Chad – A Country in Crisis

Report of the follow-up visit, Inter-agency Health and Nutrition Evaluation

Washing day, Bredjing. Picture: Nigel Pearson

Nigel Pearson

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Photos in this report were taken by Dr. Nigel Pearson. Please mention Dr. Pearson if using the photos for purposes other than this report.

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Acronyms

ARV	Anti-retroviral
BPRM	Bureau of Population, Refugees and Migration
CAP	Consolidated Appeals Process
CNAR	Commission Nationale d'Accueil des Réfugiés
COOPI	Cooperazione Internazionale
CTC	Community based Therapeutic Care
EDF	European Development Fund
EPI	Expanded Programme of Immunisation
HAC	Health Action in Crises
HIS	Health Information System
IHE	Inter-agency Health Evaluation
JAM	Joint Assessment Mission
LSHTM	London School of Hygiene and Tropical Medicine
MoH	Ministry of Health
PEP	Post Exposure Prophylaxis
PFA	Pharmacie Préfectorale d'Approvisionnement
PMTCT	Prevention of Mother to Child Transmission
RC Federation	International Federation of Red Cross and Red Crescent Societies
SFC	Supplementary Feeding Centre
STI	Sexually Transmitted Infection
TFC	Therapeutic Feeding Centre

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Executive Summary and Key Recommendations

This visit follows the Inter-agency Health and Nutrition Evaluation conducted in February 2006. It analysed the sector-wide impact of the collective efforts of the humanitarian community in the south and east of Chad. One consultant visited the capital N'Djamena and the east of Chad from 17th to 20th November 2006. The south of the country was not visited. Due to the limited amount of time for the mission, this report should be regarded less as an evaluation than a general appreciation of the efforts invested since last February, a follow up of the recommendations and an analysis of the complex context in which the partners work. The evaluation was conducted using direct observation of activities in refugee camps and health services in the east, analysing documents and available data and conducting interviews with several partners, donors and beneficiaries. The consultant also tried to gain an impression of the capacities of the Chadian health system and analyse the health indicators of the country which are amongst the lowest in the world.

The situation in Chad was very tense during the month of November, with an increasing displacement of populations in Dar Silva district following inter-ethnic attacks in villages. In addition, the rebellion present in the east of the country for several years, has been stepped up, with an attack on Abéché (the main city in the east of Chad) which was accompanied by looting of the depots of the humanitarian agencies. The consultant left Abéché just a day before the attacks, after having visited three sites of displaced people around Goz Beida, and conducted the visits as originally planned in the refugee camps of Djabal, Farchana, Trequine and Bredjing and health facilities of Adre and Goz Beida districts.

Key Recommendations

III. Humanitarian Aid

1/ WHO should take responsibility for health data collection in refugee camps and take a clearer lead in the health sector.

2/ UNFPA should plan with the MoH for an annual reduction in maternal mortality.

3/ A consultancy is needed looking into the integration, coordination and management of UN agencies in the health sector.

4/ A better line management system with performance indicators should be put in place for UN agencies.

5/ Inter-agency reports should be more widely distributed by sending hard copies as well as electronic versions of reports.

IV. Water and Sanitation

1/ Respect of Sphere standards should be considered in conjunction with the volume of available ground water. It is recommended that the quantity of ground water be determined so that water can be used in a sustainable way and the reserves exhausted.

2/ Some camps still need more latrines.

V. Nutrition

1/ The nutritional status of the population is so severe that a donor should fund UNICEF and WHO, in collaboration with specialised agencies, to establish nutritional surveillance in sentinel sites in regions not affected by refugees, with the possibility of implementing cost-effective community-based therapeutic care (CTC).

2/ The government should provide the National Direction for Nutrition with appropriate resources to create feeding centres and a surveillance programme.

3/ WHO should include severe malnutrition as a cause of mortality and acute malnutrition as a diagnosis in the morbidity surveillance.

4/ In general, agencies should provide support to districts by creating SFCs and TFCs in health facilities. The feeding centres in the camps should be transferred. More funding is needed in this area to ensure appropriate surveillance and effective responses.

VI. Health Services

VI.1. Surveillance System

1/ It is important that WHO analyses data more effectively so as to help partners better design their intervention strategy against priority diseases.

2/ The MoH needs to make more effort to computerise and strengthen the HIS, with the support of WHO.

3/ Ideally epidemiologic cluster studies would be carried out in villages in the east to collect baseline data.

VI.2. Response to epidemics

1/ The early warning system needs reinforcing so that every structure sends data punctually on notifiable diseases.

VI.3. Curative Care

1/ Malaria requires greater efforts to control it.

2/ It is very important to provide centres with microscopes and lab technicians. In the mean time, blood transfusion safety should be reinforced as a priority.

3/ WHO, UNICEF, UNHCR and OCHO should coordinate closely to ensure that every hospital in Ouaddai and Wadi Fira can carry out blood transfusions.

4/ UNICEF needs strong financial support and more personnel so that it can expand its child survival project and cover every health district in Chad.

5/ The government of Chad should focus on the training of nurses, midwives and all health professionals.

6/ The agencies need to participate in training future health professionals by facilitating practice internships in facilities supported by agencies.

VI.4. Reproductive Health

1/ Every NGO should encourage all pregnant women to deliver in health facilities.

2/ UNFPA should promote a Safe Motherhood programme in every health structure.

3/ It is necessary for the government and the agencies to launch a social marketing programme in Chad for condoms and a PMCT programme.

VI.5. Preventive Care

1/ Vaccination of pregnant women against tetanus should be a focused priority, both in camps and districts, and should be increased.

VI.6. A District Perspective

1/ Camp health centres should be transferred to public health facilities. Remote health structures require more support from the MoH, UN agencies and NGOs. The host population which has always suffered from poor access to health services, should be offered the same access as displaced people.

2/ Districts neighbouring the districts benefiting from humanitarian assistance should benefit from the expanded programmes of partners. Innovative approaches are necessary to fund partners working with the districts.

VI.7. Health Financing in Chad

1/ Donors should acknowledge that the chronic crisis responsible for the poor health and nutrition status of the Chadian population can only be resolved through approaches combining development with humanitarian intervention. The programmes needing priority support are child health and reproductive health. The response requires an innovative joint-initiative from donors, UN agencies, MoH and NGOs. A “consortium” approach, or even a multi-trust fund should be promoted. The Global Fund should support programmes that are managed by the MoH in collaboration with NGOs.

2/ The level of investment in health services for the Chadian population is extremely limited. OCHA should advocate for districts not affected by refugees. The government, donors, humanitarian and development agencies should provide resources and deliver emergency interventions to reduce the mortality rate of children under five, the maternal mortality rate and rates of acute malnutrition. In a country with a chronic crisis that is rapidly deepening, it is important to develop imaginative interventions that work at all levels (national, regional, district and health facility).

3/ The Chadian government needs to provide sufficient resources to fund health care by improving management capacities of health systems. Millennium Development Goals will not be achieved without significant investment in cost-effective clinical services and preventive programmes targeting children and women.

4/ The LSHTM and the inter-agency committee should envisage the possibility of commissioning a consultancy on the capacity of the Chadian health service (not

including ones for refugees), and an economic analysis of the resources needed to fund essential health services in Chad.

5/ Donors, UN agencies and partners should discuss how to fund under-five child healthcare and deliveries in Chad. UN agencies and NGOs, together with district medical doctors in districts where there is a presence of refugees and displaced populations should start discussions on abolishing user fees for the most vulnerable groups amongst the Chadian population. The government of Chad should fund free health care for children and women.

Camp of Farchana and a Masalit child, Treguine. Picture: Nigel Pearson

I. Introduction

This Inter-agency Health and Nutrition Evaluation (IHE)[i] in February 2006 was the sixth in a series that set out to analyse the impact of health and nutrition emergency interventions of humanitarian agencies in crises. This follow-up visit was coordinated by the London School of Hygiene and Tropical Medicine (LSHTM) and organized in the field by UNHCR.

It was originally planned that the consultant would facilitate a meeting with the partners in the east of Chad in order to review the recommendations of the evaluation and participate in the elaboration of the action plans for 2007. However, two other meetings were organized during the same period and the one organized by UNHCR was postponed to December. In the end, an IHE meeting took place on November 26th at the WHO office in N'djamena with UN agencies and NGOs in N'djamena despite the events that occurred during the weekend in the east of the country. Limitations of the visit were the short period of stay in Chad (9 days) with only a 5-day field visit conducted by one consultant, which explains why the report is a series of impressions rather than a detailed evaluation.

