United Nations

**Office for the Coordination of Humanitarian Affairs (OCHA)**
**Emergencies Unit for Ethiopia (EUE)**

# Green famine in Sidama and Welayta

**Therapeutic feeding brings partial relief, new hotspots**

*Assessment Mission: 18 –22 May 2003*

*By Hugo Rämi, UN-Emergencies Unit for Ethiopia*

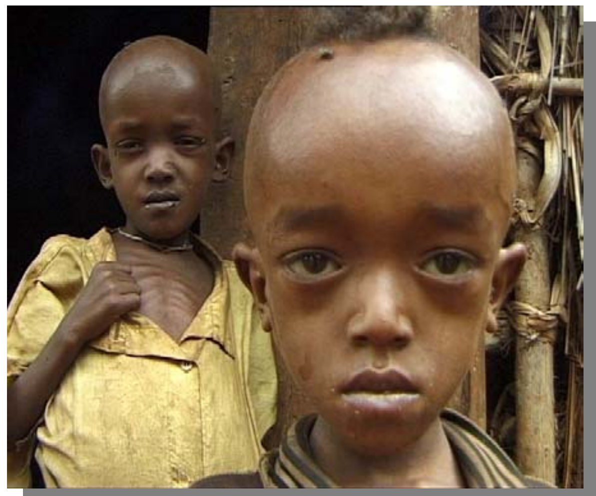
## 1 Introduction and background

Green landscape in Welayta (Photo by Hugo Rämi, OCHA-EUE, May 2003)

### *1.1 Situation deteriorating since last year*

Many parts of the Southern Region of SNNPR, in particular the zones along the Rift Valley, experienced a prolonged drought during the last year. This led to large scale and in many places total failure of harvests for the *belg* and *meher* seasons. Hardest hit were the lowlands in all the zones, where lack of water and food made survival hard for people and livestock. Therefore, early on, the lowlands were the focus of relief operations conducted by the government in conjunction with WFP and by NGOs operating in the affected areas.

During the pre-harvest assessment, which was conducted last fall, some misjudgements led to inflated harvest expectations for midland and highland regions, where the actual crop-yield turned out to be far lower than assumed. This, combined with the focus on lowlands, led to severe shortfalls in the provision of food aid in some pocket areas in the somewhat productive midlands. A post harvest assessment conducted in March increased the number of eligible food aid recipients by 324,600 to 1,439,252. But at that time the situation had already begun to deteriorate in Silti, Eastern Guraghe, Kambata, Sidama and Welayta zones *(Dechassa, OCHA-EUE, April 2003)*.



Father and sister died: Malnourished children in Deheye kebele, Offa (Phto by Hugo Rämi, OCHA-EUE May 2003)

The shortage of food at household level, lack of relief in some areas and total absence of supplementary food for small

children in most places, was compounded by severe targeting problems mainly at local level (*Rämi,OCHA-EUE March 2003)*. In many places food aid was distributed according to those in charge and did not reach all the needy. This prompted the federal DPPC to intervene in the area and entire populations had to be retargeted, all of which led to month-long delays in food distribution that further aggravated the already dire situation.

While the warning signs were obvious and the situation was communicated on a regular bases by OCHA-EUE and other organisations, responses often were slow and sometimes inadequate. Now we are faced with a situation whereby NGOs supported by UNICEF and WHO had and still have to set up therapeutic feeding centres (TFCs) in order to keep severely malnourished children from dying. UNICEF estimates that up to 80'000 children need special care and therapeutic feeding countrywide. The organisation is presently conducting a training program for TFC staff in SNNPR.

This OCHA-EUE mission-report assesses the present situation and ongoing relief operations mainly of therapeutic feeding centres. Some new hotspots – probably not the last – are also investigated.

