

03 September 2003



## Cattle dying near Gewane of contagious diseases

Near Gewane, cattle are dying of Contagious Bovine Pleural Pneumonia (CBPP), blackleg and suspected cases of endemic animal tuberculosis. ▶

UNITED NATIONS COUNTRY TEAM ETHIOPIA



## Health crisis in SNNPR: Not subsiding

Measles, malaria, malnutrition, acute respiratory infections and diarrhea diseases are among the five most deadly diseases in acute-humanitarian crises due to the weakened state of affected populations. In many famine situations excess mortality is driven by the presence of these killer diseases and only partly from starvation or malnutrition. In Southern Nations Nationality and People's Region (SNNPR), all five of these killer diseases are present and active.

In April and May international organizations and government expanded their health and nutrition activities in response to the sharp increase in malnutrition levels. Numerous therapeutic feeding centers (TFCs) and supplementary feeding programs (SFPs) were opened in the region. The general ration was increased from 12.5 kg to 15 kg and now includes blended food and oil for the entire needy population. Together with rapid response efforts to reduce malnutrition, measles vaccination, malaria prevention and treatment and provision of safe water became a primary focus of emergency health interventions. However, despite this robust response the health and nutrition situation remains critical.

The magnitude of the current health crisis was triggered not only by the poor *meher* (long season) rains in 2002, but by the lack of alternative sources of livelihood for the population, insufficient health services, late and inadequate food distribution and scarcity of non-food responses. Some of the key health system constraints that hamper the delivery of emergency health and nutrition services include weak disease surveillance and epidemic response systems; the low coverage and utilization of health services; poor logistics and supply management; high staff turnover and lack of skilled personnel, especially in rural areas; poor infrastructure; and poor capacity to deal with health and nutrition emergencies. Decentralization was identified as another hindrance to improved

## NEWS ▶

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### WFP finalized food aid use and impact pilot survey in West Hararghe zone

WFP has finalized the results of a pilot survey on food aid use and impact in West Hararghe Zone of Oromiya Region. ▶

### WFP sub-office in Awassa fully operational

The newly opened WFP sub-office in Awassa, the regional capital of Southern Nations, Nationalities and Peoples Region (SNNPR), is now fully operational, with an international staff member as sub-office head and four national food aid monitors, whose work focuses on districts not covered by NGOs. An additional three monitors are being recruited in the region. ▶

emergency health services in SNNPR resulting in communication problems within the region and between the region and federal level.

A rapid health and nutrition assessment was conducted in SNNPR in the last two weeks of July to gain a better perspective on the current health and nutrition situation in SNNPR and update the 2003 December Joint Government-UN appeal document to reflect the current health and nutrition needs of the country.

WHO reports that the general health and nutrition situation is getting worse countrywide. Although therapeutic feeding centers (TFCs) and supplementary feeding programs (SFPs) are running well, a continued problem of targeting of the general ration is undermining their achievements. Improvements in the general rations and a direct link between them and the TFCs and SFPs are critical.

Recommendations following the assessment include increasing the provision of essential drugs, routine Expanded Program on Immunizations (EPI) programs should be reactivated in areas where they are currently not running, support for TFCs and SFPs should be sustained, improve the general ration mechanism and ensure increased quantity and quality of ration distribution and provide technical support to the Regional Health Bureaus in health program coordination.

NGOs working in SNNPR state that the crisis is not over but just beginning. New pockets of malnutrition are popping up all the time. Underlying causes of malnutrition and destitution are so deep rooted that the situation is not likely to be solved even with a good *meher* harvest. Looking at the scale of the national health and nutrition emergency program, UNICEF estimates that 450,000 people suffer from Global Acute Malnutrition (GAM) or moderate acute malnutrition and 60,000 suffer from Severe Acute Malnutrition (SAM) in Ethiopia. In SNNPR, UNICEF roughly estimates (non-scientificly) 30,000 or 10% of children suffer from acute malnutrition and 6,000 or 2% suffer from severe acute malnutrition. The humanitarian community is only reaching 30% of the malnourished population, or 1,800 children in treatment at the end of August in 26 TFCs, indicating that more needs to be done.

### **Health officials warn of malaria epidemic**

In addition, there is a need to continue to address the immediate threat of a malaria epidemic in the county, particularly in SNNPR. WHO estimates that malaria kills an African child every 30 seconds. Many children who survive an episode of severe malaria may suffer from learning impairments or brain damage. Pregnant women and their unborn children are also particularly vulnerable to malaria, which is a major cause of perinatal mortality, low birth weight and maternal anemia. There are four types of human malaria with *Plasmodium Falciparum*, prevalent throughout SNNPR, being the most deadly type of malaria infection.

