



**MALNUTRITION IN THE SAHEL: ONE
MILLION CHILDREN TREATED –
WHAT'S NEXT?**

The «permanent emergency» in the Sahel

9.7 to 14.5 %

Rate of global acute malnutrition (moderate and severe) among children under 5 years in eight countries of the Sahel* between May and August 2011 (source: Governments)

12.3 %

Rate of global acute malnutrition (moderate and severe) among children under 5 years in Niger in June 2011 (source: Government of Niger)

20 and 24%

Rates of global acute malnutrition (moderate and severe) among children under 5 years reported in the villages of Yao and Biltine districts in the Sahel region of Chad in February/March 2012 (source: MSF, rapid nutritional assessment)

29 %

Estimated incidence** of severe malnutrition among children 6 – 23 months in Niger in 2011 (MSF estimate)

35 %

Estimated percentage of malnutrition-related deaths among children under 5 years in the Sahel (source: WHO)



Nutritional crises are **recurrent and cyclical** in the Sahel. In a region where malnutrition rates always hover near the warning level, the number of malnutrition cases rises every year during the «hunger season» .

Additional factors (including food price fluctuations, poor harvests, population movement and epidemics) can come into play, as in certain areas in eastern Chad and southern Niger. In the latter region, an additional 5 000 children (compared to 2011) were admitted into MSF programs between January and June 2012. In the Malian refugee camps in Burkina Faso, Mauritania and Niger, children are also increasingly vulnerable.

The annual spike in malnutrition cases (between July and September, depending on the country) is approaching. The number of malnutrition cases admitted into MSF's programs has risen, exceeding the 3 000 admissions/week in June. This figure is higher than, although still comparable to, the number of admissions over the same period in 2011.

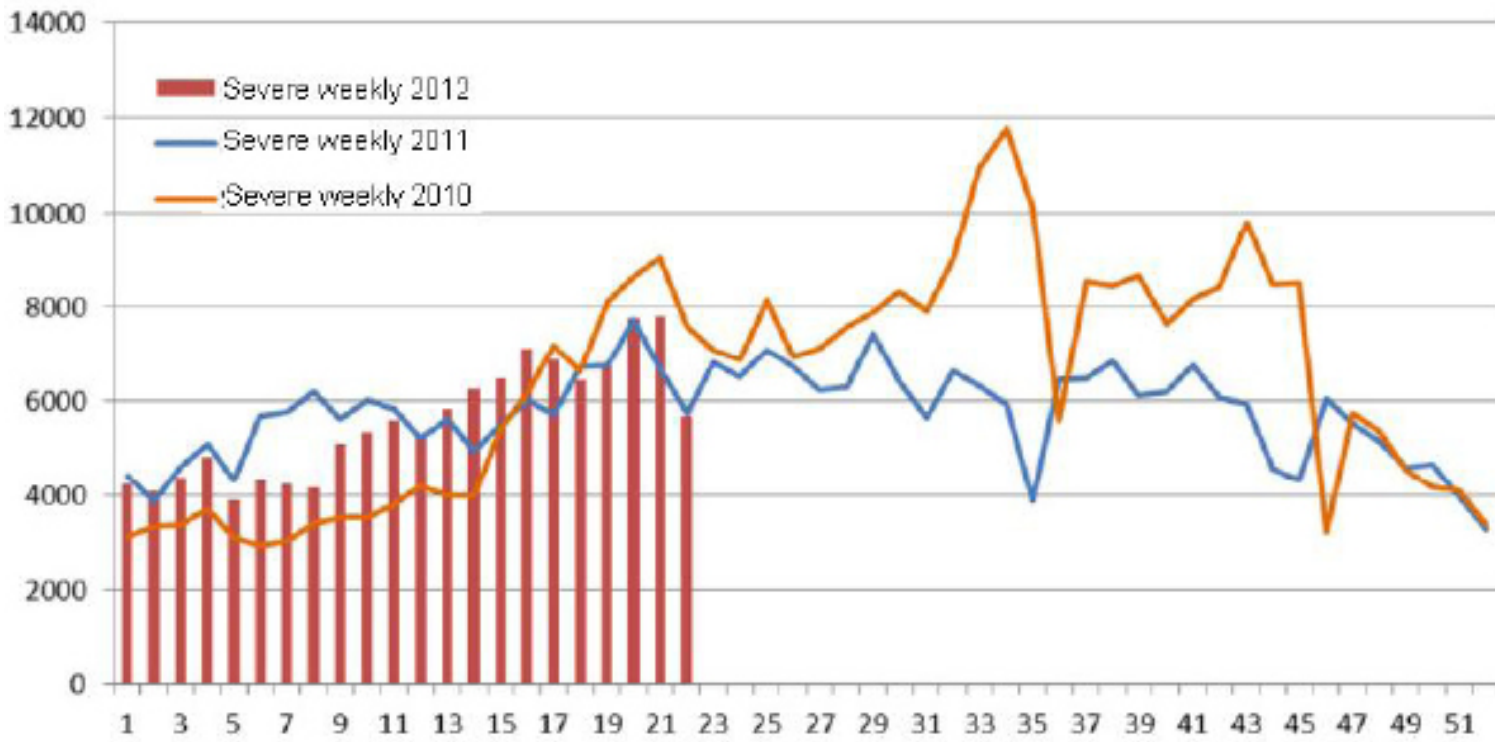
It is difficult to compare malnutrition's impact from year to year and particularly difficult when the comparison involves a very diverse group of regions and countries. However, given that hundreds of thousands of children are at risk of death every year, **we must rethink the meaning of «normal» and «crisis» in the Sahel.**

