Darfur Humanitarian Response

Nutrition Sector Report

Khartoum, Sudan
August 2004

Compiled by UNICEF Sudan in collaboration with Nutrition Sector Coordination Group which includes members of the MoH, OCHA, WFP, ICRC, MSF-H, MSF-F, MSF-Spain, MSF-CH, MSF-B, CARE, ACF, GOAL, SC-UK, SC-US, Islamic Africa Relief, World Vision International, Concern WW, Tear Fund, NCA, DFID, USAID/OFDA and the EU.

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1. Introduction

This is the second report which reviews the progress of implementing partners in the Nutrition Sector. It covers the period from July-August 2004. The report is compiled from information submitted to UNICEF by NGOs who are implementing nutrition activities in Darfur. These reports ranged from feeding centre data, results of nutrition surveys and/or assessments, as well as individual agency reports, submitted at Nutrition Coordination meetings. These reports have been compiled to provide an overview of implementation and the nutritional situation, as well as an analysis of the key indicators in feeding centres which can be compared against Sphere Minimum Standards. The analysis also explores the impact of underlying factors which influence nutritional status, such as food insecurity; health; environmental sanitation; support systems for health and child care; and the impact of disrupted economic activities and community livelihoods, on the present situation.

The report highlights important activities and policy level discussions that have taken place within the Nutrition Coordination group which are key for understanding and achieving the overall objective of improving nutritional status in Darfur. Finally, suggestions are made on strategies that should be used to address effectively the challenges faced. A matrix detailing all planned and operational nutritional interventions and the agencies supporting them is also attached at the end. Areas of intervention gaps are also indicated.

2. Background

In February 2003, the Sudan Liberation Army (SLA) and the Justice and Equality Movement (JEM) took up arms against government forces. As government attempts to route out insurgents failed, government aligned civilian militias soon attacked and burned villages, killing residents and looting assets such as livestock, which is the main source of livelihood for a large number of the Darfur communities. This led to massive displacement of about 1.2 million people, and affected host communities and other residents. Unfortunately, during the reporting month, this figure has risen to about 1.5 million people due to persistent insecurity and increased displacement, as well as improved methods of identification and registration of displaced communities.

This increased displacement has further exacerbated the food security situation for a population that was already afflicted by chronic food insecurity, inadequate health services, disease, inadequate water services and environmental sanitation facilities. The combination of these factors has resulted in increased levels of malnutrition and mortality among children (mostly under five) and adults. Unfortunately, the rainy season, although relatively mild in comparison to past years, has exacerbated the sanitation and health situation. In addition, none of the IDP camps have reliable access to farms, thus foreshadowing food insecurity next year, as planting season has been missed. IDP communities and some vulnerable host residents therefore, are living in a precarious predicament, with almost complete dependence on humanitarian aid.

In early 2004, a number of Nutrition NGOs, UNICEF, WFP and the Government of Sudan responded to this crisis with activities which included initial assessments and nutrition surveys as well as the implementation of specialized programs such as Therapeutic and Supplementary Feeding Programs. Interventions started as early as March-April in a few locations in North and West Darfur but the majority of the nutrition interventions kicked off in June or July 2004, following the establishment of the 90 Day Plan.

The 90 Day Plan established programmatic targets for humanitarian assistance delivery during the period of 1 June to 31 August 2004, and appointed UNICEF as the overall coordinator for the Nutrition Sector. UNICEF is also tasked however, with the responsibility of providing technical assistance to MOH and NGO partners. UNICEF provides food and equipment required for TFPs, Surveys and SFPs, while WFP has the responsibility of providing the entire food requirement for SFPs.

Eleven NGOs namely, MSF-F, MSF-H, GOAL, Concern WW, SC-US, ACF, CARE, SC-UK, MSF-CH, MSF-B and MSF-Spain have already implemented nutrition programs in the three states of Darfur. Three additional NGOs namely Tear Fund, World Vision, and NCA have plans to open selective feeding programs. In the last two month, ACF, SC-UK, MSF-H have expanded and opened additional programs to improve coverage. MOH is also supporting two TFCs, one in South Darfur and the other in North Darfur. To strengthen the management of the MOH support SFP and TFCs, UNICEF trained 60 MOH staff who will be managing one TFC in El Fashir town and seven SFPs in the outskirts of El Fashir town. For details on activities and areas of gap, please refer to Annex 1 which shows matrix of the NGOs working in the region and their planned activities.

In addition to the NGO and MOH nutritionists, UNICEF has placed nutritionists in all field offices to facilitate coordination, as well as appointed a Khartoum level Nutrition Coordinator. WFP also has one Nutrition Coordinator in place and one additional Field Nutritionist to be based in North Darfur. NGOs on the other hand have adequate representation at both field and Khartoum level.

I. 90 Day Plan –Review of Progress and Gaps in Interventions

The 90 day plan for nutrition interventions (June-August 2004) aimed at setting up 24 TFC and 24 SFC in Darfur, covering a total population of 4,400 and 31,000 respectively. To date, 30 TFCs and 30 SFC have been established. These centres have admitted 8,094 children in TFCs and CTC and 30,712 children in targeted SFP between April and 31 August, compared to 4,820 and 18,039 respectively, at the end of July. This figure should be interpreted as achievements but not coverage because it is not known how many children have become malnourished after the first surveys on which the estimates of global acute malnutrition (GAM) were based. If the GAM rate has increased, so has the target population. Data on coverage should be collected during a nutrition survey where information on feeding centre coverage is considered. Despite these clarifications, these figures clearly indicate that the number of children reached has exceeded the target number established in the 90 Day plan.

Unfortunately, the targets established in the 90 Day Plan are now understood to be inadequate, in comparison with the current needs of the population. Using the conflict affected population at the end of August (1.5 million), approximately 300,000 (or 17%) are children less than five years old. Taking an average prevalence of severe acute malnutrition of 3% and moderate acute malnutrition of 17%, close to 9,000 children under 5 years of age are at risk of dying and thus, are in need of Therapeutic Feeding, while more than 50,000 children are moderately malnourished and in need of Supplementary Feeding.

