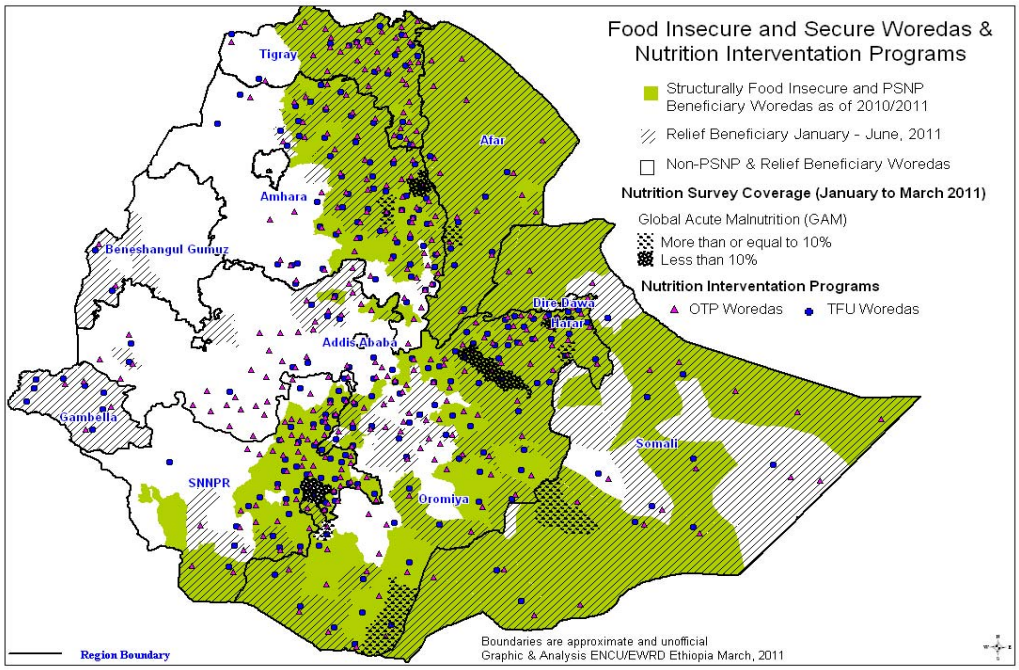
EMERGENCY NUTRITION QUARTERLY BULLETIN

(First Quarter 2011)

Emergency Nutrition Coordination Unit

Early Warning & Response Directorate

(Disaster Risk Management & Food Security Sector)



1. NUTRITION SITUATION ANALYSIS

Toward the last quarter of 2010, the La-Nina effect was reported to have affected a number of countries in the Horn of Africa. In Ethiopia, about 90 woredas were affected in three regions (Somali, Oromia and SNNPR). As the result,ENCU of the DRMFSS intensified monitoring of

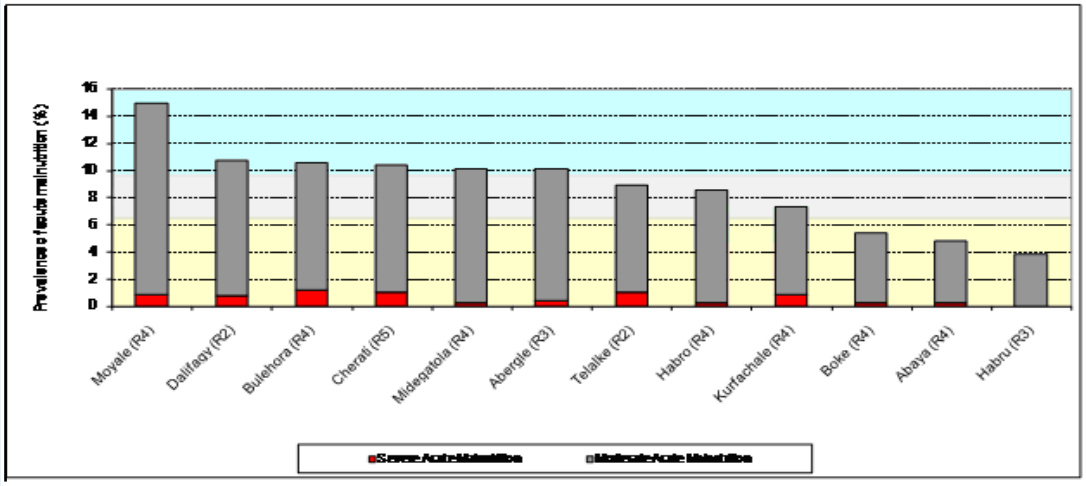


Figure 1: Nutrition Survey Results from January to March 2011

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emergency nutrition situation and response in those areas at both national and regional levels. Nutrition information and data were collected, analyzed and shared with partners from four sources i) Ad hoc nutrition surveys; ii) monthly TFP admissions collected from government regional health bureaus and NGOs supported therapeutic feeding sites and consolidated by regional ENCUs; iii) updating hot spot woredas and iv) monitoring of nutrition response in the hot spot woredas across the country with particular focus in the La-Nina affected woredas. The four sources of information are briefly described below.

1.1 NUTRITION SITUATION BASED ON STANDARD SURVEY RESULTS

A total of 14 surveys were conducted during the first quarter of 2011. Out of these, two surveys were rejected due to poor data quality, poor survey methodology applied during data collection and failure to adhere to existing national procedures and guideline governing emergency nutrition assessment. Data quality and survey methodology for the rest 12 surveys were good. Partners involved in the surveys were; GOAL-E, SC-UK, CARE, CONCERN-E. Eight of the surveys were conducted in major cropping areas of Oromia (6) and Amhara (2) while four were conducted in pastoralist areas of Somali, Oromia and Afar regions. Most (75%) surveys were carried out to monitor emergency nutrition responses/ interventions supported by the nutrition cluster partners in collaboration with FMOH /RHB (see Table 2 & 3). The remaining three were conducted to confirm deteriorating nutrition and food security situation.

Survey Methodology: Cross-sectional two-stage cluster sampling approach based on the ENA SMART methodology was applied in all surveys. Number of clusters included in the survey ranged from 34 to 47. To maintain survey data quality, all surveys (i.e. proposals and reports) were reviewed & validated by the ENCU/DRMFSS in terms of survey methodology, rationale, data analysis, result interpretations and its recommendations. Timely feedback on the survey proposals and reports were shared with respective partners. Survey data sets for anthropometric and mortality rates were analyzed using the ENA - SMART software. The rest of the contextual data were analyzed using EPIINFO, SPSS or Excel.

1.2 NUTRITION SURVEY DATA QUALITY CHECK

Anthropometry and mortality raw data were subjected to quality test using the plausibility function of the ENA - SMART software (mostly Beta version) against the major quality criteria set for nutrition surveys which included flagged records of WHZ, sex ratio and age distribution of the sample children, digit preference of weight and height measurements, the WHZ distributions as measured with standard deviation, Skewness & kurtosis. Out of 14 nutrition surveys conducted by partners two of them were rejected due to poor survey methodology applied on the field, poor data quality and failure to adhere to existing national procedures and guideline governing emergency nutrition assessment in Ethiopia.