* Senegal, Mauritania, Mali, Niger, Chad, Burkina Faso, Cameroon (northern), Nigeria (northern)

** Number of new cases of an illness in a given period in relation to a given population (age group). The rate of prevalence represents the number of cases of an illness in relation to a given population (age group), at a given time.

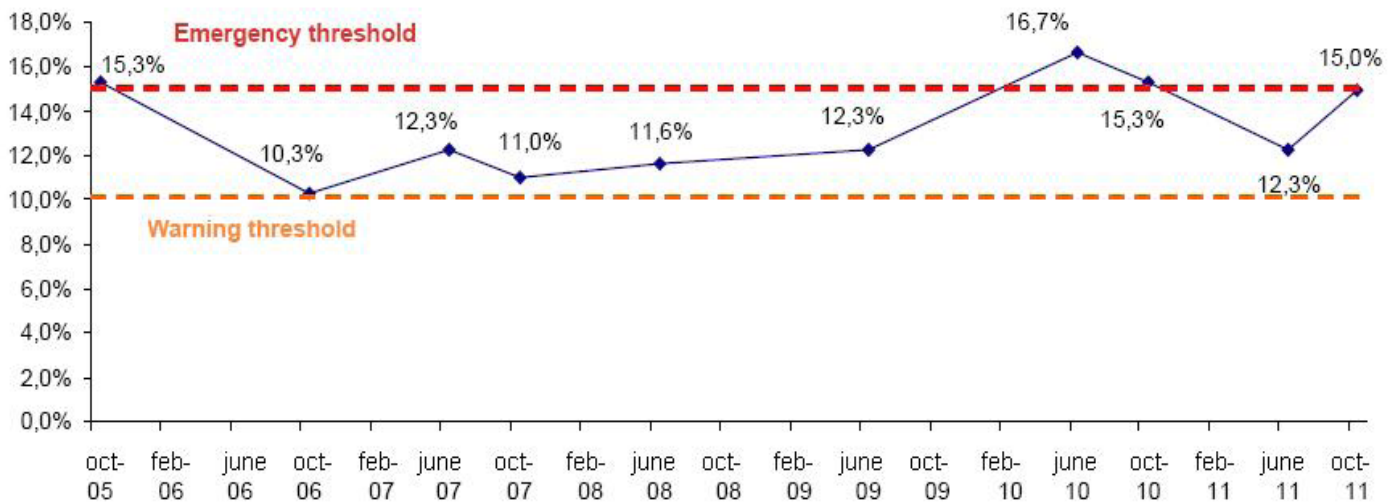
*** Niger, Mali, Burkina Faso, Chad, Nigeria (northern)

Weekly admissions for acute severe malnutrition CRENI and CRENAS – Niger 2010, 2011 and 2012



(source: Government of Niger and UNICEF)

Fluctuations in the rates of acute severe malnutrition in Niger 2005-2011



(source: Government of Niger and UNICEF)

The 2012 emergency response: goals and reality

For the first time, **all of the countries most affected have acknowledged the problem** and have issued appeals starting last fall. **Governments and international aid actors developed a very ambitious and encouraging response plan**, which includes the most up-to-date standards on volume, quality and timing of aid.

