

INTER AGENCY HEALTH EVALUATION
HUMANITARIAN OASIS IN A PARCHED
HEALTH SECTOR: REFUGEES AND HOST
POPULATIONS IN EASTERN AND SOUTHERN
CHAD
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This report has been produced at the request of the Core Working Group for Inter-agency Health Evaluations. The comments contained herein reflect the opinions of the consultants only.

ACRONYMS

ACF	Action Contre la Faim
ACT	Artemisinin Combination Therapy
CAP	Consolidated Appeals Process
CAR	Central African Republic
CHAP	Common Humanitarian Action Plan
CHW	Community Health Worker
COOPI	Cooperazione Internazionale
CORD	Christian Outreach Relief and Development
CNAR	Commission Nationale d'Accueil des Réfugiés
EOC	Emergency Obstetric Care
EDF	European Development Fund
EPI	Expanded Programme of Immunisation
FGM	Female Genital Mutilation
GAM	Global Acute Malnutrition
HAC	Health Action in Crises
IASC	Inter-Agency Standing Committee
IEC	Information, Education and Communication
IHE	Inter-agency Health Evaluation
IMC	International Medical Corps
IRD	International Relief and Development
ITN	Insecticide-Treated (bed) Nets
ILO	International Labour Organisation
JAM	Joint Assessment Mission
KAP	Knowledge, Attitude and Practice
LSHTM	London School of Hygiene and Tropical Medicine
NCA	Norwegian Church Association
NFI	Non-food items
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
SG	Secretary-General
SGBV	Sexual and Gender-Based Violence
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFC	Therapeutic Feeding Centre
VCT	Voluntary Counselling and Testing
VIP	Ventilated Improved Pit Latrines

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	II
ACRONYMS	III
TABLE OF CONTENTS	IV
EXECUTIVE SUMMARY	VI
I. INTRODUCTION	1
II. CONTEXT	2
II.1 THE HOST COUNTRY	2
II.2 THE REFUGEES	2
II.3 INFLUENCE OF REFUGEES AND OF HUMANITARIAN AID ON THE HOST CONTEXT	3
II.4 THE LOCAL HEALTH SYSTEM	4
II.5 CONCLUSIONS	6
III. HUMANITARIAN AID	6
III.1 ACTORS	6
III.2 CO-ORDINATION, PLANNING AND FUNDING	7
III.3 HUMAN RESOURCES	8
III.4 COMMUNICATION, LOGISTICS AND SECURITY	9
III.5 CONCLUSIONS	9
III.6 RECOMMENDATIONS	10
III.7 LESSONS LEARNED	10
IV. WATER & SANITATION	11
IV.1 DRINKING WATER	11
IV.2 LATRINES	12
IV.3 WASTE DISPOSAL AND PERSONAL HYGIENE	13
IV.4 CONCLUSIONS	13
IV.5 RECOMMENDATIONS	13
IV.6 LESSON LEARNED	14
V. NUTRITION	14
V.1 NUTRITIONAL STATUS	14
V.2 FOOD SECURITY	15
V.3 MICRONUTRIENT DEFICIENCIES	15
V.4 NUTRITIONAL SURVEILLANCE	16
V.5 CURATIVE AND SUPPLEMENTARY FEEDING	16
V.6 HOST POPULATION	17
V.7 CONCLUSIONS	17
V.8 RECOMMENDATIONS	18
VI. HEALTH SERVICES	18
VI.1 BURDEN OF DISEASE & HEALTH INFORMATION SYSTEM	18
<i>Conclusions</i>	19
<i>Recommendations</i>	20
VI.2 PREVENTIVE CARE AND HEALTH PROMOTION	20
<i>Conclusion</i>	21
<i>Recommendations</i>	21
VI.3 FIRST-LINE CURATIVE CARE	21
<i>Conclusions</i>	23
<i>Recommendations</i>	23
VI.4 FIRST-LINE REFERRAL HOSPITALS	23

<i>Conclusion</i>	24
<i>Recommendations</i>	24
VI.5 DISEASE-SPECIFIC INTERVENTIONS	24
<i>HIV/AIDS</i>	24
<i>Malaria</i>	26
<i>Mental health</i>	26
<i>Conclusions</i>	27
<i>Recommendations</i>	27
VI.6 REPRODUCTIVE HEALTH	27
<i>Conclusions</i>	29
<i>Recommendations</i>	29
VI.7 EMERGENCY PREPAREDNESS AND RESPONSE	30
<i>Conclusion</i>	31
<i>Recommendation</i>	31
VI.8 RELATIONS WITH AND INTEGRATION INTO MoH SERVICES	31
<i>Conclusions</i>	33
<i>Recommendations</i>	33
VII. CROSS-CUTTING ISSUES	34
VII.1 ACCOUNTABILITY	34
<i>Conclusions</i>	35
<i>Recommendations</i>	35
VII.2 GENDER ISSUES	35
<i>Recommendations</i>	36
VII.3 REFUGEE PARTICIPATION IN IMPLEMENTATION AND DECISION-MAKING	36
<i>Conclusion</i>	36
<i>Recommendation</i>	36
VIII. CONCLUSIONS	37
VIII.1 RELEVANCE	37
VIII.2 EFFECTIVENESS	37
VIII.3 EFFICIENCY	38
VIII.4 IMPACT	38
VIII.5 COHERENCE AND CONNECTEDNESS	39
<i>Conclusions</i>	40
<i>Recommendations</i>	40
ANNEX I: TERMS OF REFERENCE	41
ANNEX II: ITINERARY	49
ANNEX III: LITERATURE USED	50
ANNEX IV: CONTACTS BY PLACE	51
ANNEX V: MAP OF CHAD	55
ANNEX VI: REFERENCES	56

EXECUTIVE SUMMARY

This Inter-agency Health Evaluation is the sixth in a series that sets out to analyse the sector-wide impact of the collective efforts of the humanitarian community. Three external consultants visited camps in Chad for refugees from Sudan (Darfur) and the Central African Republic, between February 2nd and 23rd 2006. The investigation was conducted using document studies, semi-structured interviews with all groups of stakeholders, direct observation of activities and transect walks through camps.

Refugees continue to arrive into one of the poorest countries in the world with one of the worst health systems and worsening health indicators. 'Traditional' resource conflicts between refugees and host populations (especially about scarce firewood) are exacerbated in some places by inter-ethnic tensions. The influx of refugees and humanitarian actors, however, has also brought fringe benefits to the host populations.

HUMANITARIAN AID

The humanitarian system has generally managed to satisfy the basic needs of the refugees. Synergy between the UN agencies active in health and nutrition is not obvious: gaps were observed, such as lack of health co-ordination in the south and duplications, such as the presence of three expatriate nutritionists in three UN agencies in the east. Human resource gaps in mid-level management result in a lack of strategic guidance and operational capacity for UN agencies and NGOs alike. Limited funding is a constraint especially for the south.

Recommendations

- UN agencies should streamline their resources through better structural arrangements. Among the possibilities to consider are:
 - to hand over key sectoral responsibilities to agencies with known capacities, e.g. nutrition to UNICEF and epidemiological surveillance to WHO.
 - to divide and document responsibilities at the onset of the humanitarian crisis and review them regularly. Memoranda of understanding should be established between the respective agencies.
 - to distinguish clearly between country and emergency programmes; staff for the latter, including funds and project management, should be seconded to a lead agency, in this particular case, UNHCR.

- In order to better fulfil its humanitarian mandate, WHO/HAC should consider managing activities directly from HAC Geneva (instead of being integrated in country and regional offices) and should enhance its operational capacity. OCHA and UNHCR should develop a joint strategy to increase funding and development partners for host populations in the east and south.

WATER AND SANITATION

The supply of safe drinking water is generally satisfactory but planning is not always appropriate. Where local integration of refugees is a realistic option, funds are being wasted through building and maintaining expensive and unsustainable water supply schemes (as is happening in one refugee camp in the south). On the other hand, poor quality options are sometimes implemented: unventilated pit latrines, and unlined protected shallow wells that would become contaminated are planned instead of boreholes. A small number of blatant gaps exist with regard to the availability of latrines; waste collection and disposal is rudimentary in all camps.

Recommendations

- In the south, sustainable water supply solutions should be implemented in Amboko and Gondje camps; the number of boreholes in Yarougou camps must be increased.
- Villages in the vicinity of camps should always be included in water supply projects.
- Where still no latrines exist, these need to be built urgently.
- Hygiene promotion activities need to be reinforced

NUTRITION

Humanitarian action to combat malnutrition has been extremely effective. Among the host population, however, malnutrition is worse and without prospect of improvement. The quality of nutritional programmes is generally good. Data on malnutrition and program indicators, however, are often insufficiently analysed on the spot.

Recommendations

- Agricultural activities (fruit trees, vegetable gardens and growing cereals) need to be greatly expanded. Possibilities for larger-scale agricultural, livelihood and environmental programs should be explored with development agencies and donors.
- The introduction of fuel-efficient stoves and solar cookers should be scaled up in order to reduce the demand for firewood.
- Especially in the south, decisions regarding the decrease of food rations should be linked to food security and nutritional surveillance data, rather than based on availability of funds.

HEALTH SERVICES

Refugees enjoy incomparably better health services than the general Chadian population. The negative impact of refugees and refugee health services on local health services, though true for a small number of health centres, is vastly exaggerated; access to health services has actually improved for local host populations.

A wide range of preventive and health promotion activities are carried out. Their impact, however, is insufficiently measured and host populations remain mostly excluded. The profile and quality of curative care is good, with the exception of the very limited complementary diagnostic means. Compared with the poor standard of hospital care in Chad, first-line referral care for refugees is adequate, with few exceptions. While HIV/AIDS prevention is considered as part of the health promotion activities in the camps, concrete and effective HIV/AIDS prevention programmes are lacking. The monitoring of sexual and gender-based violence (SGVB), namely rape, is not standardised, with very different estimates on the number of rapes from NGOs compared with UNHCR's figures. There has not been sufficient care of women reported as being raped in Sudan as they fled (hundreds according to one NGO). Although UNHCR documents and helps rape victims, referral of rape victims to the health structures is rare and often weeks to months after the incident.

Coordination and monitoring of health services is much better in the east than the south. UNHCR has no medical coordinator in the south and WHO has no active involvement in the south (except in case of outbreaks). UNICEF has only recently participated in a joint evaluation in the south

Recommendations

- NGOs must be more aware of the district health perspective. Humanitarian and development actors and donors should also explore ways of teaming up with the aim of improving health services in the regions concerned.
- Where there are nearby MoH health services, humanitarian aid should be used to support these, for the benefit of host and refugee population alike, instead of maintaining parallel health services in the camps.
- Concrete action needs to be taken with regard to HIV/AIDS and sex education, with the expertise of an inter-agency team or a specialised NGO. Efforts to introduce family planning need to be increased dramatically; ways have to be explored to overcome cultural resistance to condom utilisation.
- UNFPA needs to develop a coherent programme strategy for the east and south – including refugee and host population - and be accountable through a targeted reduction in maternal mortality and other reproductive health indicators.
- WHO should take the clear lead not only in epidemiological surveillance, but also with regard to emergency response capacity.
- Microscopy and laboratory facilities need to be strengthened at all levels.
- The district hospitals in the south need to be equipped to treat children with severe malaria complicated by anaemia.
- SGBV monitoring needs to be standardised, and programmes enhanced to ensure that victims of sexual and gender-based violence receive appropriate care, and preventive measures initiated and identification and referral mechanisms for rape victims improved.

CROSS-CUTTING ISSUES

Chances for long-term sustainability for health service provision are limited unless there is a significant policy change in the country. Knowledge gains and change of behaviour among the affected population would then also have a better chance to have a longer lasting effect. Sphere standards are the standards most commonly referred to. While on the one hand, their applicability has certain limitations (e.g. regarding amounts of drinking water), on the other hand, they are not always fulfilled where they could, and should be: with regard to latrines, sharps disposals, provision of family planning and support of local health services. The effect of displacement on the problems faced by girls and women is not fully understood and more could be done to identify and address gender based violence.

Almost all refugee contributions are paid for, be it manual labour or social services. It may be argued that this strategy fosters a certain *mentalité d'assisté*. Whereas it may be appropriate to give food to refugees working on a water supply for the camp, it may be more questionable that agencies should pay people to dig holes for a latrine for their own family.

Recommendations

- Where local integration of refugees is an option for a durable solution, sustainability considerations should be paramount in making strategic choices for health care provision, water supply and food security.
- Accountability could be increased with greater transparency and documentation of responsibilities of different agencies, and by encouraging more peer pressure. Activities and outcome/impact indicators of all actors should be formulated more clearly and published quarterly.
- The few examples of good practice in tackling violence against women (e.g. FGM and forced marriage) merit replication. UNHCR should consider inviting a specialised NGO that works with other actors on gender-based issues.



Refugee House, Iridimi, Eastern Chad

Photo by Nigél Pearson

I. INTRODUCTION

This inter-agency health evaluation (IHE) is the sixth in a series that sets out to analyse the sector-wide impact of the collective efforts of the humanitarian community. The IHE evaluations were initiated by the inter-agency standing committee (IASC) in 2003 and are managed by a core working group brought together by UNHCR and WHO¹. This evaluation was managed by the London School of Hygiene and Tropical Medicine (LSHTM) and organised in the field by UNHCR. In Chad, the existing health sector working groups in Ndjaména and Abéché will function as steering committees to follow up its conclusions – which are also expected to feed into the CAP mid-term review.

No need was felt by the evaluators to change the terms of reference (Annex I). After a preparatory meeting at the LSHTM, the field visit in Chad was carried out between 2 and 23 February 2006 (for detailed itinerary, see Annex II). Three external consultants (two international public health specialists and a national nutrition expert) visited 14 of the 15 refugee camps and surrounding areas. The investigation was conducted using primary and secondary data collection techniques, including semi-structured interviews with all groups of stakeholders, document studies (see endnotes and Annex III), direct observation of activities, and transect walks through camps; Annex IV lists contacts by place. Formal feedback sessions were held with members of UN agencies, NGOs, Red Cross and MoH in Goré, Abéché and Ndjaména.

The main limitations of the evaluation were a lack of contact with donors other than ECHO (humanitarian donors and OCHA's Humanitarian coordinator, but also development donors such as the 8th EDF of the European Commission) and limited time to collect sufficient detailed data on funding and activity implementation of UN agencies other than UNHCR in relation to the refugees and the host populations concerned. Owing to security constraints, neither Am Nabak camp nor Adré hospital were visited. Attempts to build a more gender-balanced team (the three consultants were male) were made until the last moment, but no suitable female consultant was found in time. Conscious efforts were made, though, to ensure women were well represented as respondents among the affected population. Translators, when needed, were chosen *ad hoc* as volunteers for short periods; care was taken to avoid responder bias by choosing a member of the community rather than a representative of an organisation or a person of authority. Primary stakeholders were included as respondents through purposive sampling in all locations visited; MoH health services and, wherever possible, 'control groups' were also included, such as neighbouring villages.

None of the consultants had any prior involvement with any of the programs and no other evaluator bias or conflict of interest are declared; the national consultant, though an employee of the MoH, focused on nutrition programs run by international organisations and not on MoH health service delivery.

¹ The IHE Core Working Group includes the following members: Action Contre le Faim-France/AAH-UK, Centre for Disease Control, Atlanta, Epicentre, London School of Hygiene and Tropical Medicine, Merlin, MSF, SCF-UK, UNFPA, UNHCR, UNICEF, WFP and WHO.

II. CONTEXT

II.1 *The host country*

Chad has its own complex history of internal strife, coup d'états, and war with Libya. It is one of the poorest countries in the world with a UNDP Human Development Index of 173 (of 177) for 2004. Four-fifths of its population live on less than \$1 US a day¹. It has a high population growth rate of 3.2% with an estimated population of over nine million. Petrol revenue from the oilfields around Doba in the south started to flow as from mid 2003. Countries, however, which rely heavily on natural resources are said to suffer from a 'resource curse' and tend to perform poorly in various measures of economic, social and political development². Unprecedented World Bank policy interventions to ensure both equitable distribution of oil revenues and enhance poverty reduction are commonly considered to have failed^{3,4}. The current political climate is described as tense (but relatively calm until mid-April 2006) owing to a generalized feeling of dissatisfaction among the population – against a backdrop of increasing regional instability⁵.