In Ethiopia, malaria affects 75% of the population and 5 million clinical cases are reported annually. In 2000, malaria was the number one cause for medical consultations and hospital admission and the third cause of deaths in hospitals. Malaria is seasonal, with September to December being the high transmission period. Major epidemics occur cyclically every 5 to 8 years. There has been a four-year build up (low transmission years) since the 1998 epidemic when an estimated 150,000 people died. Furthermore, malaria was top on the list of major causes of morbidity in 1995.

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the population is already weakened by malnutrition. The traditional malaria risk areas are located at an altitude of less than 1500 meters above sea level, although due to unseasonably high temperatures, the recent outbreak has also spread to highland areas. Reports are being received indicating that the problem is more severe than previous years with a dramatic increase in the number of cases. The peak period for malaria transmission is projected to occur after the current rainy season concludes at the end of September.

Just over US\$ 2 million has been received by UNICEF (through the USA, Belgian and Swedish governments) for malaria control countrywide in July and August 2003, and more support is pledged to address the anticipated epidemic. The malaria response includes procurement of essential anti-malarial drugs (Chloroquine, Fansidar and Quinine), laboratory supplies, insecticide-treated mosquito nets, insecticide for indoor residual spraying (IRS) and training of health workers on malaria epidemic prevention and control, and other supportive and preventive measures. The real challenge now is to reach all people at risk.

A major setback in the response to fight malaria is the lack of malaria morbidity and mortality data available in SNNPR. Only a few woredas were able to collect data and therefore, health officials do not have a regional picture of malaria morbidity and mortality. Without this data, it is not possible to know whether or not this is an epidemic. The majority of data thus far is mostly anecdotal. Certain woredas who have been able to compile numbers, are reporting high mortality rates, like Humba Woreda in Welayita Zone who are reporting that 57% of morbidity is due to malaria, when 30% is normal for malaria. This high level of morbidity is most likely related to increased malnutrition, the physical weakness of the population in the region and the prevalence of the *Plasmodium Falciparum* strain. Aid workers are reporting that without statistics malaria efforts are similar to firefighting. As hotspots become apparent, efforts are then refocused. The worst areas for malaria are still unknown due to lack of data, but areas that seem to suffer the most are Badawacho Woreda in Hadiya Zone, Humbo Woreda in Welayita Zone and Sidama Zone. However, the Regional Bureau of Health was able to collect the information in the chart on the side panel.

Some assessments are being undertaken to gather data. A quick assessment was undertaken by a Regional Health Bureau (RHB) malaria expert and the team leader a for child health and health service strengthening project<sup>1</sup> in Welayita, Kembata Tembaro, Silti, Gurage and Sidama, the most drought affected zones in SNNPR. The assessment enabled the collection of data on Insecticide Treated Net (ITN) stocks and shortage of drugs that provided a general picture of the malaria situation. The assessment indicated a need over the next eight weeks for 3660 insecticide treated nets.

To combat poor organization and data, UNICEF is providing funding to SNNPR for a micro planning workshop in early September with health officer participants from zonal and woreda levels. All zones will be mapped and a cohesive strategy developed. UNICEF support will also go towards supportive supervision training to enable woredas to oversee their own malaria activities. Operational costs for spraying are also being provided. Furthermore, UNICEF has hired an international malaria expert who will arrive in early September.

Other problems with the malaria response are a delay in the annual chemical (DDT) spray program due to a budget shortage and lack of chemicals. However, WHO has provided US\$ 91,500 for training

### Reported Malaria cases in SNNPR from March-June 2003 (By zones who reported)

Zone/SW	No of woredas affected	No. of Population affected
K/T	2	14,895
Wolayta	4	19,275
Hadiya	3	20,030
Sidama	4	22,041
Dawro	2	15,550
Alaba	1	12,833
Gurage	5	19,600
Gamo G.	3	8,602
Yem	1	150
<b>Total</b>	<b>25</b>	<b>132,976</b>

Source: RHB

### Species of Malaria Reported in SNNPR from March-June 2003 (By zones who reported)

Zone/SW	Species	
	<i>P. falciparum</i>	<i>P. vivax</i>
K/T	246	106
Wolayita	602	86
Hadiya	288	143
Sidama	646	198
Dawro	13	0
Alaba	201	83
Gurage	176	8
Gamo G.	82	17
Yem	-	-
<b>Total</b>	<b>2,254</b>	<b>641</b>

According to the above information, 77.8 % of cases are *P. falciparum*.