For example, preventive food distributions for young children will systematically include food developed specifically to meet their nutritional requirements and that contains milk. These foods have long been limited in favor of a mix of flours that are not suitable for a young child's diet.

Overall, according to governments and international aid organisations, **one million severely malnourished children** are expected to receive treatment in the Sahel* this year, by far the largest number in the history of humanitarian interventions. **This represents a significant challenge and will require a considerable effort from authorities, aid actors and donors.**

While certain countries, such as Niger, established a treatment system several years ago, others, such as Chad, must develop their response against the backdrop of a weak health system.

With the **rainy season** already starting, several of the affected regions will be inaccessible. **Political instability** and insecurity, which affects part of Mali, Niger, Chad and Nigeria, will also complicate aid deployment.

More than 1 million

Projected number of children under 5 years treated in 2012 for acute severe malnutrition in eight countries of the Sahel* (source: OCHA), including 393 000 in Niger, 207 000 in Nigeria, 175 000 in Mali and 127 000 in Chad.

1 million

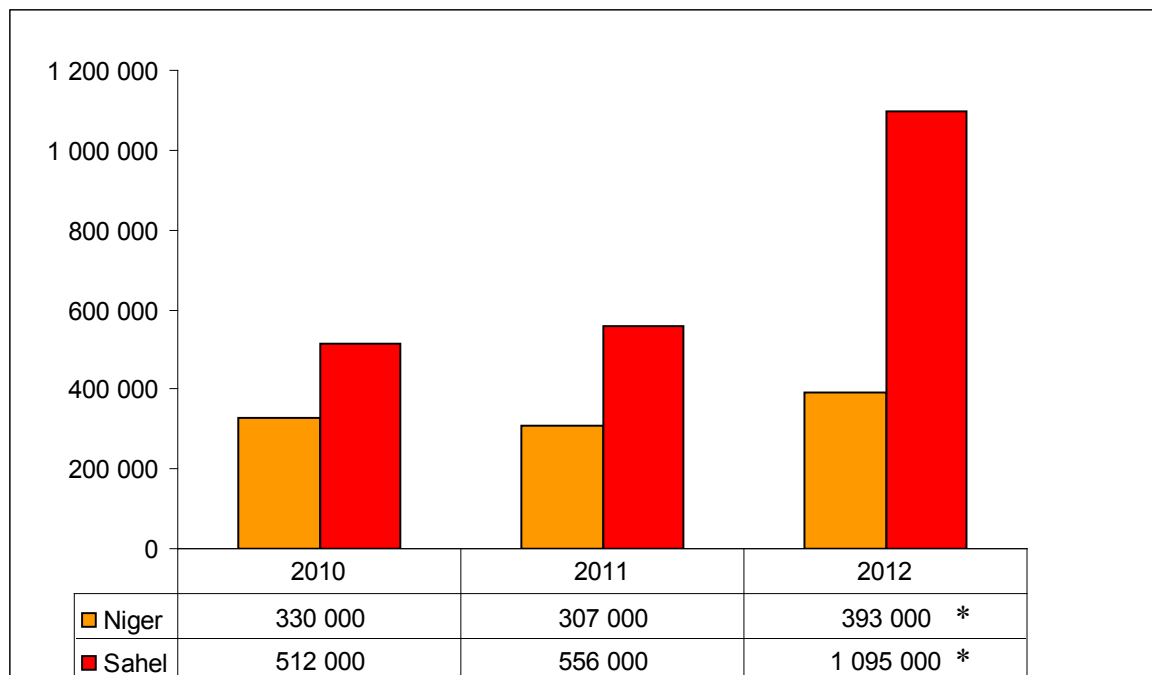
Projected number of children age 6-23 months who stand to benefit from preventive distribution of foods containing milk in eight countries of the Sahel* (source: OCHA)