II.2 *The refugees*

Refugees from both the Central African Republic (CAR) and Sudan (Darfur) started to arrive in Chad in 2003 (see map in Annex 1). All have been recognised as *prima facie* refugees by the CNAR (Commission Nationale d'Accueil des Réfugiés), with whom UNHCR works in close collaboration. Both conflicts in the border regions of the neighbouring countries are indirectly linked to Chadian politics. While the Darfur conflict is well documented^{6,7,8}, documentation and human rights monitoring of the conflict in CAR is scarce.

The first wave of refugees from CAR in the south followed in response to a coup in CAR in 2002. Instead of a planned repatriation for 2005, the influx continued; over 12,000 arrived in the latter half of 2005 and during the field visit, 100 - 300 new refugees were arriving every day (4200 in one week), which triggered the planning of a fourth camp in the south. In cases where there is either delayed or no feasible repatriation, the durable solutionⁱⁱ foreseen in the south is integration. The environment has the potential to sustain farming, and relationships between refugee (at present around 45,000) and host communities are generally good⁹.

The influx of refugees from Darfur in the east started with spontaneous settlements along the border that were inter-mingled with host communities¹⁰. At present, twelve camps are housing over 200,000 Sudanese refugees. Following continued violence in Darfur, Gaga camp was chosen as the site to house new arrivals. The rate of new arrivals to Gaga has recently increased to 100 a day, reflecting the lack of resolution of the conflict in Darfur, and continuation of attacks on villages in Darfur. One or two camps (Am Nabak and

ⁱⁱ Durable solutions for refugees are: 1. repatriation, 2. resettlement (in a third country) and 3. local integration

possibly Ouré Cassoni) are liable to be displaced further inland, because of deteriorating security conditions and limited availability of drinking water.

Similar to all settings of forced displacement¹¹, the vast majority of the refugee population consists of women and children.ⁱⁱⁱ Some of the men are engaged in agricultural and herding activities back home or are fighting, others were killed. The refugees live in tents, which they themselves replace over time with traditional mud brick huts. Access to primary education in the camps is nearly universal; access to secondary schools, is lacking (and thoroughly missed by the refugees) with the exception of the south where UNHCR facilitates attendance at local secondary schools.

Participation in economic activity varies. Although a number of refugees had livestock, few have been able to bring their animals. Where the possibility exists, they turn to small-scale farming, encouraged by NGO projects: kitchen gardens in the compound and vegetable gardens in the vicinity of the camp. For growing cereals, there is a large differential, with substantial production in the south and very limited agriculture in the east. Brick-making is common, mostly for domestic use. Income-generating activities are limited and include thriving markets and small businesses in the camps (e.g. video and TV cinemas, and bars), working for humanitarian agencies and seasonal agricultural labour.



Security for refugees is hardly an issue in the south, where ‘normal’ incidents include disputes over grazing and agricultural land and collection of scarce firewood. In the east, in addition to similar conflicts over resources, inter-ethnic tensions and a spill-over from the Darfur conflict play a role; several cases of rape have been reported.

II.3 Influence of refugees and of humanitarian aid on the host context

Refugees represent a sizeable portion of the total population in the host areas: in Goré district, for example, they represent 30% of the population and in eastern Chad, almost 22%¹²; moreover, the host population itself is mostly impoverished. Little wonder, therefore, that overuse of existing natural resources (water, grazing areas and arable land) leads to tensions¹³. Most acutely felt is the competition for collecting scarce firewood, including for the production of charcoal, for which refugee women in the south walk up to

ⁱⁱⁱ Whereas 23% of women are aged between 18 and 58, only 11.4% of men are in the same age range (UNHCR figures)

three days from the camps. In order to reduce the environmental impact, work is undertaken by agencies with fuel-efficient stoves, as also practiced in Darfur, but this is on a very limited basis¹⁴. UNHCR has also proceeded to buy firewood for free distribution to the refugees from the host population in areas at some distance from the camps and distributes kerosene in Ouré Cassoni camp.



In the east, which is notoriously short of skilled human resources and job opportunities, riots have occurred about employment of Chadians from other parts of the country by humanitarian agencies. Tensions have fortunately lessened as the host population realises that the local market cannot supply all the skilled staff that are needed.

A noticeable negative impact is the rise in living costs in towns near refugee camps. Local authorities generally paint a negative picture of the refugee influx, although some, when prompted, admit the positive sides. An interesting explanation of the rather negative attitude of central authorities towards the refugees is the argument that the host populations have expressed discontent towards their own authorities, having seen services they themselves are deprived of being quickly provided for the refugees.

Like in other refugee situations, there is also a positive impact for the host country¹⁵ - jobs have been created, commerce has increased and local infrastructure has improved. UNHCR has assigned 5% of its budget for projects that benefit host communities and other UN agencies and NGOs include local communities among their beneficiaries. Anecdotal evidence was found that informally the local population is learning horticulture from refugees.

II.4 The local health system

The Chadian health system consists of health centres as first-line health services (each one covering a 'zone' within a district), and district and regional hospitals. The MoH pursues a policy of essential drugs; procurement and distribution of drugs and medical supplies is centralised in the Pharmacie Préfectorale d'Approvisionnement (PFA), which is supported by the World Bank and the European Commission. Supply to the periphery, however, is ineffective owing both to the PFA's disagreements with donors and unpaid debts by the regions to the PFA. Lack of access to essential drugs is therefore a major handicap across the country and especially in the periphery¹⁶. The regional hospital of Abéché, for instance, was found to be out of stock of syringes.

Chad suffers from a very severe shortage of health professionals. The few hundred medical doctors are mostly concentrated in Ndjaména and rural health facilities are usually staffed by non-professionals, not by nurses. In none of the districts visited were all the health centres functioning. The MoH ensures payment of salaries to trained health staff, whereas salaries for ancillary staff must be provided from the health structure's income. Infrastructure and equipment show similar shortcomings¹⁷ There is also no technical capacity for maintaining equipment, so that a broken generator in a district hospital means no operations are carried out, no computers are available for data analysis and laboratory equipment does not function. Until a few years ago, the MoH benefited from MSF-Belgium's decade-long 'district operational' support, discontinued as a consequence of a major policy shift within MSF movement¹⁸. Budget support to the MoH by the EC (8th FED) has just recently been interrupted, too.

The biggest and major obstacle to health care is limited financial access for the population. With extremely limited central MoH support, first-line health services function de facto like the private non-profit sector: a simple paediatric consultation in the south including drugs cost between three and five US \$; a Caesarean section or surgery for bladder stones in the south and east costs between 50 – 90 US \$ and the patient's family are obliged to go out looking for drugs and supplies in local shops before emergency surgery can be carried out. Exemption schemes for indigents do exist, but are difficult to verify; also, in order to guarantee access, a large part of the population would have to be exempted from paying. The health structure receives no recompense from the MoH if it gives free care to those to whom exemptions should apply. Low-income households therefore rely heavily on unregulated drug markets¹⁹. According to the World Bank brokered agreement linked to the pipeline investment, a proportion of oil revenues were to be invested in health. There is little health policy debate to date²⁰ and a World Bank inspection panel found that there is no program or plan to develop the health care infrastructure of the Government of Chad²¹.

There is a high degree of denial by the MoH of the lack of access to health care. Usually it justifies its position by referring to the Bamako Initiative. However, recent literature on cost recovery²², which was advocated for by the Bamako Initiative, generally finds that poor and vulnerable groups are heavily disadvantaged by the existence of user fees²³. In reality, the public system in most countries where the Bamako Initiative was implemented was neglected by the politicians and privatised by its employees who were looking for ways and means to extract a living from individual clients, having given up any pretence of fulfilling a public function²⁴. Health care in Chad, too, has become "the good of the market place rather than a public good"²⁵ In a time when even the World Bank has considerably backed off from the Bamako Initiative, WHO demonstrates a remarkably uncritical position towards the MoH policy of cost-recovery²⁶. There has been very little analysis of willingness-to-pay versus ability-to-pay within various parts of the Chadian population. This includes analysis of how often families have to sell assets to pay for healthcare, leading to deepening impoverishment.

Health indicators of the Chadian population paint therefore a bleak picture, and have actually been worsening over the last decade: taking maternal health indicators as an example, the Maternal Mortality Rate has increased from 827 per 100'000 live births in 1989-97 to 1099 in 1997-2004; professionally assisted deliveries have decreased from 24% in 1996 to 21% in 2004 and the average number of children per woman has increased from

5.2 in 1993 to 6.3 in 2004²⁷. Vaccination coverage is low as well; in Goré district, for instance, only seven out of 12 zones have EPI activities and in a village visited between Moundou and Goré, villagers reported a recent measles epidemic. There are serious shortages in the national EPI vaccine supply which particularly effects the southern camps.

II.5 Conclusions

- Refugees from both Darfur and CAR continue to pour into Chad, which is one of the poorest countries in the world with one of the worst health systems. Inter-ethnic tensions are exacerbated in certain places by ‘traditional’ resource conflicts between refugees and host populations which is exacerbated in the east. On the other hand, the influx of refugees and humanitarian actors has brought some fringe benefits to the host populations.
- Despite pledges to invest part of the oil revenue in health, the Chadian health system continues to perform extremely poorly, with a high rate of exclusion from access to care, resulting in very poor - and worsening – health indicators.

III. HUMANITARIAN AID

III.1 Actors

UNHCR, WFP, WHO and their NGO partners are key actors for health and nutrition, with UNICEF providing significant inputs as well. UNHCR and WFP maintain field offices in the east and south; UNICEF and WHO are present in the east only (in Abéché). Whilst UNICEF’s programmes are straightforward (e.g. EPI and nutrition), well known and used by NGOs and the MoH, WHO’s role is less clear. Its main objective is “to strengthen the coordination of health interventions in eastern Chad by reinforcing the consistency between the health services provided to the refugees and local population”²⁸. WHO’s effectiveness has been hampered, until recently, due to discontinuity in the presence of key international staff in Abéché^{iv} WHO had no clear separate programming for local and refugee populations. UNHCR bears the brunt of the health management burden and synergy between the three offices of UNHCR, UNICEF and WHO is not obvious: the evaluation found a number of overlaps (e.g. three expatriate nutritionists in the three UN offices, with ill-defined roles, and inaccurate EPI statistics in the camps). UNICEF have been poorly represented, with only one staff member in the east, and a country medical coordinator in post only from October 2005.

^{iv} It can also be argued, once again, that WHO/HAC is potentially hindered in fulfilling its humanitarian role because it only works through the MoH/government; the latter may be part of the problem in Chad, as it has partly abdicated its responsibilities towards the population.

The relationship between UNHCR and OCHA is poor. OCHA's role in mobilising donor funding and development organisations, and coordinating various agencies could be further developed with more cooperation by UNHCR. Despite part of OCHA's role in Chad being to coordinate "the humanitarian response, specifically regarding local populations"²⁹, OCHA does not yet have a permanent presence in the east and UNHCR's regional coordinator in Abéché also acts as the representative for the Humanitarian Coordinator in the east. This means that UNHCR coordinates assistance for the local population, but within the confines of its mandate with inevitably much less of a priority going to host populations.

Most agencies are running business-as-usual country programmes with emergency components added depending on availability of resources. In order to achieve better synergy among the latter, a model could be envisaged whereby all emergency programmes are subordinated to the management of one lead agency, in this case UNCHR, similar to the health cluster approach recently piloted in Pakistan³⁰.

In every camp, an international NGO plays the role of camp manager that implements site planning, food distribution and, in some cases, other tasks, e.g. water and sanitation. The distribution of these technical tasks - health, food security etc. - is different in every camp, but as a rule, one INGO is in charge of health and nutrition services (see Table 2 in VI.3). In a continuous shift of tasks and actors, there has been an evolution from the (often-overburdened) generalist camp manager to the specialised NGO; also, typical emergency INGOs pass the work on to actors with a double mandate, tender out projects or, in rare cases, incompetent actors are simply replaced. In general, the pieces of the puzzle fit together, with a few exceptions (see below on security, and Chapter IV on Water and Sanitation).

III.2 Co-ordination, planning and funding

In an attempt to clarify roles and responsibilities of (mainly UN) agencies, a draft version of a very comprehensive task matrix has been established - better late than never. But despite the shortcomings of the set-up, operational co-ordination is satisfactory. In peripheral locations, both weekly health sector meetings and weekly inter-sectoral meetings are held in camps. In Abéché, a monthly health sector meeting takes place and there are steering committees for nutrition and HIV/AIDS. The MoH is included in most, if not all of these meetings. UNHCR as the lead (and funding) actor is in a position to maintain coherence among most NGO partners. It has little hold, however, on other UN agencies and on INGOs working with their own funds (see Chapter VII.1 on accountability).

A weakness was observed in the planning process. In the rush to resolve problems, inappropriate solutions are sometimes chosen for problems that could be resolved more efficiently. Choices of 'emergency solutions' such as tented hospitals or an expensive water distribution schemes are sometimes made when funds are initially easily available, burdening the successor with recurrent costs and/or missed opportunities for integration at a time when less funds are available for making strategic corrections.

Two joint assessment missions (JAM) were carried out in 2005 and, during this evaluation, an inter-agency UN health evaluation went to Goré. The resulting reports provide well-founded technical recommendations^v which were, however, not always followed, due to lack of financial and human resources.

While the emergency phase lasting up to 2005 has been described as “traumatic” by NGO staff, the refugee situation has clearly entered a new phase requiring consolidation and longer-term planning, while still being able to cope with the influx of new arrivals. Unfortunately, this new phase is hampered by decreased donor support, especially for the south, where new funds are urgently needed. This most effects WFP, UNHCR and their partners at a time when refugee numbers are increasing. NGOs that are reliant on UNHCR funds are worse off than those that have other funding sources.

Knowing the number of refugees has obvious implications for calculating food rations and analysing epidemiological data. A year ago, a census in the east brought down the official refugee figures by more than 10%. In the South, unofficial estimates lowered estimates for Amboko camp by as much as 25%. The Joint Assessment Missions have already pointed out the urgent need for a renewed camp census in early 2006, and this was being carried out in Touloum and Iridimi during this research.

III.3 Human resources

Apart from limited funding, human resource shortfalls are the biggest limiting factor for humanitarian action. WHO’s staffing problems have been mentioned. UNHCR had to fill a managerial gap from headquarters during the emergency phase in the east and the health & nutrition action in the south have begun to be coordinated by technical sections of UNHCR, with negative repercussions on strategic planning. In the few cases observed of under-performing NGOs, the main cause, in addition to under-funding, were human resource gaps at a managerial, rather than at a technical or clinical level. Even if positions are filled, the high turnover rate and poor handover practices seriously effect strategic planning and can lead to burn-out of clinical staff. Recommendations made by UNHCR staff have at times to be followed up by several reminders until they are taken up. Managerial gaps may also be the key reason why many of the recommendations made by numerous expert evaluations remain without follow-up.

With regard to nationals, even clinical staff are hard to come by in Chad. MoH employees who are positioned in far-flung regions tend to absenteeism and desertion, owing to poor working conditions, inadequate remuneration and high living costs. NGOs try to overcome these obstacles by offering higher salaries and better conditions. In the east, notoriously short of skilled human resources, most health professionals are hired from Abéché or from Ndjaména. While almost all medical doctors employed by agencies are expatriates, national nurses are hired by NGOs usually in the period between their graduation and ‘integration’

^v which are not repeated in this report

into the national health system^{vi}. The MoH has a generally positive view of this practice in the debate of ‘poaching vs. professional mobility’³¹, owing to the potential for acquiring additional useful skills. Most NGOs engage in a number of formal and informal capacity building activities, but in certain cases scaling up of activities is limited by lack of experienced staff. While UNHCR has unified the salary scale for national staff hired by its partners, INGOs that have their own funds don’t always respect this scale.

III.4 Communication, logistics and security

Means of communication are plentiful and effective: local mobile phones in the cities, HF and VHF radios and Thuraya phones in the field. Air transport is excellent with WFP and UNHCR-chartered humanitarian flights. Road transport poses a problem in the rainy season for bulk food transportation and local medical referrals (e.g. between Goz Amer and Goz Beida).