Data quality check for the rest 12 surveys revealed that the digit preference score ranged from 1 (good) - 5 (acceptable) for weight and 1(good) - 8 (acceptable) for height and the standard deviations of WHZ for all surveys were below 1.2 as recommended in the National Guideline. Moment of Skewness and kurtosis for all the surveys was also within acceptable range of +1 and -1. Data quality check results of all the 12 surveys are presented in Table 1 below.

Table 1: Survey data quality check results

Agency	Woreda	Digit preference Score		SD of WHZ	Skew ness WHZ	Kurtosis Of WHZ	No of WHZ Flags (%)	Representative - ness of the samples	
		Weight	Height					6-29 and 30 -59 months age ratio	Sex ratio
SC-UK	Cherrati	4	6	0.83	0.43	0.78	0.60	0.71	0.96
CARE	Moyale	5	8	0.86	0.09	-0.03	0.20	0.80	0.95
GOAL	Bulehora	1	2	0.90	-0.12	-0.07	1.20	0.95	1.02
GOAL	Abaya	2	2	0.81	-0.22	0.01	0.00	0.93	0.93
SC-UK	Telalke	4	7	0.82	0.05	0.12	0.50	0.75	1.00
SC-UK	Delifagy	3	4	0.87	-0.05	-0.11	0.30	0.74	1.04
GOAL	Habroo	3	2	0.78	-0.28	0.38	0.20	0.93	0.97
GOAL	Boke	2	3	0.76	0.06	0.14	0.20	0.93	1.03
GOAL	Midegatoal	2	2	0.83	0.03	-0.03	0.00	0.90	1.10
GOAL	Kurfachale	1	1	0.82	0.09	0.02	0.00	0.93	1.13
GOAL	Abergale	3	3	0.78	-0.25	-0.03	0.20	0.98	0.96
CONCERN	Habru	4	4	0.79	0.09	0.25	0.30	0.75	0.93

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Key survey findings: Global Acute Malnutrition (GAM) in the surveys conducted ranged from 3.8 percent in Habru Woreda of Amhara region to 14.9 percent in Moyale of Oromia region. Severe Acute Malnutrition (SAM) ranged from 0.0 percent in Habru of Amhara to 1.2 percent of Bulehora Woreda in Oromia region.

Seven survey's findings indicated that nutrition situation on the ground was serious as per the national guideline for classification of nutrition survey results in Ethiopia (See Table 2 & 3). The remaining five survey results were classified as normal. Despite the ongoing nutrition response three (Moyale, Delifagy and Abergale Woredas) out of nine monitoring survey results were rated as serious due to deterioration of food security situation and suggested continuation of the nutrition response in the area. Common aggravating factors reported in six (monitoring and emergency) of the surveys with serious nutrition situation were poor performance of deyer rain in pastoralist areas and poor household food security associated with poor meher production in agrarian areas.

All crude and under five mortality rates were below the national and the sphere standard emergency thresholds as presented in Table 2& 3

The prevalence of morbidity among under five children ranged from 2.6 percent in Habru Woreda of Amhara region which have a lowest GAM to 23% in Abaya in Oromia region. The most common reported morbidities two weeks prior to the survey period included: Cough, Diarrhea, and ARI. There was no reported outbreak of any disease of public health significance in the surveyed Woredas during the first quarter. Measles immunization coverage by card and recall were below the recommended thresholds of 90 percent in 10 surveys with the exception of Moyale (Oromia) and Delifagy (Afar) Woredas. In Moyale and Delifagy Measles immunization coverage was well above 90 percent.

Vitamin A supplementation coverage was above 90 percent in five Woredas; namely Moyale, Abaya, Midegatola, Kurfachale Woredas of Oromia and Habru woreda of Amhara region. Four Woredas coverage fell between 80 and 90 percent while the rest were below 80 percent coverage. (See Table 2 & 3)

Table 2: Survey Results in Somali and Oromia regions against key indicators

Key indicators	Somali	Oromia		
	Cherrati	Moyale	Bule hora	Abaya
Survey date	28 Dec 2010- 06 Jan 2011	31 Jan – 08 Feb 2011	24 Feb – 09 Mar 2011	Mar 10, 2011
Survey objective	Emergency Survey	Monitoring Survey	Emergency survey	Monitoring Survey
Study design	713 children from 38 clusters	651 children from 38 clusters	765 children from 42 clusters	479 children from 34 clusters
% GAM Z-Score (95 % CI)	10.4 (8.1 - 12.7)	14.9 (11.2 - 19.6)	10.5 (8.4 – 13.0)	4.8 (3.2 – 7.2)
% SAM Z-Score (95 % CI)	1.0 (0.3 – 1.6)	0.8 (0.3 – 2.1)	1.2 (0.6 – 2.3)	0.2 (0.0 – 1.6)
% Kwashiorkor	0.00	0.20	0.10	0.00
CMR Death/10,000/day (95 % CI)	0.41 (0.2- 0.62)	0.35 (0.17 – 0.70)	0.02 (0.0 – 0.17)	0.18 (0.07 – 0.47)
U5MR Death/10000/day (95% CI)	0.57 (0.03- 1.17)	1.12 (0.49 – 2.56)	0.13 (0.02 – 0.97)	0.42 (0.10 – 1.71)
Major causes of U5MR	Diarrhoea	Bleeding during pregnancy and TB	NR	Pneumonia and accident
%Morbidity	16.6	10.6	11.00	23.00
Major illnesses or symptoms	Diarrhea and cough	Diarrhea and cough	Diarrhea and cough	Diarrhea and ARI
% Measles coverage by card (95 % CI)	34.74 (21.96-47.51)	26.90 (23.3-30.4)	1.60 (0.2-3.1)	23.40 (15.6-31.2)
%Measles by card + recall (95% CI)	78.50 (70.35-86.65)	95.40 (93.7-97.1)	36.70 (26.5-47.0)	79.20 (70.4-88.1)
% BCG coverage –scar (95% CI)	5.47 (0.25-1069)	77.00 (73.7-80.2)	11.80 (8.5-15.1)	44.70 (35.4-53.9)
%Vitamin A supplementation in past six months (95% CI)	82.19 (74.82-89.55)	96.30 (94.9-97.8)	68.10 (58.7-77.5)	94.60 (86.5-99.6)
Classification of nutrition situation	Serious	Serious	Serious	Normal

Table 3: Survey results in Afar, East and West Hararghe & Amhara regions against key indicators