<sup>1</sup> Essential Services for Health in Ethiopia (ESHE)/John Snow International (JSI)/USAID Project

and deployment of local, community based malaria control agents for spraying activities in the worst affected areas.

The lack of staff and organized malaria teams for the woredas are also hindering the malaria response. Additionally, newly developed water ponds and wells create the right environment for breeding of mosquitoes. Other factors that have contributed to further aggravating the malaria situation and causing a high death toll are the resistance to available drugs (Chloroquine and Fansidar to the *Plasmodium Falciparum* malaria in the lowlands) and the lack of capacity to deliver available drugs and respond to unexpected needs quickly.

USAID's Office for Foreign Disaster Assistance (OFDA) has been very active in the prevention of malaria epidemics. OFDA provided funding (US\$1.6 million) to UNICEF for a malaria prevention and treatment campaign, to the regional health bureau in SNNPR and deployed a malaria specialist to Ethiopia at the end of August to support the Disaster Assistance Response Team (DART) and enhance current response efforts.

Development Cooperation Ireland is providing approximately US\$ 300,000 million for anti-malaria drugs and vector control supply in Ethiopia, of which a substantial portion will target SNNPR.

World Vision (WV) is responding to the malaria outbreaks in Kembata Tembaro Zone by establishing a well-integrated malaria control component into the TFC and SFC they established in early July in the woreda center Mudula. TFC statistics indicate that malaria is taking a heavy toll. Out of the total admission of 153 severely malnourished children, 142 or 93% had proven cases of malaria. Of the six deaths recorded in the TFC, four or 66% were due to *Plasmodium Falciparum* malaria. In addition, 225 parents were treated for malaria. World Vision is providing training and insecticide treated nets for all children discharged from the TFC.

Structural problems are also affecting the fight against malaria in SNNPR. Decentralization has hindered resources reaching people at the grassroots level. Aid workers report that they keep encountering this same problem and it is having an adverse effect on the malaria response. A very promising initiative that has recently started in SNNPR with NGO assistance is the distribution of malaria and other essential drugs to health centers and TFCs. Collaborating closely with local health staff, this initiative is working to ensure that these resources are being more effectively used. This is a good way of addressing both the immediate needs and to build capacity in the future. In addition, UNICEF is providing support for logistics and warehousing of drugs both to ensure effective distribution during the current crisis and to build an improved system in the future.

### **Need for more TFCs**

The need to open therapeutic feeding centers during 2003 was an indication of the scale and depth of crisis in some areas. There is no doubt that these centers have already saved many lives.

Humanitarian partners are taking advantage of the TFCs and targeted SFPs to provide other emergency health services. To help fight the current malaria emergency, Insecticide Treated Nets (ITNs) are being distributed free of charge at TFCs. The supply, however, is currently insufficient to distribute through targeted SFPs. Deworming medicine and iron supplements are now supplied through targeted SFPs. (These drugs are currently in short supply, but more have already arrived in Addis Ababa.) Emergency health services are also being expanded for health education and promotion and cover topics such as malaria, nutrition, HIV/AIDS, hygiene etc. Although,

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educational services are normally linked to TFCs, a more systematized approach is needed.

26 therapeutic feeding centers (TFCs) are now operational in SNNPR including two new centers opened by Save the Children US (SC-US) in Aroessa and Hulla Woreda in Sidama Zone. Action Contre la Faim (ACF) are now managing TFC activities in Darara located in Boricha Woreda in Sidama Zone and will soon take over the Leku center in Shebedino Woreda in Sidama Zone. TFCs open in areas where nutritional assessments indicate a level of 15% or greater Global Acute Malnutrition (GAM) and/or two to four percent of the population suffer from severe acute malnutrition (SAM). Currently in SNNPR, two TFCs were established in Gurarge, two in Kambata, 11 in Sidama, one in Silte, one in Konso Special Woreda and nine in Welayita.

