Humanitarian Bulletin
Chad

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In this issue

HIGHLIGHTS

- In 2017, more than 4.7 million people will need humanitarian assistance in Chad.
- According to the SMART Nutrition Survey of November 2016, 10 regions have severe acute malnutrition (SAM) rates above the WHO emergency threshold (2%).
- Chad loses about 9.5 per cent of its gross domestic product (GDP) each year, or more than 578 billion CFA francs because of undernutrition.

FIGURES

Population	13.2M
Literacy rate	37.3%
GDP / capita	US$2,171
Life expectancy	51.6 years
<5 mortality rate	133/1,000
Maternal maternity rate	860/100,000
Affected people	8.1M
People in need	4.7 M
Access to drinking water	52%
PDI (of which registered on31/10/2016)	105,070
Refugees	391,745
Returnees	86,901
Third-country nationals	322

FUNDING

541,4 million
requested (US$)

39% funded

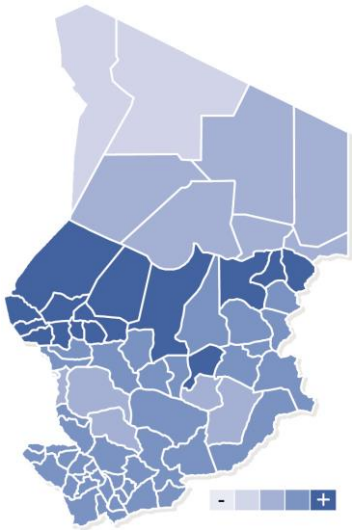
Over 4.7 million people will need humanitarian assistance in Chad in 2017

Multiple humanitarian crises

Low human development exacerbated by climatic and health risks associated with severe food insecurity and population displacement precipitate the majority of the Chadian population, about 8 million people, into acute or chronic vulnerability. According to the Humanitarian needs overview (HNO) of 2017, over 4.7 million[1] people among whom 52% are women will need humanitarian assistance next year.

Regarding **food security and nutrition,** despite good prospects for the 2016/2017 crop year compared to the previous year, the analysis from the Harmonised Framework of November 2016 estimated that about 3.9 million people will be food insecure, including over one million severely food insecure during the next lean period (June-August 2017). This represents an increase by 100,000 people compared to the 2016 lean period. Over two million people will be food insecure as of June in the eight regions of the Sahel belt (Batha, Kanem, Barh El Ghazal, Ouaddai, Sila, Wadi Fira, Guera and Hadjer Lamis), including about 702,000 people in severe food insecurity. These people will need emergency food assistance as well as support for agricultural production and livestock to help them get out of their vulnerable situation. In addition, nearly 500,000 people in displacement still need food assistance[2].

Regional distribution of people with food security and nutrition needs



Source : HNO 2017

The nutritional situation remains worrisome, with almost 438,101 expected malnutrition cases in 2017 (a deterioration compared to 410,314 expected cases in 2016), including 237,807[3] moderate acute malnutrition (MAM) cases and 200,294 cases of severe acute malnutrition (SAM) affecting children under five years old who will require urgent

[1] The 4.7 million figure is calculated by taking the highest value of those identified as "in need" by each of the clusters. This analysis is done at the departmental level.
[2] 87 000 returnees, 322 third country nationals and 389,000 refugees, a total of476,000 people. Internally displaced persons (105,000) are already included in the Harmonized Framework Analysis.
[3] Nutrition Cluster estimation based on data from the November 2016 SMART survey.

nutritional treatment. Given the correlation between food insecurity and malnutrition, food assistance should be combined with the treatment and prevention of malnutrition in children and pregnant and lactating women. To reduce the prevalence of acute malnutrition, an integrated nutrition - health - education - water, hygiene and sanitation response is needed.

Nearly 600,000 people in displacement

Population movements affect 581,000 people in Chad, including 389,000 refugees, 105,000 internally displaced persons and 87,000 returnees.