The consultant, Dr Nigel Pearson, is an expert in international health and humanitarian interventions. He had no prior involvement with any of the programs and has declared no conflict of interest.

II. Context

Chad – A country in crisis

Chad is a country in crisis facing an insurrection in the east that increasingly affects the whole country. The temporary take-over by rebels of Abéché, the main city in the east, and the displacement of 30,000 people during the last month, indicates that the situation is rapidly worsening. At the same time a chronic crisis in terms of lack of access to basic

[i] L'ESI est dirigée par un groupe de travail composé des membres suivants : ACF, CDC, Atlanta, Epicentre, LSHTM, Merlin, MSF, SCF-UK, UNFPA, UNICEF, PAM et OMS

health care affects the whole country and contributes to the deteriorating health indicators, many of which are above emergency levels.

The intensity of the "proxy" war that has been taking place on the border between Sudan and Chad has increased since the end of 2005. The Sudanese government has actively exported the conflict from Darfur to Chad by supporting Chadian rebels in their cross border attacks[1]. Chadian soldiers overwhelmed by the rebels have not offered any protection to the villagers against the Janjawid who run trans-border attacks and stir up Arab-Chadian groups against their neighbours. This year, the Chadian government has not been able to either defend its border with Sudan or protect villagers against the Janjawid and Chadian rebels or to repel the attacks of rebels[ii]. On November 25th, the rebels controlled the city of Abéché after a confrontation that only lasted 2 hours. The rebels seized munitions of the national army and left the city of their own will, seemingly playing cat and mouse with the Chadian authorities. They then intentionally lied about their position and their intentions to advance towards the capital. The medical partners had pre-positioned surgical kits and effectively cared for the injured

Refugees

Since February 2006, the number of refugees has been continuously increasing. According to a recent census, there were 233,589 Sudanese refugees in Chad at the end of October and 47,467 refugees from Central African Republic (including registered refugees and non assisted refugees)[2]. Although many initiatives had been taken to transfer the refugees from the camps of Oure Cassoni and Amnabak to sites further from the border[iii], the transfer has not yet taken place. There are 16 refugee camps in total in Chad (12 in the east and 4 in the south), including the extension of Amboko Camp in the south. A new site in Dosseye was created when the situation in CAR started to deteriorate at the beginning of the year creating an influx of new arrivals. 5,000 refugees are to be transferred to this camp in December 2006. WFP stopped food supply to the refugees of Yaroungou camp even though the local agricultural production in the camp does not yet fulfil the nutritional needs of the population. After the looting of 500 tonnes of food by the rebels in Abéché, WFP was left with only 7 tonnes of food. 14,000 additional refugees from Sudan arrived this year and were sent to the Gaga camp. This is the only camp this year that had to deal with an epidemic.

The repatriation of refugees is not possible either in the south or east. The insurrection in the north of CAR continues without any visible sign of improvement. The lack of solutions to resolve the critical situation in Darfur, either by the neighbouring countries or the international community, has generated a continuous influx of refugees to Chad. Sudanese rebels have even recruited Sudanese refugees[iv] [3]. Moreover, the present context of impunity in Sudan and the porosity of the borders have increased the influx of arms and combatants to Chad and have created inter-ethnic tensions this year and attacks on villages[v]. These attacks are very similar to the ones organised by Janjawid[vi] in Sudan.

[ii] During a rebel ambush in the east of Goz Beida on 29th October 2006, more than 90 Chadian militaries were killed and 40 injured.

[iii] The government proposed a transfer of refugees to Kanem and BET. However citing camps in these desert regions would present huge logistic difficulties.

[iv] UNHCR estimates that 4,700 refugees had been recruited by the Sudanese Liberation Army in the east of Chad

[v] These attacks are run by people who regard themselves as "Arabs" attacking "African" villages.

The army of CAR has launched military operations against rebels in the north-west and has banned any humanitarian intervention in the city of Paoua.

Insecurity has become an important concern for humanitarian partners and increasingly limits access to camps. The International Rescue Committee team was once again forced to evacuate Bahai after their driver was injured in an attack on November 11, which has had a significant impact on the life of refugees in Oure Cassoni camp. Amnabak camp was not accessible to the International Medical Corps team or other partners for several months. Two of their vehicles were stolen on November 4th by bandits. The roads in the east have become more and more insecure for WFP for the transport of food. The warehouse in Abeche, containing 483 tons of food,[vii] was looted on November 25th when rebel forces were controlling the city[4]. Due to the increase of violence in the east, agencies had to evacuate several members of their teams.

Displaced populations

Since December 2005 many Chadians have fled from villages mainly in the districts of Adre and Goz Beida [See map in annex IV]. Those who live close to the border fled the attacks from Chadian rebels. Those displaced (from the Dajo group) who were the victims of the most recent attacks in the villages in the south of Goz Beida[viii], witnessed groups of Chadian rebels (Zaghawa and Ouaddaï), and groups of Chadian arabs[ix] sometimes (but not always) accompanied by Sudanese wearing military uniforms and Arab Chadian militia. Those who took part in the attacks were heavily armed[x] and arrived by camel, horse and vehicles and stole livestock. Very near to the village of Kerfi[xi], armed groups systematically looted fields during the days following the attacks. Despite the risks, most displaced people came back to their village to harvest despite the fact that 23 people had been killed and 20 injured. One village was attacked because villagers refused to collaborate with the rebels.

The number of displaced people was estimated at 66,260 at the end of October 2006[5], but an additional 30,000 moved during the month of November, indicating that the crisis is quickly worsening. 140 villagers were killed on October 31 and 220 were killed between November 4th and 8th in villages in the south of Goz Beida [See map, annex V].

[vi] « Janjawid » means militia in arabic

[vii] Estimated at a value of half a million US dollars and around 80% of the humanitarian items in the UNHCR warehouse were stolen

[viii] Interviews during the present visit with three different groups of displaced people

[ix] The groups who attacked the villages as mentioned by displaced people were diverse : The Salamat, Muru, Mimi, Mafasa, Mahami, Himat and Awalfi. The Chadian context is very different from Darfur and requires more in-depth research to better understand the origin of the conflicts.

[x] All injured people hospitalised in Goz Beida had been shot

[xi] The village of Kerfi is not a safe place for displaced people – Kerfi was attacked on November 5th and two people died. Several hundred of displaced people from Kerfi moved to Goz Beida.

Food distribution, displaced people, Habile, Picture: Nigel Pearson

III. Humanitarian Aid

Role clarification of UN agencies
UNHCR continues to play an effective role heading up health and nutrition activities for the refugees, including data analysis, reproductive health, HIV/AIDS prevention and child health. The planning of activities is very clear. The new UNHCR health coordinator for the south has just arrived.

WHO has carried out very pertinent studies, for example, about the functioning of hospitals and the cost recovery scheme in districts. WHO has just reinforced its team for the sub-office in Abeche, with a second epidemiologist and an operator who will provide support in the currently lacking analysis of epidemiological data and a better graphic presentation of information. The line management of the sub-office of Abéché by the national office or the HAC seems limited. The team in Abéché is dynamic and committed but the supervision and support from the central office is poor.

The impact of UNFPA activities can not yet be evaluated, with the distribution of some reproductive health kits not accompanied by appropriate follow-up visits. UNFPA's gynaecologist in Abéché left but they have setting up a new office in Abéché, which could improve their visibility. UNFPA is currently reinforcing its presence and planning in the country in response to the critical situation of maternal mortality and the under-utilisation of family planning methods.

UNICEF has significantly improved its presence and leads in areas of nutrition, water and sanitation for displaced populations. This is done in collaboration with WHO, who distributed emergency kits to displaced people. However, coordination should be improved including a better health and nutrition surveillance system. The displaced have received limited food. WFP has no food stock in Goz Beida. UNICEF's offices were strengthened in the east with reinforced HIV/AIDS prevention activities and in the south with the arrival of a new coordinator. The vaccination programme has not always achieved its objectives in the camps due to stock shortages and the weak capacity of some partners, which has necessitated accelerated EPI campaigns. EPI in the districts has been significantly improved since 2005 when there was a very low immunization coverage, and a lot of effort was invested to improve the cold chain. UNICEF continues to support feeding centres.

