease burden  
• Support the deployment of mobile teams  
• Support the deployment of health workers to increase access to health care including reproductive health  
• Support to mobile clinics  
Prevent and control disease outbreaks  
• Strengthen disease surveillance and EWARN and response (mainly in Tillaberi with refugees and ongoing cholera)  
• Respond to the meningitis and measles outbreaks  
• Preposition medical supplies for the control of communicable diseases  
• Support EPI intervention in refugee and host population  
Severe Acute Malnutrition  
• Provision of medical supplies to manage malnutrition and related illnesses: support free access to health care  
• Train health staff in the management of medical complications of acute malnutrition and IMCI coordinated health interventions  
Coordinated health interventions  
• Strengthen health coordination mechanisms with MoH (resources for field visits and eventual presence) |
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| Nigeria | • Seven states in northern Nigeria affected: Sokoto, Katsina, Jigawa, Yobe, Zamfara, Kebbi and Kano. (Combined population: 38 576 735; of which 7 715 347 are under-five)  
• GAM > 10% in four states (Katsina, Sokoto, Jigawa and Yobe) | • Recurrent outbreaks of infectious diseases such as measles, cholera and meningitis in the affected states.  
• Lassa fever: 932 cumulative cases and 92 deaths (CFR: 9.87%) (weeks 1-21).  
• Major causes of child morbidity: malaria (26%); diarrhoea (15%), ARI (15%).  
• There are five hospital beds, four medical doctors and 16.1 nurses per 10 000 population (national level, 2004). | • Scaling up of Vitamin A supplementation, integrated with polio and measles immunization programmes  
• Improving deworming coverage  
• Improving coverage of feeding programmes for under-fives  
• Promoting improved infant and young child feeding practices  
• Facility-based treatment of severe acute malnutrition  
• Heightening nutritional and disease surveillance | Disease burden  
• Increase coverage of Vitamin A supplementation and deworming in most of the affected states.  
Prevent and control disease outbreaks  
• Strengthen disease surveillance and EWARN and response  
Severe Acute Malnutrition  
• Strengthen the capacity of primary healthcare workers and community volunteers on infant and young child feeding in emergencies.  
• Supply of therapeutic food, medications and nutrition equipment.  
• Strengthen nutrition programme in affected districts with joint nutrition and health interventions at community and facility level to address chronic malnutrition in children and young mothers  
Coordinated health interventions  
• Strengthen health coordination mechanisms with MoH (resources for field visit and eventual presence) |
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<tr>
<td>Senegal</td>
<td>• Drought affected regions: Ziguinchor, Kolda, Sédhiou, Kédougou, Tambacounda, but mainly Matam and Diourbel&lt;br&gt;• Affected population: 850 000&lt;br&gt;Population targeted by UNCT: 237 000&lt;br&gt;• Women and girls: 120 000&lt;br&gt;• Men and boys: 117 000&lt;br&gt;• Children under five years old: 44 650&lt;br&gt;• GAM prevalence above 15% in Saint-Louis, Matam and Louga regions, and above 10% for Tambacounda and Thiès regions (EDS5/MICS 2010-2011).&lt;br&gt;• Diourbel is the most affected region with SAM above 10% with worsening factors: SAM at 2% (SMART 2011).&lt;br&gt;• Stunting: &lt;40%; but chronic undernutrition in Kédougou and Kolda with prevalence &gt;25%. Underweight &lt;30% but Matam and Kolda need to be monitored</td>
<td>• Main cause of morbidity for children under five: ARI (due to the dry season), malaria and malnutrition in affected areas; Malaria (19%), ARI (17%), diarrhoea (14%).&lt;br&gt;• 728 cases meningitis (most of them, W135) and 3 deaths (CFR: 0.41%) reported (week 1-21).&lt;br&gt;• Cholera cases confirmed in 2011 in Bakel District in Tambacounda region (10 reported cases/0 deaths); 1 confirmed case so far in 2012.&lt;br&gt;• Measles coverage &lt;70% for children 9-59 months in 2011, 394 suspected measles cases in 2011 in seven regions (SMART survey).&lt;br&gt;• There are three hospital beds, 0.6 medical doctors and 4.2 nurses per 10 000 population (national, 2008)</td>
<td>• Development of a joint government and partners response plan&lt;br&gt;• SAM case management capacity assessment in existing operational structures in the most affected regions: Matam and Diourbel.&lt;br&gt;• Increasing formative supervision (CERF, WHO and UNICEF) to improve case management in the two regions Matam and Diourbel.&lt;br&gt;• Training of health workers not yet trained, provision of anthropometric equipment and other supplies to SAM case management to increase coverage of structures dealing with SAM&lt;br&gt;• Strengthen preventive activities for malnutrition (communication, Vit A supplementary campaigns and deworming)</td>
<td>Severe Acute Malnutrition&lt;br&gt;• Provide emergency kits for health facility-based management of SAM.&lt;br&gt;• Support capacity building (training and formative supervisions) of health workers in health centers and hospitals (IMCI including integrated management of child illnesses with SAM and counseling in child feeding)&lt;br&gt;Prevent and control disease outbreaks&lt;br&gt;• Provide technical support for nutrition and disease surveillance systems in health facilities and at community level&lt;br&gt;• Strengthen immunization activities mainly targeting measles.&lt;br&gt;Coordinated health interventions&lt;br&gt;• Strengthen health coordination mechanisms with MoH (resources for field visit and eventual presence)</td>
</tr>
</tbody>
</table>
## Annex 2: Financial requirements for health sector actors active in the Sahel crisis