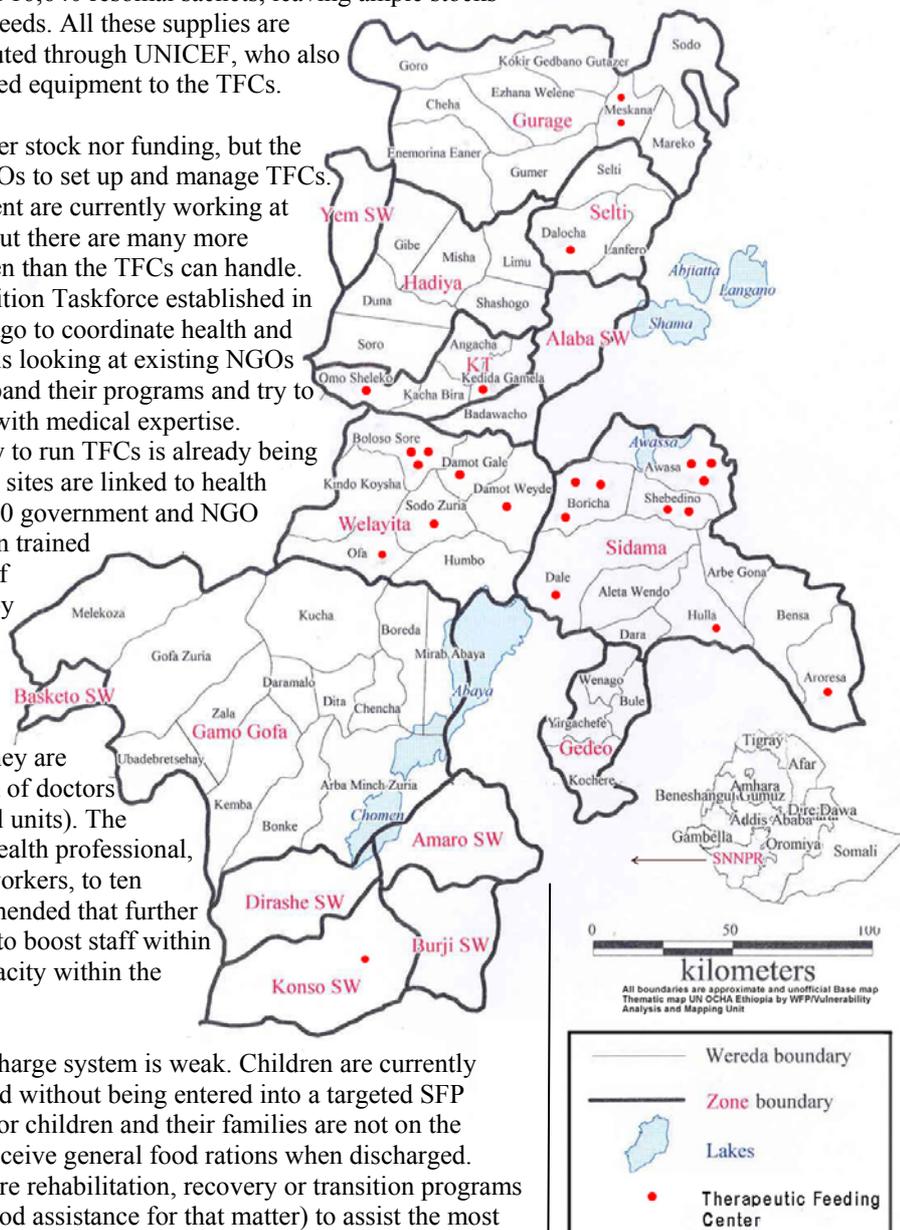
Sufficient stocks of therapeutic feeding products are available to meet the current demand. Stocks were repositioned in Awassa in July to cover a three month period and additional stocks are available in Addis Ababa. Therapeutic foods procured and in the pipeline as of 22 August amount to 808 tonnes and 61,490 sachets of resomal (rehydration solution for malnourished) versus a consumption thus far of 148 tonnes and 16,640 resomal sachets, leaving ample stocks to meet emergency needs. All these supplies are procured and distributed through UNICEF, who also provides other selected equipment to the TFCs.

The problem is neither stock nor funding, but the lack of qualified NGOs to set up and manage TFCs. NGOs and government are currently working at maximum capacity but there are many more malnourished children than the TFCs can handle. The Health and Nutrition Taskforce established in SNNPR one month ago to coordinate health and nutrition in SNNPR is looking at existing NGOs to see if they can expand their programs and try to identify new NGOs with medical expertise. Government capacity to run TFCs is already being strengthened as most sites are linked to health centers. A total of 810 government and NGO health staff have been trained in the management of therapeutic feeding by UNICEF since the beginning of 2003.

TFCs have sufficient health workers but they are suffering from a lack of doctors (especially in referral units). The current ratio is one health professional, including nutrition workers, to ten patients. It is recommended that further support be provided to boost staff within NGOs and build capacity within the government.