OCHA set up a new sub-office in Abeche and has increased its capacity with a more appropriate information system and more visible coordination activities. There is more synergy, coordination and analysis amongst the UN agencies. Several workshops were jointly organised and another joint JAM evaluation mission was carried out. The matrix elaborated by UNHCR, in collaboration with all other agencies, is a useful coordination tool but an additional mechanism is necessary for ensuring that all activities are carried out. Supervision by the Geneva UNHCR health team is appropriate but the support and follow-up provided by other agencies from their international and national offices is not so effective.

UNHCR continues to coordinate all health activities in the refugee camps, even for data collection, reproductive health and child health which were supposed to be managed by WHO, UNFPA and UNICEF. These agencies often took part in training seminars and evaluation missions but have rarely initiated activities for refugees. However, UNICEF is providing effective support for the displaced populations in Dar Sila district. They facilitated the implementation of EPI everywhere in the country, with an accelerated EPI approach for displaced populations and mass vaccination campaigns against measles, polio and meningitis.

The inter-agency committee should think about how to improve the distribution and availability of evaluation reports by field teams. Most partners who visited in November never read the final French version of the evaluation report.

Recommendations – Humanitarian Aid

1/ WHO should take responsibility for health data collection in refugee camps and take a clearer lead in the health sector

2/ UNFPA should plan with the MoH for an annual reduction of maternal mortality and annual increase in the utilisation of contraceptives based on clear indicators.

3/ A consultancy is needed looking into the integration, coordination and management of UN agencies in the health sector. The key issues to explore are: i/ How to ensure that every UN agency will accomplish the tasks described in the matrix ii/ How to improve staff line management from international offices iii/ How to increase performance and programme indicators

4/ A better line management system with performance indicators should be put in place for UN agencies to ensure that human resource management is sufficiently structured. Based on the matrix, a clearer system is needed to monitor the performance of UN agencies so as to define the responsibilities of every agency and to clarify the main coordinator in each area.

5/ Inter-agency reports should be more widely distributed by sending hard copies as well as electronic versions of reports. Every NGO should receive between 10 to 15 copies to make sure that the health personnel can read the recommendations of the evaluation reports. Donors and the government of Chad should also receive copies.

Water access, Bredjing. Picture: Nigel Pearson

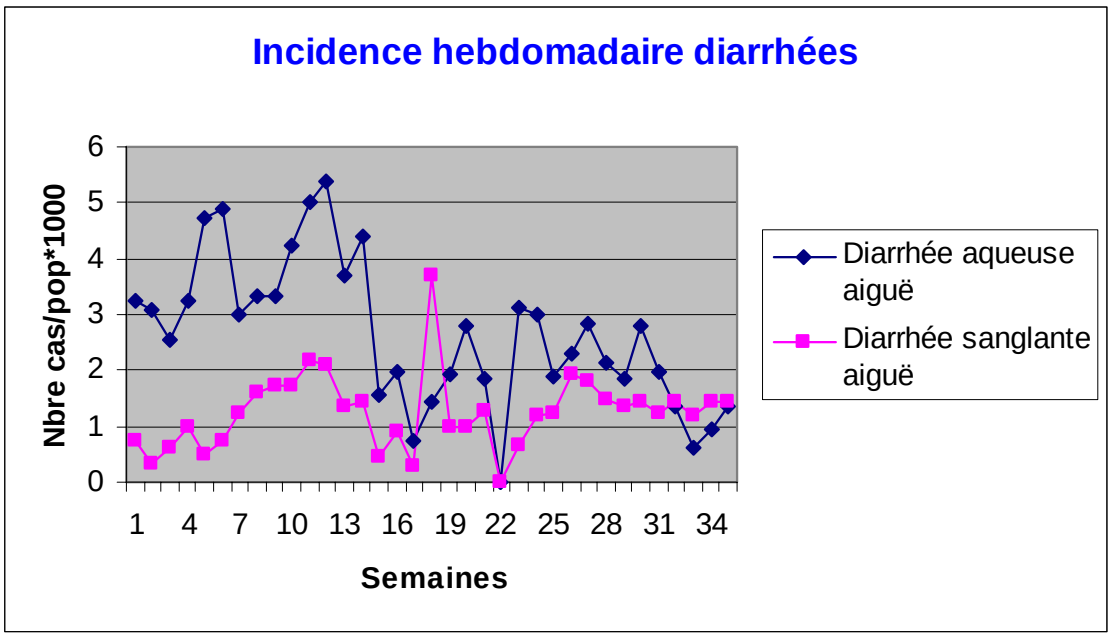
IV. Water and Sanitation

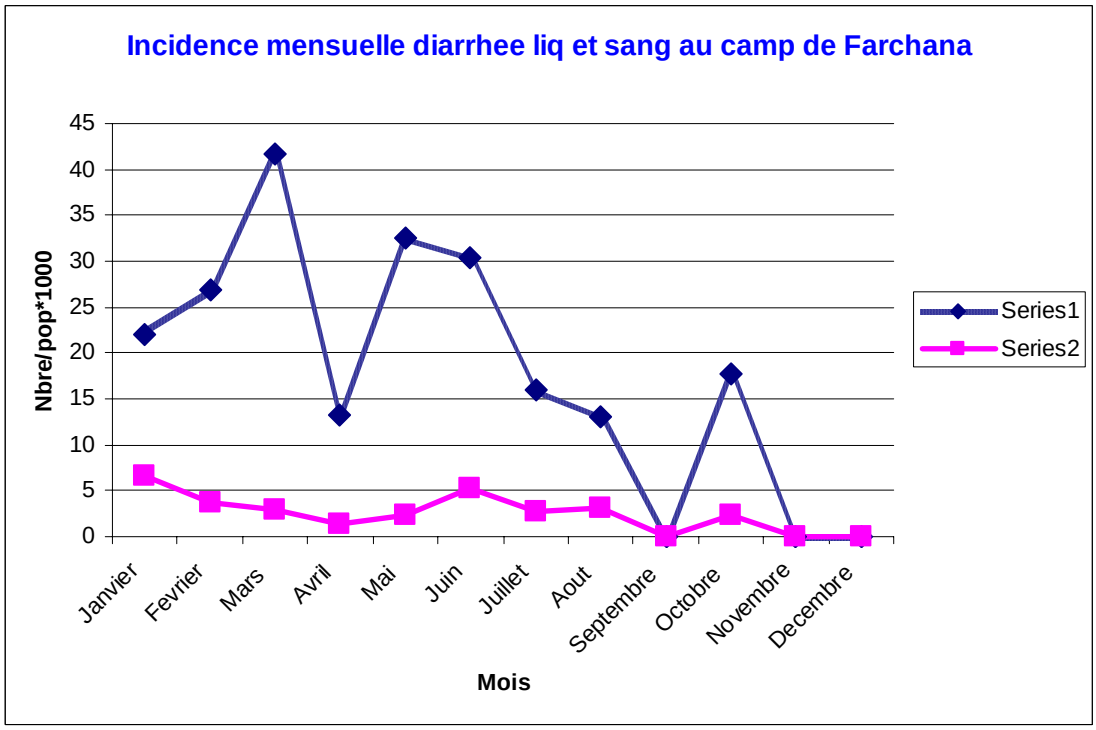
According to the inter-agency JAM visit report of November 2006, the availability of drinking water in 4 out of 12 camps is below the Sphere standards. 7 out of 12 camps do not have enough latrines. This may explain the high prevalence of diarrhoeal diseases seen in camp health centres. However, in some places, there is not sufficient ground water to supply the refugees at a level consistent with Sphere standards. 27% of morbidity in the camps was attributed to diarrhoea[xii]. However, the incidence of acute watery diarrhoea and acute bloody diarrhoea has decreased since the beginning 2005. Even if Touloum camp has the lowest number of latrines[xiii], its number of latrines has increased since the beginning of the year probably resulting in the decrease of the number of diarrhoea cases.

[xii] Analysis from UNICEF

[xiii] In August 2006, Touloum had one latrine per 64 persons and Goz Amir one latrine per 188 persons according to UNICEF

Incidence of diarrhoea cases (per week), camp of Touloum, 2006





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As a country, Chad has the second worst access to drinking water in the world (i.e. 30%, with only 45% of the population using a latrine) according to a study conducted by UNDP. In the east of the country, only 2% of the population has access to drinking water.

UNICEF rapidly supplied drinking water to displaced populations through 12 out of the 50 originally planned boreholes drilled. They also supplied chlorine and sanitation kits

and promoted hygiene. But in a few sites, access to water and sanitation remains insufficient.

Recommendations – Water and Sanitation

1/ Respect of Sphere standards should be considered in conjunction with the volume of available ground water. More sustainable and less expensive solutions should be chosen for water supply systems. It is recommended that the quantity of ground water be determined so that water can be used in a sustainable way and the reserves exhausted.