Security for humanitarian agencies has significantly worsened in two regions the east. Adré hospital (supported by MSF-F) was attacked on 18 December 2005 and about 20 people were killed or wounded. This also provoked a flight of Chadian refugees into Darfur. Also, in the two months up to the evaluation, five humanitarian cars were high-jacked in and between Guereda and Iriba. So far, humanitarian staff have not been targeted as such, but their cars have been taken by Chadian rebels, Darfur rebels and bandits^{vii}. The Chadian government is apparently unable or unwilling to ensure road safety on a 50 kilometre stretch of road. The result is that medical referrals from Guereda to Iriba are almost impossible and that health NGOs have only an intermittent presence in a number of camps^{viii}. Security procedures are not streamlined: both UNHCR and the medical INGO in Guereda reproach each other for having evacuated from the town without first informing the other agency. Decisions on whether to send staff into the camp for the day are made on the basis of rumours from local markets or by senior staff in international head offices.

III.5 Conclusions

- Synergy between the UN agencies active in health and nutrition is not obvious: gaps observed include the lack of health co-ordination in the south and examples of duplication include the presence of three expatriate nutritionists in three agencies in the east.

^{vi} a procedure that reportedly involves a monetary transaction

^{vii} Where this recent evolution will lead, is unforeseeable, owing to different interpretation of the agendas of Chadian rebels and the government of Chad: the former may continue to respect the lives and safety of humanitarian staff or, in order to prove that the government has lost control over the area, change tactics. The government itself may simply be unable to secure the roads or be inclined to allow for a certain amount of insecurity in order to justify increased military spending.

^{viii} Mile, Kounungo and especially, Am Nabak

- Human resource gaps in mid-level management result in a lack of strategic guidance and implementation capacity for UN and NGOs alike.

III.6 Recommendations

- UN agencies should streamline their resources through better structural arrangements. Among the possibilities to consider are:
 - In order to alleviate the burden on UNHCR, key sectoral responsibilities could be handed over to agencies with known capacities, e.g. nutrition to UNICEF and epidemiological surveillance to WHO. But for this to work, other agencies would have to be much stronger from the beginning of the refugee crisis.
 - the division of responsibilities should be carried out at the onset of the humanitarian crisis and documented and reviewed regularly.
 - to distinguish clearly between country and emergency programmes; staff for the latter, including funds and project management, should be seconded to a lead agency, in this particular case, UNHCR.
- In order to better fulfil its humanitarian mandate, WHO/HAC should consider managing activities directly from HAC Geneva (instead of being integrated in country and regional offices) and should enhance its operational capacity.
- OCHA and UNHCR should develop a joint strategy to increase funding and development partners for host populations in the east and south.
- UNHCR should carry out a census of refugees from CAR in the south.
- INGOs that are entirely dependent on UNHCR funding should increase efforts to diversify their funding base.
- There is an urgent need to deploy a full-time health co-ordinator to the south.
- Health services must be ensured in camps where daily access is dependent on road security, possibly by positioning staff in the camps on a rotational basis, and by reinforcing contingency planning with local health structures.
- Security procedures need to be streamlined, especially with regard to assessing road security on access roads to camps.

III.7 Lessons learned

- Leaping straight from the definition of a problem in the planning cycle to the implementation of emergency solutions without considering suitable alternatives means opportunities for more sustainable and cost-effective alternatives are missed.

- Ill-defined roles among UN agencies can result in duplication, missed opportunities and failure to achieve synergy.

IV. WATER & SANITATION

IV.1 Drinking water

Providing such a large refugee population in a relatively short time with an adequate drinking water supply and sanitary conditions has been a formidable task. With a few surprising exceptions, it has been mastered well. Budget constraints, however, will be an obstacle to make the adjustments still needed, and force humanitarian agencies to aim at times for second-best solutions.



The solution chosen for supplying drinking water has been through motorised boreholes and distribution with gravity schemes (reservoirs or bladders). The small number of exceptions includes boreholes fitted with hand pumps in Yaroungou, and trucking in water to Am Nabak and Ouré Cassoni. Am Nabak camp will almost certainly be relocated. The hand pump solution in Yaroungou, which is in southern Chad, was chosen with a view to local integration of the refugees as a sustainable solution. Yaroungou was the

only camp where significant waiting lines were observed and the quantity of water was insufficient at six litres per person per day. UNHCR engineers are aware of this and have already recommended the immediate drilling of additional boreholes.

In Amboko and Gondje camps, where integration is also considered a ‘durable solution’, the same opportunity to choose a sustainable system has been missed. Motorised water pumping in Amboko and Gondje and the (still unfinished) expensive gravity system burden UNHCR with a huge maintenance cost when cheaper and more sustainable hand pumps could have been fitted instead. Worse, as the current shortage of funds doesn’t allow anymore for drilling of boreholes, unlined, protected shallow wells will be dug instead of better-quality boreholes. Funds are also insufficient now to provide the neighbouring villages with adequate drinking water.

In the east, where integration is not envisaged as a durable solution and the hydro-geological conditions nearly preclude a more sustainable solution, there are few alternatives to the current ‘artificial solution for an artificial situation’. Though the 11–12 litres of drinking water per person per day distributed³² are below the Sphere standards (which

recommend 15-20 litres^{ix}). In both east and south, with the two exceptions of Yaroungou and Touloum^x camps, the women interviewed were satisfied with both the quality and availability of drinking water. However, water quantity is more important than quality in terms of control of water-borne diseases, and efforts should be made to increase the amount of water available, especially if there is an upward trend in water-borne diseases. The only complaint voiced in a few instances was the wear and tear on jerry-cans that need replacement; some women would prefer using plain tin buckets instead. As closed top containers are more hygienic, jerry-cans should be replaced when broken, or more robust jerry cans or traditional water storage containers produced locally should be procured.

Access to safe drinking water in Chad is generally limited; in 1996-1997, only 27% of the population had access to safe drinking water³³. In a village visited in the south during this evaluation, women reported walking eight kilometres to fetch river water. In many instances, the villages in the vicinity of camps have no access to safe drinking water at all, unprotected shallow wells being the most common source. While no action has been taken to improve the situation in the Goré area, a number of good examples were found in the east, where either UNICEF or an INGO^{xi} have implemented appropriate and sustainable village water supply projects.

IV.2 Latrines

Although a big portion of refugees may not have used latrines prior to displacement, their use is indispensable in order to prevent faecal-oral transmission of diseases and transmission of water-borne diseases in the camps. The high incidence of diarrhoeal diseases and the outbreaks of Hepatitis E in several camps in 2005 illustrate the necessity on improving latrine building and utilisation.

The solutions adopted by INGOs for latrine building in the camps differed with regard to technical solutions, social distribution and the number of latrines per persons. The absence of Ventilated Improved Pit (VIP) latrines was explained by lack of funds. Cement and plastic slabs are used, or covering with wood beams; walls are made of reed and grass, plastic sheeting or mud bricks, with results ranging from well-used and well-kept latrines to completely abandoned latrines.

During the first stage of settlement, the solution of communal latrines was usually adopted, increasing coverage later by building more communal latrines, one latrine for a small number of families, or individual family latrines. The latter have given best results with regard to use and maintenance; communal latrines, never well maintained, are generally not appreciated. While the solution of individual family latrines should of course be the objective for all camps, the second-best (latrines shared by a few households) is also acceptable according to Sphere standards. In a small number of camps, however there were hardly any latrines at all. Goz Amer, Touloum and Iridimi, where there were high rates of

^{ix} Defining, however, total basic water needs also as 7.5-15 litres/person/day

^x 7.9 litres/person/day

^{xi} for example International Relief and Development (IDR) and Norwegian Church Association (NCA)

diarrhoeal disease, were certainly the worst as the camps and surroundings were littered with faeces^{xii}.

IV.3 Waste disposal and personal hygiene

Waste removal, if it happens at all, is usually paid for by the NGO that manages the camp. Pits where waste is to be buried or burned have been dug in most camps, but are insufficiently used. Like all villages and small towns in Chad, the refugee camps and the few remaining trees are littered or 'decorated' with plastic bags. Lastly, the evaluators met with the very frequent demand for more soap by refugee women. The 375 grams per person per month are slightly below the 400 grams recommended by Sphere standards, but they were getting less than this due to stock shortages in Abéché. To confuse matters, there is a difference in the standard of the quantity of soap to be distributed (Sphere: 450 grams/person/month; UNHCR: 250 grams/person/month). In the south only 250 grams is being distributed (in line with UNHCR standards), whereas in the east 375 grams is being distributed (just below Sphere standards, and above UNHCR standards). The supply of non-food items (NFIs) to the southern camps has also been restricted, with only one blanket, water container and ITN per new family arriving and no contingency for NFIs for new arrivals.

IV.4 Conclusions

- Respondents felt that the supply of safe drinking water is satisfactory, with two exceptions. However, where local integration of refugees is a realistic option, funds are being wasted through building and maintaining expensive and unsustainable water supply schemes. Adjoining villages, in contrast, often don't have access to safe drinking water.
- Owing to budget constraints, second-best options are often chosen: pit latrines that are not ventilated and unlined protected shallow wells have been planned instead of boreholes.
- A small number of blatant gaps exist with regard to the availability of latrines; waste collection and disposal is rudimentary.

IV.5 Recommendations

- In the south, sustainable water supply solutions should be implemented in Amboko and Gondje camps, preferably boreholes fitted with hand pumps. The number of

^{xii} While in the case of Goz Amer a specialised NGO has just been newly commissioned to undertake watsan activities to remedy the situation, it is still difficult to explain how it has apparently gone un-noticed for so long

these in Yaroungou camps is to be increased. If a new camp is created, this solution should be adopted from the start.

- Villages in camp vicinity at least, should be included in water supply projects.
- Latrines need to be built urgently where they don't exist yet. In new and old camps, the solution of individual household latrines should have preference over increasing the number of collective latrines.
- Work on waste collection and disposal needs reinforcing.

IV.6 Lesson learned

Before declaring a transit or temporary site a 'definitive' refugee camp, it is advisable to have the site assessed by a hydro-geologist^{xiii} to assess if there are adequate water resources.

V. NUTRITION

Malnutrition is endemic in the *Sahel* and an important contributor to morbidity and mortality of under-fives. High rates of stunting and underweight (18.7 % and 16.5 %) were found among Chadian school children in 2002³⁴. Moreover, growth rates of under-fives in Chad do not show any improvement: national surveys^{xiv} in 1997 and 2004 found retarded growth actually increasing from 40% to 41%. In Darfur, a high global acute malnutrition (GAM) rate of 21.8% was found in 2004³⁵.

V.1 Nutritional status

There has been a huge improvement in nutritional status of children in refugee camps since 2004, when levels indicating a serious crisis with GAM of 36-39 % among refugee under-fives³⁶. By the end of 2005, GAM in the east has reached a level of 9.26% and 8% in the south (Goré camps). A range of factors contribute to malnutrition: low calorie intake, harmful feeding and weaning practices, diarrhoea and respiratory illnesses, repeated pregnancies, exposure to the cold and displacement

^{xiii} as well as an ethnologist/anthropologist to assess potential relations between refugee and host populations and a food security expert for added understanding of people's livelihoods, and how they use the land.

^{xiv} l'enquête de démographie et de la santé au Tchad (EDST)

V.2 Food security

Both in the south and east, food security is globally assured. WFP rations guarantee in principle nearly 2100 Kcal / person / day in the east, although in practice a part is sold or bartered and WFP food rations are somewhat unreliable³⁷. Especially for the south, a significant deficit is foreseen for the next months; rations are being reduced owing to WFP funding problems rather than a proven improvement in food security.

While the potential for self-reliance in the south is high (ILO experts in local economic development are working at livelihood and self-reliance strategies³⁸), the refugee population in the east will remain dependent on WFP rations. Many refugees, more in the south than in the east, cultivate vegetable gardens with the help of NGO projects. The potential to grow cereals is severely limited in the east because it's a semi-arid area^{xv}.



V.3 Micronutrient deficiencies

Despite WFP-distributed food being fortified, sufficient micronutrient intake is not always guaranteed. Anaemia is the most common micronutrient deficiency, mainly in the south and greatly exacerbated by malaria. Having lost their cattle, refugees lack milk and meat in their diet, which is a source of iron. Iodine deficiency is endemic in the east for which a prevalence study is planned. WFP-distributed salt is iodised, but the salt commonly available in the markets is not. Culinary habits don't favour sufficient consumption of vegetables and fruit; in the east, unconfirmed cases of vitamin C deficiency have been signalled³⁹. Vitamin A is given during mass vaccination campaigns (6 monthly for the under fives); in the south, there are sufficient natural sources of both vitamin A and C.

^{xv} As an added difficulty, refugees in Gaga, Treguine and Bredjine camps are opposed to cultivating; the guarantee for return and fear of losing WFP rations were given as possible explanations

V.4 Nutritional surveillance

There is no national system of nutritional surveillance in Chad nor is growth monitoring practiced in MoH health centres. WHO has trained some nurses in nutritional surveillance and furnished some centres with anthropometric materials. A coordination committee composed of UNHCR, UNICEF, WHO and WFP meets quarterly to analyse nutritional data. UNHCR is hesitant to carry out nutritional surveys among the host population when it wouldn't be able to respond its findings but UNICEF and WFP financed surveys in some surrounding villages. The standard camp procedure is a monthly door to door nutritional screening, though it is not implemented in all camps yet. Surveillance statistics and statistics from nutritional programmes are gathered monthly by UNHCR. An observation repeatedly made was that local staff gathered and forwarded these data without analysing them sufficiently on the spot.

Nutritional surveillance is based in Abéché, divided among three UN agencies^{xvi}, and although their respective responsibilities are ill-defined particularly in regard to local populations, they guarantee a certain amount of supervision^{xvii}. The nutritional programme in the south, however, lacks guidance and supervision apart from some overseeing by UNHCR staff in Abéché.

V.5 Curative and supplementary feeding

Malnourished children are referred to the programmes of supplementary and therapeutic feeding either from the health centre or through screening. The nutritional protocols applied in the SFCs and TFCs were streamlined in a regional workshop in 2004; all NGOs except MSF-H, which uses its own, adhere to it. UNICEF/UNHCR provides the therapeutic milk; no supply gaps were reported. There is also blanket supplementary feeding for pregnant and lactating women. There is a three month supply gap for supplementary feeding in the south.

A number of TFCs and SFCs employ nurses for clinical work, which is justified because of the high ratio of children with associated illness. The TFCs visited were clean, well staffed^{xviii} and well run. Records were well kept and standards respected with regard to cure and defaulter rate, mortality etc. Some TFCs have exceptionally good indicators: 100% cure rate, no defaulters nor deaths (Danamadji). The only shortfall observed a number of times, was a long duration of stay (over 60 days), usually associated with prolonged diarrhoea.

Nutritional education is usually given for the mothers of the children. Apart from the users, however, the general population, especially the mothers, don't benefit from a systematic

^{xvi} Two in UNHCR, and one in WHO and UNICEF each

^{xvii} In Abéché hospital, though, an incipient nutrition programme was observed to hand out packages of therapeutic milk for the mothers to take home, which is bad practice

^{xviii} The main reason why the defaulter rate in Amboko during the influx crisis in 2005 was very high was severe understaffing

programme of nutritional education, although this would have the potential of tackling the key causes of malnutrition. The effective monthly screening has contributed to lowering the TFC admissions through early referral to a SFC, resulting in very low admission rates to some TFCs (such as in Mile) which could now be closed.

V.6 Host population

Malnutrition among the children of the host population is now higher than among the settled refugees. In the eastern regions, a CDC nutritional survey found a GAM of 35%⁴⁰ and WFP of 15.3% in 2005⁴¹. In Djabal camp, 33% of the TFC patients were from the host population, despite the lack of active case finding outside the camp. The good initiatives to increase agriculture (such as IRD's impressive programme around Iriba) are on a comparatively tiny scale compared with the need, particularly in the east. They will not have a large impact unless they are linked to initiatives aimed at stopping desert encroachment and promoting soil stability, improving the water table and channelling rain-water run off.

Once the TFCs in the camp are closed, the appropriate strategy to take care of the remaining caseload among refugees and among the host population would be to integrate malnutrition units into MoH health centres and paediatric wards of district hospitals, and link them to educational initiatives. The main obstacle, however, is the structural weakness of MoH health services and partners' lack of experience in stimulating sustainable changes in district services.

