

Report on the Food and Nutrition Situation

in

Wolayita, North Omo, SNNPS

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<i>Index</i>		<i>page</i>
<i>1</i>	<i>Background</i>	<i>2</i>
<i>2</i>	<i>Nutrition situation</i>	<i>3</i>
<i>2.1</i>	<i>Nutrition Surveillance</i>	<i>3</i>
<i>2.2</i>	<i>Selective Feeding Programmes</i>	<i>5</i>
<i>2.3</i>	<i>Health</i>	<i>6</i>
<i>3</i>	<i>Food Situation</i>	<i>8</i>
<i>3.1</i>	<i>Food security</i>	<i>8</i>
<i>3.2</i>	<i>General Food Distribution</i>	<i>9</i>
<i>4</i>	<i>Conclusions</i>	<i>12</i>
<i>5</i>	<i>Recommendations</i>	<i>13</i>
<i>Annex 1:</i>	<i>Summary of nutrition surveys</i>	
<i>Annex 2:</i>	<i>Selective Feeding Programmes</i>	
	<i>References</i>	

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1. Background

The objective of this report is to provide an overview of the food and nutrition situation in Wolayita, the humanitarian response in the area thus far, to outline the existing problems and to provide recommendations for action. The methodology for this assessment consisted of a study of various survey and assessment reports of non-governmental organisations (NGOs), the Disaster Preparedness and Prevention Commission (DPPC) and United Nations (UN) agencies. This was followed by field visits to all woredas (except Kindo Koysha) which make up the former Wolayita area of North Omo, as well as neighbouring Kucha woreda. Information was gathered from local officials from DPPC, the zonal health department (ZHD), as well as NGOs.

Food security is fragile in Wolayita due to a high population density with a higher than average family size, small land holdings per household, and heavy reliance on rain. Therefore, any decline in access to normal food sources is likely to result in a decline in nutritional status. Paradoxically, even in years with exceptionally good harvests, there were pockets of serious malnutrition where households relied on the sale of their crops, but were unable to obtain a reasonable price.

In August 1999, the nutritional surveillance programme (see section 2.1) reported that cereal prices had gone up to a level similar to 1994, a year of severe food shortage due to the absence of root crop production and late belg rains. Reportedly some food distribution was carried out, but this was insufficient to lower market prices for cereals. Moreover, very few households benefited from this food distribution.

By early 2000, it was evident that two consecutive years of late belg rains, poor belg and meher crop performance and failure of intermediate (sapia) rains had exhausted many households' main coping strategies, including the consumption of ensete (false banana). Because root crop production was extremely low in 1998, people consumed most of their ensete the year before. This year, when sapia rains failed for the second consecutive time, households' access to ensete, which needs seven years to mature, was insufficient to cover the gap in food availability. Low root crop availability in combination with late belg rains, deteriorating livestock conditions due to lack of pasture and drinking water in the highlands and disease in the lowlands, as well as the stress sale of livestock, resulted in a quick decline in food security. The situation was exacerbated, because very little food was distributed during the first four months of the year 2000, due to countrywide low availability and prioritisation of other areas.

Nutrition surveys carried out by NGOs in the first half of 2000 indicated that malnutrition rates were alarmingly high in some parts of Wolayita. Insufficient DPPC capacity to meet food needs led some organisations to establish general food distribution for the most vulnerable population. In addition, selective feeding programmes targeting the moderately and severely malnourished have been established. Results from follow-up surveys show that nutritional status has improved in most woredas since the end of June, through a combination of food distribution, feeding programmes and harvesting of belg potatoes, haricot beans and cabbage in some areas.

2. Nutrition Situation

2.1 Nutrition Surveillance

The nutrition and food security situation in Wolayita is monitored through the Nutrition Surveillance Programme (NSP)² implemented by SCF-UK. As reported elsewhere, the anthropometric indicator that is 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. Wolayita has been included in the NSP since 1988. Figures collected during the period 1993-2000 show that overall nutritional status as measured by MWL has been satisfactory; that is between 90.0 and 94.9%. MWL tends to stay around 94% throughout the period July-January and to decline to 92% in March/April, the middle of the hunger season. This decline tends to be less in years of good root crop production. Only twice since 1993 has MWL been below the cut-off level of 90%: in April 1994 and April 1995. 1994-1995 was the last period of serious food insecurity following the failure of sapia rains. This year, in March/April, the mean WFL was reportedly 91.1%. In February, when the mean WFL was 94.1%, the nutritional status was reportedly satisfactorily, although a decline was predicted.

Because the NSP relates trends in WFL, broken down by area (lowlands and highlands, eastern and western respectively) and, sometimes, woreda, to other indicators, the system fairly accurately predicts which areas warrant extra close monitoring and/or should be prioritised for relief food assistance.