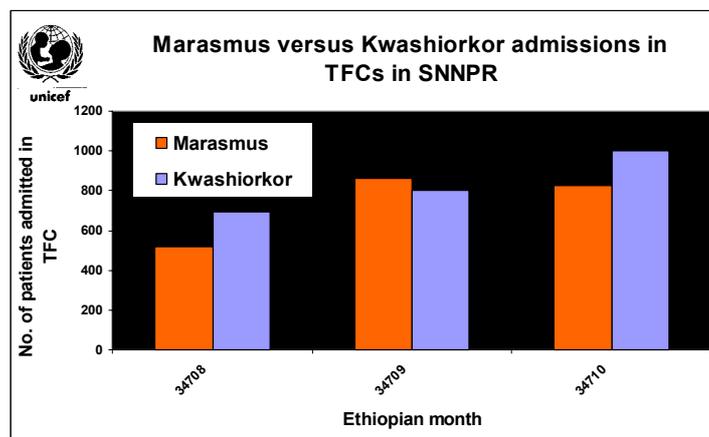
The referral and discharge system is weak. Children are currently sometimes discharged without being entered into a targeted SFP where it is available or children and their families are not on the beneficiary lists to receive general food rations when discharged. Nor, unfortunately, are rehabilitation, recovery or transition programs in place (nor livelihood assistance for that matter) to assist the most affected households to meet their basic food and other needs. They often return to the same circumstances, unbalanced diet or lack of

## Therapeutic Feeding Sites in SNNPR



access to a general ration that originally resulted in malnourishment and many children are therefore re-admitted back into the centers. These most needy populations are extremely vulnerable to the most dangerous infectious diseases without additional aid. Sometimes SFPs are not even available where therapeutic centers are operating. The SNNPR Health and Nutrition Taskforce is in the process of matching up TFCs with targeted SFPs and strengthening the linkage between the children discharged from the TFC and their admission to the SFP to solve this problem. The taskforce has also identified a set of recommendations for TFC and SFP referral. Listed on the side panel are the current TFCs and SFPs in SNNPR.

A better linkage should be created between TFCs, targeted supplementary feeding programs (SFPs) and the general food ration. WFP is currently undertaking a vulnerability profiling study to review the system and are trying to ensure that families are put on beneficiary lists. In the meantime, NGOs are submitting lists and advocating with government counterparts.



A total of 4,819 malnourished children were admitted to TFCs since the beginning of the crisis in SNNPR. Of the total admitted patients, a large number are also reported to have a high level of oedema, or Kwashiorkor (According to TFC data collection in the region, only 53% of the total admissions in TFCs are Kwashiorkor. But in certain TFCs, the proportion of Kwashiorkor is higher than Marasmus: Areka 73%, Dorebafano 59%, Karate 71%, Leku 74% Morocho 63%, Sodo 64% and Taza 74%). Kwashiorkor, like Marasmus, is a form of severe malnutrition that kills children rapidly without immediate medical aid and is seen most frequently in children aged one to three years. Recent research points to a deficiency of several key micronutrients as well as protein. It has been observed in a number of countries that the proportion of Kwashiorkor cases is higher in (and links the presence of Kwashiorkor to) areas dependent upon maize and enset. The iron-rich red soil in SNNPR also prevents the absorption into the crops of selenium and iron. USAID reports that the alarmingly high levels of Kwashiorkor among severely malnourished children under five underline the complex and increasingly critical emergency situation. The inclusion of pulses and oil into the general ration and specialized community based therapeutic feeding programs and assistance from TFCs is expected to help by providing missing nutrients, but not to the extent needed to prevent malnourishment. One long-term solution is education to try and change the population's traditional habits. People should be encouraged to grow legumes, beans and vegetables for a more balanced diet. SC-US is considering a feasibility study for a Kwashiorkor prevention trial study. Fortunately, due to improved therapeutic feeding practices, almost all Kwashiorkor patients who receive timely therapeutic feeding are living when in previous years 50% of patients died. The mortality rate for all the TFCs in SNNPR is now 5%.

### SNNPR-TFCs and SFPs

Partners	TFC	SFP
Catholic Bushulo	1	Yes A/Zuria
SCF-US	6	No
IMC	6	No
ADRA	2	No
ACF	2	Pending for Arerosa
WVI	2	Yes Soddo
Concern	2	Yes Bedessa and Ofa
MSF-CH	2	Yes Damot Gale
Project Mercy/MOH	3	Yes Mesken & Mareko
Oxfam	0	Yes Boloso Sore
Goal	0	Yes Boricha Shabedino Malgano-soon