V.7 Conclusions

- Humanitarian action to combat malnutrition has been extremely effective. As long as food security does not suffer serious degradation, the nutritional situation among the refugees is liable to remain under control with measures of continuous surveillance and early detection.
- Among the host population, however, malnutrition is worsening in certain areas with little prospect of improvement .
- Especially in the east, the population's diet may not be sufficiently balanced to prevent micronutrient deficiencies, especially with regard to iron, vitamins A and C and iodine.
- The quality of nutritional programmes is generally good. Data on malnutrition and program indicators, however, are often insufficiently analysed on the spot.

V.8 Recommendations

- Agricultural activities (planting fruit trees, establishing vegetable gardens in and around the camps and, where possible, growing cereals) need to be greatly expanded. Possibilities for larger-scale agricultural, livelihood and environmental programs should be explored with development agencies and donors.
- The introduction of fuel-efficient stoves and solar cookers should be scaled up in order to reduce the demand for firewood and to reduce tensions with local communities over this precious commodity.
- There needs to be more coordinated planning between the nutrition and agriculture partners to link nutritional education with food production for both camp and host populations. One annual nutritional survey should be conducted among the host population during the same season.
- In places where MoH health services are sufficiently strong, nutritional activities should be introduced and integrated. The possibility to introduce community-based therapeutic care (CTC)⁴² should be explored.
- Especially in the south decisions regarding the decrease of food rations should be linked to food security and nutritional surveillance data, rather than based on availability of funds.

VI. HEALTH SERVICES

VI.1 Burden of Disease & Health Information System

The burden of disease amongst the refugees follows a similar pattern of the five most common diseases in Chad as outlined in Table 1 below: malaria occupies the first place in the south and acute respiratory infections and diarrhoeal diseases (depending on the period of the year) come first in the east.

Table 1 - The five most common causes for consultation in Chad

Order of frequency	Cause for consultation	%
1	Malaria	26
2	Acute respiratory infections	9
3	Diarrhoea	6
4	Dysentery	3
5	Conjunctivitis	2

Source : Annuaire des statistiques sanitaires au Tchad, Tome A, 2003.

While there is a more or less constant base-line incidence of diarrhoeal diseases, an outbreak in Goz Amer camp at the end of 2005 was contained through sensitisation and active case detection. An outbreak of meningitis (W 135 strain of meningococcus) was successfully controlled by vaccination in Farchana, Bredjing and Trejing. Typhoid fever and suspected *Shigella dysenteriae* was controlled in Ouré Cassoni. The only other major disease outbreak in 2005 was Hepatitis E, especially in Ouré Cassoni (102 cases and 1 death), Treguine and Bredjing camps, which caused a number of deaths of pregnant women but was eventually brought under control.

WHO have been instrumental in establishing two routine reporting systems:

1. Weekly surveillance (early warning system) , including diseases with a potential for epidemics, confirmed malaria and malnutrition^{xix}, and
2. Monthly collection of routine statistics.

This health information system is shared with the MoH and is in principle adhered to by all partners^{xx}. Other important shortcomings include insufficient local analysis of data gathered even when the information is passed on, and feedback from the centre to the periphery is limited. The lack of a reliable denominator in certain camps and the need for a renewed census has already been mentioned. In UNHCR's own opinion, Chad is "one of the countries most advanced in the field use of quantifiable indicators to monitor results achieved at camp level"⁴³. In terms of human resources, however, UNHCR does not have the capacity to submit the statistics to a "rigorous and coordinated auditing process prior to their publication"⁴⁴. It is hoped that WHO manages to consolidate its strength and presence as a technical lead agency in this domain. This role should ideally include collecting more data on the health profile of the surrounding health district with more in-depth analysis of health trends.

The implementation of a prospective mortality-reporting system is a high priority component of emergency relief⁴⁵. Data on births and deaths are collected by community health workers at population level. The quality of the data obtained is variable with excellent surveillance in most camps, but the very few deaths recorded in one camp (Yaroungou) suggested that surveillance was not active enough, and in this camp the mortality rates had not been calculated. Both Crude and Under-five Mortality Rates in the east for 2005 were all well below the baseline for Sub-Saharan Africa (0.5 and 1/10'000/day), with the exception of Treguine camp, which was just on these baselines.

Conclusions

- Apart from localised Hepatitis E and diarrhoea outbreaks, few other disease outbreaks have occurred since the beginning of 2005, but the incidence of both bloody and non-bloody diarrhoea remains high in most camps.

^{xix} Cholera, acute watery diarrhoea, AFP, ARI, acute bloody diarrhoea, hemorrhagic fever, suspected malaria, confirmed malaria, suspected measles, neonatal tetanus, suspected meningitis, fever of unknown origin, acute icteric syndrome, malnutrition, others.

^{xx} Only one emergency-orientated INGO calls the utility of standardisation into question

- The Health Information System in place is usually appropriate, although in practice, shortfalls include late or insufficient reporting, insufficient local and central analysis and lack of feedback from the centre to the periphery.

Recommendations

- WHO should take the lead in improving the implementation of the Health Information System at all levels (data gathering, reporting, local and central analysis and feedback), down to visual display of data at camp level. If possible, a comparison with the health profile of the surrounding health district should be included.

VI.2 Preventive care and health promotion

All NGOs in charge of health services have trained and employ community health workers (CHWs)^{xxi} who are in charge of health-related IEC activities, data collection, and active case finding. Many refugees never had access to health services before and used to rely on traditional medicine. Poor weaning practices (other liquids introduced from birth), which contribute to the high neonatal and infant mortality rates need modifying by continued promotional programmes efforts by NGOs. Much effort was made to improve health seeking behaviour and some harmful practices have been reduced. There is more scope to train CHWs to promote health seeking behaviour in the local population who may not be used to having access to health care either. There could be a greater use of visual material for IEC activities. An excellent opportunity for health education is provided by the local radio station in Iriba supported by the NGO Internews; other NGOs should not miss the opportunity to work in closer collaboration with it. Trimesterial participatory analyses and planning in the health/nutrition sector is being encouraged and NGO have been asked to create health and HIV committees.

In the east, routine EPI started in most camps only in the second semester/third trimester, due to absence of vaccines at national level. UNICEF is now supplying to the districts in the east, but this arrangement has not been made for the South.

Vaccination activities are part of the standard service profile for the camps, although EPI coverage is disappointing in some camps. Mass vaccination against meningitis, polio and measles was implemented in all camps. Surrounding villages were included for the meningitis and polio campaigns but not always for measles immunisation. Data on immunisation coverage were often impossible to obtain from the camp health centres^{xxii} and centrally gathered data reflect either a low coverage or a failure of the reporting system: most columns in the last update are left blank. Cases of neonatal tetanus continue to take their toll among refugees in early 2005 and host populations: in Djabal camp, they represented 6% of deaths in under-fives and Ouaddaï province reports 52 cases in 2005 with four deaths (which was 12% of infant deaths in health structures in Ouaddai). Intensive efforts were made to reduce neonatal death through community sensitisation, promotion of

^{xxi} With the aim of training one CHW for 500 refugees.

^{xxii} “the figures were sent to Abéché”

deliveries at health centres, recruitment of reproductive health community workers, and introducing vaccination against tetanus and supplementary feeding programs for pregnant and lactating women. Vaccination coverage in the camps, however, is still significantly higher than for the host population^{XXIV} - 1319 cases of measles were reported in Ouddai province in 2005.

Other preventive measures include systematic de-worming of children under five (not yet implemented in all the camps) and Vitamin A distribution during mass vaccination campaigns. Zinc supplementation for childhood diarrhoea was started by IRC in Ouré Cassoni who have been asked to extend the provision for all camps in the east.

Conclusion

- A wide range of preventive and health promotion activities are carried out. Their impact, however, is insufficiently measured and host populations remain mostly excluded.

Recommendations

- Health promotion activities should be extended to surrounding villages through training of CHWs.
- The quality and range of health promotion activities must be increased by including visual material, making use of local radio stations where available, and including health promotion in the school curricula.
- In order to monitor and evaluate impact of health promotion activities, KAP studies should be performed.
- Efforts to improve vaccination coverage should be continued; data gathering needs to be improved and local awareness about immunisation coverage needs increasing. Surrounding villages should be included in mass vaccination activities.

VI.3 First-line curative care

One agency takes the lead for health services in each camp, as outlined in Table 2 below.

Table 2 - Camps, refugee population and health service providers (Dec 2005)

CAMPS DES REFUGIES	POP REFUGIEE (Stat du 31 DEC 05)	CENTRE DE SANTE	POSTE DE SANTE	ONG MEDICALE RESPONSABLE	HOPITAL DE REFERENCE DE DISTRICT DE SANTE
1 OURE-CASSONI	29.610	1	1	IRC	Hôpital de Bahai
2 IRIDIMI	14.974	1		MSF-Lux	Hôpital d'Iriba
3 TOULOUM	20.058	1		MSF-Lux	
4 AM-NABAK	16.498	1		IMC	

6 MILE	13.419	1		IMC	
7 FARCHANA	17.249	1		MSF-H	
8 BREGJING	26.769	1	1	MSF-H	Hôpital d'Adre (MSF-F)
9 TREGUINE	14.001	1		IFRC	
10 GAGA	5.978	1		CORD	Hopital d'Abeche
11 GOZ-AMER	17.701	1		COOPI	Hôpital de Goz-Beida
12 DJABAL	14.381	1		COOPI	
TOTAL EST	202 266	12			
13 AMBOKO	25.000 ^{xxiii}	1		COOPI	Hôpital de Goré, Bangor et Moundou
14 GONDJE	3.400	1		MSF-H	
15 YAROUNGO	15.857	1		COOPI	Hôpital de Danamadji
TOTAL SUD	44.257	3			
TOTAL	246.523	15			

Source: Modified from UNHCR : TCHAD – EST. RESUME D'ANALYSE D'ACTIVITES 2005

In comparison to UNHCR evaluations and reports of 2004^{46,47}, health service performance shows a marked overall improvement. Refugees have now very good access to first level health services (and in general, also to referral services). These are provided by NGOs through a package of “minimum activities” and “complementary activities”, which increasingly also benefit from UNICEF’s integrated package of childhood illnesses and preventive work. The standard of quality of curative care provided by NGOs was generally found to be good with regard to service profile, levels of staffing^{xxiv}, equipment and medical supplies^{xxv} and observation of medical practices, such as prescribing habits^{xxvi}. Some programmes are of exceptional quality. This finding is confirmed by user satisfaction which was universal in almost all camps.

The host population has free access to camp health services in all the camps. In the east consultations for them represent between 10-42% in those camps where this is monitored. User rates of camp health services (corrected for host population) are all above one new consultation per person per year, with some over two and one over three, which is within the norm for a displaced population. In a number of places, health staff complained about frivolous or over-use of health services but this is an improvement on the initially poor health seeking behaviour. The introduction of a token flat fee, however, was felt to be premature with the possible exception of the more established camps in the south (Amboko and Yaroungou) where local integration of the refugees is the accepted mid-term solution.

Complementary diagnostic capacities are the weakest part of health services. Laboratory services are scarcely available in camps, some of which have a population the size of small towns. For malaria, paracheck rapid tests (for *P. falciparum* only) are available at camp level. Laboratory facilities are limited^{xxvii} and available in few district hospitals only, but have been planned for most camps. The laboratory of the regional hospital in Abéche is unable to do cultures. Some NGOs have good initiatives to support reference hospitals and

^{xxiii} Approx. (figure from CAP 2006)

^{xxiv} but note the shortages with regard to mid-level management mentioned above

^{xxv} with the exception of supply gaps in the south, which are due to funding constraints

^{xxvi} Most NGOs use MSF clinical and therapeutic guidelines

^{xxvii} In Goz Beida, for instance, neither Hepatitis tests for transfusion nor syphilis tests for antenatal care were available on the day of the visit.

health centres that serve host populations, but the vision for integration of host and refugee health services is still quite limited. WHO and UNHCR convene joint meetings with district and NGO staff but NGO staff were often poorly informed about the health structures in the districts in which they were working.

Conclusions

- With the exception of the very limited complementary diagnostic means, the profile and quality of curative care is good.

Recommendations

- Microscopy and laboratory facilities need to be strengthened at all levels - in the camps and in the laboratories of district and regional hospitals. There is scope for a specialised partner who could support the NGOs in this.
- NGOs should be encouraged to adopt a more district perspective in their support to host communities, and be more imaginative in how they support health structures serving local communities.

VI.4 First-line referral hospitals

The referral system for refugees appeared to be adequate, especially in comparison with the national system. The quality of care is poor for Chadians in government hospitals that are not supported by an NGO, and financial access is very limited. Drugs and equipment are in short supply, diagnostic facilities very limited and wards run on skeletal staffing (see Chapter II.4 - The local health system). Wards have only one nurse, and some district hospitals have only one nurse covering for 18 hours of the 24 hour period. Safe blood transfusion is not universally ensured and in regional hospitals there is no facility for looking after trauma patients and no tertiary /specialist care except gynaecology, unless when supported by NGOs or faith-based organisations



Horse Ambulance, Oure Cassoni, Eastern Chad

Photo by Nigel Pearson

The relative neglect of hospital-based care by both governments and the international community in emergency situations is known⁴⁸. In Chad NGOs have been inconsistent with their support for referral district hospitals: a few manage to keep hospitals up and running, others either tried and failed to do so or have been very late in supporting the reference hospital (e.g. in Bahaï and Guereda). Others either don't have the means or are spending them on a tented hospital inside the camp (especially in the south).

UNHCR with its partners has established practical guidelines for the referral system. As a rule, the NGO assures ambulance services to the hospital^{xxviii}. In hospitals that benefit from solid NGO support, services are usually free for all patients. In others, the hospitals have concluded contractual agreements whereby the NGO reimburses the government-run hospital. In these district hospitals, refugees are usually over-represented, owing to insufficient financial access for the host population.

Conclusion

- Compared with the poor standard of hospital care in Chad, first-line referral care for refugees is generally adequate, with a few exceptions confirming the rule.

Recommendations

- Measures need to be taken to improve transfer facilities day and night for the camps where this is not the case. If possible, solutions should be found for emergency referrals at night and transport assured.
- UNHCR and partners agencies should be prepared to share their technical capacity to repair equipment in district hospitals and find other ways of supporting them.

VI.5 Disease-specific Interventions

HIV/AIDS

The limited data available suggest that the prevalence of HIV/AIDS among the refugee population is higher in the south than in the east. In Goré, 26% of a total of 110 blood donors in the last six months tested positive; for Abéché, UNICEF gives a figure of 3% positivity among 188 blood donors tested for transfusion (in Goz Beida and Adre it was between 6-8%). However, one should note that these data are biased and cannot be interpreted as HIV prevalence of the population.

Despite the presumably lower prevalence amongst the Sudanese refugees than among the Chadian population^{xxix}, there are risk factors for the transmission of HIV, including:

- High prevalence of sexually transmitted infections^{xxx}
- Highly mobile and transient populations vulnerable to STIs and HIV/AIDS⁴⁹
- Poor knowledge among the refugees about HIV/AIDS, although this is better in the south than in the east.

The common assumption, however, that conflict and displacement commonly fuels the HIV/AIDS epidemic, is not always the case⁵⁰. On the contrary, other factors may actually

^{xxviii} Security and road problems between Guereda (which features a district hospital in name only) and Iriba and, in the rainy season between and Goz Amer and Goz Beida, have been mentioned in chapter IV, under logistics and security. IRC have in imaginative hospital ambulance service within Ouré Cassoni camp.

^{xxix} According to UNAIDS, HIV prevalence in Chad in 2003 was 4.8% (range: 3.1%-7.2%), the same figure for Sudan is 2.3% (range: 0.7%-7.2%)

^{xxx} In the south, 9,25% of curatives consultations in the health district of Goré are for STIs; in the east, syphilis prevalence among pregnant women in five camps was between 14.1 and 40.2%.

decrease the risk for HIV transmission, such as isolation of communities and decreased casual sex associated with trauma and depression⁵¹.

In the east, activities include training of influential people, training of peer educators and CHWs, mass education campaigns, promotion/training in the syndromic management of STI treatment, and the promotion of testing for syphilis in pregnancy (in certain camps). All activities are in an early phase and need serious scaling up. An HIV steering committee has been operational in Abeche. No KAP study has been conducted, but focus group discussions have revealed improved knowledge amongst refugees. Sharing of sharps seems to have decreased.

