EMERGENCY NUTRITION QUARTERLY BULLETIN

(FIRST Quarter 2013)

Emergency Nutrition Coordination Unit

Early Warning & Response Directorate

(Disaster Risk Management & Food Security Sector)

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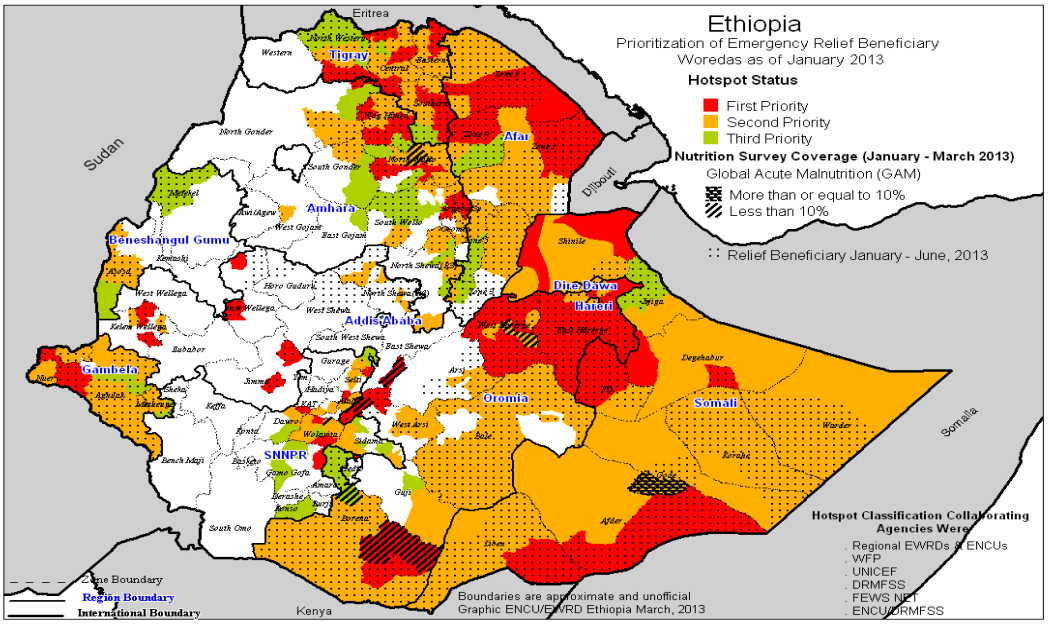

Overlay analysis of hotspot, relief beneficiary and nutrition survey woredas; map depicting hotspot woredas January - March 2013, relief beneficiary woredas January - June 2013, nutrition survey woredas January - March, 2013

1. NUTRITION SITUATION ANALYSIS

The emergency Nutrition situation (regional and national level) is monitored on monthly basis by the ENCU/DRMFSS in collaboration with nutrition cluster partners . The monitoring involve collection, analysis of monthly TFP data,emergency and biannual nutrition surveys , revision of hotspot