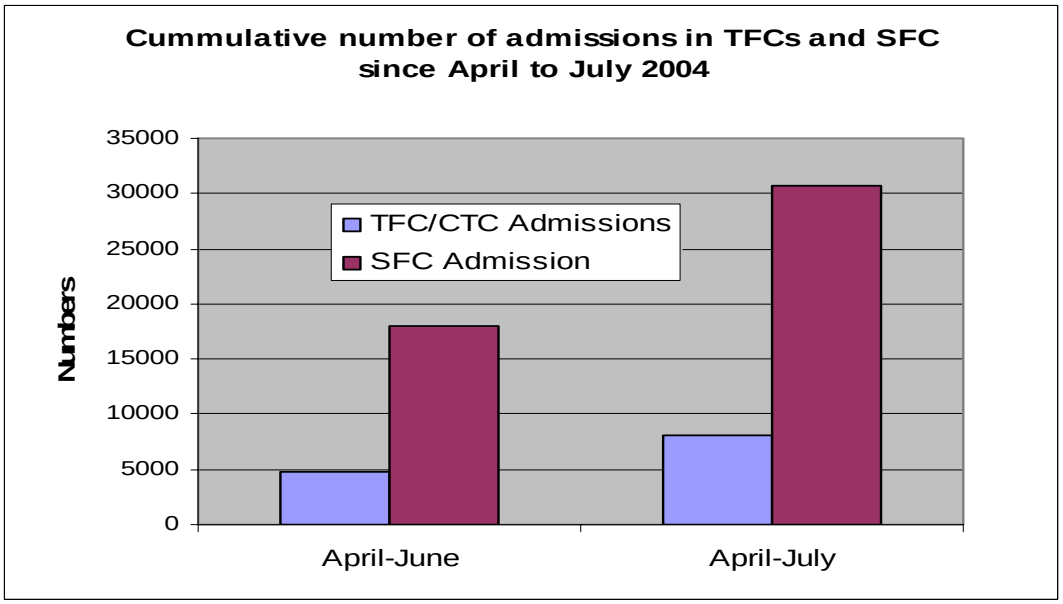
Based on this rough projection, with double the recommended number of beneficiaries in TFC (200 per centre), approximately 45 centre-based TFCs are required to cover the needs of the population and equally the same number of SFCs. At this time however, there is

limited capacity in the sector to reach 45 TFCs. Implementing partners have indicated plans to establish 11 new TFCs, bringing the total to 41. In addition, the centre-based approach to TFC management may not be feasible in serving areas with scattered, low density populations. In these cases, mobile teams or the Community Therapeutic Care approach should be employed. These types of facilities however, admit less children then the centre-based model. Thus, the target number of facilities may need to increase, depending on the strategies employed.

Community Therapeutic Care (CTC). CTC adopts a public health approach to manage acute malnutrition at community level to maximize coverage, early detection and treatment of severely malnourished children. During the reporting month, both Concern WW and SC-UK have managed to establish CTC in Geneina town and rural, reaching thousands of severely and moderately malnourished children. Two additional NGOs namely TearFund and GOAL are keen on adopting this approach. Emphasis is being made on ensuring that the approach is adapted properly, with the help of Concern or World Vision International. Additional strategies to increase coverage have been developed and this includes community level screening.

With the onset of the rainy season, increased incidence of dysentery, acute respiratory infections, acute watery diarrhoea and malaria have been reported in feeding centres causing substantial increase in caseloads. The TFCs in Kalma, South Darfur and El Geneina Hospital, West Darfur have been particularly concerning during the last two months. The establishment of CTC especially in El Geneina rural has solved the problem of congestion in El Geneina Hospital and has proved vital in increasing coverage and providing active case identification.

Figure 1: Cumulative number of children admitted in SFCs and TFC/CTCs in Greater Darfur, April-July compared to April-June 2004



Note that this figure does not included children targeted with Blanket SFP

Nutritional interventions planned in June-July by (SC-UK, Concern WW, ACF, MSF-B, and MSF-H) have been implemented. Both SC-UK and Concern WW intend to expand to more sites within the localities, thus further improving coverage. During July and August, the new

TFC/CTCs and SFPs were established around **Geneina town, Geneina rural and Habila in West Darfur, Nyala town, Muhajiria, Shariea, and Mershing and Manawashi in the South and Zamzam and Saraf Umra town in North Darfur.** Additional SFCs are planned by WVI and ACF in Nyala town, and NCA in Kubum area. GOAL also has plans to expand interventions in Kutum and possibly Jebel Mara.

During the reporting month, increase in admissions were observed in Kalma and Kutum but the rest of the camps have shown either stable admissions or a reduction, especially in the MSF-H centres in West Darfur. The areas of intervention gap are in Nyala locality where the small IDP population is scattered, and in **Shariea as well as Kass localities.** Rapid assessments in these areas would provide data on whether selective feeding programmes are required. However, with such low population figures in some areas, a TFC that requires more input in terms of human resources and facilities would not be recommended. Instead, the option of CTC approach, which can be managed through outreach, should be explored. In the West, the only area which will have a notable intervention gap after the plans of TearFund, Concern WW and SC-US are fully realized would be **Mukjar rural.** In North Darfur, the areas controlled by SLA, such as **Tina, Kornoi, and Um Baru in Kutum** locality still remain uncovered, as well as some areas in **Kutum localities and part of Kabkabiya.**

In the North part of Darfur, there were reports of SLM/A requesting more international support in the form of mobile or outreach teams that target only SLM/A areas. Security concerns and a fear that national staff seconded by the MOH are pro government however, prevents them from accepting teams without careful review. Their expressed preference for international staff is unsustainable as it will eventually place a great strain on already stretched humanitarian organisations. **This is a matter for advocacy for OCHA and the other UN agencies.**

Besides the targeted SFP, blanket SFP have been implemented in a number of camps during July-August and the camps targeted were **Abushouk and Malha in the North by ACF and SC-UK respectively, Krinding by SC-US and Arara, Beida, Kango Haraza and Mesteri in Habila locality by Medair. MSF-F has decided to stop targeted SFP and implement Blanket SFP in Nertiti and Mornei starting the first week of September.**

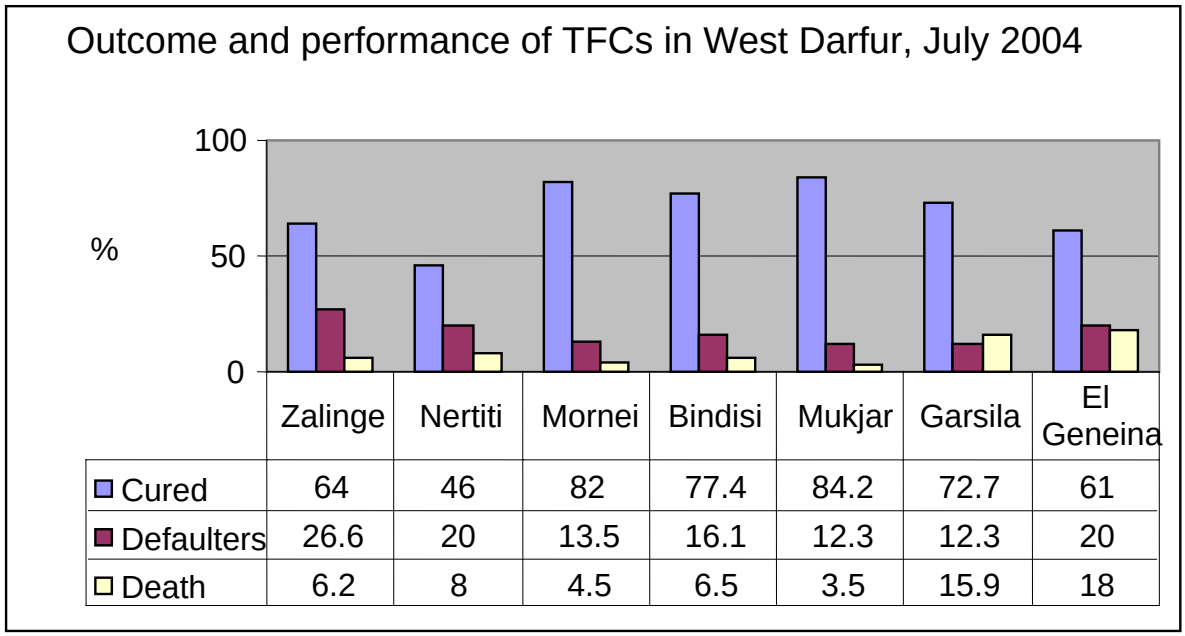
II. Quality of Care in Nutrition Interventions

Standardized reporting systems have been instituted for monitoring trends in admissions, discharges, death and defaulters and the performance of the TFCs and SFCs. The analysis here is based on 50% of the centres that have complete and current information. Reports were not received from World Vision International, CARE, SC-US, MSF-Swiss, and MSF-B. TearFund and Concern WW started their programs at the end of August so they are also omitted from this analysis. The benchmarks used here are the Sphere Minimum Standards where in TFCs, the objective is to have 70% of the children discharged from the centre cured from malnutrition, <3% death rate and <15% defaulter rate. While in SFCs, at least 80% cured rate is considered standard, there is a <5% death rate and <10 % defaulter rate.

