

**Report on the Food and Nutrition Situation in Gode, Fik,
Korahe, Jijiga and Shinile zones of the
Somali Region, Ethiopia,
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**Peter Salama, medical epidemiologist, UNICEF/CDC
Albertien van der Veen, nutritionist, WHO/ORHC¹**

<i>Index</i>	<i>page</i>
<i>1 Background</i>	<i>2</i>
<i>2 Nutrition situation and Humanitarian Response</i>	<i>3</i>
<i>2.1 Nutrition Surveillance</i>	<i>3</i>
<i>2.2 Selective Feeding Programmes</i>	<i>5</i>
<i>2.3 Health</i>	<i>7</i>
<i>3. Food Situation</i>	<i>8</i>
<i>3.1 Food security</i>	<i>8</i>
<i>3.2 General Food Distribution</i>	<i>9</i>
<i>4 Summary Problem Analysis</i>	<i>12</i>
<i>5 Recommendations</i>	<i>13</i>
<i>Annex 1: Summary of nutrition surveys</i>	
<i>Annex 2: Selective Feeding Programmes</i>	
<i>Annex 3: Food Distribution</i>	
<i>Acknowledgements</i>	
<i>References</i>	

¹ Office of the Humanitarian Co-ordinator for the Drought in the Horn of Africa

1 Background

The objective of this report is to provide an overview of the nutrition situation in the Somali region in Ethiopia and the humanitarian response thus far, to outline the major problems hindering an effective response and finally, to provide recommendations for action. Although the focus of this report is the Somali region, and many of the issues and recommendations noted here are typical for this region, we anticipate that some will also be relevant to programmes in other drought-affected regions such as the SNNPR and the Amhara region. The methodology for this assessment consisted firstly of the collation of various survey reports and assessment reports of non-government organizations (NGOs), the Disaster Preparedness and Prevention Committee (DPPC) and United Nations (UN) agencies. This was followed by interviews with key informants such as agency directors, medical coordinators and nutritionists and finally, field visits to Gode zone, Jijiga zone and Shinile zone.

The Somali region in Eastern Ethiopia comprises 9 zones and has a population of approximately 3.76 million, the majority of whom are pastoralists and agro-pastoralists. The area is remote and isolated from the highlands, also culturally and economically. Three consecutive years of poor rainfall have adversely affected agricultural yields and the condition of pastures. This has led to a gradual depletion in food stores, livestock and other household assets that has led to a severe deterioration in household food security. As a result, the prevalence of acute wasting in the population less than 5 years of age reached critical levels in many parts of the Somali region in early 2000 and remains of serious concern in some areas. There is evidence that crude and under 5 mortality rates have increased and passed the thresholds used to define an emergency.

The humanitarian response has been coordinated by the Ethiopian government's Disaster Prevention and Preparedness Committee (DPPC) and has so far been focused in particular on Gode zone. Because people traditionally gather here in times of drought on the one hand, because of its airport and relatively easy access on the other hand, Gode has drawn more attention from NGOs and the UN than any other place in the Somali region. Since the beginning of the year, the general food ration (GFR) actually received by beneficiaries has been unreliable in quantity and quality in most zones with the exception of those areas targeted for complimentary rations by major international organizations since April, 2000. This inconsistency has led to persistently high levels of acute wasting. Lack of confidence in the GFR has also led some organisations to establish blanket supplementary feeding programmes with ration size well above the level recommended by DPPC. In addition, numerous selective feeding programmes targeting the moderately and severely malnourished have been established with a high concentration in Gode district. It is clear that food availability has improved since the end of May in many geographic areas through a combination of a partial ration distributed by DPPC as well as food received through complimentary, blanket or targeted feeding programmes. Harvest predictions are also optimistic in some areas. In other areas, however, livestock losses continue, the GFR is still inadequate, levels of acute wasting remain unacceptably high, and the expected deyr rains may in fact compound existing problems, although highly welcome from another point of view. In addition to problems of food availability and accessibility, measles, diarrhoeal disease secondary to inadequate water and sanitation and compounded by population movement, malaria, tuberculosis and micro-nutrient deficiencies are likely to be contributing to the persistently high levels of wasting.

2 Nutrition Situation and Humanitarian Response

2.1 Nutritional Surveillance

There is no formal nutritional surveillance system covering the Somali region. In many regions of Ethiopia, the early warning department of the DPPC in conjunction with SCF-UK monitors the nutrition and food security situation through the nutrition surveillance programme (NSP). The NSP is a longitudinal monitoring system that utilises a standard set of food security, agricultural and anthropometric indicators to track changes over time. The anthropometric indicator that has been used by the NSP is mean weight for length (MWL) of the population. A cut-off point of 90% MWL has been used by the DPPC to define population nutritional vulnerability and the need for external food aid. Even though the NSP has not been formally operating in the Somali region, the indicator MWL has been used by a number of non-government organisations (NGOs) and by the DPPC itself as an indicator of nutritional vulnerability. Because MWL reflects the population mean and not the proportion of children falling below internationally recognised cut-offs for the definition of wasting ², the MWL alone is an inadequate indicator of nutritional vulnerability in an emergency situation.

In addition to the MWL and standard anthropometric indicators such as weight for height Z-score and percentage of the median, other anthropometric indicators used in the region include mid upper arm circumference (MUAC) and MUAC for height (QUACK stick). The different indicators used makes comparison from zone to zone or region to region difficult and international comparisons or longitudinal monitoring over time virtually impossible.