In the south, in Yaroungou camp, activities include training of peer educators and CHWs, mass education campaigns, training health staff in syndromic management of STI treatment. In Gore, some health education through CHWs is being carried out. HIV technical working groups and HIV refugee committees at camp level are being promoted.

In summary, HIV activities are still very basic and insufficient. All activities are in the early phase and need serious scaling up. In the south there is an urgent need for a VCT/care program due to the high prevalence. There is a lack of technical and HR capacity among MSP and international agencies to scale up rapidly.

UNAIDS leads assessments that criticize inaction on HIV prevention but apart from detailed plans⁵², UNAIDS has no programmes on the ground. Few mass education campaigns have taken place so far and condoms are rarely available or used. Condoms get little mention in the visual material produced by the MoH and the National Action Plan against AIDS^{xxxix}. Very rudimentary VCT services are only available in the south but are not close to the refugee camps. There is no national programme for the prevention of mother to child transmission in Chad. Universal precautions (with regard to injection material etc.) are adopted in all the camp health centres^{xxxix}, however there are frequent failures to keep the hazardous waste out of children's reach before it is burned.

Some of the constraints faced in the fight against the spread of HIV/AIDS were found within the humanitarian systems itself: HIV/AIDS awareness and HIV prevention are not always components of the response in the emergency phase^{53, 54}. Once it is on the agenda, there are funding constraints; although an HIV/AIDS coordinator was seconded to UNHCR in Abéché, two UN Volunteer positions (one each for the south and east) were refused for budgetary reasons. Among the refugee population, especially in the east, there is a strong denial of STIs and HIV/AIDS. There are significant cultural and religious barriers and hostility towards condom use, but the training of influential people was well received in all camps. Small inroads are being made as reported and observed in camps near Guereda camp - one *sheikh* who did not allow NGOs to talk about HIV/AIDS last year, has allowed it this year, and significant progress has been made in increasing knowledge about HIV/AIDS among youth groups.

^{xxxix} Plan National de Lutte contre le Sida: PNLS

^{xxxix} Government health centres, however, often lack autoclaves so instruments are washed and not sterilised.

Malaria

Already a serious problem in the south of Chad, malaria is at a higher prevalence in the rainy season in the southern camps in the east - Djabal and Goz Amer. Over 90% of the under-five mortality in the TFC of Amboko camp and Goré hospital is attributable to severe malaria complicated by anaemia⁵⁵. Goré and Danamadji district hospitals are, without NGO support, unable to cope with these severe cases, owing to a lack of transfusion capacity. Generally in Chad, treatment of malaria outside the health care system is widespread in endemic areas⁵⁶. The new treatment protocol (Artemisinin Combination Therapy) is only used by humanitarian organisations; it was not available in the MoH health services visited. Safe transfusion is generally unavailable in the Chadian health system for children with severe anaemia from malaria. In Danamadji, only HIV testing is done, without quality control, and no screening is done for hepatitis. UNFPA have given transfusion kits to agencies, but have not supervised their use. Blood is given by family members as there are no blood banks in Chad.

Reliable figures for the incidence of malaria are not available. Malaria tends to be over-reported in the east by certain INGo who don't trust paracheck: in one centre, only six paracheck tests of 26 patients categorised as malaria were positive; likewise, the inter-agency health evaluation in Burundi found that about 35% of patients treated for malaria do not suffer from the disease⁵⁷. On the other hand, most paracheck tests in Goz Beida were reported to be negative, but with positive blood smears. A possible explanation of this is that malaria, in the east, would be caused by *P. ovale* and *P. malariae* (Paracheck only identifies *P. falciparum*). This again highlights the need to improve diagnostic facilities. A quality control study of paracheck /blood smear is foreseen by WHO.

In the south and east, indoor residual spraying was done before last year's rainy season. Insecticide-treated bed nets (ITNs)^{xxxiii} have been distributed two to a family in camps around Farchana and further south and some surrounding villages and are distributed to pregnant women or to women who deliver in the health centre, but only at the rate of about one per family, which is below UNHCR's own standard, which recommends that 65% of the population sleeps under ITNs⁵⁸. Malaria control is poor in the south, with no new ITNs distributed except for pregnant women. Only 50% of refugees who received nets before they were relocated have retained them. A scaling up of the malaria control program is being prepared for the southern camps.

Mental health

Mental health programmes were surprisingly well developed for several of the camps in the east, and included treatment for psychotic and neurotic illness in camps where IMC was working, as well as counselling for post-traumatic stress and victims of SGBV. Training of MOH and camp medical staff in prescription of drugs for psychiatric disorders is being planned, but there is no mental health program in the south, and alcohol abuse is a widespread problem.

^{xxxiii} Goré MoH district has also just received 5000 ITNs from UNICEF.

Conclusions

- While HIV/AIDS prevention is considered as part of the health promotion activities in the camps, concrete and effective HIV/AIDS prevention programmes are lacking.
- Malaria continues to be the main killer disease among under-fives in the south.

Recommendations

- HIV/AIDS activities needs serious scaling up towards a comprehensive programme. More educational materials are needed, and improved identification and treatment of STIs. A safe blood programme needs to rapidly introduced in the south. There is a need for KAP surveys, more VCT and care for people living with HIV/AIDS.
- Concrete action needs to be taken with regard to HIV and sex education, with the expertise of an inter-agency team or a specialised NGO, and urgent need to increase capacity of MoH and INGO staff. Locally, inter-sectoral inter-agency task forces have to be set up^{xxxiv}, which include the host population.
- VCT and PMTCT and (especially in the south) care programmes have to be set up, and made available also to the host population.
- UNHCR needs to make partners more accountable with targets reached on condom utilisation. Cultural resistance to their use needs to be overcome with imaginative initiatives.
- Diagnostic means for malaria and updated treatment protocols need to be made available for MOH health structures. The district hospitals in the south need to be equipped to treat children with severe malaria complicated by anaemia.
- Malaria control needs to be scaled up. More ITNs are needed in the south combined with other preventive measures: community participation/sensitisation, indoor residual spraying and swamp draining, where possible. These efforts should be coordinated by an inter-sectoral inter-agency task force.
- NGOs with specialist mental health programmes should be encouraged to extend their services to camps that are not yet covered.

VI.6 Reproductive Health

The host country's reproductive health record is bleak. The devastatingly high rate of maternal deaths has been mentioned in the beginning of this report. The average number of children per women by the end of reproductive life is as high as 6.3; only two percent of

^{xxxiv} As recommended in a UNAIDS-led mission report (UNHCR (2005) Etat des lieux programmes VIH/SIDA en milieu réfugié au Tchad. 4 – 25 Mars 2005).

women use a modern method of family planning and 86% of all deliveries happen at home. Condom use during first sex contact is reported as only 3% for women and 8% for men¹. Such figures are confirmed by findings of the evaluation: government maternities visited lack mattresses, delivery packs and even autoclaves; instruments are washed in bleach. The obstetrician working with UNFPA in Abéché hospital reported a death rate of 998 per 100,000⁵⁹ pregnancies for the last quarter of 2005 because of late referrals of women in prolonged labour. Figures from the whole region of Ouddaï for 2005 are equally appalling: 25 maternal deaths out of 1647 assisted deliveries giving a maternal mortality of 1518 per 100,000 pregnancies⁶⁰. For women who deliver at home the figure can only be worse. A BBC investigative Panorama team that spent two weeks on the delivery ward of Ndjaména hospital in early 2005 witnessed five maternal deaths in as many days.

Reproductive health services in the camps were slow to be initiated, and capacity is still limited. UNFPA has maintained a remarkably low profile in supporting these services in camps. According to UNHCR⁶¹, and confirmed by the evaluation, UNFPA delivery kits are often not available. Most NGOs are promoting women to deliver in health units, training traditional birth attendants (TBAs) to encourage mothers to do so. TBAs among the refugees are often successfully hired as attendants in the health centre delivery room. COOPI in Djabal and Goz Amer has proved that very high antenatal care and service delivery rates are possible, and IRC have increased the percentage of assisted deliveries from 30 to 45%. Otherwise the proportion of deliveries in health structures remains low but is increasing in the east and approaching 100% in the south. Facilities exist in all camps to transfer women needing emergency obstetrical care, but in the wet season the road from Goz Amer to Goz Beida become impassable at times and insecurity temporarily leaves camps near Guereda cut off. The numbers of women attending antenatal clinics increase in camps where a supplementary feeding programme was offered for pregnant and breast feeding mothers.



The portion of couples using family planning methods and men using condoms is reported as unknown, zero percent or extremely low (0.0004 to a maximum of 0.04 per person per month^{xxxv}). While condoms are made available (though hardly distributed) by UNFPA, a shortage of oral and injectable family planning methods has been reported for the last six months in the south. Anecdotal evidence points to the possibility of slow, but steady, uptake of family planning methods including condom use when made available. Demand for

condoms is much higher in the south than in the east, related to higher HIV/AIDS awareness in the south.

Female Genital Mutilation (FGM) is practised in 26 African countries⁶² and also in Chad where, like elsewhere⁶³, it is rarely mentioned in open discussions. FGM is very common in

^{xxxv} in emergency situations, 0.5/p/m are recommended, in non-emergency situations, 1/p/m

the area where the majority of refugee camps are situated, both among refugee women and the host population. The challenge is to identify suitable alternatives to FGM which facilitate the transmission of group values without compromising women's health and well-being⁶⁴. UNHCR is making some attempts to reduce FGM, including an imaginative programme for reducing female genital mutilation by providing alternative employment for the *exciseuses*. This was in a camp in the south where 90% of the women have undergone excision. In the east, there is a wide variation in FGM practice with different tribal groups – it is rarely carried out on Masalit women, but is common amongst the Zaghawa and Ouddai. A KAP study was carried out by IFCR in Trejing and an HIV/FGM KAP study is being proposed, but funds have not yet been identified.

Data on sexual and gender-based violence (SGBV) - an issue which goes beyond the health sector⁶⁵ - is extremely patchy; under-reporting owing to the stigma attached to the victim is the rule. Nor was a consolidated system of data gathering apparent. Earlier assessments mention "widespread reports abducted of women and girls abducted and raped in Darfur"⁶⁶. One agency estimated 500 rapes in women arriving from Darfur. At present, while UNHCR had recorded about 20 rapes for four camps in the east in 2005, one NGO reported about 5 – 10 cases from a single camp per month. Basic SGBV care (e.g. treatment for presumptive sexually transmitted infections) is available in the camps, but post-exposure prophylaxis (PEP) for HIV infection is available only in some locations. SGBV kits, including PEP prophylaxis, are supposed to be delivered by UNFPA. UNHCR can only report verified cases that they have followed up. In some cases when they have tried to verify agency reports of high rates of violence the partner could not provide accurate data. There have been increased efforts to standardize and improve reporting, and improve the referral of victims of gender based violence. Legal mechanisms to follow up perpetrators are extremely weak in eastern Chad.

Conclusions

- The range and uptake of reproductive health services varies considerably between camps. Maternal health services are generally available and of acceptable quality, with few exceptions of limited access to emergency obstetric care, because of referral problems at night or in the rainy season. Obvious and common gaps are the near-absence of family planning (including condom use in the east) and the scarcity of initiatives to combat FGM and paucity of reporting on SGBV. Further training is foreseen^{xxxvi}.

Recommendations

- UNFPA needs to develop and implement a coherent programme strategy for the east and south – including refugee and host population and be accountable through a targeted reduction in maternal mortality and other reproductive health and HIV/AIDS indicators.

^{xxxvi} UNHCR, in collaboration with UNICEF, is planning an extensive training for camp and MOH medical staff in several areas of RH and HIV/AIDS, such as safe motherhood, family planning, SGBV, STI treatment, and HIV/AIDS (IEC, VCT, care for PLWH etc).

- Where not yet implemented, efforts have to be made to increase the ratio and quality of professionally-assisted deliveries. Equally, access to emergency obstetrical care must be made available in all locations, including at night-time through improved referral mechanisms where possible.
- Efforts to introduce family planning (including condom use, also for HIV/AIDS prevention) need to be increased dramatically. Greater efforts should be made to include men as a target group.
- There is a need to guarantee full care for SGBV victims, with: promotion of prompt treatment seeking behaviour, emergency contraception, presumptive treatment of STIs and PEP for HIV^{xxxvii}.
- Monitoring of SGBV - especially rape cases - needs to be standardised and a more culturally-sensitive surveillance set up so the scale of the problem can be better appreciated, with one UN agency taking the lead.
- Culturally-sensitive strategies to tackle FGM need to be explored and implemented.
- The Government of Chad should be expected to demonstrate political willingness to reduce the very high maternal mortality. The MoH can not do this without adequate resources.

VI.7 Emergency Preparedness and Response

As described above, there is a well-developed early warning system for the detection of epidemics. Early response capacity has been proven in a number of small outbreaks of hepatitis E and meningitis, which were well contained through intense surveillance and active case finding. For instance, there was only one recorded death in the hepatitis epidemic out of 102 cases in Ouré Cassoni, where IRC have a joint strategy plan with outbreak preparedness linked to watsan community disease control measures. On the other hand, there was a lack of recognition of the link between the poor sanitary conditions in Touloum and Iridimi camps and the high case load of bloody diarrhoea in 2005 (3-4 % of consultations). Support to the regional laboratory in Abéché is slow in coming as well.

While WHO has been instrumental in coordination and planning and in introducing epidemiological surveillance in the eastern regions, its capacity to support UNHCR and NGOs is limited. WHO has organised seminars in the identification and management of epidemics, but there is no regional pre-positioning of emergency supplies; most NGOs have created emergency stocks (which is a resource duplication). UNHCR have asked NGOs to create contingency stocks for cholera, meningitis and dysentery (to cover two weeks) and basic diagnostic material (Pastorex, Transisolate and Clary Blair). In addition, UNHCR has

^{xxxvii} see IASC guidelines for GBV interventions in humanitarian emergencies (September 2005): www.rhrc.org/pdf/GBV_guidelines_Eng_09_13_05.pdf

created a contingency stock for the same diseases and malaria. WHO has planned to improve the capacity of the regional laboratory to make rapid diagnoses of epidemic disease, but equipment and supplies have not been forthcoming. WHO staff says it is not their mandate to have contingency stocks, but it could be argued that this is one of the aims of the Emergency Response and Operations department of HAC, which aims to develop operational and logistics capacity in crises. Although WHO does support contingency planning by agencies, the effectiveness of this planning may remain limited if not backed up by a logistical capacity to supply agencies in an emergency. The MOH have very poor supplies for emergencies and epidemics (such as cholera and meningitis).

Conclusion

- In a geographical area and under circumstances that foster disease outbreaks, operational response capacity lags behind epidemiological surveillance in terms of co-ordination and streamlining.

Recommendation

- WHO should take a clear lead not only in epidemiological surveillance, but also with regard to response capacity, by coordinating epidemic response, supplying and/or pre-positioning laboratory and disease intervention kits and stocks of IV fluids and drugs for the MoH and NGOs. The capacity of the regional laboratory in Abéché needs to rapidly be enhanced, as already planned by WHO.

VI.8 Relations with and integration into MoH services

MoH officials have a tendency to blame the refugees for shortcomings of their own health services. The main complaint, widely echoed by WHO⁶⁷ and also UNHCR itself⁶⁸ is unfair competition through “dumping” practices, i.e. offering free health services that undermine the business of MoH health services that are compelled to charge patients. However, there is no evidence to back up this argument in hospitals. Fees are mostly waived in district hospitals supported by NGOs (an exception being the hospital in Goz Beida) or they are lower than usual, e.g. in Bongor hospital. For other hospitals, refugees are the source of additional income, as UNHCR/NGOs reimburse the hospital when they receive a refugee patient. MOH staff are invited and participate in most training seminars organised by UN agencies.

The argument does hold true for about half a dozen first-line MoH health services in the vicinity of refugee camps. There, the local population prefers to make the short trip for free health care in the camps, with the result that the MoH health service loses customers. Despite this, it is very likely that there is an overall improvement in access to health services as utilization goes up when healthcare becomes free (and quality is increased). This phenomenon is not singular to Chad; the fact that UNHCR health services often end up being the only available or reliable services in a particular location for both host and refugee populations has also been reported from Uganda⁶⁹.