2/ Some camps still need more latrines, with the encouragement of the construction of family latrines instead of community latrines, which will be better maintained.

Picture: Nigel Pearson

V. Nutrition

In 2006 there has been significant improvement in the nutritional status of children in refugee camps due to the collective efforts of all partners in increasing food rations, in effective nutritional rehabilitation, the impact of curative and preventive health care and thanks to a good harvest in 2005/2006. Most therapeutic feeding centres (TFCs) in the camps now treat only a few cases per week. Between January-August 2006, the average number per month of hospitalised cases has been 147 for all camps in the east with 4 deaths, i.e. a mortality rate of 3% which is very low compared to humanitarian interventions in other countries[xiv]. It had been planned to close some TFCs but the arrival of undernourished children amongst the displaced population in the districts of Goz Beida and Adré required keeping the TFCs open. In the Amnabak and Gaga camps, the acute malnutrition rate is over 10%, which is of concern[xv].

The nutritional situation of the host population is still very worrying. WHO has been implementing nutritional surveillance with the support of ECHO and the MoH. However, after 3 months, only 9 out 73 health structures in 8 districts had set up nutritional surveillance[7]. In July, 35% of monitored children were malnourished compared to 23% in August and 33% in September. In total 53 children were referred to a TFC in one

[xiv] Which questions the relevance of following the standard of 10% mortality rate in TFCs proposed by Sphere - It would be more pertinent to use a rate lower than 5%.

[xv] On average 11.2% in Amnabak and 12% in Gaga according to the survey conducted between June and September.

camp. In August, in the village of Doroti the acute malnutrition rate was 23%[xvi] for under-five children diagnosed with upper arm circumference (MUAC). The MUAC is a useful tool in rapid surveillance but if high rates are found then a weight for height survey is needed. A survey conducted by UNICEF in the region of Guerra in August, revealed an acute malnutrition rate of 24% amongst children between 6 months and 5 years. Outside of camps, there are no feeding centres in the country. WHO does not include data on nutrition in the standard morbidity and mortality surveillance at the national and international levels[xvii].

A detailed study on the environmental impact of the refugees has been carried out[8]. The Women's Commission is exploring the various sustainable solutions available to diversify the domestic sources of energy in order to reduce the risks of violence on women when they collect firewood.

UNICEF is the leading agency in nutrition for displaced children who had a malnutrition rate of about 8% in August 2006 (at the site of Gouroukoun) and 6.8% (at the site of Koukou)[9].

Recommendations - Nutrition

1/ The nutritional status of the population is so severe that a donor should fund UNICEF and WHO, in collaboration with specialised agencies in the area of curative feeding. This would be to establish nutritional surveillance in sentinel sites in regions not affected by refugees, with the possibility of implementing cost-effective community-based therapeutic care (CTC)[10].

2/ The government should provide the National Direction for Nutrition with appropriate resources to create feeding centres and a surveillance programme.

3/ Within the weekly surveillance data, WHO could include severe malnutrition as a cause of mortality and acute malnutrition as a diagnosis in the morbidity surveillance[11] to ensure better follow-up of cases.

4/ In general, agencies should provide support to districts by creating supplementary feeding centres (SFCs) and TFCs in health facilities. The feeding centres in the camps should be transferred. More funding is needed in this area to ensure appropriate surveillance and effective responses.

[xvi] Out of 989 children – 10% acute and 13% moderate

[xvii] At country level, WHO monitors only data related to seven diseases (meningitis, acute flask paralysis, yellow fever, cholera, Hepatitis E, neonatal tetanus and measles). There is no valid data in Chad about the prevalence of malaria, anemia, dysentery or watery diarrhea.

Delivery room, health centre of Kerfi. Picture: Nigel Pearson

VI. Health Services

Surveillance System

Mortality rates have decreased in 2006. The main cause of mortality amongst children of under five is malaria in the south, and diarrhoea, malaria, respiratory infection, neonatal complications or malnutrition in the east. Under-five child mortality is four times higher amongst the Chadian population than the refugee population[xviii].

There is no surveillance system in place for child and maternal mortality in villages except during demographic and health studies that are organised every 7-8 years. The key health indicators amongst the host population should ideally be estimated regularly with cluster studies on mortality and malnutrition, so as to monitor the impact of inventions.

The Health information system (HIS) in Chad is rudimentary and is not systematically computerised. Figures published by the delegations on notifiable diseases do not correspond with the WHO database of integrated surveillance at national level. WHO does not give a strong enough lead in this area. Supervisions are made on an ad-hoc basis rather than on a systematic basis. The district delegations receive reports from the hospitals but very little information from the rarely supervised health centres. The exceptions are centres managed by humanitarian agencies which are supervised by UNHCR. UNHCR has built a good database for the camps and monitors trends. The only aspect missing is an updated total for every disease. Partners do not always send their

[xviii] 191 per 1000 compared to 45 per 1000 (UNICEF « Comparaisons de certains indicateurs de santé réfugiés Soudanais/ population tchadienne »)

reports in on time and the analysis of figures by health personnel in centres is very limited, partly because data is sent directly to medical coordinators without displaying them in centres.