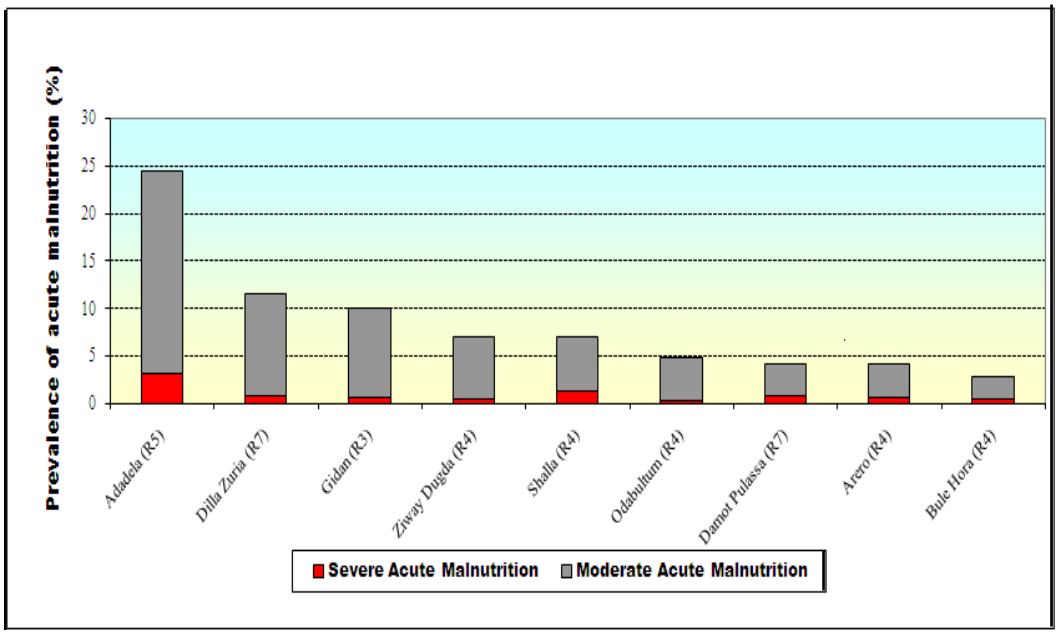

Figure 1: Nutrition Survey January - March 2013

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woredas as well as monitoring of emergency nutrition response . The first quarter bulletin summarizes the above sources of emergency nutrition situation and other technical updates of the nutrition statues in the 1st quarter.

1.1 NUTRITION SITUATION BASED ON STANDARD SURVEY RESULTS

A total of 9 standard emergency nutrition surveys were conducted in the first quarter of 2013 of which 6 of them were undertaken in three agrarian regions that included: Amhara (1), Oromiya (3), SNNPR (2), while the other 3 surveys were conducted in the pastoralist region Somali (1) and agro-pastoral areas of Oromiya (2). The surveys were conducted by nutrition cluster (NGO) partners that included: GOAL (3 surveys),IMC(2 surveys), Merlin(2 surveys),Child Fund(1 survey) and also by Oromiya DPPC(1).

When checked against the major quality criteria set for nutrition surveys, all the survey did meet the set criteria and included in this quarterly bulletin. Of the nine surveys conducted, two were carried out to confirm reports of food security deterioration. These surveys were carried out as a result of early warning reports of increasing food insecurity situation in those specific woredas of the region as confirmed by the respective regional Early warning Food Security Sectors and Health bureaus. The other four surveys were conducted to monitor ongoing nutrition interventions and inform decisions to either continue or handover nutrition interventions and the remaining three were end line surveys conducted by the implementing partners (See tables 2 and 3).

Federal ENCU engaged capable partners to conduct the assessments in these priority woredas.
Almost all the surveys were carried out in collaboration with regional EWFSSB/RHB and with the respective Zonal and woreda early warning and health offices.

Survey Methodology: All the 9 surveys applied a two- stage cluster sampling based on the ENA SMART methodology. Clusters included in the survey ranged from 33 in Damot Pulassa to 42 in Gidan, Odabultu, Shalla and Ziway Dugda woredas depending on the respective contexts. Special attention was given on both anthropometry and mortality sample size determination as well as on cluster and Households selection.

To maintain survey data quality, all surveys (i.e. proposals and reports) were reviewed &validated by the FENCU/DRMFSS in terms of survey methodology, rationale, data analysis, result interpretations and its recommendations based on the national guidelines and the set criteria. Accordingly, timely feedback on the survey proposals and reports were provided to respective partners.

Technical advises and support was given to the partnering agency to prepare the proposal according to the national guidelines. Follow up of the assessment plans and implementations by various partnering agencies were made by the ENCU to ensure timely submission of survey reports. Due to reasons beyond control, survey reports were submitted late.

Survey data sets for anthropometric and mortality rates were analyzed using the ENA for SMART software. Contextual data were analyzed using different software's by partners such as EPIINFO, SPSS or Excel. FENCU/DRMFSS also analyzed and checked both the anthropometric and Mortality raw data using the ENA-SMART software for each of the surveys.