## 2 Mission findings

### *2.1 Green famine, despite rains*

At the surface the situation in the South at present looks much better than three months ago. Though up to two months late, exceptionally good *belg* rains permitted the farmers to cultivate their lands. Almost everywhere from Awassa in Sidama zone down to Soddo, capital of Welayta, the landscape looks extremely green, with most fields planted with potatoes, maize and wheat and on smaller scale teff. But this lush landscape hides a famine that, although widely attributed to last year's drought, is the result of structural deficiencies, scarcity of land, overpopulation and lack of development.

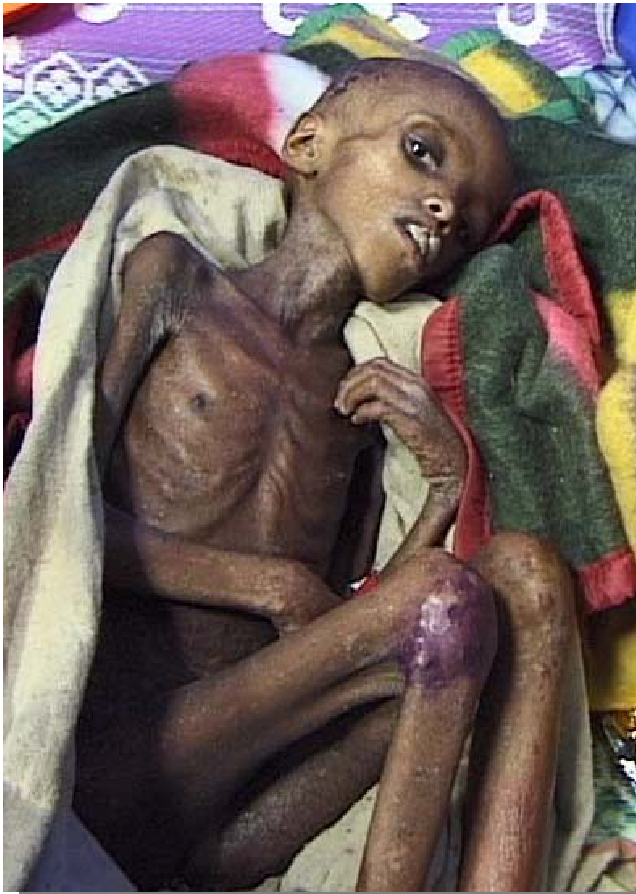
Malaria, diarrhoea and nothing to eat: Mother and child in Deheye kebele, Offa (Photo by Hugo Rämi, OCHA-EUE, May 2003)

While the markets in Awassa and Soddo are awash with fresh produce and livestock, segments of the population, mainly in rural areas, still have little access to food other than food aid. Green maize can be consumed in areas, where the *belg* rains set in early, but in most places the greenery will take at least two more months to yield edible harvests – provided some additional rains come.

### 2.2 *Dying at an alarming rate*

The situation is particularly serious in Welayta and Sidama zones where hundreds of children are severely malnourished and large parts of the population now not only suffer from malnutrition but also from Malaria. In some kebeles people die at an alarming rate, due to a combination of lack of food, disease, inappropriate diet and unsafe drinking water. This has prompted NGOs with the help of UNICEF to set up eight therapeutic feeding centres (TFCs) for severely malnourished children in Guraghe, Silti, Wolayta, Sidama and Kambata zones[1].

At least another five TFCs, but possibly more, will be set up in the coming days and weeks.[2] Unsafe drinking water still poses serious health threats. The UNICEF and other organisations continue to drill boreholes. Water tankering operations help provide safe water in TFCs.



Severely malnourished orphan at MSF's therapeutic feeding center in Buditi, Welayta (Photo H. Rämi, OCHA-EUE May 03)

In all the TFCs visited by the OCHA-EUE mission the situation is similar: feeble looking and skinny mothers and fathers camp on the floors of clinic buildings and in tents specially set up for the intervention. Doctors and nurses measure and weigh children in order to determine the grade of malnutrition, and children are placed in separate wards, each containing patients with different grades of malnutrition. The children receive a special blend of therapeutic food, and if necessary other medicines, which helps them to stabilise and finally recover.