Key indicators	Afar		West Harerghe			East Harerghe	Amhara	
	Telaleke	Delifagy	Habroo	Boke	Midegatola	Kurfachele	Abergale	Habru
Survey date	March 03 – 12, 2011	Feb 17 – 1st March 2011	Feb 21st - 04th March 2011	25 Jan – 08 Feb, 2011	22 Jan -15 Feb 2011	25 Jan- Feb 07 2011	25 Dec 2010 – 09 Jan 2011	24 Jan – 1 Feb 2011
Survey objective	Monitoring	Monitoring Survey	Monitoring Survey	Monitoring Survey	Emergency Survey	Monitoring survey	Monitoring Survey	Monitoring survey
Study design	808 children from 47 clu sters	736 children from 42 clusters	460 children from 35 clusters	650 children from 35 clusters	536 children from 36 clusters	506 children from 36 clusters	542 children from 34 clusters	568 children from 46 clusters
% GAM Z-Score (95 % CI)	8.9 (6.7 – 11.1)	10.7 (8.2 – 13.3)	8.5 (6.2 – 11.5)	5.4 (3.9 – 7.4)	10.1 (7.5 – 13.5)	7.3 (5.2 – 10.2)	10.1 (7.7 – 13.2)	3.8 (2.4 – 6.0)
% SAM Z-Score (95 % CI)	1.0 (0.4 – 1.6)	0.7 (0.1 – 1.2)	0.2 (0.0 – 1.6)	0.2 (0.0 – 1.2)	0.2 (0.0 – 1.4)	0.8 (0.3 – 2.1)	0.4 (0.1 – 1.5)	0.0 (0.0- 0.0)
% Kwashiorkor	0.1	0.1	0.0	0.0	0.0	0.6	0.0	0.0
CMR Death/10,000/day (95 % CI)	0.19 (0.13 – 0.25)	0.19 (0.05 – 0.32)	0.04 (0.01 – 0.33)	0.1 (0.03 – 0.31)	0.11 (0.03 – 0.33)	0.13 (0.05 – 0.35)	0.11 (0.04 – 0.34)	0.22 (0.14 – 0.37)
U5MR Death/10000/day (95% CI)	0.24 (0.09 - 038)	0.28 (0.16 – 0.72)	0.00 (0.0 – 0.0)	1.12 (0.08 – 1.26)	0.37 (0.09 – 1.52)	0.43 (0.1 – 1.76)	0.38 (0.09 – 1.58)	0.32 (0.08 – 1.25)
Major causes of U5MR	Diarrhea and Malaria	Diarrhea and Malaria	Unknown	Unknown	NR	Unknown	Unknown	Unknown
%Morbidity	6.06	13.31	10.70	19.20	13.40	10.50	22.70	2.60
Major illnesses or symptoms	Diarrhea and Cough	Diarrhea and Cough	Diarrhea and ARI	ARI and Diarrhea	Diarrhea	ARI and Diarrhea	ARI and Diarrhea	Diarrhea
% Measles coverage by card (95 % CI)	2.2 (0.8-3.6)	6.29 (2.0-.8.3)	9.7 (5.3-14.0)	11.90 (7.4-16.5)	9.20 (6.8-11.8)	10.70 (5.7-15.7)	22.60 (52.5-32.7)	18.50 (45.4-22.1)
%Measles by card and recall	72.70 (64.5-81.01)	93.70 (68.55-85.25)	66.40 (57.9-75.0)	82.80 (76.4-89.1)	56.70 (52.5-60.9)	79.60 (72.0-87.2)	75.80 (68.6-83.0)	73.60 (69.7-77.2)
% BCG coverage –scar (95% CI)	0.10 (0.1-0.36)	8.80 (2.4-15.3)	41.10 (34.0-48.2)	50.30 (44.0-56.6)	69.20 (65.3-73.1)	52.00 (44.8-59.1)	30.40 (22.6-38.3)	39.70 (35.7-43.8)
%Vitamin A supplementation in past six months (95% CI)	78.60 (70.2-83.4)	84.90 (78087-90.96)	76.50 (68.8-84.3)	81.50 (75.4-87.7)	92.20 (89.9-94.4)	96.40 (94.4-98.5)	88.60 (83.4-93.7)	93.90 (91.5-95.7)
Classification of nutrition situation	*Poor	**Serious	***Normal	Normal	Serious	Normal	Serious	Normal

As per the National Emergency assessment interim Guideline 2008 final draft

****Serious:** Global Acute Malnutrition prevalence 15-19% or Global Acute Malnutrition prevalence 10-14% with the presence of Aggravating factors

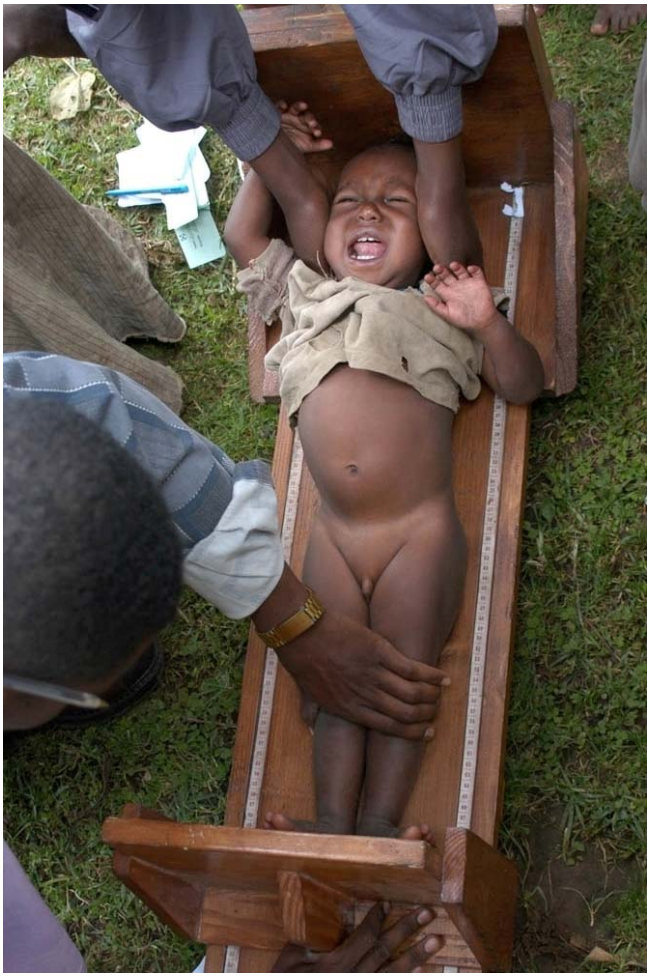
***Poor:** Global Acute Malnutrition prevalence 10-14% or Global Acute Malnutrition prevalence 5-9% with the presence of Aggravating factors

*****Normal:** Global Acute Malnutrition prevalence 2-9%

Aggravating factors includes: Poor household food availability and accessibility, Disease epidemics, lack of water supply, poor sanitation etc.

Conclusion and recommendations:

Six of the survey results indicated that the prevalence of GAM was normal and typical. This was linked to post Meher harvest season, associated with last year (2010) good rain performance. However, there were several Woredas in the Meher dependent Woredas that experienced failure or below normal Meher rains that affected production and in turn food security and nutrition situation. In Somali region, the La-Nina effect affected the deyr rains in October and December causing acute water shortage for both animal and human consumption. Emergency nutrition response were recommended and implemented by nutrition cluster partners in all the Woredas whose nutrition situation was classified as serious. In the rest of the Woredas, it was recommended to hand over the implementation of the nutrition project to the respective Woreda and regional authorities. Extending support of the existing Community based Management of Acute Malnutrition (CMAM) was recommended in all the Woredas regardless of their nutrition status as per national outpatient roll out strategy implemented by the FMOH in collaboration with partners.