100 %

Increase in the number of severe malnutrition treatment centers in Chad between May 2011-May 2012 (142 to 287) (source: UNICEF)

Five countries in the region have issued appeals for help responding to food and nutritional crisis since fall 2011: Niger, Chad, Mali, Burkina Faso and Mauritania

Admissions for acute severe malnutrition in Niger and the Sahel*: 2010-2011-2012 comparison



*prospections for 2012

(source: UNICEF)





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Transforming the humanitarian aid experience into a public health approach

< 2%

Fatality rate for acute severe malnutrition in MSF/Forsani programs in Niger

2005

First wide-scale use of ready-to-use therapeutic foods (RUTF) to treat acute severe malnutrition in Niger

2010

First wide-scale use of supplemental ready-to-use foods (RUSF) to prevent acute malnutrition in Niger.

58%

Reduction in the incidence** of severe acute malnutrition in a group of children age 6-59 months who received distributions of RUTFs in Niger in 2006 (source: Epicentre, MSF).

50%

Reduction in mortality in a group of children age 6-23 months who received distributions of RUTFs in Niger in 2010 (source: Epicentre, MSF – preliminary results).

Thanks to political will in the countries affected and advances in the humanitarian system over the last few years, the scale of the problem of malnutrition, which was previously under-estimated and even hidden, is finally visible. **The increase in the number of children treated reflects expanded treatment, not necessarily an increase in malnutrition.**

This year, the work of humanitarian actors will also save again many lives in the Sahel.

However, malnutrition is a **public health problem** in the Sahel and emergency, humanitarian response cannot be the only option.

Governments, donors, NGOs and U.N. agencies today recognize the need to shift toward longer-term solutions. To do so, we must learn from the scientific and medical progress achieved in recent years and over the long term, **continue using approaches that have proven to be effective.** They include treatment with therapeutic ready-to-use foods and prevention using milk-based supplemental foods.

These approaches **must be incorporated into basic health measures for young children** that are available year-round, similar to vaccinations and effective access to health care.

MSF's dual response

MSF runs regular programs to treat and prevent malnutrition and other childhood diseases in the Sahel. The programs are adapted and expanded as needs change, allowing children to receive necessary care before they fall critically ill, thus reducing the human and financial resources required compared to emergency response programs.

MSF also launched nine new nutritional projects in Mauritania, Senegal and Chad this year. Teams are also working in northern Mali, Niger, Burkina Faso and Mauritania to provide care to displaced persons and Malian refugees.

Additional evaluations are underway and at least three additional projects should be launched in the coming weeks.

Current activities seek to **save the lives of large numbers of children** while searching for **simpler, more cost-effective models** for combating malnutrition over the long term.

Some promising options have emerged, including decentralizing treatment and prevention and assigning non-medical workers to provide that care; making less expensive, locally-produced nutritional products available; and developing simple, inexpensive systems that provide access to foods for children.



More than 56 000

Admissions for severe malnutrition to MSF's nutritional programs in the Sahel,
*January – June 2012, including 35 500 in Niger

21

MSF's pediatric and nutritional projects currently underway in the Sahel including
9 emergency projects (opened in 2012)