Some of the admitted children were in a very bad state. One patient in the TFC run by MSF-Switzerland in Buditi, Welayta, lost both his parents to malnutrition and disease and his faith was uncertain. In all the visited TFCs children have died, either because they arrived too late, or aside from being extremely underweight, suffered from illnesses like severe diarrhoea and Malaria.

### 2.3 *Resources stretched to the limit,*

[1] Guraghe zone: Butajira Hospital and Mercy site (Project Mercy, Government), Silti zone: Dalocha Health Centre (Government), Welaty zone: Soddo Hospital (World Vision Ethiopia), Damot Weyde (Concern), Butiti and Buge (MSF Switzerland), Sidama zone: Busholo Health Centre, Awassa (Catholic Church), Yirba Health Centre, Boricha (Govt. Adventist devt. and relief assoc. Save the children USA), Kambata zone: Durame, Taza Clinic (Catholic Sisters)

[2] Offa wereda, Boloso Sore, Bela Health Centre Boricha.

***continuous lack of supplementary food***

Resources are stretched to the limit and capacity at all levels, personnel, space and equipment are in short supply. In some locations the spaces are so crowded with people, that doctors fear the spread of disease. There is a severe shortage of medical personnel everywhere. UNICEF is now responding with special training courses for TFC personnel.

In 66 kebeles of Sidama zone the NGO "GOAL" is presently screening all the children under five for supplementary food and TFC treatment. So far 220 children from Boricha and Awassa Zuria Woredas were identified, but could not yet be accommodated in a TFC programme due to lack of space and resources.

Another serious problem still is the availability of supplementary food in the home places of the patients. Treated children once discharged from the TFCs, may not be able to receive supplementary food in their villages and fall back into malnutrition. Health staff in one TFC complained about the inability of the government to provide the rations although stocks are there. In Awassa Zuria, Sidama, mothers receive supplementary food for discharged or malnourished children at the TFC of the Catholic Clinic in Busholo.

At the end of the food chain: Mother and daughter in Deheye kebele, Offa (Photo by Hugo Rämi, OCHA-EUE, May 2003)

In their area of intervention in Damot Gale Woreda, MSF-Switzerland conducts blanket distribution of supplementary food to all children under five to combat the problem. This of course is an expensive undertaking but necessary under the prevailing circumstances.

In most TFCs health personnel reported that the numbers of admitted children are still increasing. MSF-Switzerland registers an average of 15 new children per day in their TFCs in Buditi and Buge where at the time of the visit 226 children were treated. More than 400 had been admitted since the opening of the centre in Buditi May 4. An expatriate nurse nevertheless reported, that the newly admitted cases seem to be less severe. Some children were refused and sent home, where supplementary food is available thanks to the blanket distribution.

This might indicate a peaking of the crises in the area of intervention, a sign that blanket distribution of supplementary food under the circumstances is the appropriate measure.

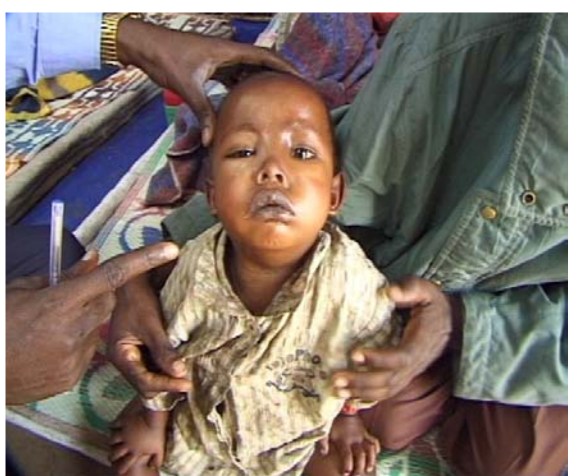
### 2.4 Permanent NGO work prevents the worst

It seems that in areas where NGOs are permanently active, the extent of the crises is smaller than in areas without them. In Durame town of Kambata zone, the catholic sisters run a supplementary food program since a long time in their Taza clinic. An outreach worker screens children regularly in the kebeles around the town and the sisters distribute money as well as food to poor mothers. The last two months nevertheless brought almost a

doubling of underweight patients to the clinic, many of them severely malnourished and sick. The nuns set up an informal therapeutic feeding centre, where they feed the malnourished children with a balanced diet. Now the numbers of newly admitted patients are slightly decreasing.