Sampling methods for nutritional surveys have also varied considerably; the minority of surveys has been formal 30 clusters surveys employing the standard EPI methodology. Rapid assessments usually reporting MUAC, results from the screening of beneficiaries of supplementary feeding programmes, or convenience samples of children less than 5 years of age measured at a central village location have been frequently employed. Survey methods that do not employ random sampling are prone to selection bias and the interpretation of results is extremely problematic. The final problem with the nutritional information being gathered is that it tends to be very specific to the area of operation of a particular organisation. While such information provides useful information for programme planning for that organisation, it is less useful for monitoring the overall nutritional situation in a region where geographic variability is so pronounced.

The majority of anthropometric information has been collected by NGOs operating in the southern zones of the Somali region. While the results have not been formally released a survey performed by SCF-US reported rates higher than 50% global malnutrition as early as December 1999. Since then, 30 clusters surveys reported indicated that the critical nutritional situation has continued. In Denan in Gode zone, in May, 2000 for example, MSF-B reported global malnutrition rate of 52.9% and a severe malnutrition rate of 11.9%. Although not directly comparable, ICRC surveys using the QUACK stick carried out in June 2000 in selected sites across Gode zone confirmed these high levels of wasting. Preliminary results from a survey performed by SCF-US and UNICEF across Gode district show a continued

² Please refer to Annex I for further details on definitions of nutrition indicators.

high prevalence of global malnutrition of 29% and consistently high mortality rates from December 1999 through July 2000. Measles transmission also continues at high rates. Planned 30 cluster surveys in July and August by MSF-B in Denan and SCF-UK in Fik zones are likely to give an even clearer picture of the nutritional situation in surrounding geographic areas.

In the northern zones of Somali region, anthropometric information is more scarce. Screening of residents and displaced in Harshin, Jijiga zone in May 2000 by CARE, revealed 32% and 50% global malnutrition respectively. In July, Oxfam UK carried out a rapid MUAC screening in Idora town in Shinile zone which revealed over 70% global malnutrition and approximately 30% severe malnutrition. Although the interpretation of results from both surveys is difficult due to methodological constraints, the levels of acute wasting reported deserve formal investigation with a 30 cluster nutrition survey that covers a wider geographic area within various zones in the Northern Ogaden, in particular Shinile zone. Numerous surveys including the above mentioned have also highlighted the increased nutritional vulnerability of displaced populations compared to residents. Please refer to Annex I for an overview of nutrition assessments carried out in the Somali region.

Although identifying underlying causes of malnutrition is necessary for the development of an effective intervention, few surveys have attempted to do so³. There is, however, evidence suggesting that high morbidity due to diarrhoeal disease, exacerbated by unusual population concentrations and poor water and sanitation conditions, has negatively impacted the overall nutrition situation⁴. Prolonged diarrhoeal illness particularly among malnourished children has been reported frequently; cases of bloody diarrhoea have also been reported, but laboratory testing has been negative for shigella dysenteriae thus far. Access to an adequate quantity of safe water is a chronic problem in the Somali region that has been exacerbated by the drought.

There is no comprehensive mortality surveillance in place in the region. But several agencies have included questions on mortality in their nutrition surveys. For example, in Denan, MSF-B found a crude mortality rate (CMR) of 8.9/10,000/day (approximately 20 times the estimated base-line rate) and an under 5 mortality rate of 27.5/10,000/day (or nearly 30 times the estimated baseline rate) for the period January through May, 2000. In June and July, mortality rates derived from direct surveillance in Denan suggested a sharp decline to near normal levels. Interpretation and comparison of these data is not straightforward however. Whereas rates reported by MSF-B from June and July are based on data collection from clinics and burial sites by specifically trained health workers, earlier data were collected retrospectively through household interviews. The former method may result in an underestimate of mortality if people are buried at alternative locations; the latter method is prone to recall bias and may result in an over-estimate of mortality if communities believe that there is a correlation between the level of reported mortality and the level of food aid. Retrospective mortality figures therefore, that cannot be cross-checked with verifiable information such as clinical records or grave counts should be treated with extreme caution. It is likely that the actual mortality figure in the region lies somewhere between the figures collected retrospectively and those collected by direct surveillance. The CMR is also likely to

³ The CARE survey carried out in Harshin being a notable exception.

² And, vice versa, morbidity and mortality have increased because of high levels of malnutrition.

have declined in many parts of the region since a peak in January to May, 2000. Some of this decline is likely to be due to high mortality among those with severe malnutrition particularly if associated with measles or watery diarrhoea. Mortality rates are also likely to show pronounced variation within zones as well as from zone to zone and to have been higher in displaced than resident populations.

2.2 Selective Feeding Programmes

In response to the high prevalence of malnutrition, international and national NGOs commenced selective feeding programmes throughout the Somali region from April to July 2000. The coverage and type of programmes vary widely within and between zones. All together there are seven INGOs and one national NGO involved in feeding programmes in Gode zone, two in Fik and only one in Kebridehar and Jijiga zones. Shinile zone has no feeding programme. Such disparity can be partly attributed to security constraints and partly to differences in population size between these zones. However, given that malnutrition prevalence rates in all five zones has been extremely high, it appears that Gode zone and Gode woreda in particular have been over-targeted while other zones have been relatively under-served.

In Gode zone, one or more therapeutic feeding centres (TFCs) for severely malnourished children have been established in each of the 5 worst affected woredas. By contrast, there is only one TFC in both Koraha and Fik zones. Clearly the resulting long distances required to travel to selective feeding centres in these zones may have resulted in non-compliance by mothers with referral advice. In the northern Somali region selective feeding programmes are even more rare. There is no TFC in Shinile zone and only one in Jijiga Zone. Please refer to Annex I for an overview of NGOs involved in selective feeding programmes.