In response to requests from DPPC and NSP findings in February 2000, advocating close monitoring and the provision of assistance, a number of (I)NGOs carried out nutritional assessments. Sampling methods for nutritional surveys as elsewhere have varied, but the majority of surveys have been formal 30 cluster surveys employing the standard EPI methodology. Rapid assessments usually reporting MUAC, resulting 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 employed also. In general however, such screenings have been followed by a representative nutrition survey covering an entire woreda. In accordance with good practice, nearly all nutrition surveys, including most rapid assessments, also covered underlying causes of malnutrition, in particular food insecurity and morbidity.

Concern, following a rapid screening of children gathered for supplementary feeding at the health clinic in Bedessa, Damot Weyde Woreda, in March 2000, carried out a thirty randomly selected cluster survey during April. Reported global malnutrition in Damot Weyde was 25.6% of which 4.3% severe. Nutritional status of mothers was poor as well³. Concern conducted a follow-up survey in July 2000, after a three

² The NSP is a longitudinal monitoring system that utilises a standard set of food security, agricultural and anthropometric indicators to track changes over time.

³ Nearly 25% of the mothers had a MUAC of less than 220 mm and 46% less than 230 mm; because there are no recognised MUAC cut-off levels for adults to define moderate and severe malnutrition, Concern has interpreted results wisely as reflecting a poor nutritional status, rather than rates of malnutrition.

month intervention consisting of general food distribution in combination with selective feeding of malnourished (refer to sections 2.2 and 3.2 for details). Global malnutrition of under fives was found to have declined to 6.4% (of which 1.0% severe). Global malnutrition among adults however, was 11.5% among the 18-49 years age group and 24% among those over the age of 49⁴.

Also Oxfam UK, in April 2000, carried out a rapid assessment in Humbo, Boloso Sore and Damot Weyde woredas. Survey findings indicated a situation of acute food scarcity that would lead to famine if adequate food was not available within weeks in all three woredas. In view of NGO coverage of Humbo and Damot Weyde, the team recommended that Oxfam should focus on Boloso Sore. Subsequently, Oxfam carried out a formal 30-cluster survey in Boloso Sore in June. The survey found an overall prevalence of 45.1% global malnutrition of which 20.4% severe. About a quarter of the severely malnourished children suffered from kwashiorkor. Mean WFL was reportedly 84%. These findings, according to Oxfam, could perhaps be attributed to the timing of the survey, the peak of this years' hungry season⁵. NSP figures on the nutritional status from the period June/July confirmed that the nutritional status was deteriorating, but mean WFL was still found to be above 90%, significantly higher than 84%. Whatever the situation was in June/July, in August the situation according to various sources had improved. A survey carried out by MSF-CH in August 2000 is expected to provide an up-dated picture of the nutrition situation in Boloso Sore.

World Vision International (WVI), as part of its food security monitoring in areas of operation, conducts nutrition surveys twice a year. The methodology used by WVI is a combination of cluster and systematic random sampling among Peasants' Associations (PAs), with inconsistent application of the principle of sampling proportional to size. Although this makes comparison to regular 30 cluster surveys somewhat difficult, it does not hamper interpretation of results from WVI surveys over time. In Humbo woreda, results of WVI monitoring in November 1999, February and May 2000, revealed global malnutrition rates of 8.2%, 9.2% and 8.2% respectively. Severe malnutrition in May 2000 was 1.3%. In Sodo Zuria, monitored during the same months, global malnutrition rates were 6.7%, 16.7% and 16.4% respectively. Severe malnutrition in May 2000 was 2.5%.

In addition to these representative surveys, rapid nutrition assessments based on MUAC were carried out in Damot Gale and Offa woredas in June 2000. MSF-CH findings in three of the eight affected kebeles in Damot Gale, showed a prevalence of 35% global malnutrition (of which 7% severe) among children under five asked to come to certain gathering points. In contrast, MSF F rapid MUAC screening of all children in the five worst affected woredas in Offa revealed a prevalence of 16.2% global malnutrition of which 2.1% severe. Please refer to Annex I for an overview of nutrition assessments carried out in Wolayita.

⁴ Body Mass Index (BMI) cut-off levels were used to determine adult malnutrition. Again, in the absence of good quality data on adult malnutrition, Concern refrained from drawing firm conclusions from these data.

⁵ Another possible explanation is that severely malnourished were measured more than once.