Population movements concern 581,000 people in Chad, including 389,000 refugees, 105,000[4] IDPs, 87,000 Chadians returnees[5], and 322 third-country nationals. These people live in the east (Sudanese refugees) and in the south (refugees and returnees from the Central African Republic) due to instability and conflicts in neighbouring countries but also due to insecurity and military operations in the Lac Region (refugees and returnees from Nigeria and internally displaced persons). The volatile security conditions in these neighbouring countries and in the Lac region do not offer any immediate prospects for return in 2017, and may even lead to new population movements.

Areas of population movements

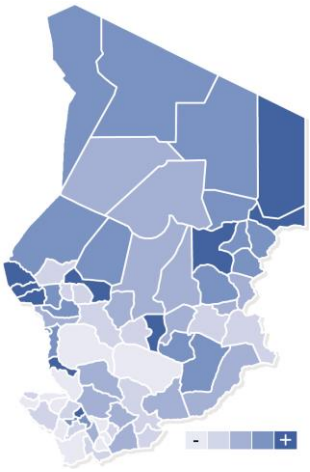
Source : HNO 2017

These displaced populations need urgent multisector assistance. Moreover, the absence of immediate prospects for return and the protracted duration of the crises require the creation of durable solutions supporting the integration and the empowerment of these populations. An integrated approach also serves to ensure the inclusion of 734,000[6] people among the host population who are weakened by these displacements, in order to respond to their heightened vulnerabilities and avoid community tensions. Finally, a continuous dialogue between humanitarian and development actors is essential in order to link humanitarian response to other types of medium- and long-term structural interventions ensuring resilience and local development.

Health emergencies marked by malaria outbreaks

Finally, the weak development of the country, poor infrastructure and widespread poverty make it difficult to access essential **services,** including **access to health services** for over 1.9 million people. Children under five and women are the most affected. Priority should be given to improving the supply and quality of primary health services, particularly in at risk areas (areas conducive to epidemics and other serious diseases such as malaria and emergency contexts). Emergency vaccination remains a priority in 2017, as well as access to reproductive and neonatal health, given the very high maternal mortality rate (860 deaths per 100,000 births, the third highest maternal mortality rate in the world) and child under-five mortality rate (133 per 1,000 in 2014[7]). It is also essential to strengthen the surveillance and

Regions affected by health emergencies



Source : HNO 2017

[4] Cluster Shelter/NFI/CCCM Data as of 31/10/2016
[5] 74 969 Chadian returnees from CAR and Chad and 12,481 returnees from Nigeria and Niger.
[6] For southern Chad, the population of the cantons hosting sites or returnees were taken into account. For the Lac region, the entire population of sub-prefectures hosting displaced, returnees or refugees were considered.
[7] *Enquête Démographique et de Santé et à Indicateurs Multiples (EDS-MICS) 2014-2015*

early warning systems in order to improve the detection of epidemic outbreaks and to be able to respond rapidly.

Nearly 750,000 suspected malaria cases, including 337,000 confirmed cases and 900 deaths have been registered since January 2016.

Malaria is the leading death cause among children under-five and affects most regions of Chad. Nearly 750,000 suspected malaria cases, including 337,000 confirmed cases and 900 deaths have been registered since January 2016[8]. In 2017, campaigns for the distribution and use of bed nets and seasonal chemo-prophylaxis should be intensified.

The root causes of crises

Chad faces low human development and chronic poverty exacerbated by successive shocks that expose people to recurring humanitarian crises, exacerbating their vulnerabilities and affecting their resilience. Limited access to basic services, environmental degradation, climate change and a population growth (one of the highest in the world) exceeding the economic growth and agricultural progress, coupled with shocks from neighbouring countries, are all root causes that partly explain the persistence of humanitarian situations in the country.