In the absence of current guidelines from DPPC or the MOH for therapeutic feeding⁵, and insufficient institutional support thus far from UNICEF/WHO in this matter⁶, NGOs have used their own criteria and guidelines. UNICEF has posted a technical officer in Gode town to assist in nutrition training, monitoring of selective feeding interventions and standardization of practice. Not surprisingly, agencies with a track record of providing health and nutritional care in emergencies have used internationally accepted criteria for admission and discharge and medication and feeding protocols. The quality of care provided by less experienced NGOs, however, has not always met minimum standards; some of the problems observed in TFCs include:

- Admission criteria are variable and often inconsistent⁷ (for example, MUAC and weight for height criteria are intermingled, children are admitted who have another illness such as tuberculosis but are not severely malnourished etc.).

⁵ Government policy has not favoured the establishing of feeding centres. This stops unnecessary feeding centres from being established, but might have resulted in NGOs facing delays in acquiring permission to open centres and also perhaps partly explains the lack of guidelines.

⁶ UNICEF has recently posted a nutritionist to DPPB/Regional health Bureau in Jijiga

⁷ Internationally accepted admission criteria are < 70% weight for height or < -3 weight for height Z score and/or oedema

- Routine medical treatment including measles vaccination, micro-nutrient supplementation, treatment of intestinal parasitosis, systematic treatment of infections with oral antibiotics is sometimes inadequate and not in line with standard protocols.
- Recommended 24 hour care is in general not adhered to (with the exception of some centres that provide 24 hour care for children in the acute phase) for a variety of reasons. These include: other obligations of mothers (care of siblings, the need to be present at general ration distributions or head counts), security considerations and lack of compliance by Somali mothers.
- Feeding protocols vary widely; frequency of meals varies from 3 to 8 per day, composition and proportion of calories derived from protein varies considerably and types of food provided are frequently not in line with Sphere/WHO recommendations. Of particular concern is the misuse of BP 5 biscuits which have an inappropriately high protein content for the early phases of therapeutic feeding and should not be given as a take-home ration overnight because of the high probability of them being shared or sold.
- Nutrition and health education strategies targeting mothers and outreach strategies are poorly developed.
- There is lack of attention to the adequacy of water supply prior to opening therapeutic feeding programmes as well as overcrowding in centres create adverse environmental conditions.
- Malnourished adolescents and adults are usually excluded (with the notable exception of SCF-UK and other agencies that include pregnant and lactating women and several agencies that include malnourished children more than 5 years of age and malnourished mothers (care-givers) or the elderly. In particular the lack of provision of iron supplementation for lactating women is a lost opportunity.
- Although some agencies do report programme indicators, there is very little standardised reporting of results; inadequate documentation and analysis of average weight gains, recovery periods, default and mortality rates.

Activity reports from NGOs reporting results indicate relatively high initial mortality percentages as a proportion of exits from the TFCs for the first 1 to 2 months. This is usually the case as centres begin activities and the number of exits is small (as recovery usually takes 4-6 weeks). The percentage of defaulters from many TFCs has been alarming. However, several agencies have recently reported a clear decline in both. Indeed, thanks to the efforts of NGOs in treating those with severe malnutrition, many excess deaths have been avoided.

Although admission rates to TFCs may give some indication of trends in severe malnutrition prevalence, the decline in admissions reported in some centres in the southern zones in the Somali region remains difficult to interpret. While a real decline in severe malnutrition is likely to partly explain this phenomenon, changing (often more stringent) admission criteria, lack of community confidence in the services, the existence of multiple centres in the same catchment area, competing obligations for mothers and care-givers and lack of outreach may also represent contributing factors.

Supplementary feeding programmes (SFPs) are also disproportionately represented in Gode zone, particularly Gode woreda, when compared with other zones. Again in the absence of guidelines and coordination, admission and discharge criteria and target groups vary widely. In addition, although levels of global malnutrition and the inadequate GFR would have justified (at least temporarily) blanket distribution of dry supplementary feeding to all children less than five years of age and pregnant and lactating women in many zones,⁸ only two agencies have been engaged in such programmes. The other seven NGOs providing supplementary feeding

⁸ WHO/MSF guidelines indicate that blanket distribution of dry supplementary food to children and mothers should be considered when global malnutrition exceeds 20% W/H, in particular when the GFR is inadequate.

target different vulnerable groups, sometimes altering criteria and/or target groups. Characteristics of supplementary feeding programmes can be summarised as follows:

- The majority of agencies use the standard criteria of < 80% W/H, although non standard criteria such as < 90% W/H with a coexisting illness were also observed.
- Discharge criteria although generally in accordance with standard practice ($\geq 85\%$ W/H for two consecutive weights) result in very slow discharge when distribution (and thus weighing) is less frequent than once a week
- Provision of health care (routine immunisation, ORT, vitamin A supplementation) does not always meet minimum standards.
- In Gode in particular, catchment areas of SFP overlap and because distributions are not on the same days, an unknown but perhaps substantial number of beneficiaries have registered in more than one feeding programme. In addition, there is substantial double registration within programmes (MSF B upon cleaning records found nearly 20% doubly registered)
- supplementary feeding centres that provided wet feeding on the spot do dis-proportionally attract displacement and are at risk of overcrowding .

As a result of the large variation (and changes) in admission criteria and target groups, considerable time lag between reaching satisfactory nutritional status and discharge and overlap/double registration, enrolment figures from SFPs are of little use in estimating the prevalence of or trends in moderate malnutrition.