2.2 Selective Feeding Programmes

Several international NGOs commenced selective feeding programmes throughout Wolayita in response to the high prevalence of malnutrition, complimenting supplementary feeding provided by (some) health clinics as part of ongoing mother and child health care. Contrary to the Somali region, programmes have started very gradually. WVI supplementary feeding in Humbo woreda started as early as June 1999 and was phased out a year later, in June 2000⁶. In May 2000 Concern followed with therapeutic and supplementary feeding in Damot Weyde woreda; and in July MSF-CH initiated similar activities in Damot Gale. Other NGOs are still in the planning phase. In general, there is only one (I)NGO per woreda involved in selective feeding. On the rare occasion there is more than one NGO, agencies co-ordinate before starting their intervention. To this end, co-ordination meetings are held regularly in Addis Ababa and Sodo. Please refer to annex II for an overview of selective feeding programmes presently implemented and planned for in the near future.

Usually the same NGO that provides supplementary feeding also operates one or more therapeutic feeding centres. WVI has opted to support Sodo hospital including the nutrition rehabilitation unit instead, because of the high needs of the hospital on the one hand and it's location in WVI area of operation on the other hand.

Despite the absence of current guidelines from DPPC or the MOH for therapeutic feeding⁷, agencies are using internationally accepted criteria for admission and discharge; provide recommended medication and adhere to feeding protocols and other standards of good practice. These include:

- measles vaccination, micro-nutrient supplementation, treatment of intestinal parasitosis, and systematic treatment of infections with oral antibiotics
- provision of 24 hour care, an adequate water supply and sufficient space to avoid overcrowding
- the provision of eight meals of appropriate composition during the first phase of admission and six meals thereafter
- sufficient attention for nutrition and health education strategies
- proper record keeping including performance evaluation records (recovery period, default and mortality rates).

As a result, mortality and defaulting rates are low and the recovery period short, at least in the feeding centres long enough in existence to evaluate their performance in these respects.

A weaker point is, that malnourished adolescents and adults are usually excluded. Also, the absence of routine micro-nutrient supplementation of lactating caretakers, and of the provision of high energy milk to malnourished mothers is a lost opportunity.

⁶ Because WVI also supports mother and child health through the global CIDA funded MICAH (Micro-nutrient and health) project, supplementary feeding is not drought induced but has rather gained momentum as a result of the drought.

⁷ Government policy has not favoured the establishing of feeding centres. This partly explains the lack of guidelines. In Wolayita, NGOs have not faced delays in acquiring permission to open centres as a result of Government policy.

Supplementary feeding, consisting of the provision of varying amounts of blended food⁸, is either provided by mobile clinics that visit a number of sites throughout the woreda or at a limited number of health clinics. The former has the advantage of potentially better coverage and quicker referral of children who drop below the cut-off level for severe wasting.

The majority of agencies target malnourished children under five by using the standard criteria of less than 80% W/H, although non-standard criteria such as H/A were also observed. In addition, all agencies target (or plan to target) pregnant and lactating mothers, sometimes only vulnerable mothers. Discharge criteria, although generally in accordance with standard practice ($\geq 85\%$ W/H for two consecutive weights) result in slow discharge, when distribution (and thus weighing) is less frequent than once a week. Because of the relative short existence of most programmes and planned new programmes, overall attendance might be expected to continue to increase in the coming months.

2.3 Health

Evidence from recent nutrition and health surveys suggests that high morbidity, due to in particular malaria and to a lesser extent to parasitosis and diarrhoeal diseases, has negatively impacted on the overall nutrition situation⁹. Concern reported that three out of four children had been ill during the week preceding their first nutritional survey. More than half of these had suffered from fever (possibly malaria which is endemic in the area), a third from diarrhoea and the remainder from acute respiratory infections (ARI)¹⁰. Similarly, results from an Oxfam health survey¹¹ indicate that more than two out of three children regularly suffer from malaria, more than half from parasitosis and one out of every three from diarrhoea and/or skin diseases. More than 90% of the children were either regularly or sometimes ill with malaria, diarrhoeal diseases, parasitosis and/or ARI. These findings are in line with health statistics from governmental and non-governmental health facilities. Likely determinants identified for this high morbidity were overcrowding (99% of the houses had only one sleeping room), a poor water supply, poor sanitation and hygiene practices, the proximity of animals to the living spaces of families and poor mosquito control activities. Although many of these are long term poverty related structural problems exacerbated by the current crisis, Oxfam is considering to address some health problems by:

- hygiene promotion and extension of spring water supply system
- assisting malaria control by supporting the existing government health system in early case-finding and prompt treatment, the provision of insecticide treated bed nets and pro-active residual spraying with insecticides and
- The provision of logistic support to existing out-reach MCH programmes, including EPI and supervision of community health workers and traditional birth attendants.

⁸ Such as Famix, Faffa and Unimix

⁹ And, vice versa, morbidity has increased because of high levels of malnutrition.

¹⁰ Another health problem reported by Concern is filiarosis, which in adolescents and adults might be confused with kwashiorkor, particularly at the early stages).