Undeniable and much more dramatic is the lack of equity, at country level, with regard to health services between refugees and host population. Humanitarian aid can neither lower the level of health services for refugees significantly without conflicting with medical and humanitarian standards, nor is it able to raise the level of health services country-wide. All it can do is smooth out the differences locally in three ways:

1. Extend health services to host populations using humanitarian funding^{xxxviii}, and do so by assisting local MoH services
2. Help to support and strengthen district level services (usually NGOs with their own funds)
3. Act in synergy with development donors at district or regional level through advocacy and increased co-ordination.

The first strategy is open to all NGOs, whether working with their own or UNHCR funds and has the added benefit that it creates a positive perception of refugee assistance programmes among the host population⁷⁰. While a number of examples of good practice have been found (e.g. extending health promotion activities into surrounding villages or supporting the local district hospital for secondary care), there is also a list of missed opportunities: a tented hospital in a camp at a short distance from an empty district hospital or a very busy health centre at a short distance from an equally empty MoH health centre. The obvious solution in these cases is changing the strategy and assisting the local health services instead of maintaining parallel services, (as already proposed by one of the JAM reports). In areas where local integration of the refugees is a likely durable solution and where refugees can survive economically without external support, the gradual re-introduction of cost-sharing mechanisms can be discussed with the district health authorities. This recommendation is made in acknowledgement of the local system of cost sharing. However, the caveat is that willingness-to-pay versus ability-to-pay, and risk of catastrophic health expenditure should be examined by those involved in the development of the Chad health sector.

The second strategy, of adopting a district perspective and acting more at district level, requires a broader funding base than UNHCR funds, and a minimum of development skills. The bottom line is that district plans are discussed yearly with all local stakeholders in order to achieve synergy where possible. It has to be kept in mind that even these activities will not be sustainable in the long run unless there is a significant improvement in the financing of the health sector, and improved health system planning.

This evaluation is unable to take the design of the third strategy - of acting jointly with development donors - further, without the participation of the latter. However, the presence of at least one significant donor acting in the health sector (the EC) is worth exploring; there is scope for much more synergy, given the important presence of NGOs on the ground.

^{xxxviii} mostly meaning: UNHCR funds

Conclusions

- Refugees enjoy incomparably better health services than the general Chadian population.
- The negative impact of refugees and refugee health services on local health services, though true for a small number of health centres, is vastly exaggerated - access to health services has actually improved also for local host populations.

Recommendations

- NGOs that have all their camp projects in control and spare human resource capacity should increase their involvement in projects for local communities.
- Where there are nearby MoH health services, humanitarian aid should be used to support these, for the benefit of host and refugee population alike, instead of maintaining parallel health services in the camps.
- Humanitarian NGOs must become more aware of the district health perspective. District health plans should be discussed yearly and evaluated each semester among all stakeholders. NGOs with spare capacity could be more imaginative in supporting the district health system.
- WHO should support District Medical Officers in getting access to a portion of the 5% of UNHCR funding reserved for the host population and ensure they use it effectively.
- UN agencies need to engage in advocacy with donors and the Government of Chad for increased support for health services in Chad. Ways of teaming up of humanitarian and development donors for improving health services in the concerned regions could be explored.



Community Health Worker with Family,
Ouré Cassoni Camp, Eastern Chad

Photo by Nigel Pearson

VII. CROSS-CUTTING ISSUES

VII.1 Accountability

A number of evaluations from headquarters and in-country joint missions have taken place; most reports have been made public. As already mentioned, evaluations have often remained without follow-up, owing to constraints of financial, managerial and human resources. There is also a danger of not seeing the wood for the trees – or how else is it possible that despite collecting “19 indicators weekly and 53 monthly”⁷¹ basic needs such as latrines are in some occasions left unmet for prolonged periods?

UNHCR as the lead agency has little leverage over other UN agencies and NGOs that may be under-performing. It also appears to be on the lenient side with regards to the performance of the NGOs it is funding. UNHCR should make clear its expectations of partners, and monitor performance indicators in health and watsan projects to ensure that all basic needs in the camps are met within certain time limits.

An improved process of monitoring and evaluation may be the key to improve over-all performance. The newly created matrix defining responsibilities by sector and organization could be expanded to include activities and a limited number of key outcome and impact indicators. Publishing these key indicators quarterly and illustrating them graphically would have some effect through increasing peer pressure.

Regarding accountability to standards, a refugee camp is one of the few situations in which the assumptions for the application of Sphere standards may be fulfilled, i.e. a common goal, humanitarian access, shared commitment to standards and sufficient funding⁷². However, the validity and usefulness of universal standards for technical performance has been called into question for a number of reasons, such as the rights-based approach for which there is often no legal basis, or the dominance of Northern values⁷³. Specifically for the case of Chad, two other issues can be raised. The first issue reflects that raised in the Liberia IHE, which was: “which standard should be applied to the fact that the majority of people in Liberia do not have access to basic, affordable health care services?”⁷⁴. Section II.3 describes the lack of access to health care for most of the Chadian population; providing much better care to the refugees may pose an ethical problem. Secondly, it has been pointed out that “the presence of refugees has a negative impact on an environment barely able to support the local population. UNHCR’s effort to comply with exacting global standards compounds the problem and may have severe consequences in the short term”⁷⁵. The use of scarce water resources in order to comply with Sphere standards is a good example for the latter argument.

Nevertheless Sphere standards are the ones most referred to by humanitarian actors, and have been used for this evaluation. Salient findings with respect to the Sphere are as follows:

- With regard to drinking water, it may be justifiable – both by environmental considerations and user habits - to apply a lower limit than prescribed by Sphere,

however water quantity is known to be important for disease control. Trends of water-borne diseases and environmental degradation should be monitored to inform water supply policy.

- Sphere standards with regard to latrines are not always, but should be, respected (maximum 20 people use each toilet and their use is arranged by households).
- Dangerous medical waste and sharps are not always disposed of properly.
- Crude and under-five mortality rates are below – mostly far below - recognised limits.
- Standards with regard to food security and treatment of malnutrition are generally respected.
- The recommendation that local health services are supported and integrated and that parallel health facilities should not be established is not always respected.
- While comprehensive reproductive health services are usually provided, they do not include enough family planning and SGBV activities.

Conclusions

- UNHCR as the lead agency has considerable leverage over NGOs it is funding, although it doesn't always use this leverage to the full. UNHCR's capacity, however, to influence other UN agencies and NGOs acting with their own funds is limited. The role of OCHA is unclear in relation to UNHCR and refugee and host communities.
- Sphere standards are the standards most commonly referred to. While on the one hand, their applicability has certain limitations, on the other hand, they are not always fulfilled where they could, and should be (revealing thereby accountability gaps).

Recommendations

- Accountability to the population could be increased with greater transparency and the encouragement of more peer pressure. Activities and outcome/impact indicators of all actors should be formulated more clearly and published quarterly.
- UNHCR should make more use of performance-related funding mechanisms, such as trial periods and stricter conditions for renewal.
- Where Sphere standards can be complied with, they should be more rigorously applied, especially in the areas of latrines, sharps disposals, the provision of family planning and the support of local health services.

VII.2 Gender Issues

A significant change in the social network may play a role in limiting access to health care for women, linked to the temporary absence of a male decision-maker (as described for nomadic populations in northern Chad⁷⁶). Women continue to suffer from FGM and forced marriages; a few examples of good practice in tackling these were observed. Security,

especially of girls and women, outside camps is an important concern in the east; incidents of rape have been reported, though not from all camps.

The special needs of men - the minority among the adult refugee population - should not be overlooked. Most have lost their role as bread-winner, although some find temporary sources of income through food-for-work programmes, or as seasonal laborers. Alcoholism is as yet an unaddressed cause of ill health and decreased economic activity in the southern camps.

Recommendations

- The few examples of good practice in tackling violence against women (e.g. FGM and forced marriage) merit replication. UNHCR should consider inviting a specialised NGO that works with other actors on gender-based issues.
- The needs of men shouldn't be neglected, especially with regard to income-generating possibilities and reproductive health and HIV/AIDS.

VII.3 Refugee participation in implementation and decision-making

Effectiveness of response in the emergency phase took precedence over a more participatory approach. CHWs are not community volunteers, but are paid by the NGOs; in one camp (Goz Amer) they are not even members of the refugee community, but local residents. Likewise, the labour for latrine construction is paid for, and the material given, although reeds for walls can be gathered and mud bricks made locally. Drainage work in the camps is paid for through food-for-work and in some cases the NGO in charge has waste gathered through paid work "in order to make a good appearance". It may be argued that this strategy of paying for community services fosters a certain *mentalité d'assisté*⁷⁷. Participation in both decision making and job seeking is particularly poor in the east, with local commentators observing that "they just wait for the next food distribution".

A few good examples were observed of including local authorities in decision-making: in Goz Beida, each of the three 'sub-sultans' was officially in charge of health, nutrition, or watsan.

Conclusion

- Almost all refugee contributions are paid for, be it manual labour or social services. Among the refugees, a certain *mentalité d'assisté* appeared to be common.

Recommendation

- Greater participation by refugees must be instigated at the beginning of the emergency.

VIII. CONCLUSIONS

The OECD-DAC evaluation criteria for humanitarian emergencies⁷⁸ include relevance, effectiveness, efficiency, impact, coherence and connectedness. These are useful categories for evaluation in that they can be used to filter information, and so guide overall analysis of the situation. In general, the humanitarian health response in Chad was found to be relevant and effective. However, there are problems with coherence and sustainability. Preliminary analysis of the overall aid response in terms the health sector in Chad was found to be weak, and more synergies between the development and humanitarian communities should be found.

VIII.1 Relevance

The health, nutrition and watsan activities implemented are all highly relevant from an objective viewpoint. Neither nutritional education, however, nor family planning and HIV/AIDS prevention are perceived needs of most refugees, which makes them more difficult to implement. The refugee's potential to learn should not be underestimated; many of them had neither access to modern health services before, nor were they using latrines, and both are well-used now.

At times, more of a process than a blueprint approach would be recommended. For example, a move from the tented hospital to support of local health services and tackling the causes of malnutrition amongst refugee and host communities as TFCs are gradually phased out would be appropriate. Good examples of highly appropriate action are camp conflict management committees, which are successfully reducing tensions between refugees and host population over firewood disputes.

VIII.2 Effectiveness

The over-all impression of this humanitarian intervention is one of great effectiveness. The jigsaw puzzle of actors in various locations and sectors fits together well, is supported by excellent communication and logistical means and is operationally coordinated in a satisfactory way. Most programs and projects are very effective in producing the planned outputs, such as medical consultations, nutritional screening or provision of safe drinking water.

Some limits to effectiveness are environment-dependent, such as access to camps dependent on road security. Other limits are design-dependent, such as the relative failure to achieve synergy between major UN agencies. Effectiveness is often hampered by limited financial and human resources; the former is felt more in the south than east and the latter more at mid-level management than at clinical level. Among the shortfalls are lack of latrines in two to three camps, lack of feedback on health data gathered, very limited availability of microscopy and laboratory services and the lack of UNAIDS and UNFPA

programmes on the ground. Promoting greater transparency and harnessing increased peer pressure may contribute to increasing effectiveness.

VIII.3 Efficiency

UNHCR and almost all NGO partners have good operational capacity. In a number of cases, however, alternative approaches could have produced the same outputs more cheaply, or resulted in better outputs. The motorised gravity water supply scheme in Goré is one example and another is the fact that individual NGOs have to preposition emergency supplies in the absence of regional pre-positioned stocks for epidemics. Drug supply itself is done by each NGO separately, which is rather inefficient. In situations in which the national Pharmacie Préfectorale d'Approvisionnement is unable to comply with the standards required by the humanitarian action, it may be worth looking into an alternative whereby one private company or humanitarian agent centralises drug procurement and logistics. With regard to health promotion, the recommended integration in school curricula is as important as adult-to-adult education. There are cases of inefficiency in NGO staff ratios to the scale of their programmes; some are understaffed to the point of becoming ineffective, others have a dozen expatriate staff working on public health programmes for one camp of 20,000.

Examples of inefficient use of resources are material support to a district hospital without a management structure (and therefore no absorption capacity), an expatriate laboratory specialist training a single – and absent – local lab technician, the use of very high capacity generators for staff compounds using a small percentage of their capacity and lastly, UNHCR professional staff overwhelmed with secretarial tasks. The recommendation has also been made that UNHCR makes more use of performance-related funding mechanisms for the NGOs it funds, such as trial periods and stricter conditions for renewal.

VIII.4 Impact

The refugees represent a sizeable portion of the total population in the host areas. Overuse of existing natural resources, especially firewood, is inevitable. There is still much scope to counteract this negative impact. The rise in living costs in towns near refugee camps is probably more than counter-balanced through job creation, the increase in commerce and the 5% UNHCR has assigned for the benefit of host communities (assuming that this percentage reaches the beneficiaries and is used effectively). The full potential to include local communities among the beneficiaries of UN and NGO project is not exhausted. Scaling up of programmes, especially in agriculture, can increase impact significantly.

The increased availability of health services in itself has had a major positive health impact. Rates of morbidity and mortality ('the ultimate impact indicator'⁷⁹), measured at refugee population level, have all shown a trend towards improvement and are below emergency levels or reflect a better nutritional status than of the host population. High rates of diarrhoea and dysentery in some camps, however, indicate that sanitation programmes have

had a lower impact than they should have done. The level of refugee satisfaction is high; where there were complaints, they were consistent and related to clear unmet needs such as a lack of sanitation or security. The negative impact of refugees and refugee health services on local health services has been exaggerated and was not verified at all at hospital level. Over-all, access to health services has actually improved for local host populations.

Increased knowledge and change of behaviour among the affected population have a chance to have a long-lasting effect, e.g. in the field of nutritional education, reproductive health and HIV/AIDS prevention. This impact can, and should, be measured through KAP studies. Lastly the opportunity to have a gender-related impact is only marginally explored, for example in relation with gender roles, child spacing, FGM and forced marriages.

VIII.5 Coherence and connectedness

The most salient finding of this evaluation is the inequality of services available for refugees and the Chadian population. For example, there are a number of examples where health service provision is insufficiently connected with district plans and services. While all actors work for the same goal with regard to refugees, there is much scope to increase coherence between policies and strategies of humanitarian and development actors, be it in the field of health or agricultural, livelihood and environmental programs, especially regarding host populations. Humanitarian actors, donors and development actors should strive at integrating activities in favour of both kinds of populations. The Consolidated Appeals Process (CAP) and Common Humanitarian Action Plan (CHAP) process, through which humanitarian agencies establish a common plan of action could serve as a forum where more strategic thinking is done about how to better link humanitarian with development activities.

The degree of sustainability sought depends on the kind of long term solution envisaged for the refugees. The possibility for “sustainability”/ integration is lower in the east, where return is still on the agenda and the region semi-arid, and higher in the south, which is wooded and much more fertile and where local integration is an option. More efforts are therefore made in the south to guarantee food security (currently with the help of the ILO). In the chapter on water and sanitation, the recommendation has been made to make the water supply system sustainable by switching to simpler technologies.

The refugee population in the east will not be able to attain a sustainable level of food security. In the section on nutrition, the recommendation was made to explore other possibilities to balance the diet through small-scale vegetable cultivation. The gathering of firewood is equally damaging to the environment in the south as in the east. Technical recommendations in this regard are beyond the ToRs of this evaluation, but preliminary suggestions include improved stoves and solar power⁸⁰. As with food security, there is the potential for humanitarian and development actors and donors to team up more. Regional programs in the wider field of food security, livelihoods and environmental protection may be envisaged, under the aegis of UNDP or other development organisations and facilitated by improved coordination by OCHA.

Strengthening local MoH health services where possible, instead of maintaining parallel health services, would contribute to sustainability. Investment in infrastructure and equipment provides benefits for the medium term, and capacity building at a clinical and managerial level does so for the longer term. Should humanitarian assistance cease in the south after successful integration, the ethical problem of whether to leave the refugee population at the mercy of the severely under-performing Chadian health system will have to be faced.