In TFCs, only 50% of the reporting centres have achieved a cure rate of 70% and above, in Kalma, Kass, Kutum, Tawilla. In Kebkabiya TFC, the cure rate is worryingly low but in the first two camps (Kalma and Kass) had no discharges during the month, and this makes the percentage of defaulters appear high as this is calculated as a percentage of total exit. **The low cure rate needs to be investigated and addressed by the various NGOs.**

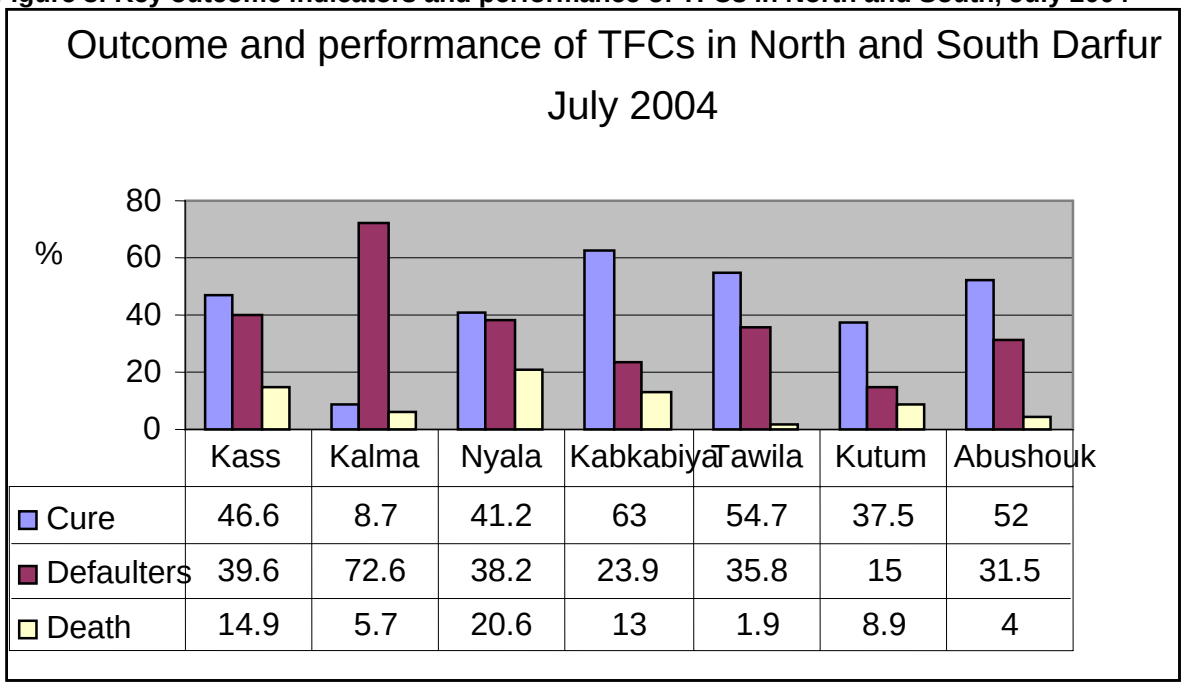
Similarly, the length of stay (the period it takes for a child fully recover before discharged) ranged from 17 days to 58 days before a child is discharged, which is generally too long. The recommended average length stay should be about 3-6 weeks for children to fully recover. It is therefore very clear that, children are taking longer to recover in 50% of these centres. Mortality rates and defaulter rates in four of the TFCs were also above the norm and the reasons for this must be established so that it can be properly addressed. Defaulter rate is very high especially in Kass, Kalma, Kabkabiya, Tawila, Abushouk and Nyala.

Figure 2: Key outcome indicators and performance of TFCs in West Darfur, July 2004



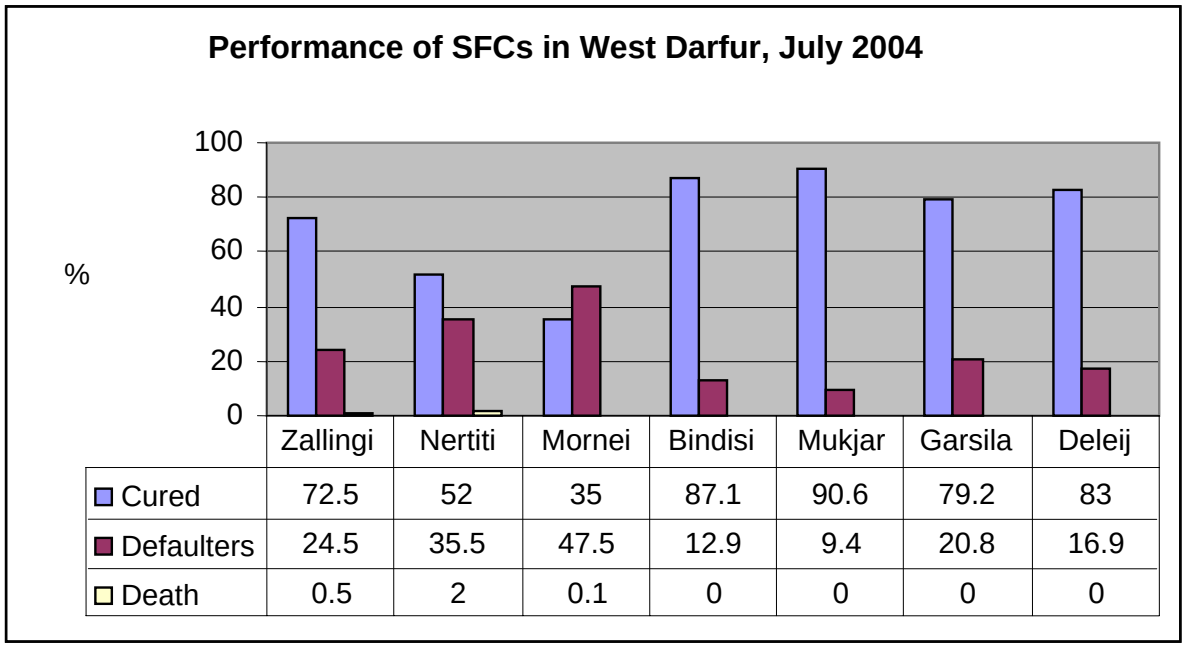
	Zalinge	Nertiti	Mornei	Bindisi	Mukjar	Garsila	El Geneina
Cured	64	46	82	77.4	84.2	72.7	61
Defaulters	26.6	20	13.5	16.1	12.3	12.3	20
Death	6.2	8	4.5	6.5	3.5	15.9	18