2.4 Health

As outlined in section 2.1, poor health is likely to be a major underlying factor for malnutrition in the Somali region⁹. There are few health facilities in the Somali region, even fewer qualified staff and a chronic shortage of drugs at the woreda level. In addition patients are generally required to pay for medications¹⁰. Mother and Child Health (MCH) is poorly developed and the immunisation coverage is among the lowest in Ethiopia. Measles outbreaks were reported from a number of zones earlier this year, and despite a mass campaign carried out by MSF in February/March, cases of measles are still being reported. A possible explanation is relatively low coverage. Theoretical overall coverage as reported by MSF was 45%, while nutrition surveys in Denan and Gode Weredas revealed 70% and 59% coverage respectively. Discrepancies in coverage might partly be attributed to substantial movement of people. Children admitted to therapeutic feeding centres usually suffer from at least one of the common causes of morbidity in the region that include: respiratory tract infections including pneumonia, diarrhoeal diseases, malaria, measles and tuberculosis.

In Gode zone, only CCM (supported by Guardian/SERR) is providing longer-term support in the health sector, supporting one clinic and 7 health posts/ stations in the three southernmost woredas of Gode zone. In Fik and Korahe there is no long-term support yet, although OWS plans to rehabilitate the hospital in Korahe and construct health posts in 5 different locations in Fik. In Jijiga MSF B runs a tuberculosis programme, while a primary health care support programme in Deghabur is being phased out, because it was not sustainable.

Emergency response in the health sector so far has mainly consisted of medical interventions directed at beneficiaries of feeding programmes and the provision of drugs to governmental

⁹ Water and sanitation facilities were not formally assessed during the mission due to time constraints

¹⁰ Please also refer to section 2.3.

health facilities. UNICEF has been involved in the provision of essential drugs in the region. Lack of drugs is (was) only part of the problem however; the lack of a sufficient number of qualified staff is generally perceived as a far more important constraint. As a consequence the provision of drugs and other medical supplies has had little impact on the quality of health services provided by governmental facilities. In an effort to improve access and care at the woreda level, in July OXFAM UK initiated a programme to strengthen health facilities and services in Adadle woreda (Gode zone). In Imi, (Gode zone), MSF F opened in-patient and out-patient facilities in May. In addition, mobile clinics at two sites provide out-patient care for people in the rest of Imi east and Imi west (Afder zone). The major causes of morbidity among in-patients and out-patients are acute respiratory infections, diarrhoeal diseases and suspected malaria. Measles still accounts for more than 15% of the cases in the in-patient department. Indeed measles is likely to have been one of the major contributing factors to severe malnutrition and mortality in this emergency in Somali region.¹¹ Little is known about micro-nutrient deficiencies in the region and the contribution of vitamin A or C deficiency to mortality. Outbreaks of scurvy among refugees have been documented in the region previously.

Despite ample drug donations from at least four different agencies, the standard of health care provided in Gode Hospital has improved only marginally. In this hospital, WVI has constructed an additional ward and seconded a doctor to the paediatric ward. The paediatric section serves as a referral facility for children from feeding centres. Since May, when WVI assistance started, admissions have declined sharply from 10-12 per day to less than three, resulting in an average of about 30 in-patients at any given time. (Severe) diarrhoea (including dysentery), pneumonia and tuberculosis (TB) are the major causes of admission. Admission of TB patients is part of a four-partite agreement between MSF-B/UNICEF/WVI/SCF-US to treat and feed TB patients referred from feeding programmes in Gode hospital and provide follow-up.

Other emergency response interventions in the health sector include the training of health workers in the treatment of malnutrition (UNICEF) and disease surveillance (WHO). In February/March, MSF carried out a mass measles vaccination campaign in combination with the provision of vitamin A. Some 46,800 children aged 6 months to 15 years were immunised throughout Gode zone. Also, UNICEF provided a public health person and a water and sanitation expert to Gode to provide technical support. More recently, UNICEF posted an additional public health person to Jijiga. Future plans include a mass measles vaccination campaign and the provision of vitamin A to children less than five years of age to be carried out by MOH/UNICEF/WHO with NGO support¹² in the whole Somali region, starting in Gode, Koraha and Jijiga zones. The campaign, which has been postponed several weeks, will start in August.

¹¹ See preliminary findings SCF-US/UNICEF nutrition and mortality survey from Gode district.

¹² OXFAM in Adadle and ACF in Koraha have cancelled plans to carry out their own vaccination campaigns as a result of the planned UNICEF/WHO/MOH measles campaign.

3. Food Situation.

3.1 Food Security

Many assessments addressing differing facets of food security have been carried out since the first reports of the deteriorating situation in the Somali region. Because the Somali region is not covered by the NSP (refer to section 2.1), there is lack of base-line food security data that makes this information difficult to interpret¹³. In addition, key information such as the proportion of livestock loss are repeatedly gathered from the same secondary sources with little independent verification. In addition the Somali region has not been affected by the drought homogeneously and important regional, zonal and woreda level differences exist.

ICRC is one of the few agencies that have carried out a detailed food security assessment of (part of) the Somali region in order to prioritise geographical areas for intervention prior to the start of their operation. Assessment results, which have not been released in full, indicate that in early 2000 Denan, Gode, Imi and Adadle woredas in Gode zone were among the worst affected. The mostly sedentary population in the southern woredas of Kelafo, Mustahil and Ferfer, normally producing a grain surplus was not considered to be severely affected, although drought and flooding (in 1999) has had some negative impact on their livelihood. At present, harvest prospects for maize in these woredas as well as in Gode appear good. According to WFP, the main concern for farmers is their ability to market their harvest at a reasonable price if food distribution continues. Other areas identified by ICRC as severely affected were Garbo, Dichun, Hamero and Segeg weredas in Fik zone, Babile in East Hararghe (bordering Fik) and Afder in Afder zone. All twelve weredas were subsequently selected by ICRC for complimentary feeding consisting of 10 kg of cereals/blended food and 2 litres of oil per person for two months. ICRC is presently re-assessing food security for future programme planning.