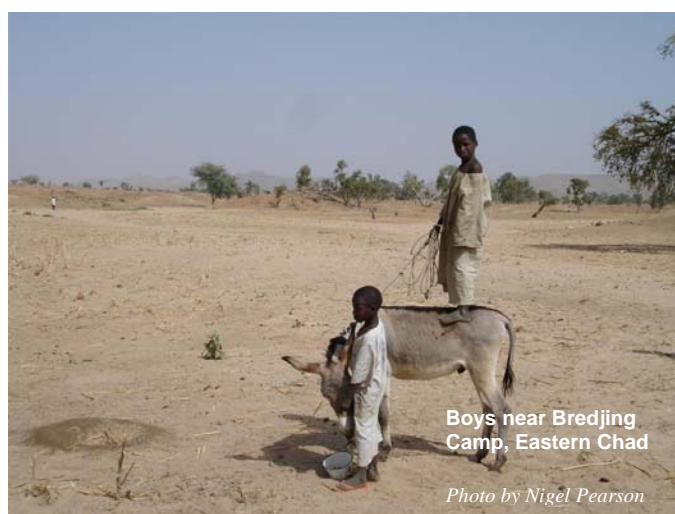
Lasting benefits can be achieved by improving knowledge of refugees (and host populations, where possible) and changing behaviour, especially with regard to reproductive health, child rearing and health seeking behaviour.

Conclusions

- Chances for long-term sustainability for health service provision are limited unless there is a significant policy change in the country and the health sector funding gap is filled. Knowledge gains and change of behaviour among the affected population would then have a better chance to have a longer lasting effect.

Recommendations

- Where opportunities were missed for working through local health services, this should be corrected. Where local integration of refugees is an option, sustainability considerations should be paramount in making strategic choices for health care provision, water supply and food security.
- Ways should be explored to join humanitarian and development efforts (for health care provision and food security, livelihoods and environmental protection) through the teaming up of actors and donors at the regional level.



ANNEX I: TERMS OF REFERENCE

INTER AGENCY HEALTH EVALUATION

REFUGEES AND HOST POPULATIONS IN EASTERN AND SOUTHERN CHAD

January 12, 2005

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 has 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.

The Interagency Health and Nutrition Evaluations in Humanitarian Crises Initiative (IHE-HCI) aims to address this gap. Inter-agency Health and Nutrition Evaluations (IHEs) look at the health sector as a whole, analyzing the impact of the combined effort of all actors on the health and nutrition situation of people affected by a humanitarian crisis. IHEs also examine 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 enables agencies working together with local health authorities and donors to review achievements, reflect upon lessons-learned, and finally, to design or review a joint action plan to implement recommendations for the future.

To date, IHEs have been conducted in Zambia, Pakistan, Nepal, Burundi and Liberia. They were conducted at the request of an in-country IHE Steering Committee, which usually consist of the Ministry of Health and humanitarian stakeholders in the health sector. The Steering Committee designed the Terms of Reference for the evaluation, and input was provided by the IHE-HCI Core Working Group (CWG), consisting of WHO, UNHCR, CDC, LSHTM, WFP, ACF, Save the Children, Merlin, UNICEF, Epicentre, MSF-H, and BPRM. The Steering Committee guided the evaluation process, and engaged in joint action planning to implement the recommendations. External evaluators were hired by the CWG, in collaboration with the Steering Committee, and were hosted by the Steering Committee during the field work.

In light of the work already done in Chad on the most recent consolidated appeals process (CAP 2006) and the preliminary identification of several topics of concern, including malaria, mental health, outbreak preparedness and response, and integration of refugee and host health services, amongst others, the country could benefit from an interagency health evaluation to review progress and performance of the humanitarian response, and its interface with the existing Chad health system. This Terms of Reference outlines a

proposed program of work for a Chadian IHE. The Ndjaména Humanitarian Committee will oversee the process, with assistance from the Abeche and Gore Technical Health Committees, and in cooperation with the IHE CWG.

EVALUATION PURPOSE

The purpose of the evaluation is to assess the collective humanitarian response to the ongoing humanitarian situation in Chad, and to assist health actors (the Chad Ministry of Health [MoH], UN agencies, the NGO community and donors) to respond to meet the ongoing needs of refugee and host populations in eastern and southern Chad.

OVERVIEW OF THE HUMANITARIAN CRISIS IN CHAD

With 64% of its population living under the national poverty line, Chad is in 88th position on the UNDP Human Poverty Index scale. Three decades of political instability have hindered economic and social development. Life expectancy is 44.7 years. Literacy rate is 46% and only 20% of the population has access to potable water.

Chad Statistics:

Total population: 8,598,000

GDP per capita (Intl \$, 2002): 724

Life expectancy at birth m/f (years): 44.0/47.0

Healthy life expectancy at birth m/f (years, 2002): 39.7/41.7

Child mortality m/f (per 1000): 212/188

Adult mortality m/f (per 1000): 513/444

Total health expenditure per capita (Intl \$, 2002): 47

Total health expenditure as % of GDP (2002): 6.5

Figures are for 2003 unless indicated. Source: The world health report 2005

Since March 2003, over 200,000 refugees from Darfur have arrived in the east of the country due to the conflict in the Darfur region of Sudan. They are settled in 12 camps along the border of Chad and Sudan (see Annex). In a major logistical operation over the last 18 months, UNHCR has transferred over 200,000 refugees from the volatile border area to camps further inside Chad. Some 1.8 million people still in Darfur have also been uprooted by the conflict. Farchana was the first camp UNHCR opened in eastern Chad in January, 2004. On May 3, 2005, UNHCR and its NGO partners opened the 12th camp in eastern Chad – called Gaga – to ease overcrowding in some of the other camps and allow relocation of 25,000 refugees still along the border with Sudan. International donor funding remains limited. For example, UNHCR has only had 60% of its funding requirements met as of 27th October, 2005.

In the south of the country, there are 30,000 refugees from the Central African Republic (CAR), and since June 2005, they have been joined by another 12,500 people due to an upsurge in violence due to gangs of armed men who attack and rob people, kidnapping children for ransom. Insecurity has been aggravated by tensions between farmers and

herders over access to land; CAR farmers allege that herders, especially those from neighbouring Chad, do not respect traditional grazing routes and destroy crops. This has led to a significant decrease in food availability and overall economic activity as farmers are discouraged from cash crop production. Increasing food insecurity and poor access to health services, including malaria prevention and treatment, has resulted in worsening health indicators. In September 2005, UNHCR noted a serious spike in the refugee's under-five mortality rate among the new arrivals of three to four times the normal rate. The refugees are located in Amboko settlement (Gore) which has hosted refugees from CAR since May 2003. With the new influx, Amboko is now over-stretched and a new site in Gondje will open shortly. There was a mission of the African Union to Southern Chad from 27 October to 1st November to assess the situation in Gore and Danamadji and the border areas of southern Chad (UNCHR, 2005).

Refugees in both areas of the country are located in already marginal lands where there is limited food, fodder and potable water (especially in the East). The local health system is ill-prepared to deal with the influx, and possible health concerns resulting from overcrowding and low standards of environmental hygiene, declining nutritional status, and low vaccination coverage. Security and access to other basic needs are precarious for refugees and host populations alike, and tensions are rising between the host population and the refugees. In early May 2005, four people were killed and at least three others injured during clashes between Sudanese refugees and local authorities at a refugee camp in eastern Chad.

The main health concerns facing the refugees—and their host communities—include: malnutrition (over 30%), acute respiratory infections, diarrhoeal diseases, malaria, hepatitis E (manifesting as acute jaundice syndrome), and violence-related trauma, particularly among women. Substance abuse (alcoholism) is contributing to domestic violence. The possibility of further disease outbreaks (including dysentery, meningitis and cholera) is especially elevated. Although cholera is not endemic in the area of Chad where the refugees are located, health agencies are preparing for the possibility that the cholera outbreaks in other parts of Chad may strike the refugee camps. Malaria is the most common reason to seek health care in the South, and case fatality rates varying between 7-12% depending on location. The crude mortality rate in the country remains under 1/10/000/day but maternal mortality rates are high at 827/100,000 live births and under-5 mortality is 222/1000 children (WHO, 2005).

HUMANITARIAN RESPONSE

There are a wide variety of health actors in southern and eastern Chad. The Chadian Ministry of Health is active in all areas, and is supported by the WHO. UN agencies, including WFP, UNICEF, UNHCR, UNFPA are also present. NGOs include the International Rescue Committee (IRC), International Federation of the Red Cross (IFRC), Medecins sans Frontieres (MSF-Luxembourg, France, Holland), International Medical Corps (IMC), Coopi, Action Contre le Faim (ACF) and Medecins du Monde (MDM). The health response has focused on epidemiological surveillance and response, nutritional programs, vaccination programs, and malaria control. Some reproductive health services

(gender based-violence initiatives, family planning, HIV/AIDS prevention) are being provided. The Abeche Technical Health Committee has highlighted the following factors as hindering health service provision: poor health seeking behaviour on behalf of the refugees, cost-recovery systems, high turnover of local and expatriate staff/low level, lack of qualified medical staff, lack of assistance to the nursing school in Abeche, and the emergency preparedness and response capacity of the MOH including the capacity of the Abeche laboratory, absence of the presence of an office of the National AIDS programme in the refugee affected areas, lack of nutritional surveillance, and programs for the local population.

The twelve refugee camps in the east are currently considered to be in a post-emergency phase. Given that most effort has been directed to meeting the immediate needs of the refugee camps, current accessibility to health care is better for the refugee population than the local population. Overall, the host population has very poor access to primary level health services. Quality of services are poor, there is limited capacity in regional and district hospitals (some hospitals in the region are not supported), and there are issues around blood safety and security. HIV/AIDS and malaria control programs are limited. Financial access to health services is also problematic, and user-fees pose a burden on the poor. Utilization rates of the government facilities are dropping as host populations access free refugee services. This has implications for government facilities, as they subsist on user fees. The situation is made more complex as there are no clear recommendations for cost-recovery in government health facilities in the regions hosting refugees. Differential access to care has created some tensions between the host and refugee communities. In the south, the emergency phase continues and efforts are directed to meeting the immediate needs of the refugees from CAR. However, a longer-term approach will also need to be considered as return to CAR in the near future is unlikely.

Several missions have occurred in the last few months. A WFP/UNHCR/FAO/GVT donors joint assessment mission undertaken in the eastern and southern Chad refugee camps done the first week of November recommended that the current ration of 2,062 kilocalories be maintained until the next joint assessment mission due at the end of 2006 (UNHCR Sit Rep 38, 2005). A USAID Bureau for Population, Refugee and Migration (BPRM) mission was done October 3-27th to assess the work done by UNHCR and its partners.

Inter-agency health planning for 2006 will take place in 17-19th January, 2006. This three day workshop in Abeche will be attended by all stakeholders from the East and South (NGOs, MoH [Director of Health Regions, Director of nursing schools, Refugee coordinator of MoH, amongst others], SNU, refugees). Day 1 will cover general health/nutrition issues, Day 2 HIV/FGM, and Day 3 mental health issues, including the development of a uniform strategy for mental health.

EVALUATION SCOPE AND QUESTIONS

The Technical Health Committee in Abeche (which includes the WHO, UNICEF, UNFPA and the MoH as well as NGOs) has identified the following issues to be evaluated:

1. The humanitarian response & health service provision for refugees – the current situation and gaps in response

Gaps that have been preliminarily identified include: mental health, outbreak response and vaccination coverage, TB control, nutrition, and malaria control (particularly in the South), and reproductive health (including HIV/AIDS, GBV). Substance abuse is also an issue, especially alcoholism, which may be leading to increased (domestic) violence. There is also a lack of qualitative research and participatory planning.

The local population to be examined should be well defined (region, which structures to visit etc). WHO/UNICEF, in collaboration with the MoH, will prepare recommendations for the definition of the local population to be evaluated before the start of the evaluation, and communicate this with Olga Bornemisza, LSHTM and Dr. Marcus Michael, the lead evaluator.

The OECD DAC guidelines for evaluating humanitarian interventions should be used. To what extent is the collective humanitarian health and nutrition response:

- Relevant to local needs and priorities; how do they relate to the burden of disease amongst the refugees and the Chadian host population? i.e. what types of surveys have been done; how good is the burden of disease information for these areas; and is it possible to prioritize needs based on this information?
- Effective in achieving humanitarian objectives and priorities? Is the collective humanitarian response timely and coordinated? What are the gaps in services (as laid out in the Sphere Health and Nutrition chapters), and why? (for eg. lack of funding, technical skills, difficulties with harmonization, inappropriate priority setting?) What can be done in terms of filling the gaps with existing resources (training, capacity building, harmonization of approaches, identifying coverage gaps?), and obtaining more resources for the humanitarian response in Chad? Finally, how accountable are health service providers (UN and NGOs) to the local/refugee population?
- Efficient in terms of the outputs of the humanitarian response (both qualitative and quantitative) in relation to the inputs. Collective funding amounts and resources that the humanitarian agencies have to work with shall also be examined to see if they are appropriate given the needs of the populations that are being targeted.
- Can the humanitarian health response be judged to have an impact on health and nutrition? For example, what are trends in mortality, morbidity and nutrition indicators, accessibility of care, quality of care?

2. The interaction between services for refugee and existing Chadian health services: tensions and possible solutions.

There are indications that refugee health program have negative effect on existing Chadian health structures. Discrepancy in care also causes pressure on the services provided for refugees, and contributes to tensions between refugees and their hosts.

How connected is the humanitarian health response to the current Chadian health system, and how does it take longer-term health system problems into account? What are the impacts of the refugee community on the Chadian health system, and how could they be mitigated by the humanitarian community? What are the dynamics between the Chadian health system and that provided for the refugees? What are possible solutions?

3. Collaboration and Coordination Issues

How well are existing inter-agency collaboration initiatives (meetings, planning processes, CHAP/CAP etc) working? What are the barriers to improved collaboration and how can they be relaxed? How do agencies monitor and evaluate their activities?

METHODS

Information on the above four topics will be collected via the following methods:

- Collect documentation from all health stakeholders
- Conduct interviews with key stakeholders. The Ministry of Health is a key stakeholder. Agencies to be consulted include UNHCR, UNFPA, UNICEF, and WHO, as well as other UN agencies working in health, plus all major NGOs working in the field of health and nutrition in eastern and southern Chad.
- Conduct informal interviews with regional and local actors, including refugees, host community representatives, and local health care providers.
- Attend inter-agency planning meetings
- Analyse trends of key epidemiologic indicators.
- Spot check health facilities if appropriate, to check validity of data collection and quality of care.
- Use the Sphere guidelines (the nutrition and health chapters) as the benchmark from which to judge overall collective programming.

STAKEHOLDER INVOLVEMENT

Stakeholder representatives will be involved in the IHE through a participatory process. Involvement has begun with discussion of the IHE during the Technical Health Committee in Abeche (including MoH, WHO, UNHCR, UNICEF, UNFPA) held on November 14, 2005.

There was a meeting of humanitarian actors intervening in health and nutrition in Ndjaména (WHO, UNFPA, UNICEF, WFP, UNHCR, OCHA & NGOS) the 2 December, 2005. The expected outputs of this meeting were to divide up the IHE evaluation tasks, identifying gaps, and editing this ToR.

PROPOSED WORK-PLAN AND TIMELINE

Action (2006)	Jan 17- 27	Feb 1-7	Feb 8- 14	Feb 15-21	Feb 22- 28	March 1-7	March 8-14	March 15-21
Team leader contacts (by telephone) stakeholders and arranges steering committee, finalizes ToR, drafts detailed work-plan for evaluation team & sorts out logistics. (3 days work)								
Evaluation team arrives and starts evaluation in East and South								
Evaluation team debriefs key stakeholders in Abeche, Gore and Ndjaména			(Abeche Feb 14 th)					
Report drafted and submitted to steering committee & CWG								
Comments given to evaluators on report by steering committee and CWG								
Report redrafted for finalization								
Final report submitted								End of March

Notes:

OCHA will follow up with OMS concerning the sectoral meeting in Ndjaména.

A technical health committee meets every Monday in Abeche at 11.00am.

EXPECTED OUTPUTS

A 30 page report, with a 4-5 page executive summary is expected to be drawn up by the evaluation team, with the team leader responsible for overall editing and quality of the report. The report will be translated into English when it is finalized (*or alternatively, if written in English, translated into French*). It will be submitted to the Ndjaména/Abeche/Gore Humanitarian/Technical Health Committees (and the Chad IHE Steering Committee), as well as to the IHE Core Working Group (focal point – LSHTM). All stakeholders are responsible for input into the draft. LSHTM will be responsible for facilitating the production of the final document.