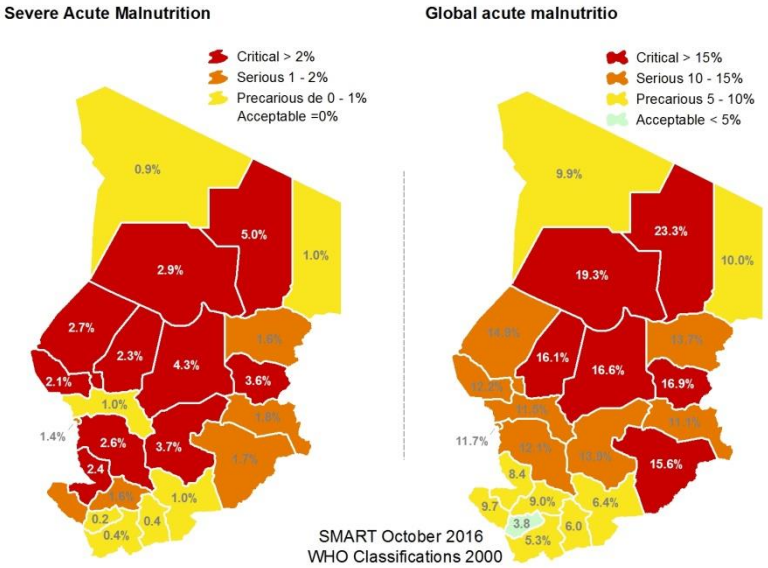
Ongoing Humanitarian Response Planning 2017-2019

The humanitarian community will not respond to all identified needs, due notably to lack of resources and because some needs are directly inherited from chronic vulnerabilities and general poverty. Humanitarian actors will tackle the immediate causes of the issues identified and development actors will respond to the root causes with the aim of improving human development, reducing structural vulnerabilities in order to improve the living conditions of the populations.

The humanitarian community has thus agreed on a strategic framework and a three-year response plan (2017-2019) to define an integrated response of humanitarian and development actors, in particular in chronic crisis contexts where the solutions are in the medium and long term. This prioritization task is being finalized and will be presented in the next Humanitarian Bulletin.

Malnutrition still worrisome in Chad

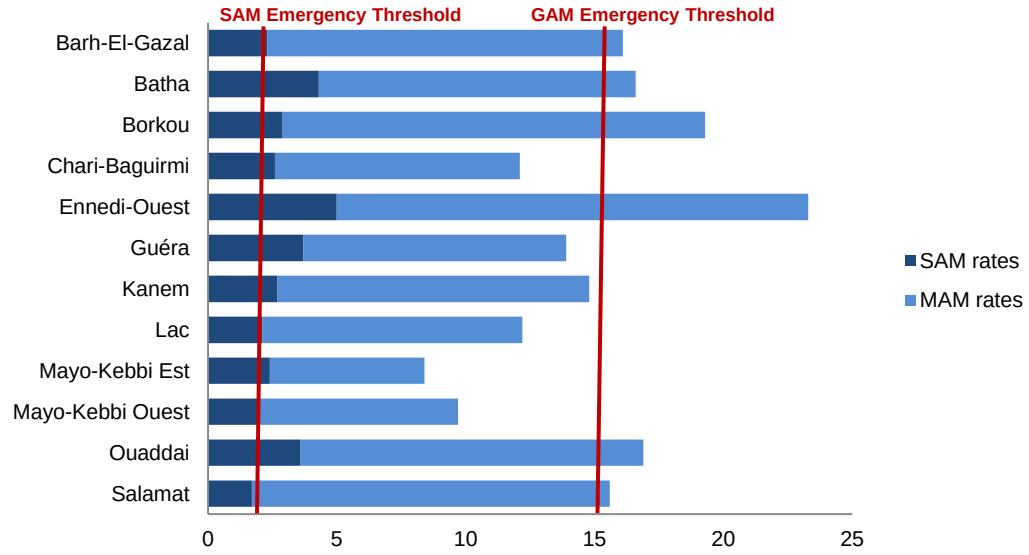
Prevalence of severe acute malnutrition: 10 regions still above the emergency threshold



[8] *Service de surveillance épidémiologique intégré (SSEI), Semaine 26*

The global acute malnutrition (GAM) prevalence exceeds the emergency threshold of 15 percent (set by WHO) in six out of twenty-three regions. Ten regions exceed the 2% SAM emergency threshold.