On a more ad hoc basis, several NGOs have included aspects of food security in nutrition surveys. For example, CARE and HCS assessed livestock losses and survival prospects in recent surveys in Harshin and Shinile/Babile respectively. Such information while useful for programming purposes, cannot substitute for a comprehensive food security monitoring system in a region where geographic variability is so pronounced.

Information on market prices, commonly used as one indicator of the food situation¹⁴, has also not been collected systematically. Trends in food commodity prices since last year (as collected by WFP and other agencies) suggest that the food situation is improving somewhat with prices for livestock rapidly on the increase since April, 2000 and cereal prices declining. Clearly, however, the market price of cereals is also influenced by the levels of external food aid and the increase in livestock price may reflect the relative paucity of remaining livestock relative to demand¹⁵. Also, without more detailed information on the numbers and condition of livestock sold, the interpretation of changes in terms of trade remains difficult.

¹³ The Somali region has in fact been excluded from many surveys including for instance the national rural nutrition survey (1992) that related nutrition to a variety of variables including some food security variables.

¹⁴ This does not provide a measure of household food security since access by households is not considered.

¹⁵ Likewise, in places where oil is distributed the price of oil has declined shortly after distribution.

3.2 General Food Distribution

Although food distribution has gained momentum during the last two months, a variety of constraints continue to result in an uneven and sometimes insufficient distribution. Verification remains difficult in the absence of accurate statistics on populations (and movements) or on food allocations and distribution. A system of post distribution monitoring at the distribution point and/or household level has not been implemented. Finally, very few nutrition surveys carried out in the Somali region have collected information on household food consumption and/or accessibility.

Initially, the zonal DPPC used official population statistics to identify affected numbers and eligible beneficiaries. Although in theory certain groups did not qualify for food distribution, in practice food has been distributed to all people counted on the day before a distribution. With increasing population displacement, partly attributable to the late and geographically uneven food distribution, beneficiary numbers in places where food distributions occurred expanded considerably. In Gode woreda, for example, the number of beneficiaries during the period January-April increased from 75,000 to over 100,000; two thirds of these resided in Gode town. It is likely that many people were initially drawn to Gode because of the food distributions and then began to return home when food distributions commenced in their villages. Substantial numbers of people were also registered at head-counts in surrounding villages. In Gode town, however, DPPC and OWS figures based on head counts remained unchanged until July. In an effort to avoid double registration, a headcount was then carried out simultaneously in 7 kebeles and beneficiary figures for the town dropped from 67,720 to 36,560 people. The exercise was carried out through a concerted effort by WFP, DPPC/B, SCF/USA, police, army, women's associations and community representatives. Similar head-counts carried out in Denan and Adadle also resulted in substantially lower case-loads, although not as spectacularly so as in Gode town. Whether this reduction is really the result of population movement or whether figures have always been inflated due to double registration is uncertain. In view of other findings,¹⁶ the latter possibility seems the more likely.

New food allocations are based on head-counts from previous distributions. As populations are attracted to areas with a reliable GFR, the amount of food allocated does not always match the eligible number of beneficiaries present during the new round of distribution. In particular in areas where substantial numbers of newly displaced were included in the food distribution and the total amount of food had been allocated on the basis of an older and lower beneficiary figure, each beneficiary received less than the intended ration. Reports suggest that, for this reason and because groups of people are permanently on the move in search for food, new arrivals in some other areas have not been included in food distributions

¹⁶ As outlined before, MSF B measles immunisation figures in Denan revealed a coverage of 46% when official under 5 figures were used. The actual coverage found in a representative survey, however, was 71%. Also, WVI blanket feeding of under fives in rural Gode woreda should according to DPPC figures cover some 22,000 children. In the period May-July, the agency has, however, only been able to register some 6,000 children less than five years of age. This figure includes (some) children from neighbouring woredas and double registrations. Because all children less than five are targeted and because the distribution consists of 10 kg of Famix distributed once a month, it is unlikely that many households would miss the opportunity to benefit from such a feeding programme.

at all. Furthermore if they do not receive the GFR, newly displaced are then not counted and beneficiary figures for future allocations are not adjusted. This results in ongoing under-allocation to the area. The resident population might then share its food with the displaced group, resulting in a lower overall general ration per person or not share, heightening the vulnerability of the both the resident population and the internally displaced.

Reliable figures on the amount of food distributed are difficult to obtain. Firstly due to a complicated and fragmented information system with most data only available at the central levels of DPPC and WFP, allocation, dispatch and distribution figures can only be compared months after actual distribution takes place. In the absence of a comprehensive tracking system, even when dispatch figures provided by the regional DPPC do not match food actually received at the community level, it is often impossible to discover the reasons for the discrepancy. Secondly, WFP on site monitoring during head-counts and distributions is extremely limited due to security restrictions and insufficient (air) transport. Furthermore WFP implementing partners such as OWS charged with monitoring distributions do not appear to have sufficient logistic or human resource capacity to effectively monitor every distribution. Misuse, diversion and simple disappearance of food can thus not be immediately tracked or acted upon. WFP and/or implementing partners have reported examples of all such incidents on an ad hoc basis, sometimes discovered only by sheer luck. Lastly, despite attempts to improve information sharing and co-ordination, neither DPPC/B nor WFP has so far managed to incorporate in its distribution figures food distributed by other organisations. This not only refers to food provided by NGOs in supplementary feeding programmes, but also to major quantities distributed complementary to DPPC/WFP distribution such as by ICRC. Nor are one-off contributions distributed through DPPC/B such as from SCF-UK included in distribution figures. The latter food has been distributed in Fik, Gode and Degahbur zones in June and July.