ANNEX II: ITINERARY

Date	M. Michael	A. Daliam	N. Pearson
Tue 31 Jan	Briefing at LSHTM		Briefing at LSHTM
Wed 1 Feb	Travel London – Ndjaména		Travel London – Ndjaména
Thu 2 Feb - Fri 3 Feb	Briefing at UNHCR Ndjaména		
Sat 4 Feb	Road travel Ndjaména – Goré, visit to Bongor hospital		
Sunday 5	Visits to Amboko, Gondje camps and surroundings		
Mon 6	Visit Moundou hospital		Road travel Goré – Danamadji
Tue 7	Visits to Amboko, Gondje camps and surroundings, visit Goré hospital		Visit to Yaroungou camp and surroundings
Wed 8			
Thu 9 Feb	Road travel Goré - Ndjaména		Road travel Danamadji - Ndjaména
Fri 10 Feb	Air travel Ndjaména - Abéché		
Sat 11 Feb	Visit to Gaga, Tréguine and Bredjine and Farchana camp		
Sun 12 Feb			
Mon 13 Feb	Contacts in Abéché		Road travel to Biltine (round trip)
Tue 14 Feb	Air travel Abéché – Goz Beida, visit Djabal camp	Contacts in Abéché	
Wed 15 Feb	Road travel to Koukou, visit to Goz Amer camp	Air travel to Bahaï	
Thu 16 Feb	Air travel Koukou – Abéché	Visit to Ouré Cassoni Camp	
Fri 17 Feb	Air travel Abéché – Guereda	Air travel Bahaï - Iriba	
Sat 18 Feb	Visit to Mile camp	Visit to Touloum camp	
Sun 19 Feb	Visit to Kounungo camp Visit to Guereda hospital	Visit to Iridimi camp	
Mon 20 Feb	Air travel Guereda - Abéché	Air travel Iriba - Abéché	
Tue 21 Feb	Debriefing Abéché		
Wed 22 Feb	Air travel Abéché - Ndjaména		
Thu 23 Feb	Debriefing at UNHCR Ndjaména		
Fri 24 Feb	Travel Ndjaména - Paris		Travel Ndjaména - Paris

ANNEX III: LITERATURE USED³⁹

Field documents

PLAN D'INTERVENTION SANTE-NUTRITION POUR LES AGENCES ONU SIENNE 2006 EST DU TCHAD (PAM, UNICEF, FNUAP, OMS, HCR). DRAFT

UNHCR (2005) Proposition de système de référence des malades de centres de santé des camps des réfugiés pour l'opération HC a l'est du Tchad 2006

UNHCR (2005) PLAN D'ACTION DE LUTTE CONTRE LE VIH/SIDA EN FAVEUR DES REFUGIES ET DES POPULATIONS HÔTES D'AMBOKO ET DE GORE - 2005-2006

RAPPORT DE MISSION DANS LES ZONES DE REFUGIES DE GORE ET DE MARO AU SUD DU TCHAD. 29 MAI AU 05 JUIN 2005. Dr DJIKOLOUM NGARBEUL, Ministère de la Santé Publique/PNLS et les IST ; Dr KEKOURA KOUROUMA, Coordonnateur Pays ONUSIDA au Tchad ; M. TATOLA BABA DENIS, Président du réseau des Associations de PVVIH.

Compte rendu réunion Coopi/MSF-H Division des activités santé pour le camp d'Amboko et Gondjé. 20 Octobre 2005

Ministère de la Santé Publique / OMS (2005) Forum sur la problématique du recouvrement des coûts de soins à L'Est du Tchad

Public domain literature

Herbst J (2000) States and Power in Africa. Comparative Lessons in Authority and Control. Princeton University Press, New Jersey, USA, p. 229 f.

HOGAN D R, SALOMON J A (2005) Prevention and treatment of human immunodeficiency virus/acquired immunodeficiency syndrome in resource-limited settings. *Bull World Health Organ* 83 (2): 135-143.

Rutta E, Williams H, Mwansasu A, Mung'ong'o F, Burke H, Gongo R, Veneranda R, Qassim (2005) Refugee perceptions of the quality of healthcare: findings from a participatory assessment in Ngara, Tanzânia. *Disasters* 29 (4): 291-309.

Tanaka A, Kunii O, Okumura J, Wakai S (2004) Refugee participation in health relief services during the post-emergency phase in Tanzania. *Public Health* 118 (1): 50-61.

Stephenson M (2005) Making humanitarian relief networks more effective: operational coordination, trust and sense making. *Disasters* 29 (4): 337-350.

³⁹ other than quoted and listed in endnotes

ANNEX IV: CONTACTS BY PLACE

London

Olga Bornemisza, Conflict and Health Program, LSHTM

Ndjaména

Briefing and debriefing with representatives of: UNHCR, WHO, OCHA, UNICEF, UNFPA, WFP, MSF-Lux, MSF-H, Red Cross Society of Chad, Coopi and AFRICARE.

MSF-Holland: Bolivar Kasangu Kalubi, Admin and Finance Co-ordinator

MSF-Luxemburg

MSF-F: Jérôme Mouton

Croux-Rouge du Chad: Yaya Mahamat Liguita, President; Iré Kertoumar, Directeur Developpement Organisationnel; Koumo Gopina Andréas, SG; Dr Amaro Touré

MoH: Dr Hassan Mahamat Hassan, SG

UNHCR: Miriam Houtard, programme co-ordinator; Rufin-Gilbert Loubaki, deputy representative

ECHO: Frédéric Bonamy, chef de bureau

WFP: Håkan Falkell

UNFPA: Togbe Ngagedeba, assistant representative

WHO: Dr Yao Kassankogmo, representative

UNICEF: Renée Van de Weerd, Responsable Santé/Nutrition; Fatimé Barounga, Assistante Nutrition

OCHA: Inés Brill, Chef de Bureau; Fernando Hesse, Humanitarian affairs; Kingsley Amaning, Humanitarian Coordinator (telephone interview with the latter)

UNDSS : Christophe KY, UN Field Security Coordination Officer

Bongor

District hospital. Mr Abdel Fallah, head nurse; other staff and patients

Goré

Préfet

District hospital: Dr Solukma, district medical officer

Coopi: Marina, Giuseppe

UNHCR: Stella, protection UNV

MSF-H: Carolyne and Helmut, outgoing and incoming co-ordinator

Amboko camp

Coopi: Maurice and Ibrahim Kanu, WatSan

MSF-H: Mr Barka, nurse, Marceline, midwife; Dr Stefan, physician; Ms Amena, CHW supervisor; two CHWs

Mr Asrael, head nurse Coopi (tented) hospital

Coopi TFC and SFC: Djimra Evariste, Agent CNT; Houltinto Asrael, Responsable CNT; Félicité Agent CNS; Foura Responsable CNS.

Gondje camp

CARE International (camp manager): Fred, Stéphane

Dangada village: Mbairam Jules, Représentant du Chef de village

Beureh village: Nangdoh clément, Chef de village ; Nodjiro Nigada, Chef de terre

Moundou hospital

Dr Kadje, chief surgeon; Christophe, head nurse; Dr Ricardo, Cuban doctor; other staff and patients

MILADI HEALTH CENTRE

Nérobé Nouel, nurse; group of women, villagers in nearby village

Sahr

Government: General Weiding Assi Assoué, Governor of Bahr Koh

MoH: Dr Mashoke, MCR; Hospital Director of Sahr regional hospital

Danamadji

WFP: Ngarasenta Ngaorndjam: Programme assistant

UNHCR: Daniella, Bureau chief; Emmanuelle Compingt, Field project officer; Olivier Louma, HIV officer;

COOPI: Micole Picasso, programme coordinator

MoH: Dr Sangbe Ndola, MCD

Sido

Government: Singa Massa, Sous-préfet adjoint

Maro

MoH : Nyereta Aindje, Nurse IC of health centre

Abéché

UNHCR: Dr Lizet Boerstra, public health co-ordinator; Jean-Paul Habamungu, food-nutrition coordinator, Bonaventure Muhimfura , nutritionist; Dr Polycarpe, reproductive health specialist; Lynn Ngugi, first administrator community services (gender issues); Roland Friedli and David Parums, watsan engineers; Claire Bourgeois, Head of Office and Deputy Representative.

WHO: Dr. André Ouedraogo, nutritionist; Dr Christian Itama, point focal, emergency coordinator; Dr Innocent Nzeyimana, epidemiologist, head of office; Domaya Diongoto, nutritionist.

UNICEF: Dr Michel Beshir; Ms Bambey Adamzara, health and nutrition; Ms Zara, HIV/AIDS specialist

MoH: Dr Raoul, Délégué Régional de Santé of Wadi Fira region; Dr Ali, Délégué Régional de Santé of Ouaddaï region

MoH, regional hospital: Mr Ali Abdelrahmad, staff manager; social worker; Director of Nursing and Midwifery School

UNFPA: Dr Fayulu Emoy David, Obstetrician-gynaecologist

WFP: Mamadou Amadou Diallo, Représentant du PAM ; Etienne Labande, chef de Programme Sécurité alimentaire et nutrition

Feedback session with representatives of MoH, UN agencies and NGOs

Gaga camp

Africare (camp management): Mr Milaiti
CORD: Ngaro Degotu, health centre supervisor
MSF-H: Mbodou, Nutrition co-ordinator

Hadjer Hadid

Ahmad Ibrahim, sous-préfet
RC Federation: Dr Yao, health co-ordinator
MSF-H : Wullens Benoît, Reproductive health; Nguen Paul, nutritionist

Treguine camp

RC Federation: Dr Judith; two refugee families

Farchana camp

Refugee widow
Group of women at water point
MSF-H: nurse in-charge of health centre; Kobobé, nutrition in-charge; Ahmat Mahamat, Chargé des mesures anthropométriques.
UNHCR: Mr Jamal, field officer

Goz Beida

Goz Beida district hospital: expatriate surgeon
Group of women villagers in Lobo Tige, halfway between Djabal and Goz Amer camp

Djabal camp

Coopi: Dr Simonetta Dolce, expatriate physician; Doumra Goissala, in-charge of TFC;
Mory Sanbarré, expatriate nutrition co-ordinator; mothers of malnourished patients
Two groups of refugee women

Koukou

WFP: Nitesh Patel, nutrition consultant

Goz Amer camp

TFC staff and mothers of malnourished patients
Coopi: Dr Martin, expatriate physician, Katrina, expatriate nurse; staff of health centre;
Mohammed, CHW
Refugee woman (household visit)

Guereda

IMC: Dr Adam Eltayeb, medical director; Dr Abdullahi Ibrahim and Dr. Alquireishi, IMC physicians
Guereda hospital: Rigobert Kazadi Kabongo, laboratory expert IMC

CARE: Jean Claude and Brian, community services for four camps in the area
Oxfam: Armand, health promotor

Mile camp

Group of refugee women
Local staff of Health Centre
Group of refugee TBAs/midwives
Group of CHWs
Local staff of psycho-social programme

Kounungo camp

Group of refugee women at water point
Refugee woman (household visit)
Male refugee youth (participant in youth group)

Biltine

Government health staff: Abakar, Nurse IC, Biltine HC; Dr Mbaihol Tamadji, MCD

Iriba

Government health staff: Dr Djikolnga, MCD
UNHCR: Pierre, Protection and Security officer; Etienne, Assistant security officer; Yayoi Suzuki, Community Services Officer
MSF-L: Jeroen Beinjsberger, Project Coordinator;
IRD (International Relief and Development): James Jean, Finance Manger;
CARE: Bakari Diarra, Project Manger; Michel le Grand, water engineer; Linda Hanne, community services officer;
MCD: Dr Djikolngar
WFP: Mr Tao

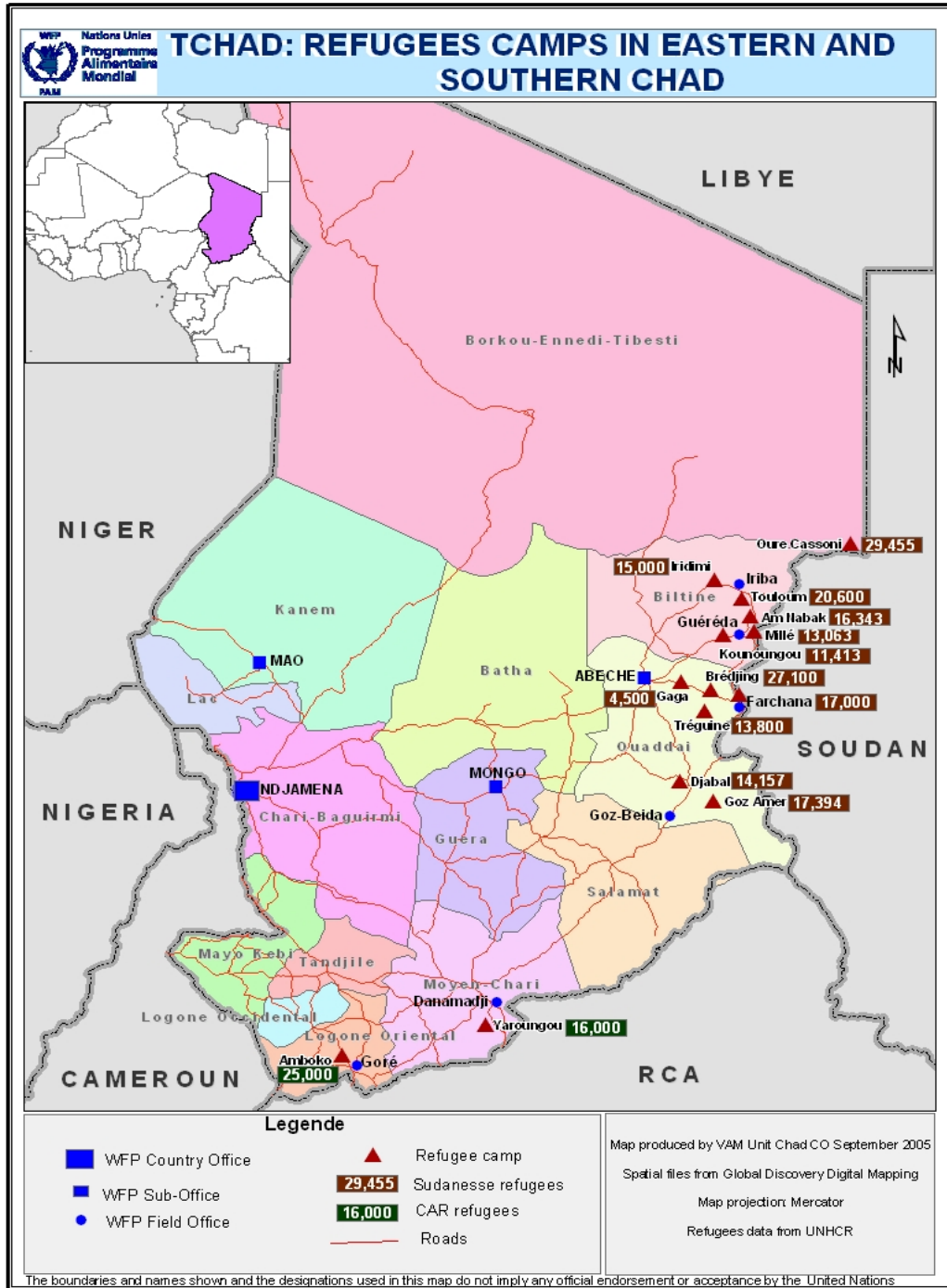
Bahai

IRC: Dr Doumbia, Medical Coordinator; Matthias Ntouriha, EH coordinator; Michael Amatta, watsan manager; Abdel Aziz, community health officer
UNHCR: Angele Djohossou, Bureau chief; Spero Comlan, community services officer;
ACTED: Mark Hemer, Responsable Bahai
ACF-US : Camille, Coordinator

Ouré Cassoni

ACF-US: Esther, nutrition in-charge
IRC: watsan team
ATHAS: Tidjani Adam, HIV/AIDS prevention

ANNEX V: MAP OF CHAD



ANNEX VI: REFERENCES

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