Global acute malnutrition (GAM) Prevalence in 2016



Source: SMART Survey

The preliminary results of the national nutritional assessment based on the SMART methodology *(Standardized Monitoring and Assessment of Relief and*

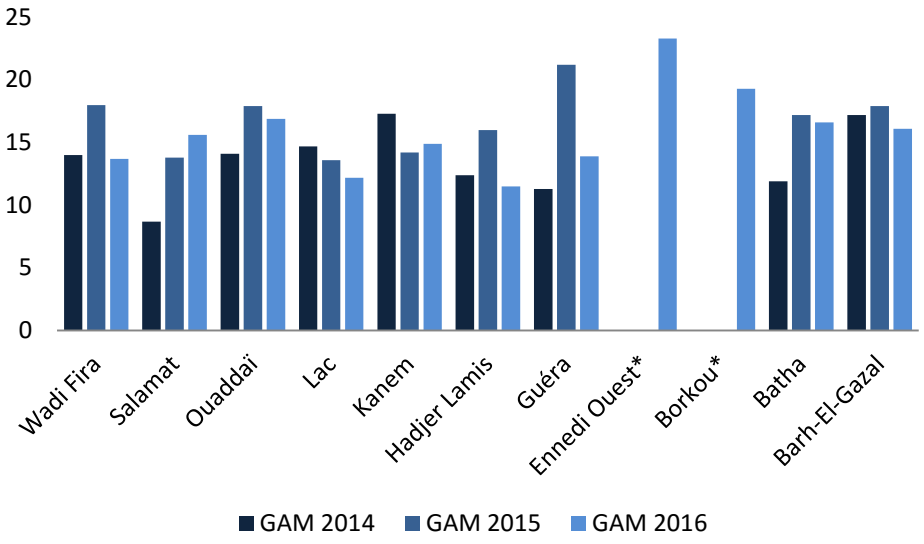
Transition) conducted in August-September and published in October, estimated the prevalence of severe acute malnutrition (SAM) at 2.6% in 2016 compared to 2.8% in 2015. Moderate acute malnutrition (MAM) is increasing (9.3% compared to 8.9% last year). This relative improvement in SAM can be explained by the increased number of trained community volunteers and the expansion of the humanitarian intervention coverage areas which have reached more people.

The prevalence of global acute malnutrition (GAM) exceeds the emergency threshold of 15 percent (set by WHO) in six out of twenty-three regions. As for SAM, ten regions exceed the two percent emergency threshold. Thus, the regions of Ennedi Ouest, Borkou, Ouaddai, Batha, Barh El Ghazel, Salamat, Kanem, Chari Baguirmi, Guera, Lac and Mayo Kebbi Est are in nutritional emergency.

Children aged 6 to 23 months have a higher prevalence of acute malnutrition compared to 24 to 59 months children. The prevalence of GAM is 15.8 per cent (above the emergency threshold of 15 per cent) in children aged 6 to 23 months, compared to 9.8 per cent for children aged 24 to 59 months. The same trend is observed in most regions. Gender disaggregation shows that boys (13.6%) are more affected by GAM than girls (10%)[9]. Overall, at national level, the nutritional status of children shows no improvement compared to last year.

However, data disparities within regions were not taken into account in the recent nutrition survey. In 2014, the SMART survey was not limited to regional prevalence. The evaluation has gone down to the departmental level to give more accurate results, enabling partners to provide localized responses to acute malnutrition. In addition, as in 2015, this year's nutrition survey covers all the country's regions, unlike 2014, where the evaluation only covered the regions of the Sahel belt.