While Gode attracted a great deal of attention and beneficiary figures were probably inflated, northern zones such as Shinile were relatively under-served. In December 1999, Shinile zone was designated as low priority for food aid and 3000 metric tonnes of grain designated for the area was diverted to Gode. With the failure of the belg rains, however, and infectious disease outbreaks in livestock, the food security and nutritional situation has steadily deteriorated. The first food aid only began reaching the area in late May/early June and arrived too late to prevent significant levels of moderate and severe wasting in children under five and signs of malnutrition in other age groups. In addition, a recent assessment by OFDA/CDC has reported consumption of unusual famine foods in the area, ongoing livestock losses and recent population displacement along main roads.

On the basis of figures available from DPPC and WFP it would appear that food, which has been officially allocated, is not being delivered in full, and is not distributed in time. An important reason for this is that food arrivals are delayed, mainly due to constraints within DPPC/B. These include lack of efficiency at regional and zonal level, among others because of insufficient logistics characterised by limited transport capacity, and contracts with inefficient transport companies; lack of petty cash to pay for on- and off-loading, fuel and other items and a poorly developed communication system¹⁷. Limited logistics compounded

¹⁷ More recently, the coming elections seem to have drawn attention away from the co-ordination of relief activities.

by heavy rain in late April and early May, caused major delays in deliveries during these months. As of the end of May, deliveries and distribution, according to figures from WFP and others, in many areas substantially increased from less than 5 kg to up to 25 kg per person in a limited number of areas. In particular in areas where ICRC and SCF/UK food (the latter through DPPC) has been distributed, the average amount of food per beneficiary was well over 10 kg from late May onwards. In addition, in Gode zone but less so in other zones, most families with children under five should have been entitled to an 3 to 10 kg supplementary food per month. Please refer to annex III for further details.

Where ICRC was carrying out complementary distribution, the ration resembled the DPPC recommended full ration consisting of 12,5 kg cereals, 0,5 kg of oil and 1,5 kg of pulses/CSB. Such rations distributed in June and July in Gode zone provided on average some 1,800 kcal, 35 gram of protein and substantial amounts of micro-nutrients (especially if CSB was distributed). In Fik zone, where average amounts were higher, this ration in June and July provided over 2,200 kcal and 45 gram of protein per day. In parts of these zones where there was no ICRC distribution as well as in Korahe and Shinelle zones, rations provided between 1,450 to 2,000 kcal and between 40 and 60 gram of protein, depending on amounts of cereals distributed. Nutrition value of the latter ration was adequate for adults, but less suitable for young children and/or malnourished because of its very low fat content and lack of important micro-nutrients such as vitamin A, C and calcium.

Because distribution figures are not verified through post-distribution monitoring or random household surveys and population figures are not always reliable, distribution figures are average amounts, masking possible disparities among households. Also, the overall distribution figures do not allow the verification of inclusion of vulnerable groups. In view of the unreliable beneficiary figures on the one hand and the system of basing food allocations on head-counts from previous distributions on the other hand, it is likely that some families received considerably more, some less and yet others no food at all. In addition there are numerous reports that relief food is bartered or sold in order to cater for other –mainly non-food needs¹⁸, suggesting that in particular poorer and/or worst-affected families consume only part of the food they receive, further diluting the impact of food aid.

¹⁸ Except for tea and sugar.

4. Summary Problem Analysis

The overall problems with the humanitarian response in Somali region relate to the lack of a comprehensive surveillance system, the lack of a suitable coordination mechanism and therefore the lack of an integrated response. The DPPC/B whose mandate is to co-ordinate the response lacks sufficient technical capacity in nutrition and food security monitoring at all levels, the human resources necessary and logistic capacity to fulfill this role. The UN agencies have their regular programmes and have provided some strategic co-ordination in support of the DPPC. As yet these mechanisms have not been effective in standardising nutrition surveys or selective feeding programmes or in effectively identifying areas requiring immediate response and ensuring a timely intervention. This has resulted in assessments and surveys of a relatively ad hoc nature that regularly do not produce useful information or meet minimum standards. Of concern is that surveys using non-representative sampling methods that may result in significant bias are being used as the basis for advocacy. This may result in a misuse of limited resources.

While some therapeutic and supplementary feeding programmes are of excellent quality, many also do not meet minimum standards. This may result in a misuse of limited resources. Lack of 24-hour care, high default rates, relatively poor education of mothers and the exclusion of malnourished older children, adolescents and adults are of particular concern. These problems were seen mainly in centres run by NGOs without significant experience in selective feeding. The fact that the quality of these programmes remains poor reflects the overall lack of nutrition co-ordination and monitoring. For a variety of reasons including high default rates and a long recovery period, beneficiary figures from therapeutic feeding centres are not suitable for monitoring trends in severe malnutrition. Figures from supplementary feeding are of even less use in reflecting moderate malnutrition because agencies use different admission criteria, target different groups (and/or change target groups), while beneficiaries may be double registered within one programme or registered in two different programmes.

The lack of a comprehensive nutrition surveillance system has resulted in a failure in targeting of food aid to the most vulnerable geographic areas and adjusting priorities according to needs. It has allowed some areas such as Gode to attract a relative surplus of food items, selective feeding programs and support in the health sector, while others areas such as Shinile and Jijiga zones remain with grossly inadequate assistance in these sectors and an ongoing nutritional emergency. Even within Gode district, it has allowed some communities in the district to receive relatively little food while resident populations in urban areas are likely to have received a surplus.