In Damot Weide Woreda the NGO "Concern" runs a development program and supports the local health centre. Concern responded very early to the crises by distributing dry rations combined with supplementary food. In November and December supplementary food was given on a blanket base to all children below five and lactating and pregnant women. From January to March general rations were handed out together with a blanket complementary pack. Still the problem kept growing. One reason was dilution of rations.

The intervention was directed at about 25% of the total population. But in a survey a full 47.3 % of the population responded that they had received food-aid. This shows a lot of double sharing, which in effect creates food deficits for the more vulnerable individuals.



15 new patients a day: Bloated, malnourished child at MSF therapeutic feeding center, Buditi, Welayta (Photo Hugo Rämi, OCHA-EUE, May 2003)

Following this logic, the situation deteriorated from 4.6% Global Acute Malnutrition (GAM) last year to 10.3% in April 2003. The fact that family sizes are generally much larger (seven to nine persons in Damot Gale) than the standard five people household for which food rations are computed, made ration dilution even worse. But thanks to the early and steady intervention severe acute malnutrition (SAM) stayed below 1%.

In April finally Concern started screening and targeting the beneficiaries. From an estimated target population of 4000 so far 2600 get their supplementary food and at the time of the visit only 10 children were admitted in their therapeutic feeding centre in Bedesa.

## Outreach feeding programs an alternative to TFCs

A serious problem of therapeutic feeding is the practice that the mother usually takes care of her severely malnourished child at the TFC, sometimes for several weeks. This prevents her to take care of her other children back home and creates additional malnutrition.

To tackle this problem Concern started an outreach treatment program for malnourished children. Severely malnourished children stay at a *therapeutic stabilisation* centre only five to six days and are then sent home, where community based therapeutic care takes over.

In practice one specially trained outreach worker per kebele covering a radius of a maximum of 10 kilometres, visits all the houses with malnourished children, instructs the mothers on feeding care and makes sure that the patients receive the rations they need. This in the long run builds capacity at kebele and household level and reduces costs and the risks of spreading diseases at crowded TFCs.

### 2.5 Targeting still a problem

While NGOs and the various UN organisations try their best to get the situation under control, the government still struggles with inefficiency, targeting problems and reports of inappropriate distributions mainly at wereda and kebele levels. The OCHA-EUE mission witnessed a government relief distribution in Yirba kebele, Boricha wereda, Sidama zone. Several Farmers interviewed complained that "rich" people, traders and owners of large numbers of cattle, went off with 50kg bags of USAID relief. One informed villager reported even soldiers from a camp in the area received food aid. DPPC and Rural Development Bureau officials have confirmed some of these unacceptable practices but seem to be unable to do much about them.

Another problem is the traditional patriarchal "macho" culture and widespread polygamy in SNNPR. Women and female children are often at the end of the food chain, even when it comes to relief food. The regional government is aware of these problems, but has a hard time changing habits that are deeply embedded in the culture. In some places the government and NGOs have begun distributions only to the women in each household to make sure they and their children receive adequate rations.

Chronic malnutrition a problem of chronic poverty: Severely malnourished child at therapeutic feeding center in Yirba, Sidama (Photo Hugo Rämi, OCHA-EUE, May 2003)

Structural deficiencies are a major part of the crises. A lack of government transport and means of communication has made monitoring and supervision difficult at best. Hardly any kebele boasts a telephone and DPPC officials often don't even have motorcycles. A lack of up to date information on a situation that is constantly changing is one result. Other consequences are inadequate communication, apathy and missing initiative. There appears to be a lack of urgency by bureau officials who feel that now that the drought seems to be over, the problem of food will solve itself.