Figure 3: Key outcome indicators and performance of TFCs in North and South, July 2004



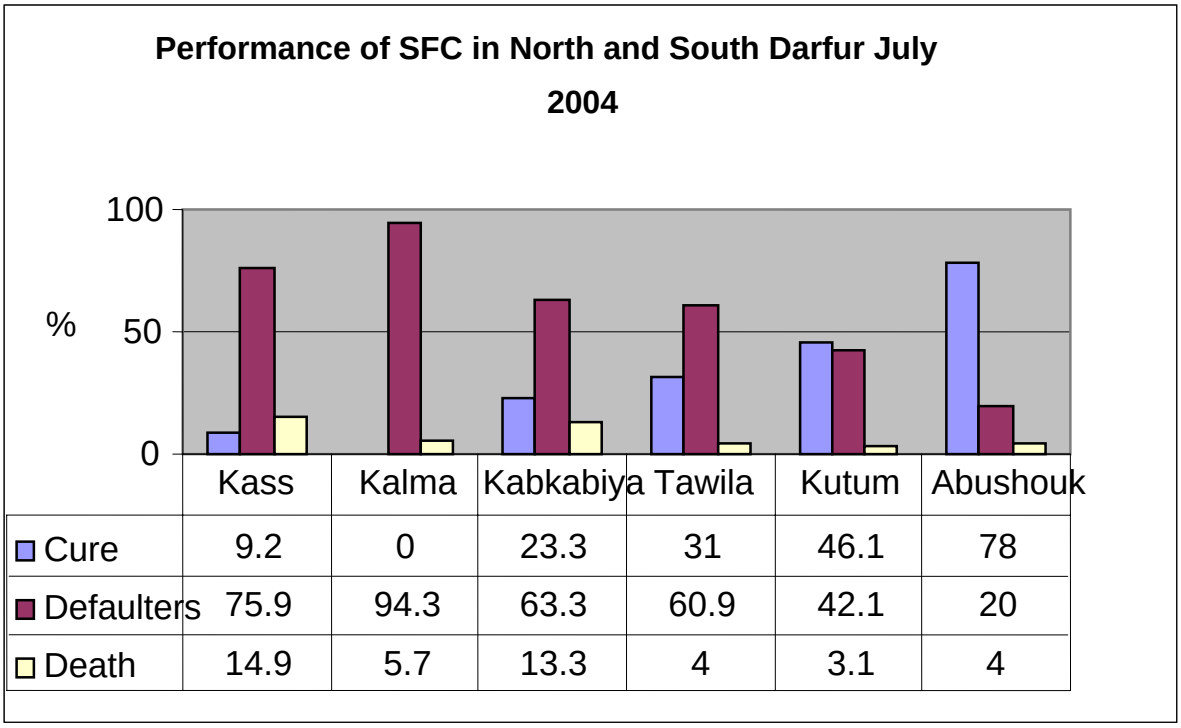
	Kass	Kalma	Nyala	Kabkabiya	Tawila	Kutum	Abushouk
Cure	46.6	8.7	41.2	63	54.7	37.5	52
Defaulters	39.6	72.6	38.2	23.9	35.8	15	31.5
Death	14.9	5.7	20.6	13	1.9	8.9	4

Figure 4: Outcome and performance of SFCs in West Darfur, July 2004



	Zallingi	Nertiti	Mornei	Bindisi	Mukjar	Garsila	Deleij
Cured	72.5	52	35	87.1	90.6	79.2	83
Defaulters	24.5	35.5	47.5	12.9	9.4	20.8	16.9
Death	0.5	2	0.1	0	0	0	0

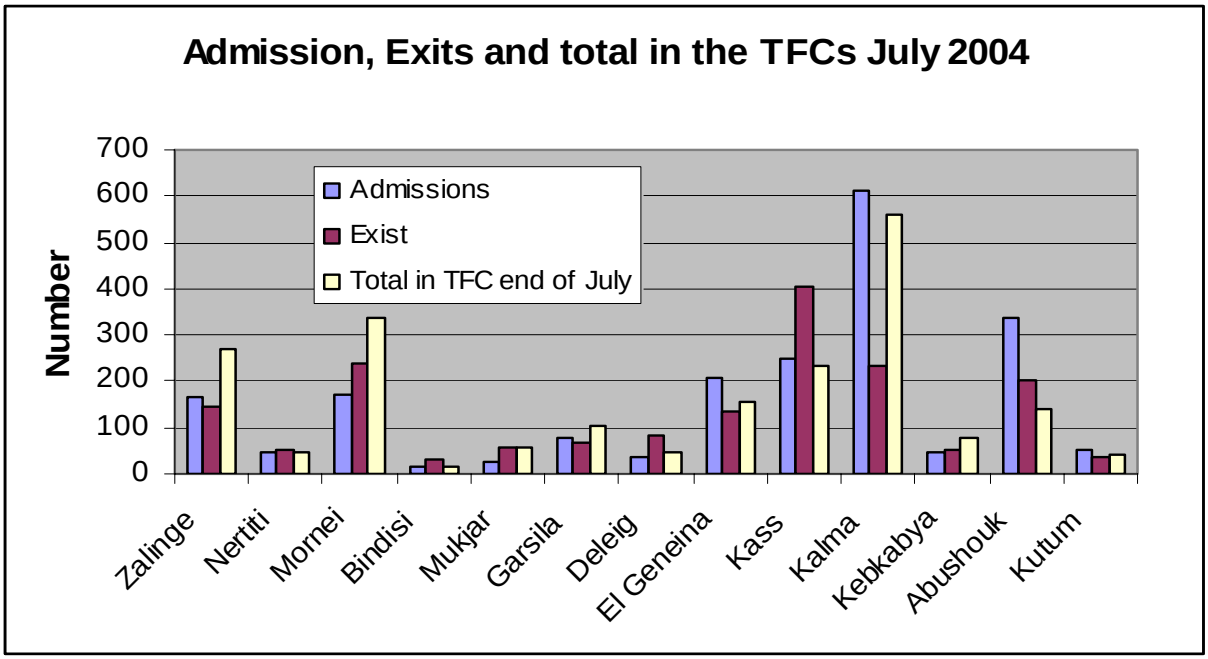
Figure 5: Outcome and performance of SFCs in South and North Darfur, July 2004



	Kass	Kalma	Kabkabiya	Tawila	Kutum	Abushouk
Cure	9.2	0	23.3	31	46.1	78
Defaulters	75.9	94.3	63.3	60.9	42.1	20
Death	14.9	5.7	13.3	4	3.1	4