Community based therapeutic feeding (CTC) is now being considered in some areas to supplement TFCs. It is an approach to the treatment of acute malnutrition that is still under study globally and like any new approach has advantages and disadvantages. CTC is good strategy that brings treatment out of the centre to peripheral areas. And it is possible to establish such a program very quickly given sufficient staff, logistic support, organization and enthusiasm. It is clearly possible to have a major impact. Home treatment though is not suitable for all patients, particularly the complicated cases, those without a willing caretaker and young infants. It remains to be seen whether it is feasible to scale up such a program and to “institutionalize” it in a non-NGO context. It would be a major problem if there was a substantial break in the means to get the staff and supplies to the distribution points at the appointed times. This would be much more serious for the severely malnourished than the moderately malnourished. On the other hand home-treatment may be the only way in which high quality services can be brought to a widely scattered population who themselves do not have access to transport. The two programs are considered complimentary, with home-treatment functioning as an intermediate program between the SFC and the TFC for those with uncomplicated anthropometric malnutrition or mild oedema. However, it would be advantageous to combine the two strategies. All programs should have active case finding in the community (this is common to both and its absence is one of the main reasons for low coverage). However, the traditional TFC can be used as a phase 1 centre and when the children are uncomplicated and into phase 2 there is no reason why they should not be treated with home treatment routinely. This would decrease the numbers of patients, the length of residential stay and the size of physical facilities required for a TFC dramatically. The “non-medical” part of treatment would then take place at home. Details of the logistic and staff requirements would be similar to those of a standard SFC. At the moment the cost of the imported RUTF (“Plumpy’nut” or BP100) is prohibitive for widespread implementation. The effectiveness of CTC is severely compromised where the general and supplementary rations are inadequate or absent and the RUTF rations intended for the malnourished child are shared with the family. CTC is not a cheaper option than the traditional TFC: it is also highly resource-intensive as it needs to be staffed by paid community health workers who need logistical mobility to follow up with cases. Concern and Save the Children UK (SC-UK) have established CTC programs in SNNPR and SC-US is starting a program in September.

### **Targeted SF needed to avoid severe malnourishment**

The lack of capacity for nutrition assessments, analysis and action is of particular concern. The assessments currently carried out are limited to simplified surveys of acute wasting and used to trigger food aid support. More appropriate responses and multiple strategies must be put in place to assess specific forms of malnutrition and analysis of health factors, care and feeding practices as well as basic causes. Emerging experiences demonstrate that accelerated, targeted supplementary feeding, together with other rapid livelihood interventions, would go a long way towards avoiding additional moderately malnourished children becoming severely malnourished with dramatically increased mortality risk. Existing capacity for such targeted supplementary feeding is also low but could be significantly expanded during the latter part of the year if sufficient support was made available.

### **Rains/lack of guidelines add to sanitation troubles**

Recent water and sanitation surveys for TFCs in SNNPR identified the lack of clear sanitation guidelines for TFCs, and also for all health facilities, as a major problem. In response, the Regional

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Health Bureau, in collaboration with UNICEF, is bringing together sanitation experts and zonal sanitation focal points for a workshop in September to establish criteria and guidelines for TFCs in SNNPR.

The rains and the resulting increased surface water in SNNPR has brought a higher risk of water borne diseases as human excrements and refuse are being washed into unprotected water sources. 75% of the population in SNNPR relies on unprotected sources not safe from disease. Improved wells with sanitation seals are necessary to protect people from water borne contaminants. People are now increasingly vulnerable and succumb to water borne diseases more easily. The Ministry of Water Resources, together with UNICEF, have undertaken a drought impact assessment on water supply and sanitation and identified the worst-affected woredas and communities. Emergency plans of action have been drawn up and are being implemented. In SNNPR, since end 2002, the efforts are underway to increase access to safe water supply in the drought affected woredas from 25% to 40%. Additionally in SNNPR, in the next six months efforts will be directed towards water tinkering for 4,000 beneficiaries, water scheme maintenance and rehabilitation projects for 40,000 beneficiaries, new water scheme development for 132,000 and sanitation and hygiene education for 90,000. To improve the quality of the water, WHO has been working closely with the Regional Water, Mines and Energy Resources Development Bureau. It has also contributed towards quality improvement in the region, particularly in drought affected regions. The improved response is mainly attributed to the extra attention on the emergency and therefore extra available resources. The Government, UN and NGOs are focusing on improving water systems and taking advantage of available resources for lasting solutions. These combined measures will offer better resistance for the population in the interim and also during future droughts.