1.2 NUTRITION SURVEY DATA QUALITY CHECK

Quality checks on anthropometry and mortality raw data were conducted using the plausibility function of the ENA - SMART software against the major quality criteria set for nutrition surveys. Major criteria applied were flagged records of WHZ, sex ratio and age distribution of the sampled children, digit preference of weight and height measurements. Other criteria included;WHZ distributions as measured with standard deviation, the index of dispersion, Skewness& kurtosis. As per the major criteria, data quality check for the nine surveys revealed that the digit preference score for weight and height measurements ranged between good and Acceptable, The Standard deviations (SD) of WHZ for all 9 surveys were below 1.2 of which 78 percent of them had SD for WHZ below 1. Moments of Skewness and Kurtosis for all the surveys were also within acceptable range of +1 and -1. Data quality check summary results of all the nine surveys are shown in Tables 1 below. Similarly, digit preference scores for height and weight in all the nine surveys ranged between good and acceptable as summarized in Table 1

Table 1: First quarter of 2013 Survey data quality check results

Agency	Woreda	Digit preference		SD WHZ	Skeweness WHZ	Kurtosis WHZ	WHZ	Representativeness of samples	
		Weight	Height				Flags (%)	6-29 and 30-59 months age ratio	Sex ratio
Merlin	Adadele	4	5	1.02	0.01	-0.26	1.4	1.1	1.12*
GOAL	Odabultu	2	5	0.96	-0.01	-0.17	0.6	0.92	1
GOAL	BuleHora	3	5	0.94	-0.03	-0.19	0.2	0.97	1
CF	Dila Zuria	2	5	0.98	-0.05	0.09	0.7	1.02	1
Merlin	Arero	5	9	0.99	0.08	-0.09	1.3	1.06	1
GOAL	Gidan	3	5	0.92	-0.02	-0.03	0.0	0.89	1
IMC	Damote pulassa	4	5	0.91	-0.24	0.03	0.5	0.88	1
IMC	Shalla	4	5	1.01	-0.02	0.04	1.5	1.08	1.1
ODPPC*	Ziway Dugda	8	10	0.98	-0.06	0.04	1.6	0.74*	1.01

*Oromia Disaster Prevention and preparedness Commission

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Key survey findings: The level of malnutrition as measured by Global Acute Malnutrition (GAM) ranged from 2.7 percent in BuleHora woreda in Oromiya region to 24.4 percent in Adadele woreda, in Somali region. Of the 9 surveys 4,3,1 and 1 were classified as normal,poor,serious and critical respectively. Seven surveys (78%) had GAM prevalence below 10 percent. The prevalence of Severe Acute Malnutrition (SAM) ranged between 0.2 percent in Odabultu woreda in Oromiya and 3.0 percent in Adadele woreda in Somali region. Similarly (78%) of the survey results reported SAM levels below 1 percent.

Crude and under five mortality rates for all the nine surveys were very low (See Table 2 and 3) falling below 0.60/10000 pop/day as per the national sphere standards. Diarrhoea was the major causes of the under five mortality that accounted for about 67% of the reported causes of deaths followed by Respiratory Tract Infection (RTI).

The prevalence of morbidity among under-five children was between 1.4 percent in Arero woreda to 31.5 percent in Adadele woreda of Somali region. The most common morbidities reported two weeks prior to the respective survey periods included: Diarrhoea, Cough, and fever in their order of prevalence magnitude. Diarrhoea was the most leading causes of morbidity in all the surveys. There was no any major disease outbreak reported as public health significance in the surveyed woredas.

Measles coverage by recall +card varied significantly across all the nine woredas ranging from 25.3 percent in Adadale (Somali) to 86 percent in Gidan woredas (Amhara). however, in all the 9 woredas coverage was below 90 percent as per the sphere standards. BCG coverage as assessed by presence of scar ranged between 22.2 and 71.2 percent with the lowest coverage reported in Bulehora woreda in Oromiya region. (See Table 2&3).

The vitamin 'A' supplementation coverage was below the recommended standards of 90 percent in 8 of the surveys except in Damote Pulassa woreda where it was estimated to be 91.6 percent. Summary results of the key indicators for all the 9 surveys are presented in Tables 2 and 3 below