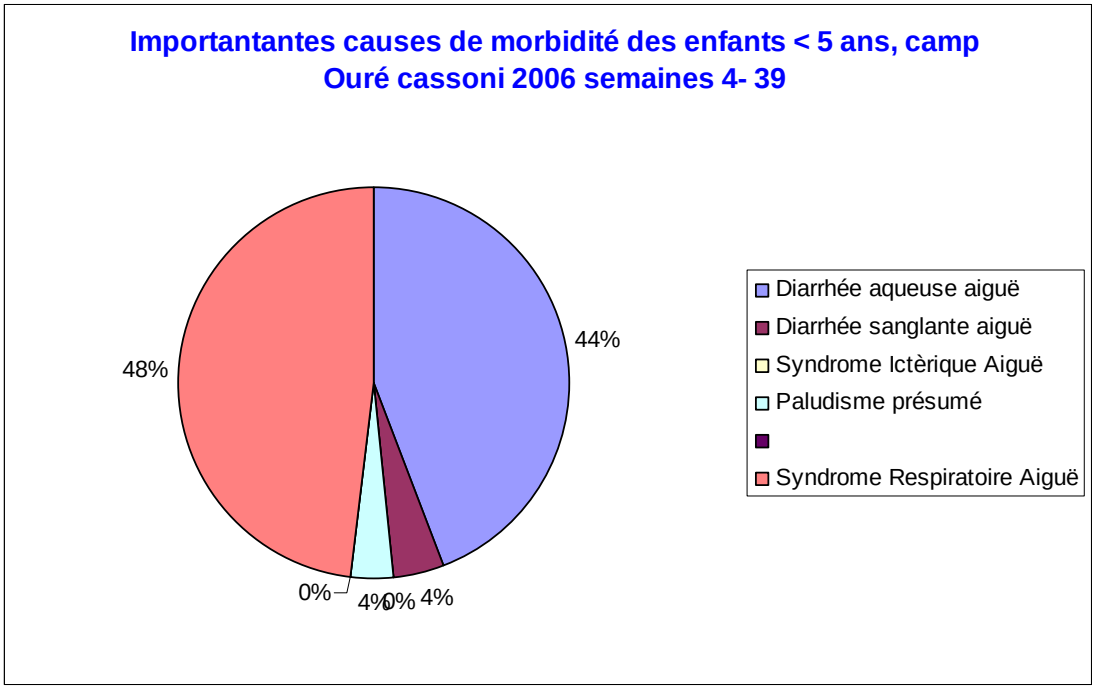
Response to Epidemics

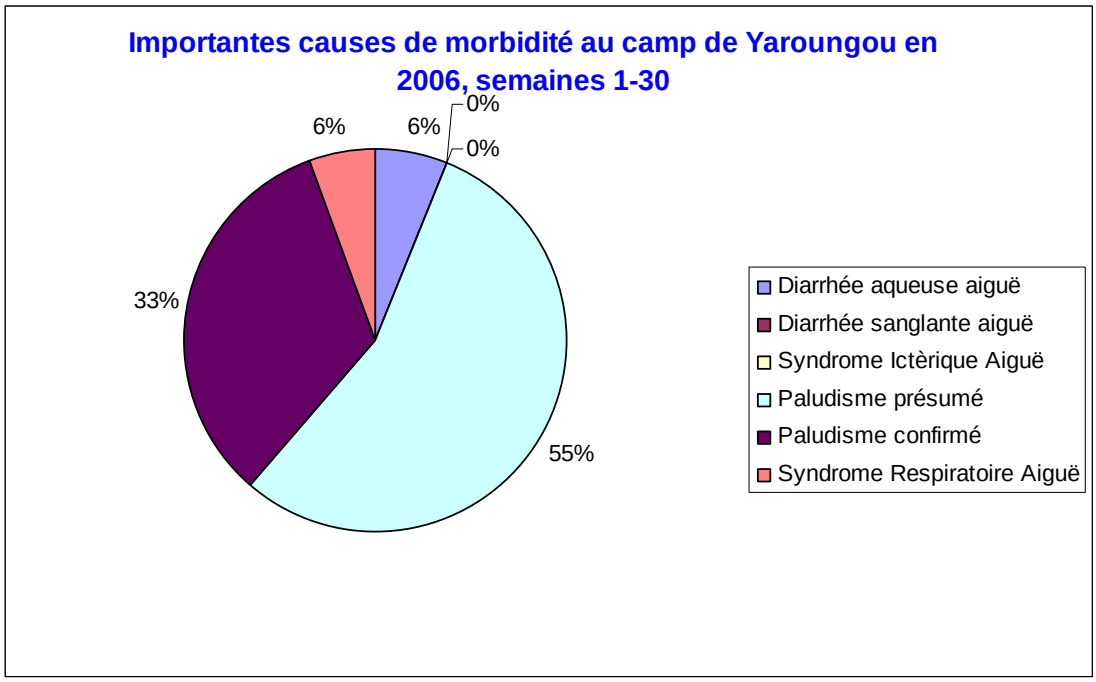
The planning elaborated by WHO and UNHCR to prevent, identify and respond to epidemics in the camps has been very successful. There was only one outbreak in 2006: Hepatitis E in the Gaga camp amongst the new arrivals with 280 cases and 3 deaths from July 2006. An intervention stock has been pre-positioned and the laboratory of Abéché has been supplied with appropriate bacteriologic equipment.

Isolated cases of meningitis continue to present, but the last mass vaccination campaign for meningitis was in Djabal camp, and in Adré and Abéché and surrounding villages in 2005. UNICEF has improved the vaccination coverage in the camps and districts during the year and, together with partners, was very prompt to set up vaccination programmes against measles and polio for displaced people. However, in health districts, it is worrying that 59 cases of neonatal tetanus were reported in 2006 causing 20 deaths. Only 35% of health structures (and only 3 amongst 12 centres in the camps) sent their weekly data for week 43.

Curative Care

Malaria represents a priority problem and a main cause of morbidity in the camps in the south, as well as south of Abéché. This is not the case in the drier saharo-sahelien zones.





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These pie graphs on the causes of morbidity were done by UNHCR and facilitated by the new assistant to the health and Nutrition unit in Abéché. Several partners have continued to spray houses and distribute mosquito bed nets in camps.

The Mentor Initiative[xix] has just started an anti malaria programme in the districts of Goz Beida and Danamadji with funds from BPRM. They will provide resources for the screening and treatment of malaria in every health structure in these two districts. However, they do not have resources to distribute non-impregnated mosquito bednets. UNICEF distributed bednets to the displaced population. But a rapid survey carried out by Mentor Initiative showed that 40% of bednets had been resold by the population. In the refugee camps, less than 50% of bednets were kept by beneficiaries. There is an issue of efficiency regarding the budget required by Mentor. They should revise their strategy to reach more beneficiaries within the same budget.

Access to curative care for refugees and the population living close to the partner-supported hospitals is very high. However, the district hospitals of Biltine, Am-dam and Danamadji are not supported by humanitarian actors. The surgical theatre in Biltine had remained closed until the arrival of the generator by the 8th EFD project. However, Am-dam has not received any assistance yet and cannot carry out any surgical operations. Only 94 patients were hospitalised in Am-dam during the first months of 2006. The NGOs in Bahai and Guéreda were very slow in delivering support to hospitals. The hospital of Abéché has just benefited from the arrival a new surgeon, a GP and two medical assistants[13].

Mental health programmes have been implemented in every camp, and some partners have had good quality programmes with experts either in psychiatry or psychosocial support. There is no programme to decrease alcohol abuse.

[xix] A UK organisation funded in collaboration with the WHO Roll Back Malaria Programme.

WHO has provided the regional laboratory of Abéché with equipment for coproculture which will be used to conduct tests to confirm cholera, dysentery and other diarrhoeal diseases epidemics.

A WHO expert trains staff. Regarding structures in the camps, they use Para check for malaria and urine tests. However, microscopy services are only available in hospitals. There is a new budget from OPEC available to strengthen the safety blood of transfusion. UNHCR and WHO are setting a blood transfusion service in the hospital of Abéché.

Except for in the camps, the quality of diagnosis and treatment is not monitored. A health centre team is usually composed of a single technical sanitation assistant helped by a few nursing "aids"[xx] who consult and prescribe drugs, even those which should be exclusively prescribed by medical doctors[xxi].

Most of the Chadian population does not benefit from access to health care. Health indicators have not improved and have even deteriorated during the past twenty years. While the under-five-child mortality has gradually decreased in the Sahelian countries of sub-Saharan Africa, the rate in Chad has remained at 191 per 1000 children[xxii]. The infant mortality rate was 102 in 2004[xxiii]. 13.5% of children between 6 months and 5 years are acutely malnourished and 41% are stunted[14, xxiv]. A study carried out in Moundou in 1997 showed that 89.8% of children with diarrhoea were malnourished and that child mortality was attributed to malnutrition for 30% of them[15]. In zones where the population move between areas each year, including Wadi Fira where several refugees camps are located, the mortality rate was 28%. 115 households were in a situation of severe food insecurity.[16] The worst figures concern maternal mortality which have increased from 827 in 1997 to 1,099 per 100,000 pregnant women in 2004 – which means that 8 women out of 10 die during their procreation years. 19% of children were born underweight[17].

Reproductive Health

The agencies in the camps perform very well in the south in terms of reproductive health, with 90% of deliveries occurring in the health centres, and without any death reported between January and August 2006. In the east, the maternal mortality rate was 240 per 100,000 deliveries[xxv], which seems to be high considering the intervention of humanitarian actors, but not surprising considering so many divergent strategic options. In two different refugee camps 15 km away from each other and composed of the same ethnic group, the rate of assisted deliveries is 5%[xxvi] in one camp and 90% in the other. It

[xx] The health region of Ouaddaï only has 35 technical assistants and 5 trained midwives, but 136 nursing aids (demeaningly called "garcons" and "filles de sale" who assist the assistants but have not received any training except in-service practice at the health centre.

[xxi] The health centre of Kerfi (population of 16,370 people) only has one medical assistant and one nursing assistant who prescribes chloramphénicol, gentamicine, diazépam and dexametasone and who has to help with deliveries when the medical assistant is not there. There are only 2 to 3 deliveries per month (and no bed, mattress, sheet or blanket in the centre) and 3 to 4 new consultations per day. Only 3 to 4 women per month receive contraceptives. However, vaccination is well supported by UNICEF. But health promotion is not current practice.

[xxii] 191/1000in 2004 and 194/1000 in 1997 according to Health Demographic Studies.

[xxiii] 103/1000 in 1997

[xxiv] In their "analysis and mapping of vulnerability" carried out in December 2005, WFP found the same figure of retarded growth for 41% of children.

[xxv] The neonatal mortality rate was 6.7 per 1000 deliveries in the camps in the south and 12/1000 in the east (January-august 2006).

[xxvi] Although this agency soon plans to build a new maternity service in the camp

is not acceptable that a woman has no access to a well equipped centre staffed with a trained midwife[18]. The strategy of authorising[xxvii] traditional birth attendants to intervene in home deliveries is not appropriate in the context of refugee camps. However, some NGOs run good quality reproductive health programmes for refugees.

The UNFPA kits are not always available and there is no follow-up of the reproductive health programme by UNFPA. The mortality rate of 1,227 per 1000 deliveries[xxviii] in the Abéché hospital illustrates why Chad is still one of the most dangerous country in the world for a woman who delivers a baby. This indicator is shocking and demonstrates the lack of investment in reproductive health by the government. Close to Am-Dam hospital, there is a cemetery with graves of women who died during delivery. There was no surgical theatre for caesarean interventions or means of transportation to transfer patients during floods across the wadi during the rainy season. There are only five trained midwives in the health region of Ouaddaï (with a total population of 742,000) who work in public health facilities. The partogrammes of WHO are now used in a few centres. UNFPA is sending seven gynaecologists to district hospitals including Abéché, Goré and Sahr[xxix].