53.3 million €

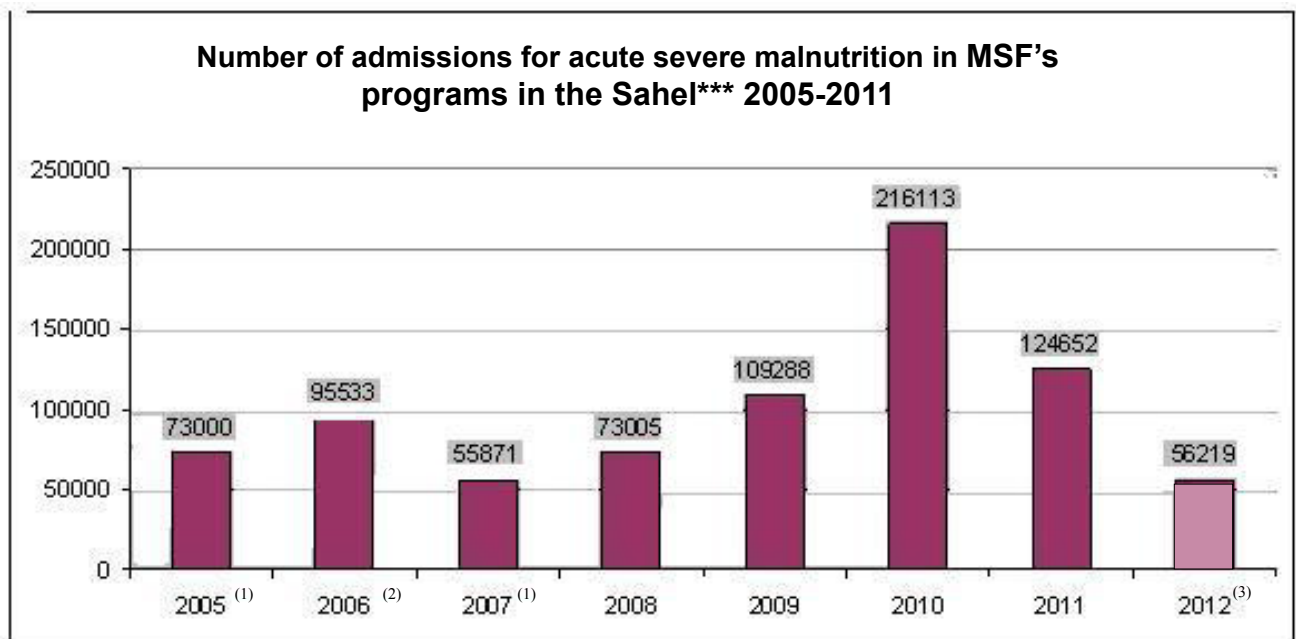
Projected MSF budget for its programs in the Sahel*** in 2012, including **27** for pediatric and nutritional projects.

104 000

Severely malnourished children treated in MSF's nutritional programs in Niger in 2011

34 500

Children who received supplemental nutrition in MSF's programs in Niger in 2011



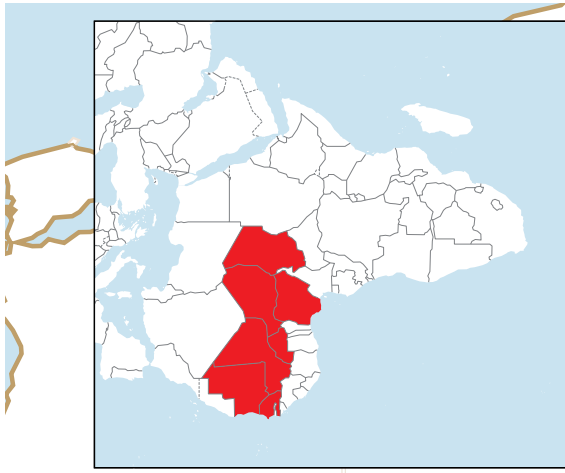
(1) 2005 et 2007 estimates, lower figure