[9] SMART Survey 2016



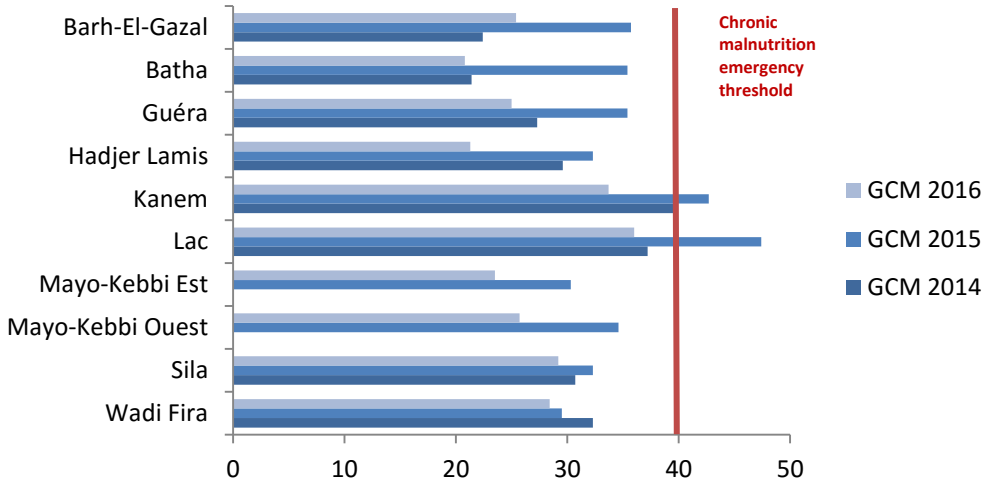
* Areas not covered by the 2014 and 2015 SMART survey

Chronic malnutrition also persists, but decreasing

Stunting or chronic malnutrition remains a health problem in Chad, although the trend is declining. According to the results of the SMART survey, the Lac and Kanem regions are under alert (36% and 33.7%) of acute chronic malnutrition (above 30%), while they had respectively reached 47.4 per cent and 42.7 per cent (above 40%) by 2015. This year, therefore, no region is in an emergency phase.

Trends in global chronic malnutrition (GCM) 2014-2016

Chad loses over 578 billion CFA francs (US$1.2 billion) annually, or 9.5 per cent of its gross domestic product (GDP) to child malnutrition.



Source: SMART Survey, OCHA

Chronic malnutrition is strongly linked to undernutrition, which has important consequences for the development of the country.

Undernutrition is costly to Chad

Chad loses over 578 billion CFA francs (US$1.2 billion) annually, or 9.5 per cent of its gross domestic product (GDP) to child malnutrition. This is the result of a study on the *Cost of Hunger in Africa: Social and economic impact of under-nutrition in children in Chad.* The study was conducted by the African Union, the New Partnership for Africa's Development (NEPAD), with support from the World Food Program (WFP) and the United Nations Economic Commission for Africa (UNECA). This cost is determined by the rising health expenses, inefficiencies in education and declining productivity.

According to the study, when a child suffers from undernutrition, the negative consequences of this condition follow them for the rest of their life. These negative

consequences also have serious effects on the economies where the child lives, learns and works.

With regard to health, in 2012, almost 1.5 million clinical cases associated with undernutrition were recorded among children under five. This has generated a cost for the country and families over CFAF 168.4 billion.

As for education, children suffering from undernutrition have a repetition rate of 29%, compared to 22% for those who have not suffered from stunting. In addition, children with stunting complete an average of two years less of schooling[10]. This leads to a cost of more than CFAF 9 billion.

On productivity, 56.4% of the Chadian working-age population suffered from stunting during childhood (3.4 million adults aged 15-64 years prevented from reaching their full potential). Annual economic losses are estimated at CFAF 334.5 billion (5.5% of GDP in 2012).

Causes and consequences of malnutrition in Chad

The mortality rate of children under 5 years is among the highest in the world (in 2014 it was 133 per 1,000)[11]. The Global hunger index (GHI) places Chad in an alarming situation, at the second last place in 2015[12] and shows that 43% of infant mortality is linked to undernutrition.

The mortality rate of children under 5 years is among the highest in the world (in 2014 it was 133 per 1,000).

Underdevelopment and poverty are among the root causes of malnutrition with a considerable impact on the level and quality of household food consumption, leading to the adoption of adverse survival strategies and aggravating morbidity and mortality, especially in the Sahel belt. In this zone, the food and nutritional situation is fragile, due in particular to the harsh climate, aggravated by climate change, which causes more and more frequent droughts, attacks by crop pests and localized floods[13]. Poor access to quality health services and lack of access to potable water, hygiene and sanitation (which expose children to waterborne diseases) are other causes of malnutrition. Some socio-cultural practices such as early marriage and frequency of births increase the risk of malnutrition among young mothers and children[14].

