

SUDAN CASE STUDY UNICEF/WFP/FANTA

EMERGENCY CONTEXT

- Internally Displaced Persons (IDPs) crisis since 2003 with ongoing displacement and insecurity
- Pre-crisis began with annual trends of Global Acute Malnutrition (GAM) of 19% North Darfur, 17% South Darfur and 14% West Darfur.
- 2004 GAM 21.8% (18.2-25.3); SAM 3.9% (2.3-5.6)
- 2005 GAM 11.9% (10.3-13.6); SAM 1.4% (0.9-2.0)
- 2006 GAM 12.9% (11.1-14.8); SAM 1.9% (1.3-2.5)
- 2007 GAM 16.1% (14.1-18.2); SAM 1.9% (1.3-2.6)
- High levels of GAM and SAM from May to October

INTERVENTION AREA

- IDPs in camps and host communities
- Agronomists (annual millet and sorghum yields)
- Limited livestock and cash crops
- Small nomadic pastoralist groups raising cattle and camels; few are involved in the displacement

CMAM SERVICE SITES

- Presently 15 partners (down from 23 in 2006)
- Outpatient care sites: 65
- Inpatient care sites: 11
- Supplementary feeding sites: 83
- SAM cases admitted in 2007: 10,098
- SAM cases August 2004-December 2007: 33,874
- MAM cases admitted in 2007: 11,016

PROCESS OF INTEGRATION

- 2001: CMAM program was piloted in North Darfur by one NGO
- 2004: CMAM grew gradually with assistance from UNICEF, WFP and NGOs, and funding from OFDA, DFID, ECHO, UNICEF, WFP and private funding from NGOs
- 2008:
 - Outpatient care and community outreach are managed by NGOs
 - Inpatient care is established in MOH hospitals and NGO sites
 - Referral system between MOH and NGO services is not functioning well
 - High turnover of international and national staff is a limiting factor
 - Therapeutic food and anthropometric equipment supplies are provided by UNICEF and NGOs; supplementary feeding supplies from WFP
 - Various protocols and monitoring tools are used
 - Capacity development is weak apart from MOH providing training in inpatient care WHO training. Some MOH staff are also involved in NGO activities.
- Primary health care system is weak and integration of outpatient care is not discussed

PROGRESS AND CHALLENGES IN INTEGRATION

1. Political will, leadership and capacity development

- MOH Nutrition Department lacks expertise in CMAM to provide leadership and suffers from high staff turnover. No true leadership emerged from the partners to support the MOH effectively with CMAM. Major efforts for advocating CMAM have been ongoing from the start of the Darfur crisis.
- MOH and UNICEF have been training pediatricians and other senior physicians in the WHO SAM Management training (inpatient care). Training in inpatient care for MOH has reached to the Darfur State levels.
- It is not clear how much the Curative Care Department and PHC Dispensaries and Clinics Department are involved in CMAM. The Health department of UNICEF is not involved.

2. Policies and plans including CMAM

- National health strategies do not include CMAM
- The National Nutrition Strategy is drafted and includes CMAM. The strategy outlines all elements needed for capacity development and currently a plan of action is being developed.
- MOH and UNICEF have launched several important initiatives. The Accelerated Child Survival Initiative is a national initiative in target states and includes screening and referral of SAM (based on MUAC for children 1-5 years).
- Referrals done in those states where there are no CMAM services.

3. CMAM Guidelines

- Draft CMAM guidelines in different forms are being reviewed, but poorly cover outpatient care. The guidelines are expected to be endorsed in May 2008.
- The national guidelines will play an important role in the standardization of protocols and monitoring tools, and to strengthen the information system. The guidelines will enable the MOH to take on a leadership role (tool for accountability of partners' activities).

4. Coordination and partners

- A task force of senior pediatricians has been initiated but it is not clear if it is linked with the MOH Nutrition Department. The bi-annual pediatric council is a potential forum to address CMAM.
- MOH and UNICEF lead coordination meetings that are limited to exchange of information. Strategies for CMAM or evaluation of best practices are not covered.
- UNICEF has an established Nutrition Surveillance System for Greater Darfur. It is a resource for understanding the nutritional situation and trends.

5. Funding

- Extensive funding for nutrition interventions was available in 2004-05 and then dramatically decreased. Nutrition is not a high priority (new interest after the 2007 GAM increase).
- Implementation and supplies for selective feeding are provided by UNICEF and WFP and NGO partners, with short-term emergency funding from multiple donors.
- It is not clear if long term funding is available for sustainable capacity development
- OFDA currently funding Nutrition Surveillance System (funding to end soon)

6. National production RUTF

- The MOH and pediatricians are cautious and do not fully understand the role of RUTF in the treatment of SAM.
- Initiative for national production of RUTF is ongoing with UNICEF support.

7. Free treatment of SAM

- Free treatment for children under five is required by law and is outlined in the health sector five-year strategic plan. However, a registration fee is sometimes asked upon admission to hospitals. Primary health care services are free but drugs are not necessarily available.
- Access to services and supplies for the management of SAM is only available in the Darfur States.