### **Drug stores in SNNPR systematized**

Regional Health Bureau (RHB) drug stores in Awassa for SNNPR were insufficient to meet the needs of the current crisis. In response, the Regional Health Bureau together with UNICEF logisticians reorganized stores and set up a comprehensive inventory system. The system was computerized, shelving reorganized and training was provided to RHB staff. Since it is now known what drugs are in stores, drug availability has improved considerably. The distribution system as a whole is being looked at and a request and dispatch system is being developed. Field monitors are making sure that health centers request the right amount of drugs and that they receive them. Aid workers hope that this system can be replicated in other regions.

Furthermore, the RHB will conduct a regional and zonal review of the drug availability and distribution system. If necessary, the RHB will develop a redistribution plan and ensure equitable distribution and availability in all clinics. In the meantime, RHB has sent several communications to zonal level health centers to indicate that there should not be a shortage of drugs and that beneficiaries should not have to pay or be refused free medical care and prescriptions. Cleaning up stores has enabled a clearer picture of what drugs are in shortage. Anti fungal medicines in TFCs are in short supply, however, they are now ordered. Malaria quinine injections are also in shortage, but they are currently in customs and will be available soon. Antibiotic stocks are low.

55 emergency drug kits have been provided to SNNPR since the start of the current crisis in mid 2003. However, contents of kits are not providing sufficient quantities of the required drugs for TFCs and do not have adequate anti-malaria drugs. Complementary drugs have been ordered to meet the TFC needs and are now distributed to the TFCs.

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## Measles campaign reaches over 50 woredas in SNNPR

The measles and Vitamin A campaign was largely considered successful as greater than 90% of children were vaccinated based on administrative reports and surveys.

Before the current crisis, the Ministry of Health had a regular measles plan in place. Due to the growing emergency and an increased potential of a measles epidemic, attributed to widespread malnutrition and low level of routine vaccine coverage, the campaign was accelerated. Particular attention was focused on SNNPR, the epicenter of the emerging crisis. Prioritization was based on nutritional assessment data, available vaccines and resources. In April, Gurarge and Silte were targeted and then in June, Welayita and Sidama. Hadiya, Dawro and Kembata Tembaro zones and Alaba Special Woreda in SNNPR were targeted in a subsequent phase that was completed at the end of July. The campaign will reach Yem Zone in October and as part of the Ministry of Health's Measles Control Plan, remaining areas in SNNPR will be targeted in early 2004. In total, seven zones in SNNPR and over 50 woredas were covered by measles immunization and Vitamin A supplementation reaching 3.6 million children. Though Adverse Events Following Immunization (AEFI) surveillance is not well established, only 36 AEFI's were reported during the campaign in SNNPR, an indication that injections were likely administered properly. Vaccination coverage ranged in zones from 84% in Silte to 99% in Dawro. Pre-campaign assessments were completed to assess campaign preparedness, rapid convenience surveys were undertaken to identify children not vaccinated and post campaign coverage surveys were also carried out after the campaign. One of the most important strategies hereafter will be measles case-based/lab-based surveillance as part of the Ministry of Health's Integrated Disease Surveillance and Response System.

The main focus is now on keeping up the momentum, strengthening measles surveillance, improving cold room storage capacity and ensuring adequate supplies. To take advantage and maximize opportunities from the drought, human capacity at operational level should be strengthened for future response through training at the woreda and community level, along with routine immunization, nutrition and disease surveillance as part of early warning systems.

### The way forward

The health crisis in SNNPR is at a serious stage. The United Nations will closely monitor the possible malaria epidemic, and together with their partners, improve data collection and ensure that necessary precautions are taken to reduce malaria transmission and treat malaria cases. In response to the malnutrition in the region, NGOs that could expand their therapeutic and supplementary feeding capacity are being encouraged to do so. The humanitarian community as a whole should strengthen their health response to address the health emergency. Furthermore, while this report has concentrated on the serious health situation in SNNPR, other regions in the country suffer from similar problems and should be addressed with the same energy as is done in SNNPR.

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## NEWS ►

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### UNFPA supports NGOs with HIV/AIDs prevention activities in SNNPR

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the UNFPA supported NGOs, Integrated Service for AIDS Prevention and Support Organisation (ISAPSO) and Family Guidance Association of Ethiopia (FGAE) operate in the Southern Region. ISAPSO focuses on HIV/AIDS/Sexually Transmitted Disease (STD) prevention amongst truck, long distance bus and middle distance transport drivers through the establishment of booth based services along the Addis – Moyale highway. The booth based centers are staffed with peer educators who provide as well as contraceptives. UNFPA supports FGAE in the strengthening of 3 health centers in Assela, Zeway and Yirgalem in order to integrate VCT and STI treatment into their youth friendly health services.