### CAP: Health Appeals funding requirements versus funding received (source OCHA-FTS 18-June-2012)

<table>
<thead>
<tr>
<th>Country</th>
<th>Appeal date</th>
<th>Requirements (US$)</th>
<th>Funding (US$)</th>
<th>Unmet requirement (US$)</th>
<th>% Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>15-Apr-12</td>
<td>5,381,330</td>
<td>2,551,412</td>
<td>2,829,918</td>
<td>47%</td>
</tr>
<tr>
<td>Chad</td>
<td>14-Dec-11</td>
<td>22,969,612</td>
<td>4,306,330</td>
<td>18,663,282</td>
<td>19%</td>
</tr>
<tr>
<td>Mali (in process, need: about US$ 13 million)</td>
<td>31-May-12</td>
<td>9,472,083</td>
<td>0</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Mauritania</td>
<td>15-Apr-12</td>
<td>4,617,300</td>
<td>192,611</td>
<td>4,424,689</td>
<td>4%</td>
</tr>
<tr>
<td>Niger (the)</td>
<td>14-Dec-11</td>
<td>13,106,968</td>
<td>3,414,129</td>
<td>9,692,839</td>
<td>26%</td>
</tr>
<tr>
<td>Gambia (the)</td>
<td>No Appeal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senegal</td>
<td>No Appeal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cameroon</td>
<td>No Appeal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>No Appeal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional Coordination</td>
<td>No Appeal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>US$ 46,075,210</strong></td>
<td><strong>US$ 9,410,901</strong></td>
<td><strong>US$ 36,664,309</strong></td>
<td><strong>19%</strong></td>
</tr>
</tbody>
</table>
### Annex 3: WHO financial requirements for the Sahel crisis (by country)

**Source:** OCHA FTS, and WHO for non-CAP countries as of 18 June 2012

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Funding (US$)</th>
<th>Unmet requirement (US$)</th>
<th>% Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>2,376,621</td>
<td>787,359</td>
<td>1,589,262</td>
</tr>
<tr>
<td>Chad</td>
<td>12,276,187</td>
<td>350,686</td>
<td>11,925,501</td>
</tr>
<tr>
<td>Mali</td>
<td>8,071,052</td>
<td>0</td>
<td>8,071,052</td>
</tr>
<tr>
<td>Mauritania</td>
<td>2,018,300</td>
<td>192,611</td>
<td>1,825,689</td>
</tr>
<tr>
<td>Niger (the)</td>
<td>6,164,010</td>
<td>632,667</td>
<td>5,531,343</td>
</tr>
<tr>
<td>Gambia (the)</td>
<td>766,300</td>
<td>63,910</td>
<td>702,390</td>
</tr>
<tr>
<td>Senegal</td>
<td>826,050</td>
<td>266,430</td>
<td>559,620</td>
</tr>
<tr>
<td>Cameroon</td>
<td>809,975</td>
<td>578,236</td>
<td>231,739</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1,484,770</td>
<td>0</td>
<td>1,484,770</td>
</tr>
<tr>
<td>Regional Coordination</td>
<td>558,000</td>
<td>0</td>
<td>558,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>US$ 35,351,265</strong></td>
<td><strong>US$ 2,871,899</strong></td>
<td><strong>US$ 32,479,366</strong></td>
</tr>
</tbody>
</table>

**WHO’s internal contribution to support health sector coordination and emergency operations (filling gaps):**

1. WHO/HQ allocated from its rapid response account: US$ 426,000 to Mali, the Niger and IST (regional coordination)
2. About USD 190,000 value Emergency medical and surgical kits have been sent to Burkina Faso, Chad, Mali, Mauritania, the Niger (funded by AFRO and Norway and Australia donations) for a population of about 60,000 for three months.
3. The AFRO regional Office has so far committed about US$ 300,000 to support immediate human resources and logistical needs in Mali, Mauritania, the Niger, Chad and Burkina Faso.