(2) 2006 : severe and moderate acute malnutrition

(3) 2012 : January to June

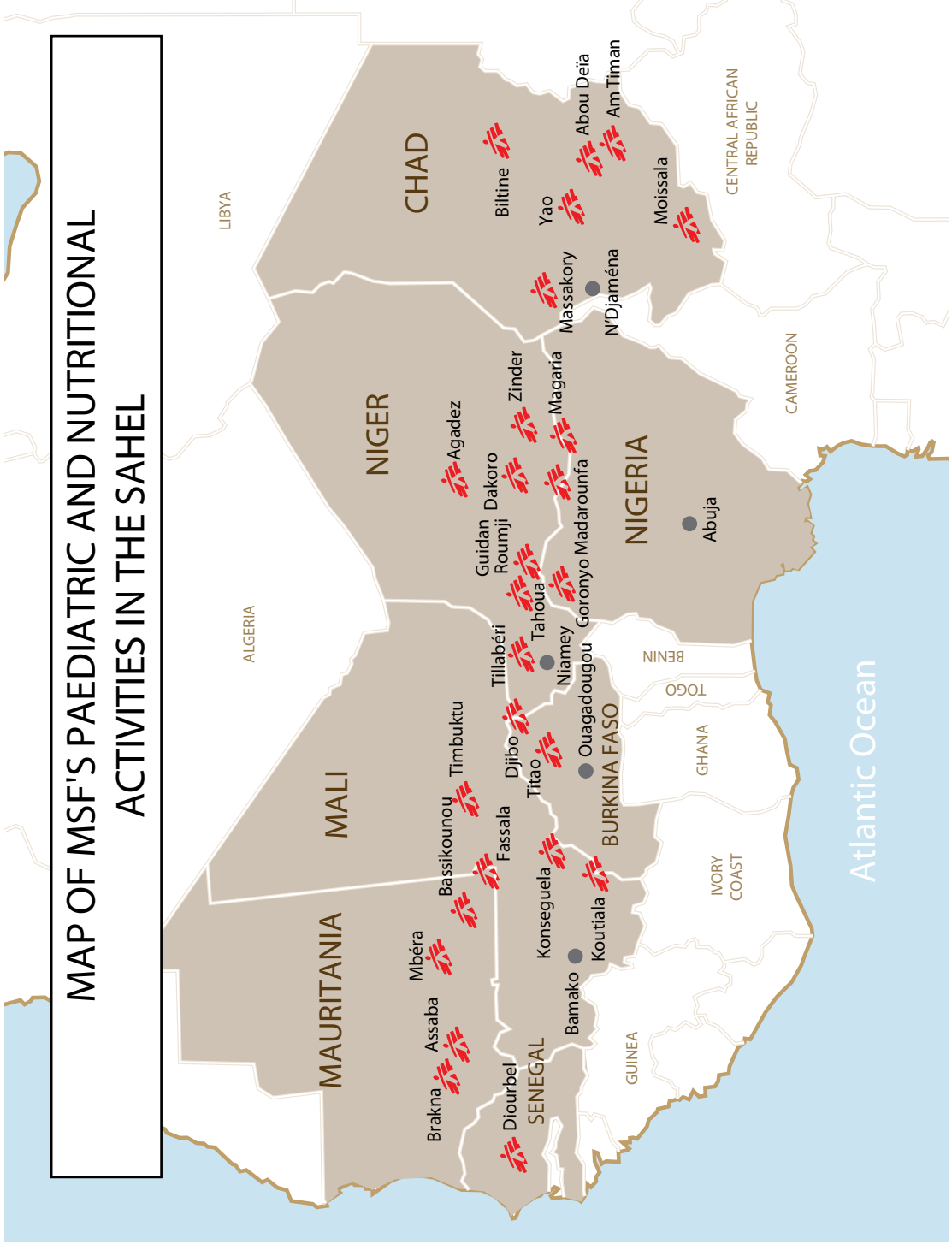
NB : in 2006 and 2009, new admissions criteria for severe acute malnutrition treatment have been issued by WHO and progressively introduced in MSF programs.

MAP OF MSF'S PAEDIATRIC AND NUTRITIONAL ACTIVITIES IN THE SAHEL



Admissions for severe malnutrition to MSF's nutritional programs, by country (January to June 2012)

NIGER	36 500
CHAD	9 100
MALI	3 000
BURKINA FASO	1 000
NIGERIA	3 300
MAURITANIA	2 000



- MAURITANIA:** Brakna, Assaba, Mbéra
- SENEGAL:** Diourbel, Bamako
- MALI:** Bassikounou, Fassala, Timbuktu, Niamey
- NIGER:** Agadez, Zinder, Magaria, Massakory, N'Djaména
- CHAD:** Biltine, Yao, Moissala
- NIGERIA:** Abuja
- BURKINA FASO:** Ouagadougou, Goronyo, Madarounfa
- Other locations:** Tahoua, Goundam, Goronyo, Magaria, Abou Deia, Am Timan