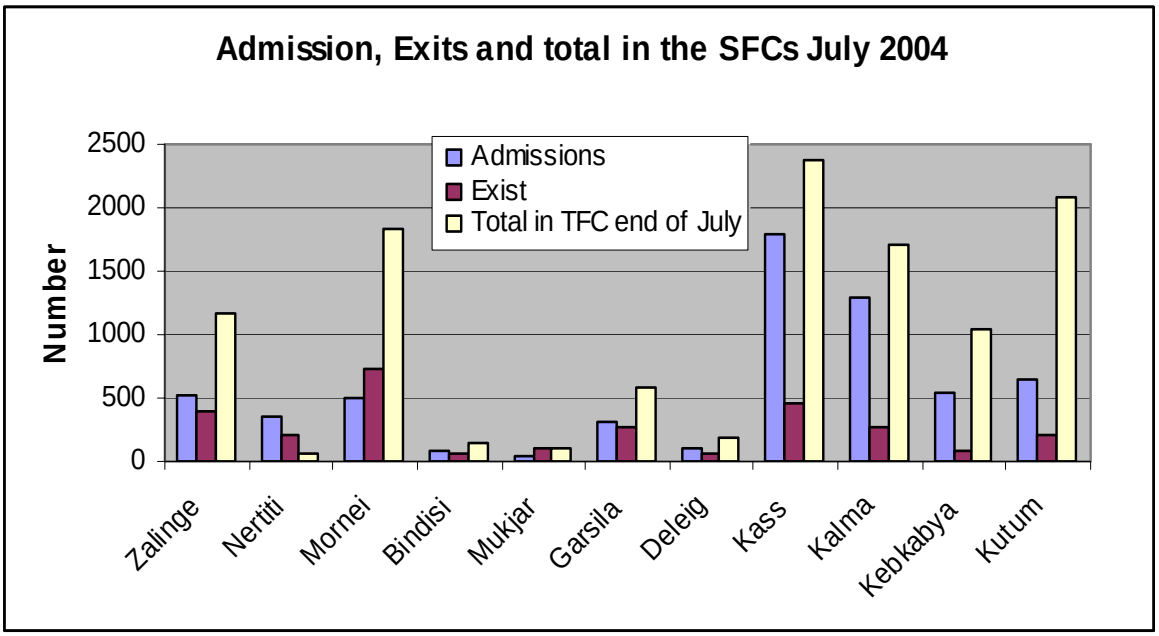
Overall, it appears that the outcome indicators of SFCs in Kalma, Kass, Kabkabiya, Tawila, Kutum and Mornei are below the recommended Sphere Minimum Standards. In Kass and Kalma, this is reportedly associated with distribution of food and non food items and also partly because no discharges were made. It also seems that a number of IDPs are engaged in paid labour which induces defaulting of programs. Reason for this high rate of defaulting must be investigated in the coming month.

Figure 6: Admissions and exits in TFCs in Greater Darfur



In TFCs, the total exits seem to be almost equal to admissions. This is because a number of the centres have opened very recently. This trend is expected to change during the third month of the program as more children will be eligible to be discharged. Since this is data from one month, it is difficult to establish trends in admission, but the weekly reports show increase in admissions, with only very few centres showing stable levels. With the exception of few camps, admissions have started to stabilize in some MSF-H, MSF-F and ACF feeding centres (especially Zalinge, Nertiti and Kebkabya) and the same trend is seen in ACF centres in Abushouk.

Figure 7: Admission and exits in SFCs in Greater Darfur



In the SFCs, both admissions and exits seem also appear to be stabilizing, except in the cases of Kass, Kalma, Kebkabiya and Kutum. Ideally, admissions should be high at the beginning and go down as the nutrition situation improves. However, in this particular situation, many camps are not receiving adequate general food rations due to registration problems and are experiencing a high prevalence of disease as a result of the rainy season, thus increasing admissions. Analysis of data in the coming months will better indicate the trends.

III. Prevention of Malnutrition

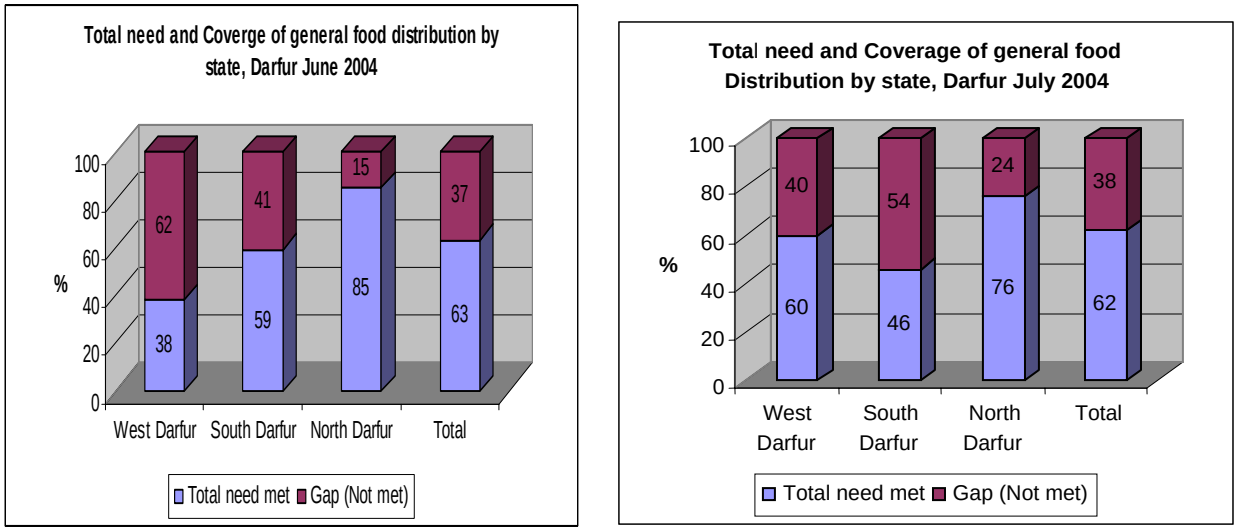
Rains started in July and will continue throughout September/October. This period is normally characterized by increased incidence of dysentery, acute respiratory infection, acute watery diarrhoea and malaria. The high prevalence of diseases has already been recorded in a number of camps and this could partly have contributed to an increase in admissions. The reported death rates among children in the surveys conducted during July-August were attributed to preventable disease such as diarrhoea, measles, and malnutrition, **therefore the need for hygiene promotion activities alongside nutrition interventions as well as routine immunization can not be over emphasized.**

During the month of July, WFP managed to reach approximately 62% of IDPs with the general food ration compared to 63% in June. Unfortunately, this means around 38% of the IDP population had insufficient access to food. WFP and other implementing partners are faced with problems of capacity, verification of figures, registration and management of distribution systems, monitoring and logistics, as well as an unstable pipeline. The problems involved with moving food into Darfur are many. Although WFP has adequate food stocks until September, gaps are expected during parts of September. WFP is swiftly responding to the staffing, logistical and pipeline problems by hiring additional staff and opening new key field locations; bringing in trucks which can withstand the road conditions in Darfur, and using the option of limited air drops, especially in West Darfur.

In some camps in North Darfur (such as Tawilla and Kebkabiya) where the rains have not greatly affected delivery, MSF-B Epicentre survey showed that about 95% of the population mentioned having received food. This indicator is very good although the qualities of rations might differ from one distribution site to the other. The challenge for WFP is maintaining the level of food in the pipeline until the next harvest season. Unfortunately, this is not the coming season since none of the IDPs have managed to access land for cultivation.