1.3 NUTRITION SITUATION BASED ON HOT SPOT WOREDAS

The November/December hot spot woredas list was revised in February and released in March 2011. The revision was necessary following the release of the Meher assessment results and fast evolving water, food security and nutrition situations in the La-Nina affected woredas in the three regions (SNNPR, Oromia and Somali). A federal technical team comprising of members from FEWS-NET, WFP, and DRMFSS/ENCU completed revision/updating the hot spot woredas list in mid March 2011. As it was done previously, the hot spot list was done in two phases. First, the classification was done at regional level with regional partners under the coordination of the regional Food Security/ Early Warning departments and secondly at federal level under the coordination of the DRMFSS. In both phases, same criteria as recommended in the hot spot revision guideline were used.

The approved March 2011 revised hot spot list indicated that, priority 1 hot spot woredas increased significantly by 62 percent from 77 in December 2010 to 128 in March 2011. However, priority 2 and 3 decreased slightly by 13 and 4.8 percent from 123 to 107 and from 103 to 98 respectively during the same period. The most increase in priority 1 woredas was noted in Oromia and Somali regions associated with the La-Nina phenomenon effect. For example, all the La-Nina affected weoredas in Somali region were classified as priority 1. In Oromia, priority 1 increased more than four times from 10 to 44 woredas. Decrease in priority 2 and 3 were not surprising as considereble number of the woredas changed its status to priority 1. Based on the revised hot spot list, about 77 percent of the 90 La-Nina affected woredas in the three regions (Somali, Oromia and SNNPR) were classified as priority 1.

Overall, priority 1-3 hot spot woredas increased slightly by 8.9 percent from 303 in December to 330 in March 2011. The hot spot classification is an important undertaking as it guides all stakeholders both government, donors and humanitarian agencies in planning implementation and allocation of limited resources. And from nutrition point of view it helps to be focused and guides the nutrition cluster partners/ coordination unit to monitor the evolving nutrition situation, nutrition responses being or should be implemented in those woredas. The distribution of hot spot woredas March 2011 is presented in the Table 4 below.

Table 4: Distribution of hot spot woredas by priority and region in March 2011

Region	Priority 1	Priority 2	Priority 3	Total
Tigray	7	23	0	30
Afar	7	2	23	32
Amhara	14	11	19	44
Oromiya	44	50	16	110
Somali	44	8	0	52
B/Gumz	2	2	4	8
SNNPR	6	8	26	40
Gambella	4	3	5	12
Dire Dawa	0	0	1	1
Harari	0	0	1	1
Total	128	107	95	330

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ENCU Nutrition Survey Database:

By the end of the first quarter of 2011, total of 12 ad hoc emergency nutrition surveys were conducted in hot spot woredas both La-Nina and emerging hot spot woredas in Ethiopia, bringing the total number of verified surveys in the last 11 years to 650. All the 12 surveys that passed the agreed quality check criteria implemented by the ENCU/DRMFSS from planning; survey implementation, analysis and reporting are stored at the ENCU base. Summary of the key surveys findings (GAM, SAM, CMR and U5 MR) are usually posted on the DPPC website at www.dppc.gov.et/pages/ENCU.htm As it was explained in the previous bulletin , all the surveys posted on the ENCU page were conducted either as emergency or monitoring surveys. Emergency surveys are usually conducted to ascertain information of deteriorating food security and/ or nutrition situation and use the information for either planning response or close monitoring. Monitoring surveys (mid or end line) are conducted to monitor performance of the nutrition response and guide decision making on the fait of the project . Both emergency and monitoring surveys were conducted at different period across the years depending on the need. They are usually not conducted for surveillance purposes as such though some could provide useful nutrition situation trends especially in woredas that have been experiencing chronic and or repeated droughts. The distribution of the surveys by year and region is presented in Table 5.

Table 5 : Number of Nutrition Surveys Conducted per Region per year since 2000

	Year												
Region	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
SNNPR	9	5	35	30	14	25	20	16	36	26	11	0	227
Oromia	3	2	20	27	22	20	14	6	9	13	20	7	163
Amhara	5	9	24	17	9	7	6	4	8	13	17	2	121
Somali	8	5	5	5	8	11	12	2	0	7	7	1	71
Tigray	0	0	6	7	3	3	0	8	0	4	2	0	33
Afar	0	0	4	5	1	6	4	2	1	1	2	2	28
Gambella	0	0	0	0	0	0	0	0	0	0	1	0	1
Benshangu .G	0	0	0	0	0	0	0	0	0	1	2	0	3
Harare	0	0	0	0	0	0	0	1	0	0	1	0	2
Dire dawa	0	0	0	0	0	0	0	0	0	0	1	0	1
Total	25	21	94	91	57	72	56	39	54	65	63	12	650

1.5 NUTRITION SITUATION BASED ON TFP ADMISSIONS AND REPORTING RATE

First quarter (Jan-March) of the year is usually characterized by the lowest TFP admissions in most of the regions. Due to the La-Nina phenomenon, close monitoring of TFP admissions were made in the La-Nina and other emerging woredas in particular in the six regions that are prone to nutrition emergencies. Based on the monthly monitoring of TFP reports collected from the six regions (SNNPR, Oromia, Tigray, Amhara, Somali and Afar) a total of 54, 558 SAM cases were admitted in an average of 6,606 TFP sites in the six regions with about 83.4 reporting rate of which 72 percent of the total cases were admitted in La-Nina affected three regions of Somali, Oromia and SNNPR.

Within the first quarter, new TFP admissions in the six regions increased by 8.4 percent from January to February and by about 30 percent from February to March. However the increase varied considerably by region as explained below in the regional TFP admission analysis. Compared 2010 first quarter; 2011 TFP admissions in the six regions were lower by 12.6 percent.

Table 6: TFP Admissions and Reporting Rate in First Quarter 2011

	January 2011		February 2011		March 2011	
Region	Adm	RR%	Adm	RR%	Adm	RR%
SNNPR	4268	89.1	4579	84.0	6518	91.7
Oromia	5018	84.6	6071	79.7	8210	83.6
Afar	385	36.5	132	5.2	1054	28.1
Amhara	3261	76.0	3738	81.3	3664	78.1
Somali	1501	83.3	755	83.4	725	83.5
Tigray	1191	91.8	1718	92.0	1880	95.6
Gambella	11	94.1	17	100.0	28	100.0
Benshangu.G	35	100.0	28	100.0	34	100.0
Dire dawa	113	88.9	152	100.0	96	100.0
Addis Ababa	2	100.0	0	0.0	3	100.0
Total	15785	83.5	17190	81.3	22212	84.6

Regional wise, SNNPR accounted for 28.1 percent of the total admissions in the six regions in the first quarter of the year. Within the first quarter, admission increased slightly by 7.3 percent from January to February and 42 percent from February to March. TFP admissions trend for first quarter in SNNPR is indicated in figure 2, When the TFP admissions in SNNPR were compared with first quarter in 2010; 2011 admissions were lower by 6.2 percent.