Finally, a major problem in assessing the food situation is the absence of accurate statistics on populations (including displaced) and food distributions. DPPC/B and WFP co-ordination and information sharing in the food sector has so far not succeeded in providing precise figures on quantities of food distributed, let alone whether all eligible beneficiaries were included and how much food people actually received. Official figures suggest that from (the end of) May onwards, most zones have received sufficient food to rapidly reverse famine conditions. Further analysis of the reason why the overall situation seems to have only

marginally and/or slowly improved,¹⁹ is needed before any decision is taken to continue and/or increase humanitarian food assistance.

5. Recommendations

Short term: Specific

- Conduct a formal nutrition survey in Shinile zone
- Conduct a rapid assessment in other areas of Jijiga zone
- Identify NGO or NGOs able to respond with complimentary or blanket dry supplementary feeding and selective feeding if indicated in Shinile zone
- Conduct emergency measles immunization/vitamin A administration campaign in the whole region including displaced camps in Shinile zone

Short to medium term: General

- Ensure the provision of adequate general ration at the community level in emergency-affected areas through advocacy and support of DPPC/DPPB
- Strengthen the role of the DPPC/UNICEF nutrition task force in coordination by encouraging the regular participation of major NGOs, donors, the DPPC as well as UN agencies and ensure technical expertise
- Through the nutrition task force strengthen response by the:
 1. Compilation into a data-base of information on surveys and interventions
 2. dissemination of guidelines on best practices and minimum standards
 3. provision of technical assistance upon request
- Strengthen the DPPC/B in data collection and monitoring through immediate and substantial logistical support from WFP and technical support from UNICEF/WHO in the priority regions
- Strengthen the nutrition surveillance system in the short term by requesting implementing partners to do 3 monthly nutrition surveys following standard methods that include the analysis of underlying factors such as morbidity, care and food security.

Short to medium term: Health and Selective Feeding

- Encourage the reporting by implementing partners of standardised summary indicators so that programmes can be monitored and technical support given when needed
- Boost and accelerate the regional health bureau/UNICEF/WHO measles immunisation campaign, ensuring cold chain monitoring and support where necessary
- Boost regular EPI, vitamin A and ferrous/folic acid supplementation with WHO/UNICEF technical support
- Strengthen communicable disease surveillance by WHO

¹⁹ See results from July -August SCF-US / UNICEF survey in Gode district.

Short to medium term: Food (DPPC/WFP)

- Develop efficient and effective mechanisms to monitor population movements and adjust beneficiary case-loads and general food rations according to needs
- Improve the logistic capacity of DPPB at regional/zonal level to distribute the general ration more quickly
- Strengthen food tracking and food distribution monitoring at all levels
- Initiate comprehensive food basket monitoring system at site of distribution as well as at the household level
- Target the internally displaced by allocating and distributing food at their new location or if possible at their area of origin
- Improve the flow of information by ensuring standardised, regular and timely reports integrating information from all relevant actors (DPPC, UN in particular WFP, NGOs) at central, regional/zonal and woreda level

Long term:

- Strengthen the nutrition surveillance system of the early warning department of the DPPC and morbidity surveillance at the Ministry of Health by training and mobilising staff at central and regional levels and integrate these two surveillance systems
- Improve the monitoring role of DPPC in selective feeding interventions. This will require the support of the ministry of health at central, regional and zonal level and significant training at these levels by WHO/EHNRI
- Extend EWS to cover the entire country
- Use the information gathered through this system to target geographical areas and (if necessary/feasible) vulnerable groups within these areas for assistance in the food and health sectors. The latter may include age groups other than children less than 5 years such as elderly persons living alone.
- Through the strengthened surveillance mechanisms improve:
 1. targeting of food aid by identifying areas requiring immediate response, identifying an implementing partner and if possible a funding mechanism
 2. targeting of assistance in the health and water and sanitation sectors if problems in these sectors have been identified as (important) underlying causes of malnutrition such as measles and diarrhoeal disease.

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Annex I

Summary of Nutrition Surveys in the Ogaden

Organisation	Date of survey	Location	Sample size	Methodology	Indicator to define malnutrition ²⁰	Malnutrition prevalence
<i>Gode zone</i>						
SCF-US	Dec 1999	Gode town, Gode wereda Adadle wereda	508	Rapid assessment	W/H Z score <-2	>50%
MSF-B	Feb 2000	Gode Town (IDPs)	100	Screening	MUAC<125mm	38%
		Gode Zone (IDPs + others)	91	Screening	MUAC <110mm MUAC<125mm MUAC <110mm	13% 43% 16%
MSF-B	March 2000	Gode Zone	27,830	Screening	MUAC<125mm MUAC <110mm	32.4% 13%
MSF-B	May 2000	Denan (town + IDPs)	765	30 cluster	W/H Z score/oed <-2 W/H Z score/oed <-3	52.9 11.9
World Vision	May 2000	Gode wereda	3,863	Screening	WFH <80% WFH <70%	39.4% 5.6%
SCFUSA/ UNICEF	July 2000	Gode wereda	855	30 cluster	W/H Z score/oed <-2 W/H Z score/oed <-3	28.9% 5.3%
<i>Kebredehar zone</i>						
ACF-F	April 2000	Shilabo wereda	229	Screening	MUAC <120m	5.1%
		Kebre Dahar (town)	126		MUAC <110m	0.8%
		Kebre Dahar (IDPs)	63		MUAC <120m	2.4%
		Kebre Dahar (villages)	295		MUAC <110m	0%
		Dobowein wereda	111		MUAC <120m	15.8%
						MUAC <110m
ACF-F	June -July 2000	Kebre Dahar wereda	37	Screening	MUAC < 125mm	8.0%
		Kebre Dahar wereda	128		MUAC <110mm MUAC < 125mm MUAC <110mm	0 32.8% 0.5%
<i>Jijiga zone</i>						
Care	May 2000	Harshin (resident)	200	Convenience sample	WFH <-2 Z score	32.0%
		Harsin (displaced)	50		WFH <-3 Z score WFH <-2 Z score WFH <-3 Z score	5.5% 50.0% 22.0%
<i>Shinelle zone</i>						
OXFAM UK	July 2000	Idora (resident)	78	screening	MUAC<125mm	74%
		Idora	96		MUAC <110mm MUAC<125mm	30% 84%