In towns such as Nyala and El Geneina, where IDPs are mingled with the host community, the challenges of registering newly displaced are huge since the host community, many of whom are IDPs from previous drought, settled in the outskirts of town and are now benefiting from the services provided to new IDPs. In these cases registration can become problematic and chaotic. This is the case in camps like Sheriff in Nyala town where registration had to be stopped due to problems between communities. Unfortunately, this means that the new IDPs may miss out on general ration distribution and may subsequently experience malnutrition.

Figure 8: Need and gap in the general food distribution, June 2004



Source, OCHA Darfur Humanitarian Profile June and July Report

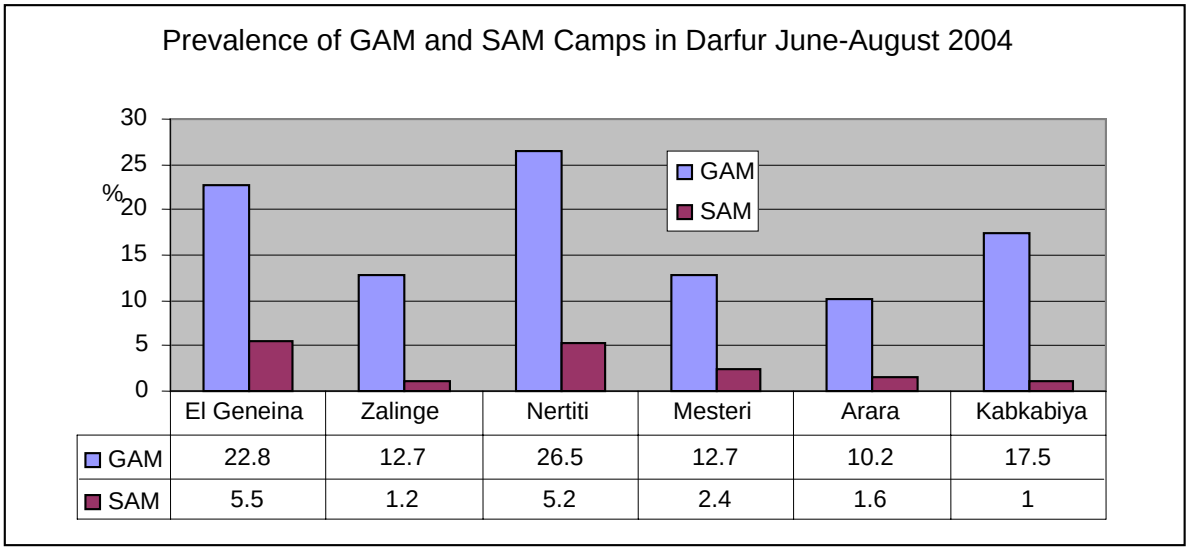
Medair, SC-UK, SC-US and ACF already started Blanket SFP in areas with high prevalence of malnutrition and other aggravating factors. MSF-F is starting BSFP in two of its centre during the beginning of September while MSF-B have also instituted additional family ration for children who are malnourished. In places like Nyala town, **it is also recommended that TFCs and SFCs should advocate for the delivery of a family ration for all the children in the programme as stop gap measure until WFP resolves the problems with registration. The practicalities of this should be further discussed with WFP by UNICEF and the Coordination group at state level.**

IV. Nutrition Information for Programming and Monitoring of Impact

During June-August 2004, a number of assessments and proper nutrition surveys were conducted in El Geneina town, Zalinge, Kabkabiya and Nertiti by MSF-Epicentre, Mesteri, and Arara by TearFund. All the surveys used 30x30 cluster sample methods except in Arara and Mesteri where systematic sampling was employed. The rate of Global Acute Malnutrition (GAM) ranged from 10.2% in Arara to 26. 5% in Nertiti, both in West Darfur. In Arara, Mesteri and Zallingi, the prevalence indicates a serious situation although the rates are not as high. Continued support is required to bring the levels down to acceptable level. In Nertiti, El Geneina and Kabkabiya the prevalence rates are relatively lower but still indicate an emergency situation.

In the case of Geneina town, the high prevalence of disease and poor sanitation were among the causes of the increase malnutrition as well as food security problem. Although TFP started in El Geneina almost three months ago, SFPs have just been implemented therefore the high levels of malnutrition could also be linked to lack of safety net for the moderately malnourished children. In Nertiti and Kabkabiya, high rates are recorded despite the fact that nutritional activities have been going on for the last four months. In both camps, the high prevalence of disease and inadequate food rations have been cited as the main cause of the high levels of malnutrition.

Figure 9: Summary of results of nutrition surveys conducted in April-May 2004



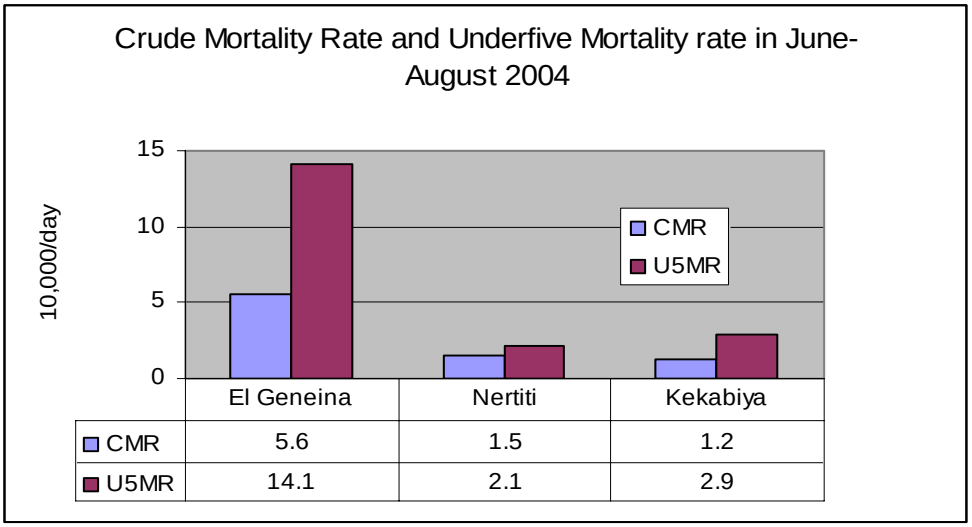
	El Geneina	Zalinge	Nertiti	Mesteri	Arara	Kabkabiya
GAM	22.8	12.7	26.5	12.7	10.2	17.5
SAM	5.5	1.2	5.2	2.4	1.6	1

Mortality rates were equality high in camps that have recorded high prevalence of malnutrition as shown in the table below. The nutrition survey reports recommended continued selective feeding, blanket SFP in El Geneina and Nertiti, improved targeting of general ration, and continued monitoring of the nutritional situation in the IDPs camps and the surrounding host communities. Improvement in health service delivery, water and hygiene promotion were also recommended.

Other surveys planned this month are in Nyala town, Kalma and Kass camps, as well as a follow-up survey in Abushouk. With these surveys and others being planned for North Darfur and South Darfur (Ed Daein area) most of the bigger camps should be covered by November. In the smaller camps, the plan is to conduct rapid screening on a needs basis

so that adequate information on planning and monitoring of the nutritional situation can be obtained.