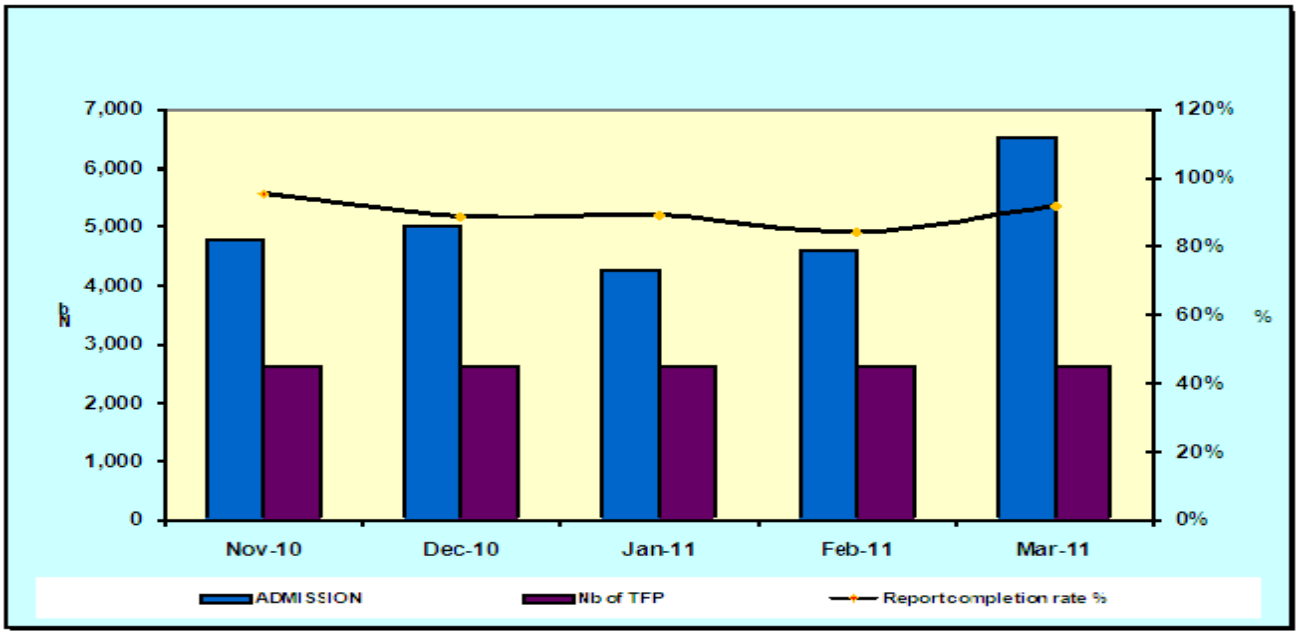

Figure 2 : Number of Admissions and Performance Indicators/TFP in SNNPR/ November - December 2010 and January to March 2011

During the first quarter, a total of 19,242 SAM cases were admitted in TFP services in Oromia region accounting for largest proportion (35.3 percent) of the total admissions in the six regions. Between January and February and February to March, TFP admissions in Oromia region increased by 20 and by about 37 percent respectively. Compared to 2010 first quarter, TFP admissions in Oromia were relatively similar (19,073 in 2010 versus 19,242 in 2011). Figure 3 below depicts Oromia region TFP admissions trend in the first quarter.

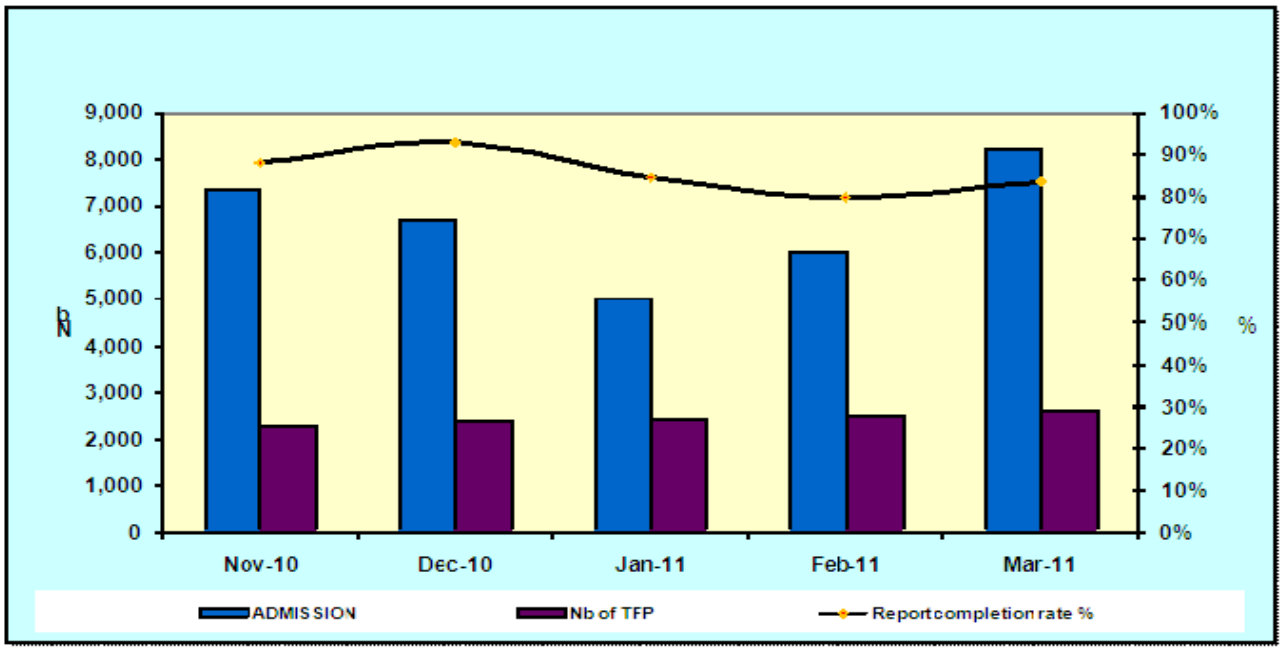

Figure 3: Number of Admissions and Performance Indicators/TFP in Oromia/ November - December 2010 and January to March 2011

During the first two months (Jan-Feb) of the first quarter, Somali region experienced the biggest (about 44%) increase in TFP admissions compared to the rest of the regions. However, it registered just 6.3 percent increase between February and March. Moreover, the region accounted for just 8.7 percent (equivalent to 4,736) of the total admissions in the six regions (See table 6 above) with over 90 percent of the TFP reports received.

TFP admissions in Amhara and Tigray regions were relatively stable throughout the first quarter with over 80 percent reporting rates in Tigray and good reporting rates in Amhara region. Compared to 2010, TFP admissions in the two regions were also lower in 2011

Overall a total of 55,187 SAM cases were admitted in the TFP services at 83.2 reporting rate in 9 regions during the first quarter of the 2011. The other three regions (Gambella, Dire dawa and Benshangul Gumuz) altogether accounted less that 1 percent of the total admissions during the reporting period.