Condoms and means of contraception are more available in health centres than before due to UNFPA and UNHCR. However, usage of them varies from one camp to another. Training about prevention and treatment of sexually transmitted infections was organised. However, the number of pregnant women reported with syphilis increased[xxx]. Great efforts to undertake education and prevention of HIV/AIDS were made by partners working in the camps. It is however necessary to proportionally increase the scale of programmes. UNHCR has targeted key leaders and health personnel with their education activities through multimedia sensitisation. Universal prevention means were well applied in all camps. A KAP survey on cultural barriers to the use of condoms is currently carried out by UNFPA. Condoms are not sold in shops in the east. There is no prevention programme on mother to child transmission in Chad, nor a programme on blood transfusion safety in health structures or reference hospitals. There is an ARV programme in regional hospitals that was launched by the National Programme of Action against HIV/AIDS with eight prescription centres that lack expertise, capacity and funding. There is only one voluntary counselling and testing centre in the east in Abéché. UNICEF is starting a psycho-social support programme for people living with HIV/AIDS. UNAIDS has just sent its delegate for the country but would need more operational capacities with additional team members and funds. UNICEF and UNFPA organised a workshop on how to assist women victims of violence. The PEP kits are available in every camp.

Preventive Care

Health promotion programmes have been well managed by partners who recruited a high number of health agents for the camps but not for the rest of the region. There has been a decrease of diarrhoea cases since the beginning of 2005 with a decrease in the incidence rate ranging from 30 to 50% in 11 camps between the first semesters of 2005 and 2006. In Iriba, health messages have often been broadcasted on the radio Internews. However,

[xxvii] And even remunerated

[xxviii] 6 women died out of 489 deliveries and 22 neonatal deaths, which corresponds to a neonatal mortality rate of 45/1000 for the six first months of 2006.

[xxix] But has a budget of only $12m for this programme for the years 2006 – 2010.

[xxx] Between 8 and 40% of pregnant women were tested positive .

apart from HIV/AIDS messages, the potential of this tool for mass education has not been fully exploited.

Prevention in the camps and even in health district structures has been improved through vaccination and the increase of routine and accelerated EPI coverage . In three camps there still needs to be a rapid acceleration of coverage. UNICEF has increased its support to delegations and partners but has not conducted supervision visits in the health structures concerned. The impact is very effective. There were only 23 declared cases of measles in the region of Ouaddaï during the first 6 months of 2006 compared to 1319 in 2005. There are very few cases of neonatal tetanus in the camps[xxxi], but there were 21 cases in the region of Ouaddaï during the first 6 months of 2006.

A District Perspective

The range of activities of partners is defined within a specific limited space around the camps. No partner has initiated global support to all activities and health structures of one district. There are various good examples of support provided by humanitarian actors to health facilities, there are also however structures neglected by partners, that are staffed with only one nursing assistant; under-equipped and not supervised by district authorities. Their consultation rates do not reach 0.1 per person per year (except when related to children during vaccination campaigns thanks to the EPI supported by UNICEF). This is the situation of health care in Chad requiring urgent involvement of the humanitarian and development actors. It is hard to believe that the two medical international NGOs working in Hadjer Hadid have not yet found joint solutions to transform the local health centre into a referral centre with surgical capacities. Seeing a refugee, injured by a bullet, treated on the dirt floor during the consultancy was not an example of good and ethical practice.

Health Financing in Chad

The World Bank ceased its support to the health sector due to problems relating to the management of resources. They spent $45m between 2001 and 2005 with the objective of reinforcing institutional capacity of the MoH. The project had limited results and will not be renewed after December 2006[19]. It happens that the MoH built new facilities with the funds of the World Bank (for example the hospital in Bikine). However, a new health structure does not automatically increase the attendance rate. The IMF ceased its support to HIV/AIDS projects due to poor management. The National Central Direction of Nutrition is supplied with milk F75 and F100 by UNICEF for the hospitals of Moundou and Mongo but does not receive any financial support from the government to create feeding centres. The European Development Fund of the European Union remains the main donor in the health sector. However, the 9th and 10th EDFs plan to fund budgetary support, which does not include any financial support to NGOs for their assistance to health districts. According to an evaluation carried out in 2003, the 8th EDF had to re-orientate its support from the centre to the districts and revise its strategy for the Pharmacies Régionales d'Approvisionnement that failed to supply district hospitals[xxxii]. Some districts receive support from donors or churches but many others are under-funded.

[xxxi] No case was reported in 2006 in Djabal camp compared to 2005 where 6% of the dead were attributed to tetanus.

[xxxii] They are currently looking for an NGO partner to manage the regional pharmacy services.

Public health facilities have adopted a cost-recovery scheme enabling them to cover salaries. Cost-recovery, combined with poor quality of care, results in a low attendance rate. The 8th EDF rehabilitates the hospitals of Adre and Iriba and provides drugs so that host populations and refugees have access to free care. In the east, WHO has just carried out a study on accessibility issues, requesting all the partners who offer free care to promote the same approach with other structures within their zone[20]. Faced by competition from the centres in the camps providing free care to patients, the health facilities supported by partners that are situated close to the camps have no chance to make their cost-recovery scheme function. However, if the cost-recovery scheme is still in use within the Chadian context for vulnerable groups, young children and pregnant women, health care will not be affordable. This however requires further study. At the end of 2005 and in April 2006 in Niger, the government adopted new laws to suppress user fees for pregnant women, deliveries and caesarean interventions and for under-five children[21] and to give free availability of contraceptives and condoms. On the other hand, the Chadian government decreased its expenses between 2003 and 2005.

Recommendations - Health Services

Surveillance System

1/ 1/ It is important that WHO analyses data more effectively so as to help partners better design their intervention strategy against priority diseases. WHO should provide more financial support and assistance in training to improve the quality of data collection and annual reports from districts and regions.

2/ The MoH needs to make more effort to computerise and strengthen the HIS, with the support of WHO.

3/ Ideally epidemiologic cluster studies would be carried out in villages in the east to collect baseline data, to measure the impact regarding of any improvements in the health services and to monitor the effect of the abolition of user fees for women and children under five.

Response to epidemics

1/ The early warning system needs reinforcing so that every structure sends data punctually on notifiable diseases. The weekly bulleting should be published every week in a more systematic way.

Curative Care

1/ Malaria, the main disease causing 90% of morbidity and mortality in the south and one third in the east, requires greater efforts to fight it. More funds are necessary to enable Mentor Initiative to add a distribution programme of mosquito bednets in the two affected eastern districts and several districts in the south and south-east of the country. The Global Fund could fund this programme and other partners, despite the difficulties they have experienced with the government in terms of financial management.

2/ It is very important to provide centres with microscopes and lab technicians. In the mean time, blood transfusion safety should be reinforced as a priority.

3/ UNHCR, WHO, UNICEF and UNFPA should coordinate their efforts to ensure that at least all the hospitals in Ouaddaï and Wadi Fira can carry out blood transfusion for all the

child who become severely anaemic from malaria and women facing obstetrical complications.

4/ UNICEF needs strong financial support in order to expand its SASDE programme (The outreach strategy for child survival and development) to cover every health district in Chad[xxxiii].

5/ The government of Chad should focus on the training of nurses, midwives and all health professionals.

6/ The agencies need to participate in training future health professionals by facilitating practice internships in facilities supported by agencies. They need to initiate contacts with training institutes and help interns for transport and on-site accommodation.

Reproductive Health

1/ Despite the quality of some NGOs' maternity services, most women in two refugee camps deliver at home with traditional birth attendants. Every NGO should encourage all pregnant women to deliver in health facilities.

2/ UNFPA should promote a maternity programme in every health structure in districts with clear indicators including reduction of maternal mortality rates, an increase in the number of trained midwives and the availability of equipment.

3/ It is necessary for the government and the agencies to launch a social marketing programme in Chad for condoms and a PMCT programme.

Preventive Care

1/ Vaccination of pregnant women against tetanus should be a focused priority, both in camps and districts, and should be increased.

A District Perspective

1/ A district perspective is not currently taken into account. Camp health centres should be transferred to public health facilities. Remote health structures require more support from the MoH, UN agencies and NGOs. It is important that agencies working for displaced populations reinforce the capacities public health structures instead of creating new parallel structures. The host population which has always suffered from poor access to health services, should be offered the same access as displaced people.