Figure 10: Summary of mortality rates from surveys conducted in April-May 2004



In all camps, both the under-five mortality rate and crude mortality rate have exceeded normal rates by 2-7 times. Although there were reports of some causality related mortalities, the rates still indicate a crisis situation. The most prevalent cause of mortality was diarrhoea, which is linked to problems with water and/or sanitation. The crude mortality rates of over 1/10,000/day and under five mortality rate of over 2/10,000/day are considered an emergency but all the above figures either show emergency or crisis level. Of particular concern is the high mortality rate in El Geneina. With the improvement in nutrition programme coverage as well as the general ration, these rates may have decreased. The importance of monitoring this situation, however, can not be over emphasized.

Table1: List of nutrition surveys conducted between June and end-August, showing malnutrition and mortality rates with 95% confidence interval

CAMPS	NGO/IP	GAM (C.I.)	SAM (C.I.)	CMR (C.I.)	U5MR (C.I.)
1. Zalinge	MSF Epicentre, June 04	23.4% C.I (19.4-28.0%)	4.5% C.I (2.8-7.0%)	1.8/10,000/day C.I (1.1-3.0)	2.2/10,000/day C.I (1.8-2.7)
2. Mornie	MSF-F April 04	20.6% C.I (17.4-24.2%)	4.5% C.I (1.9-3.9%)	1.6/10,000/day C.I (1.1-2.2)	3.4/10,000/day C.I (3.1-3.8)
3. Wade Sale/Mukjar	MSF-H April 04	21.5% C.I (18.5-23.9%)	3.2% C.I (1.9-4.2%)	3.64/10,000/day C.I (2.69-4.59)	5.23/10,000/day C.I (2.8-7.6)
4. Malha	SC-UK May 04	33.4% C.I (28.9-37.8%)	5.4% C.I (3.4-7.5%)	-	-
5. Kutum	GOAL March 04	12.6% C.I (10.2-14.9%)	0.8% C.I (0.2-1.4%)	-	2.05/10,000/day C.I (1.38-2.72)
6. Mershing/Mana washi/ 7. Duma	SC-UK June 04	15% C.I (12.2-17.7%)	1.9% C.I (0.8-2.9%)	-	2.08/10,000/day C.I (1.38-2.78)
8. Abushouk	ACF June 04	33.9% C.I (34.5-43.6%)	9.6% C.I (7.2-12.8%)	2.13/10,000/day	6.67/10,000/day

9. El Geneina	MSF Epicentre July 04	25.8% C.I (22.9-28.8%)	5.5% C.I (4.1-7.3%)	5.6/10,000/day C.I (4.1-7.6)	14.1/10,000/day C.I (9.7-20.1)
10. Zalinge	MSF Epicentre June 04	12.7% C.I (9.9-16.0%)	1.2% C.I (0.3-2.2%)	-	-
11. Nertiti	MSF Epicentre June 04	26.5% C.I (23.0-30.0%)	5.2% C.I (3.3-7.2%)	1.5/10,000/day C.I (1.2-1.9)	2.1/10,000/day C.I (1.2-3.5)
12. Arara	TearFund July 04	10,2% C.I (7.1-13.7%)	1.6% C.I (0.4-3.2%)	-	-
13. Mesteri	TearFund July 04	12.7% C.I (10.1-17.3%)	2.4% C.I (1.2-4.7%)	-	-
14. Kabkabiya	MSF Epicentre July 04	17.5% C.I (14.4-21.0%)	1% C.I (0.5-1.8%)	1.2/10,000/day C.I (0.7-1.8)	2.9/10,000/day C.I (1.5-5.3)

During the month of August, a collaborative rapid assessment was conducted in Kubum and Um Labassa by UNICEF, ACF, ARC and Norwegian Church Aid, where all children in these two camps were screened (weight/height). GAM was 25.5% in Kubum and 18.5% in Um Labassa, SAM was 3% in Kubum and no SAM was recorded in Um Labassa. Both prevalence rates indicate an emergency situation, and other key highlights were:

- Food distributed for three months took place in the camps but it was not confirmed if the outlying camps received food.
- Targeted SFPs and TFPs were recommended in Kubum while in Um Labassa, continued general ration distribution alongside water and sanitation activities was recommended.
- In both locations, continuous monitoring of the nutritional situation was required. In smaller areas where a full survey would not be possible, assessments like these will provide valuable information for targeting of food aid and nutrition interventions.

A WFP-led food security and nutrition survey started in the three state of Darfur during the first week of September. The objective of this survey is to provide an overview of the nutritional status in the whole Darfur. During this survey, data will be collected on child malnutrition, adult malnutrition, micronutrient deficiencies, and mortality. The data from this survey will be stratified to give state level nutritional status but not camps specific data. This survey is aiming to assist WFP with decision-making on food requirements for Darfur until the end of the year. Before this survey was started, UNICEF and several implementation NGOs, together with the MOH had planned for a series of locality/camp level surveys. These surveys will still go ahead as planned.

V. Sector Coordination

Both national and state level nutrition coordination activities include regular meetings, sharing of information, state level analysis of gaps and directing of new partners in areas in need. There are still challenges with collecting data from partners which is partly due to logistical constraints as well as the ability of the staff to present data in the new format. A number of implementing partners have different formats before a systematic reporting form was developed.

Geographic gaps in interventions are indicated by the areas highlighted in yellow in the matrix attached. UNICEF has had state level discussions with partners to develop a 120 day plan (September-December 2004) for the three states.

VI. Priorities of the Nutrition Sector for the coming Month

- Development of a 120 Day Nutrition sector plan with UN Agencies, NGOs and MOH for the remaining four months and direction of the nutrition supplies to identified gaps;
- Conduct surveys in areas where no surveys have yet been conducted, Nyala town (ACF) Zamzam (UNICEF/MSF-Spain/MOH), Korma, Kornoi, Um Baru, Mellit (SC-UK) and a follow-up survey in Abushouk (ACF);
- Conduct rapid assessments in the small camps to establish an understanding of the need for intervention (UNICEF and NGOs);
- Facilitate the establishment of El Fashir town SFCs following the training of 30 MOH staff and similarly, upgrade the El Fashir Hospital TFC (UNICEF);
- Establish Nyala SFC and other SFP around the town after assessments confirms the need (WVI/ACF/UNICEF) and Kubum area (NCA);
- Establish SFC in Arara, Mesteri, Beida in West Darfur (TearFund) and expand SFC and CTCs in Geneina and Habila localities (Concern WW);
- Conduct a CTC orientation workshop and update the national guidelines to incorporate the CTC approach. Training of implementing partners in CTC approach is also needed (Valid International and UNICEF);
- Establish a state level database and compile state level analysis to be shared with partners and MOH at state level (UNICEF).