¹¹ Oxfam conducted a health assessment in Boloso Sore in June 2000, among a sample of (the parents of) 1079 children aged 6 months to five years, selected by two stage random clustering.

Measles outbreaks have been reported from Humbo and Gofa Zuria this year. The Zonal Health Department (ZHD) carried out a mass measles vaccination campaign in December 1999 in North Omo, but the coverage as reported by the ZHD is less than 50%. Evidence from several nutrition surveys indicates that average coverage might be much lower, because many remote regions were not covered at all. Concern, for instance, found that measles vaccination coverage was only 5.7 % in Damot Weyde in July 2000. More outbreaks are expected during the period September-December 2000.

There is no comprehensive mortality surveillance in place in the region. However, several agencies have included questions on mortality in their nutrition surveys. For example, in Damot Weyde, Concern's July follow up survey reported a crude mortality rate of 0.6/10,000/day and an under 5 mortality rate of 1.1/10,000/day for the period January through May 2000. MSF-CH reported from the three most affected kebelles in Damot Gale crude mortality rates of 1/10,000/day, 1.5/10,000/day and 3.3/10,000/day over a 6-week period in May-June 2000. Under five mortality rates were 0.7/10,000/day, 4.4/10,000/day and 10.2/10,000/day. Most deaths were reportedly due to malnutrition, but a substantial minority was due to malaria or diarrhoeal diseases. Mortality rates show considerable variation, suggesting in some cases a normal situation (that is an under five mortality of less than 2/10,000/day), in others an emergency situation. It seems unlikely, given the high prevalence of malnutrition in combination with serious morbidity, that the former figures are reliable. In the absence of means to cross-check retrospective mortality figures, for example with clinical records, all mortality figures -also high ones- should be treated with caution.

Addressing any health problem is aggravated by the fact that health service coverage is poor. The theoretical health service coverage is less than 50%, but actual coverage is lower because some health facilities are not functioning. Moreover, staff is insufficient and insufficiently trained, particularly in health posts. Governmental health facilities are also under-resourced in terms of transport for out-reach activities and medicines, in particular for the treatment of malaria. The fact that anti-malarial drugs are available at the Regional Health Bureau¹² seems to indicate there might be a problem with the delivery of drugs.

Attendance at governmental health facilities is low, reportedly as a result of the fact that patients have to pay for treatment unless they have written evidence of an inability to pay. Lack of cash due to the drought has apparently further decreased attendance. By contrast, attendance at non-governmental clinics appears higher and increasing, because treatment and medicines are free and more readily available.

Humanitarian response in the health sector, thus far, has been marginal. No direct support is being provided to the health system yet, although several agencies have indicated their intentions in this respect.

¹² However, stocks are only sufficient to cover the immediate needs.

3. Food and Food Security

3.1 Food Security

Belg crops in the high- and middle lands account for approximately 70% of annual production. The main crops normally produced are cereals, mainly maize, inter-cropped with haricot beans and, to a much lesser extent, sorghum, barley and teff. In the highlands, Belg rains normally start in January/February after which farmers plant maize to harvest green in June/July. Thereafter the land is used to plant again profiting from the kremt rains, that will allow (meher) harvesting of teff, pulses, wheat and barley in October/November. In lowland areas, the Belg rains usual arrive by the end of March/ April. The timing is less crucial because the rains are used to start long maturing, but higher yielding varieties of maize to be harvested around October. Short intermediate rains (locally known as sapia rains) in the period October-December are important for clearing the land and the production of root crops, in particular sweet and Irish potato, and cassava. These root crops play an important role in filling the gap in household cereal production during the lean season. Ensete or false banana, available throughout the year, is consumed during the lean season and to compliment low harvests from the belg and kremt rains.

Multi-agency pre- and post-harvest assessments, conducted several times a year under the aegis of DPPC, estimate on the basis of harvest prospects, whether food assistance is needed and if yes, approximately how many people need such assistance and for how long. Although findings from these assessments and the NSP feed into each other, there appears no overall system to comprehensively link the two.

The 1999 multi-agency post-meher harvest assessment findings indicated that an estimated 433,400 people in North Omo, of whom some 247,000 in Wolayita would be in need of food aid from January 2000 onwards. Both the NSP and this assessment singled out Humbo as the worst affected woreda, needing immediate attention. In response, WVI initiated general food distribution in this woreda (refer to section 3.2 for details). Following the pre-belg harvest assessment in June 2000, figures were revised upwards to 718,500 for North Omo of whom 425,770 in Wolayita. These figures were based on the following assessment findings:

- belg harvest yields of approximately 50%, due to the combined affects of late and partly insufficient rain, lack of manpower at the peak of the planting period as a result of malaria and shortage of ploughing oxen and seeds
- poor terms of trade with high cereal and low livestock prices
- households' reliance on purchase and relief food rather than own production
- insufficient relief food and
- a significant decline in sources of income such as wage labour, sale of firewood and charcoal, and petty trade due to large numbers of people in need of raising cash.