### **Cattle dying near Gewane of contagious diseases**

After three years of low rainfall, most of the areas in Afar Region and Shinile zone of Somali Region have received rains, even an unusually high amount. Nevertheless, rains remain erratic in some locations, especially in the northern part of Shinille Zone (Aiycha, Shinile, and Dembal) and in some parts of Afar Zone 2. Up to now, browsing conditions are fully regenerated and both Afar and Issa camels are in good physical condition. But everywhere pasture availability remains a top priority for pastoralists worried about overgrazing. Last year drought and grazing at early stage of growth have largely contributed to overgrazing. Scarcity of grazing land is particularly acute around Gewane and in some pocket areas of Shinille Zone, where most of the wet grazing land in the marshes is presently infested with *Prosopis juliflora*, an acacia-like non-palatable bush. In those areas, undernourished cattle remain emaciated and affected by various animal diseases. Near Gewane, cattle are dying of Contagious Bovine Pleural Pneumonia (CBPP), blackleg and suspected cases of endemic animal tuberculosis. Farm Africa has collected post mortem tissue samples to get laboratory confirmation with histo-pathology analysis. Cattle carcasses are actually visible in settlements around Gewane. A UN OCHA assessment team counted 50 cattle carcasses, most of them close to Old Gewane and the Agricultural Training Centre located south of Gewane. Immediate action needs to be taken in order to avoid any kind of epidemic threat from these carcasses.

### **WFP finalized food aid use and impact pilot survey in West Hararghe zone**

WFP has finalized the results of a pilot survey on food aid use and impact in West Hararghe Zone of Oromiya Region. After the food security situation in East and West Hararghe dramatically deteriorated in the latter part of 2002, and large-scale programs of

**A UN OCHA assessment team counted 50 cattle carcasses, most of them close to Old Gewane and the Agricultural Training Centre located south of Gewane. Immediate action needs to be taken in order to avoid any kind of epidemic threat from these carcasses.**

relief activities were deployed, WFP and CARE agreed to collaborate to adapt a monitoring tool for use in the zones - the Coping Strategies Index (CSI) - developed by the two agencies in Kenya to address their operational information requirements during emergencies. East and West Hararghe zones, were chosen to undertake this pilot survey on food aid use and impact. Collection of data about how households manage to cope with food shortages took place in the lowland areas during the months of May and June. The information was collected through community and household interviews as well as market surveys. Both beneficiaries and some non-beneficiaries were interviewed. According to the findings from West Hararghe zone, it appears that a large majority of the beneficiary households (85%) have regularly received food aid over the last three months. The number of reports of losses or spillage at distribution sites was insignificant and no household mentioned witnessing misappropriation/ diversion of food aid at the distribution site. In more than three-quarters of the beneficiary households (76%), women are responsible for deciding about the utilisation of food aid and the repartition of its benefits among the family members. Hence, it is more likely that food aid will be used for consumption and will benefit children. In fact, beneficiary households reported, on average, consuming almost 97% of their food aid ration, sharing 2% with kin and selling about 1%. The findings of this survey and the recommendations made by the communities have been crucial for WFP and its government counterpart the Disaster Prevention and Preparedness Commission to strengthen both the targeting and the management of emergency food assistance. WFP is currently planning to undertake a similar survey throughout the country, starting in September.

### **WFP sub-office in Awassa fully operational**

The newly opened WFP sub-office in Awassa, the regional capital of Southern Nations, Nationalities and Peoples Region (SNNPR), is now fully operational, with an international staff member as sub-office head and four national food aid monitors, whose work focuses on districts not covered by NGOs. An additional three monitors are being recruited in the region. Currently 1.4 million people out of the total rural population of 12.6 million in SNNPR are receiving food assistance. NGOs are responsible for food distributions in 26 of the 57 affected districts (of a total 104 districts in the region) while WFP and DPPC food is used in the remaining 31 affected districts. Food allocations in SNNPR from January to August totalled 135,400 tons, of which NGOs distributed about 50%. Of this, current allocations for August are 23,350 tons (15,350 tons through NGOs and 8,000 tons through DPPC, much of the latter being WFP food). About 58,000 tons are needed for the region for September to December. Targeted supplementary food distributions take place in 12 districts (all by NGOs). The total number of general food distribution sites in the region is 126 (of the 997 distribution sites throughout the country which serve a total of 12.3 million beneficiaries in August; total food allocations for all beneficiaries in the country for August are 195,000 tons, half of which is covered by DPPC/WFP food and half by NGO food).

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