Malnutrition leads to stunting (chronic malnutrition), cognitive developmental disabilities, and increased susceptibility to disease and mortality in children under five and is a major cause of failing and leaving school.

Need for a multisector humanitarian response

Given the strong correlation between food insecurity and malnutrition, a combination of food assistance, treatment and prevention of malnutrition among children under five and pregnant and lactating women is essential. The fight against malnutrition must be carried out through a series of interventions in nutrition, health, education, water, hygiene and sanitation, social protection and the strengthening of the economic status of women.

Strengthening and harmonizing acute malnutrition treatment programs in high prevalence regions through an integrated community-based treatment of acute malnutrition (PCIMA), which involves identifying and treating acute undernutrition but also other diseases directly within the community, will strengthen prevention and treatment of cases. While developing a community-based approach for the prevention of child malnutrition, it is important to address chronic malnutrition in children under five by ensuring access to safe drinking water and hygiene and making sure every health facility has a minimum package of WASH activities, or through campaigns to promote good family practices (exclusive breastfeeding, infant and young child feeding, hygiene, use of bed nets, etc.). Strengthening the implementation of school canteens with community participation can help alleviate malnutrition in school-aged children while providing a strong incentive for parents to send children to school.

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[10] Study on the Cost of hunger in Chad, October 2016
[11] *Service de surveillance épidémiologique intégré (SSEI), Semaine 26*
[12] Out of 128 countries assessed in 2015
[13] INFORM Index for Risk Management 2017
[14] The lack of biological and psychological maturity of young mothers has implications for pregnancy and breastfeeding, as well as their ability to adopt appropriate behaviors in children's diets

In brief

Facing the suspicion of hepatitis E epidemic in Am-Timan in Salamat region, a reinforced intervention in water, hygiene and sanitation is necessary

MSF-Holland has identified about 270 cases of hepatitis E since early September in the Salamat region. At the end of October, 36 patients were hospitalized and eight people died, including two pregnant women and two children. Of the 25 samples sent to the reference laboratory in Amsterdam for official confirmation, 20 were confirmed positive, 13 of which were in acute phase.

MSF-Holland's response includes treatment of patients at health centres and at the hospital, active identification of cases in communities, recruitment of community volunteers for hygiene sensitization, distribution of non-food items (NFIs), and treatment of water sources. Nevertheless, enhanced intervention by WASH partners is needed in the region, especially outside of Am-Timan. The weakness of WASH structures and practices in the area may explain this situation, as hepatitis E is transmitted via fecal-oral route. In the region, less than a third of the population has access to drinking water (29.5% according to the national NGO ATPCS - *Association pour l'Assainissement Total Piloté par la Communauté au Salamat*). Moreover, the response is difficult in the context of health worker strikes, which do not allow for the minimum service. In late November, UNICEF assessed the situation in the WASH sector in the Salamat region, with the objective of a possible positioning in order to strengthen the response.

According to the epidemiological model used by MSF, 14% of the population of Am-Timan, nearly 8,000 people, could be affected by hepatitis E, among whom 600 people may require hospitalization. Lethality rate for hepatitis E can reach 4%, and can rise up to 25% for pregnant women. However, the actions taken so far to cut the chain of transmission have had an impact on controlling the spread of the virus.

The Ministry of Health and the World Health Organization (WHO) have already assessed the measures to be taken after a joint mission has been deployed in the field from 22 to 29 October 2016. To date, the epidemic has not been declared by the government. (Source: MSF)

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For further information, please contact:

Florent Méhaule, OCHA Head of Office, mehaule@un.org, Tel. (+235) 68 85 10 04
Naomi Frérotte, Public Information Officer, frerotte@un.org, Tel. (+235) 66 90 16 33
Augustin Zusanné, Assistant Public Information Officer, zusanne@un.org, Tel. (+235) 63 90 09 13

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