In addition to information from these pre- and post-harvest assessments and the NSP regarding overall food security, results from nutrition surveys have provided additional useful information on food security at household level. WVI in November 1999 reported substantial stress sale of animals in order to purchase food, despite the fact that there were no unusual animal diseases, in Humbo and Sodo Zuria. Primary

sources of food at the time were purchase from the market, own production, food aid and sharing of food as compared to crop production, milk and milk products and purchase from the market in normal years. Average daily wage rate for unskilled labour had decreased to 2.5 Birr/day. In May 2000, according to WVI, main sources of food were purchases from the market, ensete and relief food. Concern's findings in April 2000 indicated that nearly 70% of the households in Dalot Weyde consumed only one meal a day, mainly consisting of ensete¹³. Less than 7% of the interviewed households was (still) consuming their own harvest, while more than 50% had to purchase food on the market. The remaining 39% was either begging or bartering to obtain food. Oxfam's findings similarly indicated that people in June were mainly relying on ensete. In July, according to the follow-up survey from Concern, food security remained fragile. Households continued to eat one to two meals a day only, although food variety had increased. Nevertheless, virtually all cases of severe malnutrition consisted of kwashiorkor, indicating that the diet in some households continued to be extremely low in protein. Purchase from the market and food aid were the two main food sources. All agencies also reported that households were employing a variety of coping mechanisms such as the consumption of wild plants, borrowing money, out-migration, stress sale of animals, sale of firewood, charcoal, daily labour and petty trade.

NSP results from August 2000 confirmed that, despite availability of potato and haricot beans harvest and increased relief distribution, cereal prices continued to rise. At the same time, daily labour rates and firewood prices were lower than those recorded in March/April 2000. NSP findings also indicated that production prospects between areas varied considerably. For the highlands and eastern lowlands, prospects were better than for the western lowland, in particular Boloso Sore, Kindo Koysa and Offa. This could be confirmed by own observations. Moreover, various sources have reported that, as a consequence of this years' late belg rains, land in the high and middle highlands was still occupied by belg crops when the kremt rains started. Because farmers tend to use the same plot of land for both belg and meher crops, it is expected that the area, planted during the kremt period, will be less than normal.

3.2 General Food Distribution

As in most other parts of Ethiopia, food needs for Wolayita this year were estimated by a multi-agency (meher pre-harvest) assessment mission. This assessment leads essentially to geographically targeting and an estimation of the total number of beneficiaries per woreda (but not who). Actual implementation of the food distribution is undertaken by the regional DPPBs, through zonal DPP departments, woreda councils and community (kebele) level administration¹⁴. The (sub)kebele administrative structures undertake relief operations as one of their regular activities. These structures play a vital role in linking area (geographical) to household targeting by identifying the most needy and by determining the final number of beneficiaries.

¹³ A menu consisting of only ensete (or cassava root) might cause protein deficiency (kwashiorkor), which is classified as severe malnutrition.

¹⁴ An excellent overview of the food aid system in Ethiopia is given in "Report of Consultancy on Monitoring and reporting of Food Aid Assistance to relief Operations in Ethiopia", by Beyene M, Bekele F. And Lulie S., December 1998.

Allocation of food by the federal DPPC is based on confirmed donor pledges and availability of stocks. This year, due to low availability and priorities elsewhere, the official allocation for North Omo was about 75% of the requirements. As of May 2000 only 50% had been delivered and around 40% distributed.

In theory, if actual allocations are less than previously determined requirements, affected woredas are revisited and informed of the official allocation in meetings between woreda officials, DPPB/D and PA representatives. PAs are then requested to identify the most vulnerable families (among those previously identified) and to submit a beneficiary list to the woreda/DPP committee¹⁵.

According to a recent WFP mission, in SNNPS the regional authorities following the 1996 bumper harvest dissolved the DPPB/D. DPP Departments at zonal level, that supervise and co-ordinate food distribution, have been dismissed. A task force consisting of officials of various departments ensures participation in assessments, but mechanisms to link geographical and household targeting no longer exist. As a result, there are no reliable distribution figures¹⁶. Moreover, figures reported do not necessarily reflect distribution to the most vulnerable. In addition, due to the breakdown of the system of checks and balances to assure accountability, there is at present no guarantee even that food has actually been distributed¹⁷. Observations by NGOs working in the area and various assessment missions confirm a serious gap in information on DPPC food distribution.