2/ Districts neighbouring the districts benefiting from humanitarian assistance (e.g. Am-dam and Biltine) should benefit from the expanded programmes of partners. While it is essential to promote the management capacity of the MoH, the allocation of funds should not depend on the level of capacity. Innovative approaches are necessary to fund partners working with the districts and ensure that the capacity of delegations and teams be strengthened.

[xxxiii] The SASDE programme is operational in 18 out of 62 health districts and is supported by the donors CDC and SIDA but really needs much more support.

Health Financing in Chad

1/ Donors should acknowledge that the chronic crisis responsible for the poor health and nutrition status of the Chadian population can only be resolved through approaches combining development with humanitarian intervention. The programmes needing priority support are child health and reproductive health. The response requires an innovative joint-initiative from donors, UN agencies, MoH and NGOs. A "consortium" approach, or even a multi-trust fund should be promoted. The Global Fund should support programmes that are managed by the MoH in collaboration with NGOs.

2/ The level of investment in health services for the Chadian population is extremely limited. OCHA should advocate for districts not affected by refugees. The government, donors, humanitarian and development agencies should provide resources and deliver emergency interventions to reduce the mortality rate of children under five, the maternal mortality rate and rates of acute malnutrition. In a country with a chronic crisis that is rapidly deepening, it is important to develop imaginative interventions that work at all levels (national, regional, district and health facility).

3/ The Chadian government needs to provide sufficient resources to fund health care by improving management capacities of health systems. Millennium Development Goals will not be achieved without significant investment in cost-effective clinical services and preventive programmes targeting children and women.

4/ The LSHTM and the inter-agency committee should envisage the possibility of commissioning a consultancy on the capacity of the Chadian health service, (not including ones for refugees, and an economic analysis of the resources needed to fund essential health services in Chad.

5/ Donors, UN agencies and partners should discuss how to fund under-five child healthcare and deliveries in Chad. UN agencies and NGOs, together with district medical doctors in districts where there is a presence of refugees and displaced populations should start discussions on abolishing user fees for the most vulnerable groups amongst the Chadian population. The health district of Goz Beida could be an ideal site, as this type of population is present and the level of response delivered by donors and humanitarian agencies has been adequate. A more comprehensive system should be created for the indigents, in particular widows. The government of Chad should fund free health care for children and women. This would require subsequent targeted investments to reduce maternal and infant and child mortality rates. For older children and adults, the MoH should emphasize the 2003 law of limiting hospitalisation fees to 5,000 FCFA [$10] and ambulatory care to 1,000 CFA [$2][22].

Midwife with a new-born baby, Goz Amir. Picture: Nigel Pearson

VII. Conclusion

Security conditions in Chad have worsened since the evaluation of February 2006. Despite the increasing risks faced by humanitarian partners, the level of health care and nutrition has improved and the priority needs of refugees have been fulfilled. The response to displaced people issues was effective but requires additional interventions in water and food supply.

The humanitarian agencies provided support to the health services situated close to the camps even if their intervention is very space-limited. Public health facilities are not equitably supported. Neither donors nor agencies have assessed the priority needs of the Chadian population even if some would argue that this would go beyond their humanitarian mandate. The Chadian government has not monitored any impact indicators during the last 15 years. Basic programmes on health and nutrition for children and pregnant women are not accessible to most of the Chadian population.

Chad is a country in crisis that requires the contribution of humanitarian agencies in the strengthening of public health structures combined with a strategy of capacity building and funding from the central level to adequately support health care services. The government and donors should allocate sufficient funds and strengthen the capacity at every level to ensure the good functioning of primary health care services.

Annex 1 - List of contacts met in Chad

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Annex 2 – List of participants at the debriefing meeting

Inter-agency meeting, debriefing of the follow up visit related to the Inter Agency Health and Nutrition Evaluation – List of participants

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Health and nutrition of refugees, displaced people and the Chadian host population

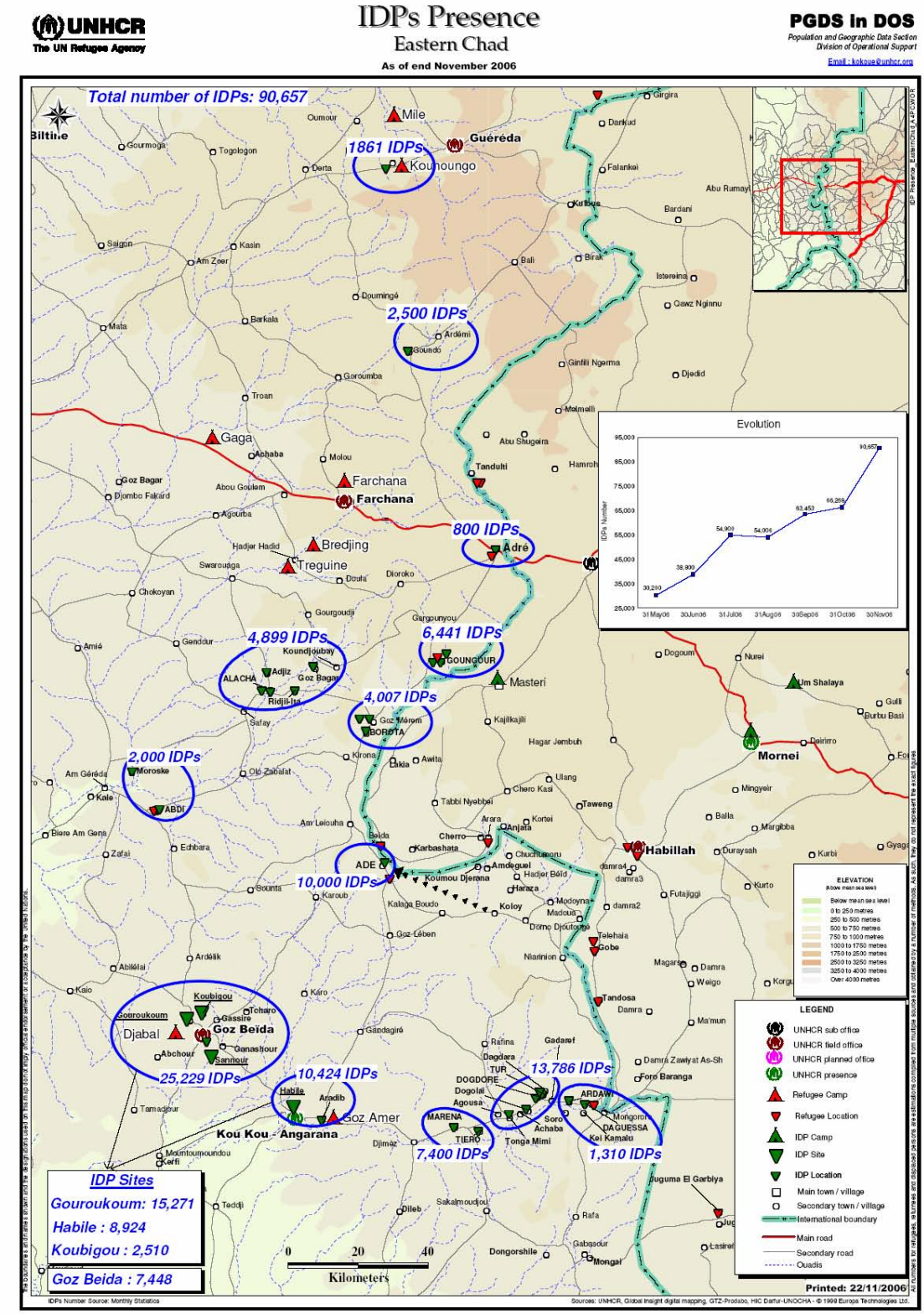
Inter agency meeting facilitated by Dr Nigel Pearson, member of the pool of evaluators selected by the Inter Agency committee.