²⁰ Mean weight for length (WFL) expressed in % of mean of reference population (=100%);
Global malnutrition expressed in % weight for height (W/H) with a Z score < -2 + oedema
Severe malnutrition expressed in % weight for height (W/H) with a Z score < -3 + oedema
Global malnutrition expressed in % weight for height (W/H) < 80% of the median + oedema
Severe malnutrition expressed in % weight for height (W/H) < 70% of the median + oedema
Global malnutrition expressed Mid Upper Arm Circumference (MUAC) < 125 mm + oedema
Severe malnutrition expressed Mid Upper Arm Circumference (MUAC) < 110 mm + oedema
Body Mass Index (BMI) as expressed in weight /height x height

		(displaced)			MUAC <110mm	29%
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Annex II

Selective Feeding Programmes (July 2000)

Zone	Wereda	Location	agency	Target population	beneficiaries
<i>Therapeutic feeding</i>					
Gode	Danan	Danan (2x)	MSF B	Majority < 5 y	425
	Gode	Gode town	OWS/ SCF USA	< 5y	500
		Hadawe	OWDA	< 5 y, but also others	350
	Kelafo	Kelafo	CCM*	< 5y	30
	Mustahil	Mustahil	CCM	Plans to open in August	
	Imi E.	Imi E	MSF F	60% < 5y; 40% > 5 y	250
	Adadle	Boholhagare	OXFAM UK	< 5 y	230
Korahe	Kebredehar	Kebredehar	ACF	80% < 5y; 20% > 5 y	120
Fik	Fik	Fik	SCF-UK	< 5 y and PNW	150 + 0
	Hamero	Hamero**	SCF-UK	< 5 y	100
Shinelle	CRS/MoC??				
Jijiga	Jijija (?)	Fafan	MCDO		45
<i>Supplementary feeding</i>					
Gode	Danan	Danan	MSF B	< 5 y + PNW + elderly	2800 + 700
	Gode	Gode town	OWS/ SCF USA	< 5 y + care -takers	1000 + 2000
	Gode	Gode rural	WVI	Blanket < 5 y PNW + destitute	6000 8000 (?)
	Kelafo	Kelafo	CCM	< 5 y + care -takers	80 + 120
	Imi E.	Imi E Gudis	MSF F	< 5 y	200 150
	Adadle	Boholhagare Busaredo Derihay	OXFAM UK	< 5 y PNW + elderly	± 1400 ± 300
Korahe	Kebredehar	Kebredehar Dalaad Waji-waji Geladid	ACF	< 5 y + > 5 y	460 100 100 275
	Doboweyn	Doboweyn	ACF	< 5 y + > 5 y	375
	Shilabo	Dawacaale	ACF	< 5 y + > 5 y	300
Fik	Fik	Fik	SCF-UK	Blanket < 5 y + PNW	± 11,000
	Segeg	Segeg	SCF-UK	Blanket < 5 y + PNW	
	Dichun	Dichun	SCF-UK	Blanket < 5 y + PNW	
	Hamero	Hamero	SCF-UK	Blanket < 5 y + PNW	
Shinelle	ACO????				
Jijiga	Jijija (?)	Fafan	MCDO	< 5 y + PNW	230 + 150

* CCM/Guardian/SERR

** special supplementary feeding; extra supplementary ration and health care for severely malnourished

ANNEX III

Food Distribution

location	April-May		June		July	
	beneficiaries	quantity (kg)	beneficiaries	quantity (kg)	beneficiaries	quantity (kg)
Gode zone						
Gode town	67,620	12.3	67,620	11.3	36,560	12.5
Gode rural	15,300	14.8	15,300	8.2		
Denan	42,000	18.0	48,700	17.0	37,800	26.0*
Adadle	21,950	16.2	34,950	8.5	29,424	25.6*
E.Imi	23,430	26.4	35,895	17.3	35,895	25.7*
Kelafo	39,770	10.0	51,060	13.9*	128,579	4.5 (11.7**)
Mustahil	36,280	10.6	41,325	12.7*	41,325	11.0
Ferfer	25,800	10.0	29,540	11.3*	29,540	10.1
total	272,150	14.1	324,390	13.0	339,123***	13.1 (17**)
Korahe zone						
Kebridehar	50,000	7.7 kg (13 kg)**	44,450	12.5	44,450	12.5
Doboweyn	24,000		11,404	12.6	11,404	12.5
Shegosh	13,000		10,630	11.0	10,630	12.5
Shilabo	20,000		18,254	12.5	18,254	12.5
total	107,000		84,738	12.3	84,738	12.5
Fik zone						
Fik	54,230		122,178	16.2	122,178	17.5
Dihun	9,500					
Hamero	33,640					
Gerbo	16,890					
Segeg	16,000					
Selehat	9,400					
total	139,660					
Shinelle zone						
Afdem	4,300		142,949	13.5		
Aisha	11,340					
Denbel	18,720					
Erer	17,090					
Mieso	13,200					
Shinile	19,690					
total	84,340					

Bold preliminary figures based on dispatch and planning figures

* Including SCF-UK distribution

** based on the more realistic June population figure of 51 060 for Kelafo and of 85,000 for Korahe.

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22 August, 2000