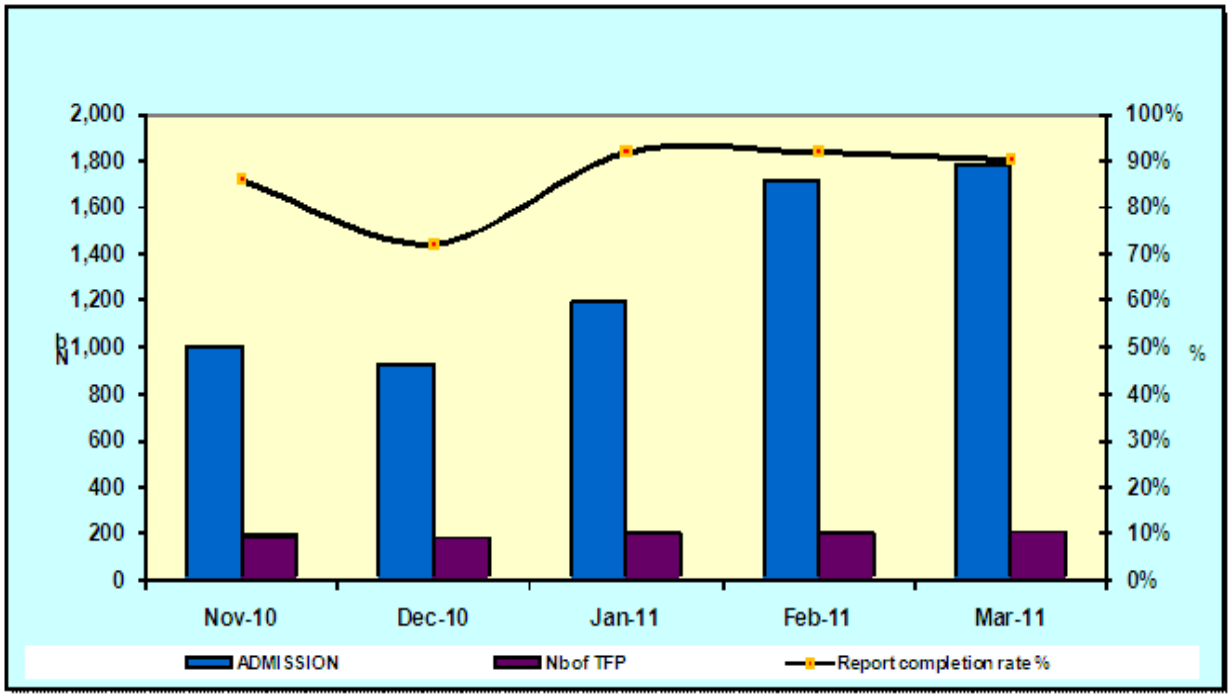

Figure 4: Number of Admissions and Performance Indicators/TFP in Somali/ November - December 2010 and January to March 2011

Outlook of the nutrition situation second quarter 2011:

The continuing worsening of water and pasture availability in most of the La-Nina affected woredas in the three regions will aggravate further the nutrition situation in those areas. Though increase in TFP admissions is a normal phenomena between April and June, the increase is likely to be significant than normal, as water, pasture and food security continues to worsen in most of the Woredas in La-Nina and non La-Nina is specially in three regions (Somali, Oromia and SNNPR).

Moreover, the nutrition situation would worsen further in most of priority 1 woredas if humanitarian response will not be provided in a timely manner. The delayed commencement of the Belg rains in the Belg dependent areas was likely to increase the likelihood of more emerging hot spot woredas or changing hot spot status from priority 2 to 1 or from 3 to 2. This will put more pressure on prioritization and allocation of available scarce resources and partners capacity to respond. However, the ENCU/DRMFSS believes that nutrition cluster partners have the capacity to respond to the impending nutrition crisis if the current nutrition response is timely strengthened or initiated in all the affected La-Nina and other emerging hot spot woredas.

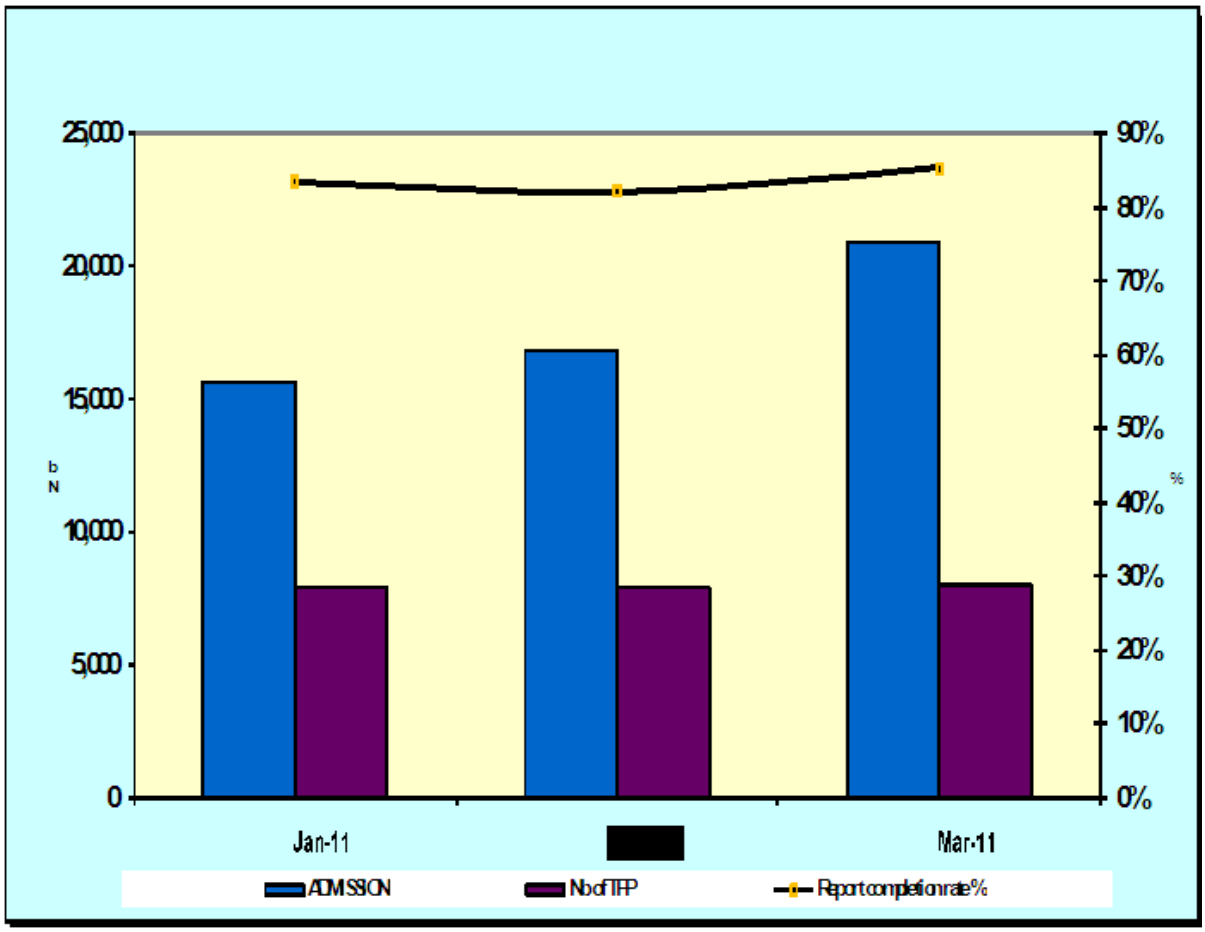

Figure 5 : Number of Admissions and Performance Indicators/TFP in Ethiopia/January to March 2011

2. NUTRITION RESPONSE

This section summarizes partners' response and gaps in the La-Nina affected woredas; expanding capacities for managing SAM cases within the framework of CMAM and performance of the TFP services implemented by both government and partners at national level.