### 2.6 New hotspots

Looking at the development of the past months it seems that the famine is a wave rolling down south. Serious targeting flaws and malnutrition were first encountered in Guraghe and Silti. Than scores of children suffered from severe malnutrition in Sidama and the midlands of Soddo Zuria. Now a new hotspot is opening up in Offa, in the South of Welayta, a wereda that covers all agro ecological zones. New hotspots are to be expected.

The OCHA-EUE mission visited Deheye kebele, about eight kilometres outside Gesube, main town of Offa, seemingly a green and fertile place. In almost every house people reported that one, sometimes more members of the family had died recently out of food

shortage and disease. A visit of the huts revealed a shocking sight of people skinny to the bone, sick and weak, most of them suffering from malaria and diarrhoea.

One mother of three, who lost her husband, was unable to feed her youngest child – her breasts severely emaciated. She and her children have to survive on one meal a day. The kebele receives food aid since last month only, most of which was quickly consumed. One mother spent her only family ration for entertaining guests during the burial of her daughter.

Most people in the kebele now survive on immature false bananas *(enset)*, which causes diarrhoea. Malaria is epidemic in the area and sick people reported, that the medicines they received, worsened their condition and they stopped taking them. A group of farmers, many of them also suffering from malaria, claimed that out of 250 people in their kebele 60 died. This figure could not be verified.

While Deheye kebele is the worst affected, the situation is similar in 15 of the 26 kebeles in Offa Woreda according to the representatives of the DPPD and Rural Development Bureau. The officials confirmed claims made by the Deheye kebele people that there was a problem with corruption and that food aid did not always reach the right people in Offa Woreda.

### *2.7 No end of the problem in sight*

It is nothing new that the underlying causes of the green famine in Welayta and Sidama are small landholdings, large family sizes, underdevelopment and in general a lack of the most basic infrastructure. With an average population of more than 600 people per square kilometre agricultural production under the given circumstances can just about meet the subsistence needs of the population in good years. In bad years the system rapidly breaks down. Malnutrition therefore is chronic mainly in families with many children and little or no land.

Development, which is key to a better future of the peasants in SNNPR, unfortunately receives a setback every time a new crisis erupts. The NGO World Vision Ethiopia (WVE) for example, runs numerous development projects in Welayta and now operates a TFC in Soddo hospital. Funds which were intended for development, had to be redirected into relief.

As one local doctor in the TFC of MSF in Buditi put it: “Only resettlement and family planning can solve the problem.”

## 3 Conclusions and recommendations

The humanitarian crises in the South seems to reach its peak in areas where TFCs are established and supplementary food as well as general rations reach their rightful addressees. In areas, where no NGOs are present and general food distributions and supply of supplementary food is in the responsibility of the administration, further hotpots of malnutrition, and malnutrition related deaths must be expected. Malaria is epidemic in lowland areas and threatens many lives.

Short term: To keep on top of the problem it is essential that assessment-missions to all potential hot spots be continued on a regular bases and the findings communicated to all players. Communication in general must be improved. OCHA-EUE is planning to set up an office in Awassa.

Malaria medicines, supplementary food, must be dispatched to the problem spots as soon as possible.

Medical staff is in short supply everywhere. UNICEF is conducting training programs for TFC personnel and tries to recruit temporary emergency staff at local universities and nursing schools.

Medium term: In order to strengthen and supplement weak government structures NGO presence in SNNPR should be increased.

Capacity at woreda level should be improved. DPPC personnel should at least have motorcycles and telephones at their disposal. Better targeting and monitoring systems for food aid should be developed.

Long term: Root cause for the current crises is the chronic problem of poverty due to underdevelopment and overpopulation. Development, cultural changes, policy changes and above all family planning are necessary.