In Boloso Sore, according to Oxfam, woreda officials reported that in May 2000 food distribution amounted to 1,063 MT. The number of beneficiaries was 85,000. In June the woreda received 1,800 MT of maize, an amount sufficient to cover the needs of 144,000 people (at a ration of 12.5 kg) as compared to an identified 220,000 in need. Contacted at the end of July, DPPC claimed 128,000 people in need and distribution of 1,657 MT. Disparities between amounts distributed, number of people in need and beneficiaries actually receiving relief food were noted in Kucha and Offa as well.

Reports from all woredas agree however, that DPPC food distribution to date has been late, irregular and insufficient to prevent serious levels of malnutrition. Only in Humbo woreda, singled out in 1999 as the worst affected woreda, response has been in time, as can be concluded from relatively modest and stable malnutrition rates. During the second half of 1999, Humbo was one of the few woredas where DPPC food, consisting of approximately 12.5 kg of maize per person per month, was distributed more or less regularly. In addition, starting in June 1999, WVI was providing supplementary food (4.5 kg of blended food) to children. When DPPC food ran out, WVI initiated DPPC complementary general food distribution early this

¹⁵ According to various sources, in many places quantities distributed are a function of quantities available rather than the prescribed ration scale. Or, in other words, the number of beneficiaries is not always adjusted in line with allocations.

¹⁶ For instance, the DPPC pre-belt harvest assessment mission from the ZDPPC obtained figures suggesting that dispatch and distribution figures were identical. Moreover, in July, figures from May were not yet available.

¹⁷ The official system requires that food is distributed in the presence of accountable regional or zonal DPPB/D officials.

year WVI¹⁸. In March, WVI substantially increased food assistance in Humbo. The food basket was extended to include 0.5 kg of oil and 1.5 kg of CSB in addition to 12.5 kg of maize/wheat for 68,000 beneficiaries. Distribution will continue to December this year. In May 2000 WVI also started complimentary general food distribution in Sodo Zuria to 55,500 beneficiaries. Distribution will continue to September and might be extended to December.

Concern, in April 2000, also commenced complementary general food distribution to the most vulnerable households in June 2000. Because Concern's programme consisted of selective feeding as well,¹⁹ the nutritional status of children under five years could be used to identify vulnerable beneficiary families. With sufficient food to provide 55,000 people twice with 12.5 kg of maize, Concern was thus able to cover approximately 70% of the families of the malnourished children, with DPPC food covering the balance. In view of increasing numbers of vulnerable people, Concern plans two more rounds of complimentary food distribution. In Damot Gale MSF-CH as of the end of July, is implementing a similar programme. Families of malnourished children receive, in addition to blended food, 13 kg of maize per person. The number of families targeted is 3,000 (18,000 people).

Despite DPPC policy to promote Employment Generating Schemes (ESG) in favour of free food distribution, very little food for work is actually going on in Wolayita. Only SOS Sahel as a response to the drought has scaled up its EGS in Koysha. The programme at present targets approximately 30,000 people through EGS and an additional 10,000, who are unable to work, with free food

In the meantime, in-country food availability and allocations –also to Wolayita– have increased significantly. Gross amounts are sufficient to cover the needs, rendering complimentary food by NGOs superfluous, providing that food reaches the most vulnerable. Also, to improve targeting to the most vulnerable, WFP has committed itself to assist North Omo in (re-)building DPPD/B capacity, including the provision of material resources. To this end, WFP opened an office in Sodo in August 2000. Because of these developments, some NGOs, including Oxfam UK, plan to strengthen and assist DPPC food distribution capacity rather than carry out complimentary food distribution.

¹⁸

WVI and NCA provided 510 and 400 MT of maize for distribution in January and February.

¹⁹

Concern filled the gap between April and June by providing 12 kg blended food per malnourished child, rather than the common ration of 4.5 kg

4. Conclusions

Although the food and nutrition situation in Wolayita is monitored as part of the national surveillance programme (NSP), drought response has, in general, not been timely in Wolayita, except in Humbo woreda. This can be related to the fact that Humbo was already singled out in 1999 as the worst affected woreda in the area, attracting early response, among others from WVI.

Because the food security situation in Wolayita is extremely fragile, any change in access to food might result in a sharp decline in the nutritional status of a very substantial number of people in a relatively short period. During the first three months of 2000, very poor harvests due to unfavourable rains and extremely limited food distribution combined to rapidly bring about such a change. In January 2000 nutritional status, as measured by mean WFL, was still satisfactorily according to the NSP. In view of the effects of poor rains, the NSP nevertheless advocated close monitoring and the provision of assistance in its February 2000 issue.