2.1 NUTRITION RESPONSE IN THE LA-NINA AFFECTED WOREDAS (SOMALI, OROMIA AND SNNPR)

Following the identification of the 90 La-Nina affected woredas in the three regions (Somali, Oromia and SNNPR) 18[2] (14 NGOs) UNICEF, WFP and government partners were mobilized by the nutrition cluster to respond to the impending nutrition emergency in the three regions. Monthly MANTF forum and bilateral meetings were held during which emergency nutrition response strategies were discussed and agreed with partners. These included: i) advocacy for timely/early initiation of comprehensive nutrition response as well as coverage of the entire woreda by partners (as opposed to few kebele only), ii) integration of the emergency response with WASH and Health sectors, iii) capacity building of nutrition and health staff, iv) increased monitoring frequency of the nutrition situation, v) strengthening coordination of the emergency nutrition response at woreda, regional and federal levels. vi) Monitoring, evaluation and application of standards.
In addition, priority interventions were also identified, discussed and agreed among nutrition cluster partners depending of the context. However, the following emergency nutrition response was given top priority. i) initiation/strengthening implementation of TFP and TSF in all La-Nina and Belg affected woredas, ii) support to logistics and reporting, and iii) Blanket supplementary feeding programme for woredas that were inaccessible or had no NGOs to strengthen nutrition response on the ground and iv) conducting surveys in some of the woredas as part of the response package to provide information that could be used as benchmarks for subsequent response monitoring actions.

Partners responded positively to the ENCU/DRMFSS/UNICEF appeal to strengthen response in the La-Nina affected woredas. By the end of March, partners had committed themselves to initiate/strengthen nutrition response in 73 woredas (81 percent) of the 90 and were expected to commence response in 59 of them. Emergency nutrition response were also implemented by nutrition cluster partners[3] in other non-La Nina affected woredas in (Benshangul Gumuz, Gambela, Amhara and Afar regions. UNICEF supported the FMOH with capacity building of health staff on SAM management, TFP supplies including procurement and distribution of plumpy nuts that amounted to 1205 metric tons. Meanwhile, the nutrition cluster reviewed and recommended 6 nutrition projects covering a total of 18 La-Nina affected woredas that were funded by HRF. The project were were implemented by SC UK in two woredas (Shinile and Aysha) in Somali region; Mercy Corps in two woredas (Kasadula and Guladamole) also in Somali region; SC US in a total of 8 woredas (5- Dolo Ado, Dolo Bay, Filtu and Hudet and Moyale in Somali region and 3 in Oromoya region (Liben, Golo Dola and Sababoru)). The WVE project for three woredas in Oromia was put on hold pending further monitoring of the situation in the three woredas.
Despite partners commitment to initiate and strengthen nutrition response in the La-Nina affected woredas there were still considerable gaps in nutrition response. By the end of March, 5 woredas in Somali; 4 woredas in Oromia and 8 woredas in SNNPR were still having no partners. In terms of nutrition response, 25 woredas had no TFU services and 40 of the 90 woredas were yet to be initiated with targeted supplementary feeding programme. Low coverage of TFP services (OTP) in some of partners operational areas were also noted.

[2] SC-UK, SC-US, Merlin, IMC, ADRA, Islamic Relief, OWDA, MSF -Spain, Holland & Belgium, ACF, CARE, GOAL, CONCERN, Mercy Corps, WFP, UNICEF and Government
[3] GOAL funded by OFDA; CON CERN, MSF Holland; MSF France

2. 2 INTERVENTION COVERAGE IN THE HOT SPOT WOREDAS

The November/December hot spot woredas continued to be used in the first quarter of 2011. By mid February and throughout March, most hot spot woredas had changed its status due to the La-Nina impact. As explained earlier in section 1.2 above, priority 1 had increased by about 62 percent from 77 to 128 by the time the revised hot spot woredas was released end of March. Therefore using it to track intervention coverage in hot spot woredas in first quarter would be misleading. Because of this reason the intervention coverage for the first quarter will not be presented.

2.3 INCREASING CAPACITIES TO MANAGE SAM CASES IN TFP SITES

Since the FMOH in collaboration with partners started to expand TFP services in 2008, the momentum and commitment to bring the services proximal to vulnerable beneficiaries continues to date. TFP sites providing life saving therapeutic nutrition services increased by 5 percent at national level from 7721 TFP sites in December to 8109 sites by the end of March 2011.
While there was no new TFP sites that were opened in SNNPR and Amhara; Tigray and Oromia each increased its TFP sites by above 8 percent. However, numerically, Oromia opened 207 new TFP sites from 2409 in December to 2616 in March. Overall, Oromia region accounted for over 50 percent TFP sites that were opened during the first quarter. Most of the TFP sites (96 percent) are located in the four regions (Amhara, SNNPR, Oromia and Tigray) that have been implementing the FMOH OTP roll out approach. However, about third (65%) of the total TFP sites at national level are located in only two regions (SNNPR and Oromia TFP site expansion in the first quarter is presented in figure 6).

The FMOH Thereaputic Feeding Programme expansion target is to cover all health posts in Ethiopia with TFP services provided to all eligible children in their own communities that in turn will lead to early detection, improved case management and accelerate referrals for complication cases. Current TFP coverage figures indicate that 59 per cent of health posts, 50 per cent of health centers and 83 per cent of hospitals are providing services for the management of SAM in Oromia, Amhara, Tigray and SNNPR.