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## Annex

### Therapeutic Feeding Centres (TFCs) in SNNPR, status May 18

**a) Operational TFCs**

| ***Zone*** | ***Site*** | ***Organisation*** |
|---|---|---|
| Guraghe | Proj. Mercy site, Butajira | Project Mercy |
| | Butajira Hospital | Governement |
| Silti | Dalocha Health Centre | Government |
| Wolayta | Buge, Damot Gale | MSF Switzerland |
| | Buditi, Damot Gale | MSF Switzerlando |
| | Soddo Hospital | WVE |
| | Bedesa, Damot Woyde | Concern |
| Kambata | Taza Clinic, Durame | Catholic Sisters |
| Sidama | Busholo HC, Awassa | Catholic Church |
| | Yirba HC, Boricha | Adra, Governement |

**b) Planned TFCs**

| | | |
|---|---|---|
| Wolayta | Boloso Sore | IMC, Oxfam |
| Sidama | Belela HC, Boricha | Adra, Save US, Govt. |
| Offa | | |
| Kindokoscha | | |

### Abbreviations

| | |
|---|---|
| ADRA | Adventist Development and Relief Association |
| DPPC | Disaster Prevention and Preparedness Commission (Federal Government level) |
| DPPB | Disaster Prevention and Preparedness Bureau (Regional level) |
| DPPD | Disaster Prevention and Preparedness Department (Zonal level) |
| IRC | International Rescue Committee |
| GAM | Global Acute Malnutrition |
| IMC | International Medical Corps |
| MSF | Médecins Sans Frontières |
| NGO | Non-Governmental-Organisation |
| OXFAM | Oxford Committee for Famine Relief |
| SAM | Severe Acute Malnutrition |
| SC-US | Save the Children Fund United States |
| SC-UK | Save the Children Fund United Kingdom |
| TFC | Therapeutic Feeding Centre |
| OCHA-EUE | United Nations Emergencies Unit for Ethiopia |
| UNICEF | United Nations Children Fund |
| USAID | United States Aid for International Development |
| WFP | World Food Programme |

## Glossary of important meteorological and seasonal terms used for Ethiopian highland areas

*Meteorological Drought Defined*
Drought is a period of insufficient water initiated by reduced precipitation. The impacts of drought on crops and society are critical but not easily quantified. The result is that "drought" does not have a universal definition. "Meteorological drought" is defined as a sustained period of deficient precipitation with a low frequency of occurrence. While crops may be damaged by lack of precipitation and high temperatures in just a few days, such short periods are not considered to be meteorological droughts. A three-month period is defined by the American Meteorological Society to be the shortest period that can be defined as a drought. (Source: *The American Meteorological Society*)

*Ethiopia's 'Keremt' or 'Meher' Rains Defined*
Since Ethiopia and Eritrea are in the tropics, physical conditions and variations in altitude have resulted in a great diversity of climate, soil, and vegetation. Rainfall is seasonal, varying in amount, space, and time. There is a long and heavy summer rain, normally called the big rain or *keremt*, which falls from June-September. It is followed by the *baga* hot, dry period from October through February (see below for definition). In some areas there are short and moderate spring rains in March and April known as the little rains or *belg*. These rainy periods correspond to Ethiopia's primary and secondary agricultural seasons, known as the *meher* and *belg*. (Source: *FEWS*)

*Ethiopia's 'Belg' Rains Defined*
In spring, a strong cyclonic centre develops over Ethiopia and Sudan. Winds from the Gulf of Aden and the Indian Ocean highs are drawn towards this centre and blow across central and southern Ethiopia. These moist, easterly and south-easterly winds produce the main rain in south-eastern Ethiopia and the little spring rains to the east central part of the north-western highlands. The little rains of the highlands are known as *belg* rains, referring to the second most important sowing season of the region. (Source: *FEWS*)

## Literature list of referred papers

Rämi H (2003) Targeting problems cause malnutrition, shortage of seeds leads to next crises – OCHA-EUE assessment mission report to SNNPR, March 2003

Dechassa L (2003) Summary of SNNPR Emergency Situation Report – OCHA-EUE, April 2003