In response to NSP results and requests from the DPPC, a number of (I)NGOs carried out nutritional assessments. The majority of surveys have been formal 30 clusters surveys employing the standard methodology. Results of these nutrition surveys clearly indicate, that mean WFL alone as reported by the NSP is an insufficient indicator of nutritional vulnerability in an emergency situation. In addition, results of nutrition surveys cast serious doubt on the validity of using a cut-off level of 90% mean WFL to determine the need for emergency food assistance²⁰. Nutrition surveys at present thus not only provide useful, but also essential complementary information. The NSP should systematically report the number of children falling below the 80% and 70% W/H cut-off levels, in order to facilitate prioritising areas that warrant such nutrition surveys.

Following nutrition assessments, various agencies commenced selective feeding programmes and general food distribution complimenting DPPC. With the exception of WVI, who was already in the area and Concern, who has a history in Wolayita, response has been slow. Several agencies are at present in the process of setting up programmes, which were badly needed before the harvest.

A strong point of the drought response programmes implemented by WVI, Concern and –later– MSF CH is the combination of selective feeding of malnourished children and pregnant and lactating women, and the provision of general rations. Concern and MSF CH provide cereals to all family members of malnourished children, thereby targeting the most vulnerable. Therapeutic and supplementary feeding programmes are of excellent quality, because nearly all agencies are using internationally accepted criteria for admission and discharge; provide recommended medication and adhere to feeding protocols and other standards of good practice. Moreover, response is

²⁰ As early as 1993, analysis of the use this system revealed that child mortality is likely to increase before area mean WFL fall to 90% of the reference, indicating that emergency interventions should be triggered earlier. And also that (... such) nutritional status data provide confirmation of a developing crisis rather than early warning. Lawrence M., Tayech Yimer & O'Dea J.K., Eur. J. Clinical Nutrition (1994), 48.

characterised by effective co-ordination among NGOs, resulting in even coverage of woredas, albeit late in the case of some woredas. A weaker point is that malnourished adolescents and/or elderly are usually excluded from these feeding programs.

Response in the health sector has thus far been marginal, despite findings of nutrition surveys indicating that morbidity, in particular due to malaria and diarrhoeal disease, is a major underlying cause of malnutrition and that vaccination coverage is extremely poor. Statistics on morbidity are kept at clinic level, but there is no morbidity surveillance system that can trigger quick response and/or support in case of outbreaks or epidemics.

DPPC food distribution to date has been late, irregular and insufficient to prevent serious levels of malnutrition. Increasing cereal prices as reported in August 2000, despite harvest of potatoes and haricot beans, would seem to suggest that relief food distribution is still insufficient, although in-country food availability and allocations – also to Wolayita- have increased significantly. The situation is complicated by the fact that the regional SNNPR authorities, following the 1996 bumper harvest, dissolved the DPPB/D. As a result, mechanisms to link geographical and household targeting no longer exist; neither are there any reliable distribution figures. Moreover, figures reported do not necessarily reflect distribution to the most vulnerable. In addition, due to the breakdown of the system of checks and balances to assure accountability, there is at present no guarantee even that food has actually been distributed.

5 Recommendations

Nutrition

- Information on the nutritional status presented in the NSP should be optimised and include reporting of the percentage of children falling below the cut-off level of 80% for moderate and below 70% for severe wasting. This information should be presented by area and woreda.
- Nutrition surveys should (continue) to compliment NSP information, while follow-up surveys should (continue to) be carried out to measure impact and adjust programmes according to need. These surveys should (continue to) include questions which will help identify the underlying cause of the malnutrition
- Other vulnerable groups, such as elderly and pregnant and lactating women should be included in nutrition surveys to the extent feasible and included in selective feeding programmes if high numbers are found malnourished.

Health

- The link between nutrition, food security and health needs to be strengthened among others through better co-ordination between (national) NGOs working in

the health sector, INGOs planning to provide support in the health sector, MOH and UN agencies.

- There is an urgent need to:
 1. Support the ZHD in carrying out a mass measles vaccination campaign
 2. Boost regular EPI, vitamin A and ferrous/folic acid supplementation and ORT with WHO/UNICEF technical support
 3. WHO to explore possibilities to link one or more of the above to its polio eradication campaign
 4. Strengthen communicable disease surveillance (WHO)
 5. Support ZHD in malaria control by the provision of appropriate drugs, means to prevent malaria and the logistics to effectively implement such a programme at woreda level

Food

- DPPD/B capacity to effectively ensure food distribution to the most vulnerable population has to be re-build as soon as possible. WFP's commitment to assist North Omo in this respect should be strengthened by encouraging woredas to establish drought management committees in which all actors participate. NGOs providing assistance in the food and nutrition sectors should consider providing material and human resource support to strengthen the operational capacity of such committees.
- Employment Generating Schemes (ESG) should be encouraged when and where possible and replace the vast majority of free food distribution as soon as feasible.