Administrative Unit/ Location*	Total Population	Nutrition Situation	Source	# of TFCs	TFC Cum # Served May - Aug	# of SFCs	SFP Cum #Served May -Aug	Agency
South Darfur								
Nyala Locality								
Kalma Camp	26,658	Early Sep	Epicentre	1	1384	2	3319	MSF-H
Ta'asha Area	10,464							
Yara	8,907	-	-	-	-	-	-	-
Nyala Town	25,000	Early Sept	ACF	2	176	2	213	CARE/MOH & ACF
Bielel camp	4,940							
Abu Ajura	59,270							
Nyala Hinterland	-							
Kass Locality								
Kass Town	48,025	Early Sept	ACF	1	857	1	3155	MSF-H
Dogdousa	6,000		-					
Jemeza Komera	3,673	-	-	-	-	-	-	-
Hashaba	953	-	-	-	-	-	-	-
Korele	-	-	-	-	-	-	-	-
Dibis	517	-	-	-	-	-	-	-
Nyamma	1,417	-	-	-	-	-	-	-
Thur	6,489	-	-	-	-	-	-	-
Singita	1,575	-	-	-	-	-	-	-
Limo	366	-	-	-	-	-	-	-
Kirew	204	-	-	-	-	-	-	-
Guba	1,312	-	-	-	-	-	-	-
Kass Hinterland	1,427	-	-	-	-	-	-	-
Shariea Locality								
Shariea	45,000			1	42	1	112	MSF-H
Mersheng	24,000	GAM: 15% SAM: 1.9%	SC UK survey Jun-04	1	101	1	653	SC-UK
Manawashi	5,677							
Duma	6,515							
Muhajiria	15,923	-	-	1	83	1	152	MSF-H
El Malam	26,750	-	-	-	-	-	-	-

Ed Daein Locality								
Ed Daein, incl Khor Omer	27,166							SC UK
El Ferdous	14,481	-	-	-	-	-	-	SC-UK
Adilla Locality		GAM: 14% SAM: 2.2%	SC UK survey Apr-04	-	**-**	**-**	**-**	**SC-UK**
Adilla Town	5,415			-	-	-	-	-
Buram Locality								
Joghana	2,024	-	-	-	-	-	-	SC-UK
Buram Town	974	-	-	-	-	-	-	SC-UK
Sanam El Naga	9,500	-	-	-	-	-	-	SC-UK
Edd Al Fursan Locality								
Kubum	2,338	-	-	-	-	-	-	NCA
Um Labassa Town	2,117	-	-	-	-	-	-	NCA
Edd Al Fursan	500	-	-	-	-	-	-	NCA
Dogodoussa	6,000	-	-	-	-	-	-	NCA
Habuba	1,297	-	-	-	-	-	-	NCA
Rehed Al Berdi Locality								
Rehed Al Berdi, incl Safia	-	-	-	-	-	-	-	-
Tulus Locality								
Tulus	1,200	-	-	-	-	-	-	-
SubTotal South Darfur								
West Darfur								
ElGeneina Locality								
El Geneina town	16,646	GAM: 25.8% SAM: 5.5%	Epicentre, (MSF), July 04	1	388	1	144	MSF-F/Concern WW
Ardamatar	23,652			1	9	1	75	ConcernWW
Sisi camp	6,710							
Sanidadi Village	3,383							
Al Riyad	22,666			1	19	1	249	Concern WW
Krinding	22,249					BSFP	3,000	SC-US
Dorti	3,643			1	6	1	75	Concern WW

Abu Zahra	12,278			1	9	1	170	Concern WW
Masteri	18,000	GAM: 12.7% SAM: 2.4%	TearFund, June 04	-	-	-	-	TearFund
Kerenik	20,932	-	-	1	98	1	266	MSF-CH
Mornei	73,676	GAM: 20.6% SAM: 4.1%	MSF-F April 04	1	1733	1	4235	MSF-F
Kulbus Locality								
Sirba	5,851	-	-	-	-	-	-	SC-US
Seleia	7,619	-	-	-	-	-	-	SC-US
Kandabei	5,270	-	-	-	-	-	-	SC-US
Habila Locality								
Arara	11,142	-	-	-	-	-	-	TearFund
Beida	13,750	-	-	-	-	-	-	TearFund
Kongo Haraza	6,060	-	-	-	-	-	-	TearFund
Mesteri	13263	-	-	-	-	-	-	Tear Fund
Habila	15,238	-	-	**1**	**100**	**BSFC**	**3000**	MSF-CH
Furbaranga	26,124	-	-	**1**	-	**1**	-	SC-US
JebelMara Locality								
Nertiti Au	25,738	-	-	1	183	1	1,059	MSF-F
Golo AU	32,544	-	-	-	-	-	-	GOAL
Gorno	7,000	-	-	-	-	-	-	GOAL
Gildo	7,315	-	-	-	-	-	-	GOAL
Mukjar Locality								
Artala AU	-		-	-	-	-	-	-
Um Dukkhon AU	17,012	-	-		-	-	-	-
Mukjar AU	25,000			1	229	1	317	MSF-H
Wade Saleh Locality		GAM: 21.5% SAM: 3.2%						
Garsila AU	31,788		MSF-H Survey	1	408	1	1405	MSF-H
Bindisi AU	18,989		Apr-04	1	138	1	288	MSF-H
Deleij AU	16,345			1	234	1	296	MSF-H
Um Khair AU	13,312			1	119	-	-	MSF-H
Zalinge Locality								
Zallingi AU	80,000	GAM: 23.4%	MFS-Epicentre,	1	639	1	2,633	MSF-F

Azom AU	6,164	SAM: 4.5%	June 04	-	-	-	-	
Rokerro AU	12,472			-	-	-	-	
Sub Total West Darfur								
North Darfur								
El Fasher Locality		GAM: 39% SAM: 9.7%	ACF, June 04					
Abu shouk	43,300			1	420	1	1400	ACF
El Fasher Town	20,000			1	250	1	-	MOH
Tawila	32,980			1	181	1	983	US-UK
Shengil Tobayi	7,284							MSF-Spain
Zamzam	12,340			1	36	1	230	MSF-Spain
Kutum Locality								
Kutum Town	54,378	GAM: 12.6%	Goal	1	104	5	4286	GOAL
*Kutum rural	12,220	SAM: 0.8%	Feb-March 04			2		GOAL
Fata Burno	2,605	-	-	-	-	1		GOAL
Tina	17,000	-	-	-	-	-	-	-
Kornoi	7,500	-	-	-	-	-	-	-
Umm Baru	13,000	-	-	-	-	-	-	-
Kabkabiya Locality								
Kabkabiya town	85,639	-	-	1	150	1	1120	ACF
Birkat Seira town	7,040	-	-	-	-	-		ACF
Gurra Farjawia	4,750	-	-	-	-	-	-	-
Saraf Umra town	29,694	-	-	1	-	1		MSF-B
Mellit locality		GAM: 33.4% SAM: 5.4%	SC-UK, May 04					
Malha Area	37,210			1	40	1	877	SC-UK
Sub Total North Darfur								
Grand total	**1,358,511**			**30**	**8,094**	**35**	**33,712**	

* Kutum Rural SFC include Kassab, El Garbia, El Refia, Abdul Shakour, and Al Dour

Area where programmes are implemented although coverage might not be adequate

Areas without programmes (or possible coverage from nearby programmes), and with little/no nutritional information available. For these areas, the following will be investigated:

Area where assessment is done or under way and interventions are planned by the NGO indicated