Objectives of the meeting

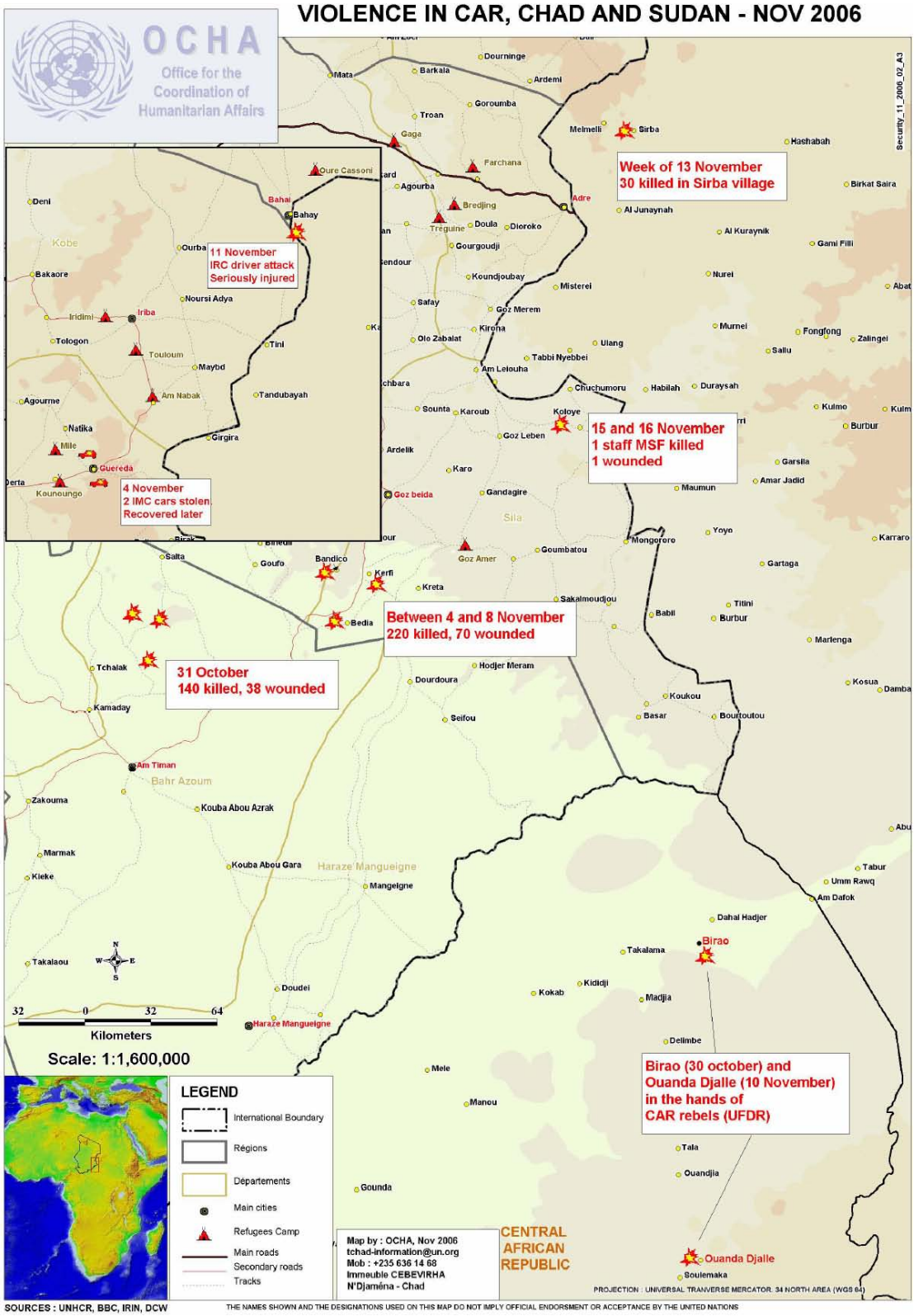
1. Review the recommendations of the evaluation carried out in February 2006 – presentation and feedback
2. Observation of changes since the follow-up visit of November 2006
3. Discussions about the level of synergy between UN agencies working in health
4. Discussion about coordination issues during the intervention with displaced people
5. Review the main challenges in health and nutrition faced by the Chadian population.

Annex 3 – Map of Chad

Annex 4 – Map of displaced people



Annex 5 – Map of violent events in the three countries



Annex 6 – Terms of Reference

INTER AGENCY HEALTH AND NUTRITION EVALUATION

REFUGEES AND HOST POPULATIONS IN EASTERN AND SOUTHERN CHAD

DRAFT TOR FOR FOLLOW-UP ACTION-PLANNING WORKSHOP

November 9, 2006

1. INTRODUCTION

Many actors are working together with a combined budget of several million dollars to support health initiatives targeted at the 200,000 Darfuri refugees in eastern Chad, and 42,500 Central African Republic (CAR) refugees in southern Chad, while also channeling assistance to the host communities in both areas. Although individual agencies conduct evaluations of their programmes, there had been no sector-wide evaluation looking at the impact and performance of humanitarian interventions as a whole on the health and nutrition of the population. Then, in February 2006, an Interagency Health and Nutrition Evaluations (IHE) Initiative was done to assess the situation. This evaluation reviewed progress and performance of the humanitarian response, and its interface with the existing Chad health system. It also examined the health effects and implications of cross-border population movements, and health service accessibility for both refugees and the host population. The process of carrying out an IHE enabled the agencies, working together with local health authorities and donors, to review achievements and reflect upon lessons-learned.

This contract is to conduct a follow-up, action-planning mission in Chad to review progress made, to identify barriers to further progress, and to suggest ways to overcome these barriers to improve humanitarian health programming in Chad. The consultant will also present his findings, and give feedback to two 2007 health sector planning workshops.

2. PURPOSE OF ACTION-PLANNING MISSION

The purpose of mission is to review the recommendations made in the evaluation. to assess whether they have been acted on, if not, why they have not been acted on. The consultant will develop action plans for addressing these recommendations, with the ultimate aim being to assist health actors (the Chad Ministry of Health [MoH], UN agencies, the NGO community and donors) to respond to meet the on-going needs of refugee and host populations in eastern and southern Chad.

3. RESPONSIBILITIES OF DR. NIGEL PEARSON

The Terms of Reference attached describe the body of work to be done by Dr. Nigel Pearson. He was one of the three evaluators who conducted the IHE in February, and has been hired to do the follow-up action-planning work. In brief, his responsibilities and timeline are as follows:

Dr. Pearson will assess the situation in the field and present his findings at two meetings. The first will be the 2007 joint planning meetings on the 21-22 November in Abeche, and the second will be hosted by WHO on the 27th November in Ndjamena.

- Thursday November 16 - Flight to Ndjamena, arriving 21:45 pm.
- Friday November 17 - flight to Abeche and meetings with key UN personnel
- Saturday 18 – Monday 20 November – visits to representative camps in east and meetings with NGO and UN staff
- Tuesday 21 and Wed 22 November – planning meeting with NGOs and UN in Abeche
- Thursday 23 – Saturday 25 November – further visits to health and nutrition programmes mainly in government facilities in 3 or 4 representative health districts.
- Sunday 26 – rest day
- Monday 27 November - Meeting with key UN health coordinators in Ndjamena
- Tuesday 28 November – meeting with key donors of health and nutrition programmes in Chad, looking at needs for both Chadians and refugees.
- Tuesday 28 November – (00:15 on 29th November) Return flight to London
- Between Nov 30th and Dec 11th – 2 days write up key findings/recommendations.

UNHCR Chad will oversee the process, in collaboration with Dr. Nigel Pearson. The N'djamena Humanitarian Committee, with assistance from the Abeche and Gore Technical Health Committees, and in cooperation with the IHE core working group, will also lend assistance.

4. EXPECTED OUTPUTS

The mission will result in two briefing sessions and a short report. The consultant will report on the current situation and how it differs from that of February this year. He will also outline the key barriers to improved humanitarian health action, as well as opportunities for enhanced health activities. Possible avenues for increased donor funding will be explored, as well as mechanisms to facilitate this (i.e. are more surveys needed to inform the situation in Chad). An action-plan will be developed during the two meetings, facilitated by Dr. Nigel Pearson. A summary note of the meeting including the action plan (no more then 10 pages) will be submitted to the group and LSHTM within two weeks after return to London (by Dec 11th). All stakeholders are responsible for input into the draft summary note. LSHTM will be responsible for facilitating the production of the final document.

5. SUPERVISION ARRANGEMENTS

UNHCR Chad will oversee logistic arrangements while in Chad, and give input into process. The work will be supervised by staff of the Conflict & Health Programme of the London School of Hygiene and Tropical Medicine. Input will also be given by the Senior Public Health Coordinator UNHCR (Nadine Ezard) and WHO (Andre Griekspoor) as well as by the Core Working Group (CWG) -- ACF-France/AAH-UK, CDC, Epicentre, London School of Hygiene and Tropical Medicine, Merlin, MSF, SCF-UK, UNFPA, UNHCR, UNICEF, WFP and WHO.

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