ANNEX I

NUTRITION SURVEYS 1999 – 2000 In SNNPR

Zone woreda	Date of survey	Agency	Sample size	Metho- dology	Nutrition Indicators ²¹					
					W/H <-2 Z score + oed		W/H <-3 Z score + oed			
North Omo DamotWeyde	April 2000	Concern	960	30 clusters	W/H <-2 Z score + oed		W/H <-3 Z score + oed			
					25.6%		4.3%			
North Omo DamotWeyde	July 2000	Concern	891	30 clusters	W/H <-2 Z score + oed		W/H <-3 Z score + oed			
					6.4%		1.0%			
North Omo DamotWeyde	July 2000	Concern	777 + 132	30 clusters adults + elderly	BMI < 17	BMI < 16	BMI < 17	BMI < 16		
					11.5%	3.5%	24.0%	12.0%		
North Omo Damot Gale	May 2000	MSF CH	3105	screening	MUAC <125mm		MUAC <110mm			
					35.3%		7.6%			
North Omo Humbo Sodo Zuria Bor.Abaya Chencha	Nov 99 Feb 2000 May 2000	WVI	1506 1611 739 747	Randomly selected PAs	W/H <-2 Z score			W/H <-3 Z score		
					Nov 99	Feb 00	May 00	Nov 99	Feb 00	May 00
					8.2%	9.6%	00	NA	NA	1.3%
					6.7%	16.7%	8.2%	NA	NA	2.5%
					7.9%	-	16.4%	1.9%	-	0.5%
					5.7%	-	5.3%	0.3%	-	0.8%
North Omo Boloso Surie	July 2000	Oxfam	901	30 clusters	W/H <-2 Z score + oed		W/H <-3 Z score + oed			
					45.1%		20.4%			
South Omo Salamago	May 2000	MSF CH	102	screening	MUAC <125mm		MUAC <110mm			
					38.4%		4.5%			
South Omo Kuraz Hamer Bena	March 2000	NCA ECCMY DIA	730	5 clusters per wereda	Mean WFL		WFL < 80%		WFL < 70%	
					88.3%	89.9%	15.3%	14.5%	2.6%	2.1%
Hadiya Badawacho Soro	Feb 2000 May 2000	WVI	996 751	Randomly selected PAs	W/H <-2 Z score			W/H <-3 Z score		
					Feb 2000	May 2000	Feb 2000	May 2000		
					3.9%	6.1%	0.6%	0.5%		
					4.7%	11.9%	1.1%	0.7%		
Hadiya Bedawatcho	July 2000	Concern	103	Rapid assessment	MUAC <125mm		MUAC <110mm			
					53.3%		19.4%			
Hadiya Badawacho Soro	Nov. 99 May 2000	WVI	996 751	Randomly selected PAs	W/H <-2 Z score			W/H <-3 Z score		
					Feb 2000	May 2000	Feb 2000	May 2000		
					3.9%	6.1%	0.6%	0.5%		
					4.7%	11.9%	1.1%	0.7%		
K.A.T. Kacha Bira Ged.Gamela OmoShekelo		WVI	708 773 742	Randomly selected PAs	W/H <-2 Z score			W/H <-3 Z score		
					Feb 2000	May 2000	Feb 00	May 00		
					10.2%	17.4%	0.8%	2.8%		
					NA	17.2%	NA	1.3%		
					15.3%	23.3%	1.1%	3.0%		

²¹ 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 as 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

Annex II

Supplementary and Therapeutic Feeding Programmes in Wolayita

Woreda	agency	Therapeutic Feeding		Supplementary Feeding	
		Number of centres	Time-frame		Time-frame
Boloso Sore	Oxfam/ MSF Spain		Sept.-Dec. 2000		Sept.-Dec. 2000
Damot Gale	Concern	3 TF centres Attendance down from > 800 to 125	one closed in July. Others till Oct. 2000	10 sites 3,000 < 5 y 500 > 5 y 1,500 PNW	April – Oct. 2000
Damot Weyede	MSF CH	2 TF centres attendance after 2 weeks: 220	Opened in July	3 sites 1,500 < 5 y 1,000 PNW capacity:	July- Oct. 2000
Sodo Zuria	WVI ACF	Support Sodo hospital nutrition rehabilitation	June2000-?	ACF nutrition survey presently carried out to identify need for TFC and suppl. feeding	
Offa	ARC/ERC			7,000 < 5 y and PNW	August 2000- April 2001
Humbo	WVI	Support Sodo hospital nutrition rehabilitation	June2000-?	6500 < 5 y	Closed in June

Annex III

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28 August, 2000