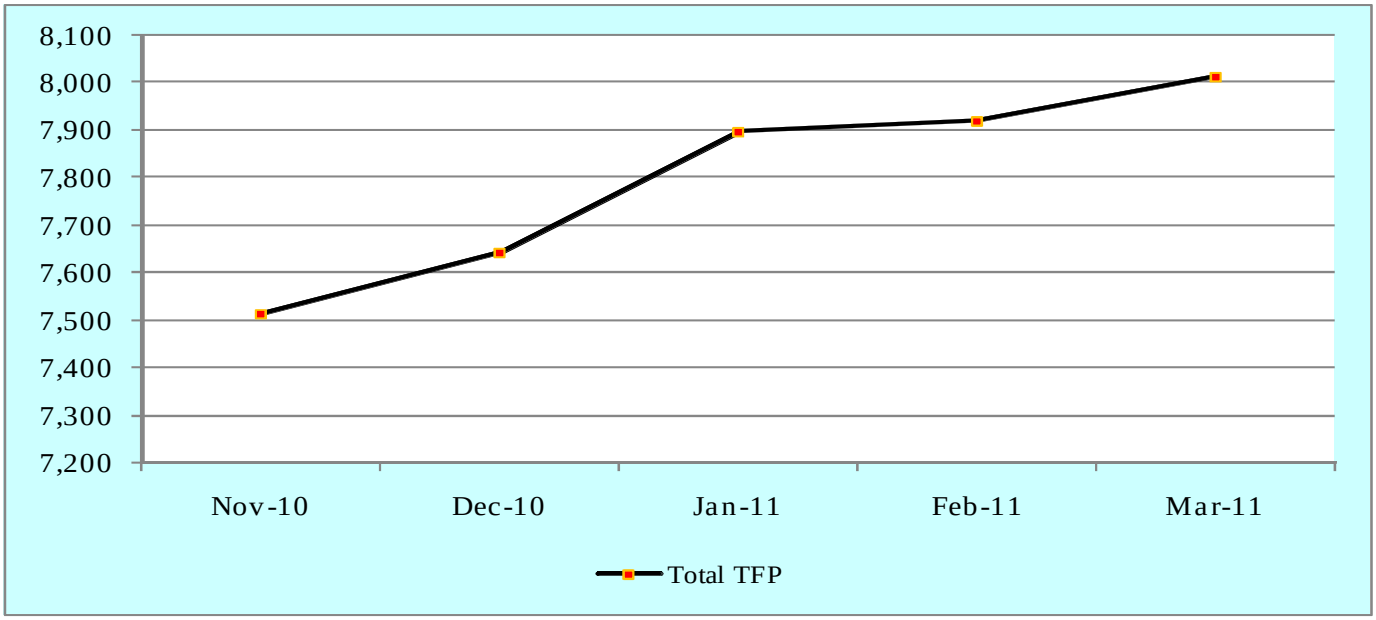

Figure 6 : TFP Sites Expansion from November - December 2010 and January to March 2011

2.4 Performance of emergency and non emergency TFP Interventions in Ethiopia

The quality of the TFP services were monitored at regional and national level using traditional indicators both national and Sphere standards as benchmarks. The indicators are used by both government run TFP sites and those supported by NGOs.

Based on the 83.4 percent of the TFP reports that were received from the six regions, a total of 48,507 children were discharged form over 6,600 TFP sites. Of the 47,786 total discharge, about 81 percent of them were cured; death rate continued to be below 1 while defaulter rate was less than 7 percent. All the three traditional indicators continued to be better compared to the national and Sphere Standards thresholds

Table 7: Performance of TFP services during the first quarter of 2011

Region	Number of admitted	% Report completion	Total Discharge	Recovery Rate	Mortality Rate	Defaulter Rate	Other
SNNPR	15365	88.3 %	11,974	83.1 %	1.4 %	3.2 %	12.2 %
Oromia	19299	82.6 %	17,481	81.5 %	0.5 %	6.3 %	11.7 %
Somali	4789	93.2 %	3,557	80.6 %	1.0 %	7.4 %	11.0 %
Tigray	2981	83.4 %	3,247	76.0 %	1.1 %	8.3 %	14.6 %
Afar	1571	23.3 %	629	92.8 %	0.6 %	4.6 %	1.9 %
Amhara	10663	78.5 %	11,243	80.0 %	0.6 %	6.3 %	13.1 %
Gambella	56	98.0 %	51	78.4 %	0.0 %	0.0 %	21.6 %
Dire Dawa	361	96.4 %	244	92.2 %	0.0 %	1.2 %	6.6 %
Beneshangul. G	97	100.0 %	70	91.4 %	1.4 %	1.4 %	5.7 %
Addis Ababa	5	50.0 %	11	36.4 %	0.0 %	18.2 %	45.5 %
Ethiopia	55187	83.2 %	48,507	81.3 %	0.8 %	6.3 %	11.6 %

3. TECHNICAL ACTIVITIES COORDINATED BY THE ENCU DURING THE FIRST QUARTER

There were two major technical activities that was coordinated by the ENCU.
1) the revision of the national guideline and 2) Development of the sampling methodology proposed bi-annual nutrition surveys as indicated in the proposed nutrition sector assessment methodology.following the DRMFSS needs assessment workshop, june 2010.

3.1. REVISION OF NATIONAL GUIDELINES FOREMERGENCY ASSESSMENT AND INTERVENTIONS IN ETHIOPIA

The need for revision of the national guideline (assessment, intervention and moderate acute malnutrition) was extensively described in the forth quarter bulletin of 2010[4]. During the first quarter the recruitment of the consultant that would develop the national Moderate Acute Malnutrition guideline was completed. The development work was expected to commence on 1st April in the second quarter of 2011. Meanwhile, the federal ENCU identified a consultant that will revise/finalize the interim national emergency nutrition assessment guideline (Sept 2008) and one institution that would revise the 2004 emergency nutrition intervention guideline. Recruitment of the two consultants were expected to be finalized in the 2nd quarter of 2011. This implied that the HRF project should be extended to September 2011.

3.2. DEVELOPMENT OF THE NUTRITION SECTOR SAMPLINGMETHODOLOGY FOR THE PROPOSED BI-ANNUAL SURVEY AS PART OF THE DRMFSS SEASONAL ASSESSMENTS.

During the first quarter, the nutrition sector under the coordination of the ENHRI discussed the implementation of proposed methodology for conducting timely nutrition assessment and response within the framework of the needs assessments coordinated by the ENCU/ DRMFSS. A technical group comprising of EHNRI, DRMFSS/ENCU, UNICEF, WHO, WFP, GOAL, SC UK, CONERN, MSF Holland and ACF was formed in February 2011 charged with two main tasks. 1) Develop a methodology for conducting the proposed bi-annual nutrition surveys to guide timely and implementation of nutrition response and 2) develop a strategy for strengthening nutrition information system in Ethiopia under the coordination of the EHNRI.

The technical group developed the methodology that takes into consideration the nutritional/food security vulnerability in terms of hot spot woredas, livelihoods and seasonality. The proposed sampling methodology was presented to the EHNRI and DRMFSS for guidance. By the end of first quarter, it was learnt that further technical discussions and clarification were needed by the DRMFSS/EHNRI before a decision on the proposed methodology is made.

[4] EMERGENCY NUTRITION QUARTERLY BULLETIN (Forth Quarter 2010)

4. CHALLENGES

The nutrition partners faced several important challenges. TSF implemented by WFP faced 66 percent funding shortfall during the reporting period that affected implementation of the TSFP in some of and non-non La-Nina affected woreda; Limited capacities among some of the nutrition cluster partners to conduct emergency nutrition surveys based on SMART methodology; late initiation of response in some hot spot woredas. Others included: weak capacity in some of the partners to implement high quality response; bureaucratic engagement of partners in one of the regions; limited accessibility in some of the regions that impaired monitoring and follow up of project beneficiaries; failure of some partners to follow the existing national guidelines and therefore making comparison difficult and lastly weak involvement of woredas and regional authorities in planning, implementation, monitoring and evaluation of nutrition responses in some of the regions.