Table 2 : First Quarter of 2013 Results in Oromia region against key indicators

	Surveyed woredas in Oromiya region				
Key indicators	Odabultu	BuleHora	Arero	Ziway Dugda	Shalla
Survey date	5-15 March 2013	2-15 Mar 2013	21-26 Mar2013	1-17 Mar2013	21-27 Jan 2013
Survey objective	Monitoring	Monitoring	Monitoring	Emergency	Monitoring
Study design	534 children from42 clusters	522children from 36 clusters	631 children from 38 clusters	547 children from 42 clusters	738 children from42 clusters
% GAM Z-Score (95 % CI)	4.7 (3.2-6.9)	2.7 (1.5 - 4.8)	4.0 (2.6 - 6.0)	7.0(5.3 - 9.3)	6.9 (4.8 - 9.9)
% SAM Z-Score (95 % CI)	0.2 (0.0-1.4)	0.4 (0.1 - 1.6)	0.5(0.2 – 1.5)	0.4(0.1 - 1.5)	1.2 (0.6 - 2.6)
% Kwashiorkor	0.0	0.0	0.2	0.0	0.1
CMR Death/10,000/day (95 % CI)	0.09 (0.03-0.29)	0.13(0.04-0.44)	0.08(0.03-0.27)	0.12(0.04-0.32)	0.07 (0.02-0.23)
U5MR Death/10000/day (95% CI)	0.0	0.34(0.08-1.43)	0.0	0.52(0.17-1.62)	0.28 (0.07-1.15)
Major causes of U5MR	0.0	Diarrhoea, ARI	0.0	ARI, Malaria	Diarrhoea
% Morbidity	9.9 (7.6-12.9)	26.2(15.9-36.6)	1.4(0.51-2.29)	28.9(21.15-32.65)	14.9 (12.35-17.45)
Major illnesses or symptom	Diarrhoea, cough and fever	Diarrhoea, cough and fever	Diarrhoea, cough	ARI, Fever and diarrhoea	Diarrhoea, fever &ARI
% Measles coverage by card (95 % CI)	11.3(8.7-14.5)	15.5(12.6-19.0)	7.5(5.6-10.0)	3.7(2.3-5.7)	34.4 (31-38.1)
% Measles by card + recall (95% CI)	60.2 (55.8-64.5)	54.0(49.6-58.3)	71.5(67.7-75.1)	81.7(78.1-84.8)	70 (65.4-74.6)
% BCG coverage – scar (95% CI)	35.2(31.2-39.4)	22.2(18.8-26.1)	53.1(49.1-57.0)	41.2(37.1-45.5)	49.2 (45.5-52.9)
%Vitamin A supplementation in past six months (95% CI)	60.9(56.6-65.0)	45.8 (41.5-50.2)	82.1(78.8-85.5)	80.7(77.1-83.9	81.4 (78.4-84.2)
Classification of nutrition situation	Normal	Normal	Normal	Poor	Poor

Table 3: First Quarter of 2013 survey Results in Amhara and SNNP Regions against key indicators

Key indicators	Amhara	SNNPR		Somali
	Gidan	Damote Pulassa	Dila Zuria	Adadele
Survey date	19 jan-09 Feb2013	18-23 Feb 2013	06-19 Mar 2013	16-23 Mar, 2013
Survey objective	Emergency	Monitoring	Monitoring	Monitoring
Study design	403 children from 42 clusters	440 children from 33 clusters	563 children from 39 clusters	636 children from 36 clusters
% GAM Z-Score (95 % CI)	9.9 (7.1 - 13.6)	4.1 % (2.6 - 6.4)	11.4 (9.5 - 13.6)	24.4(20.4 - 28.9)
% SAM Z-Score (95 % CI)	0.5[0.1 - 3.7)	0.7 % (0.2 - 2.1)	0.7(0.2 - 2.4)	3.0(1.8 - 5.0)
% Kwashiorkor	0.2	0.2	0.0	0.2
CMR Death/10,000/day (95 % CI)	0.04(0.01-0.28)	0.13 (0.05-0.34)	0.13(0.05-0.30)	0.16 (0.07-0.37)
U5MR Death/10000/day (95% CI)	0.0(0.0-0.0)	0.24 (0.03-1.85)	0.36(0.10-1.32)	0.31 (0.08-1.29)
Major causes of U5MR	0.0	Malaria, diarrhoea	Fever and ARI	Diarrhoea, Unknown
% Morbidity	10.1(6.7-13.5)	17(13.52-20.48)	11.2(8.64-13.76)	31.5 (27.95-35.05)
Major illnesses or symptom	Cough, Diarrhoea, and fever	Diarrhoea , fever and ARI	Diarrhoea, cough and fever	cough, diarrhoea and fever
% Measles coverage by card (95 % CI)	5.3 (3.1-7.6)	13.6 (10.6 -17.3)	13.3(8.5 – 20.3)	3(1.9- 4.7)
% Measles by card + recall (95% CI)	86.6(83.0-90.2)	65.7 (61-70)	80.2(73.5- 85.6)	25.3(22.0–28.9)
% BCG coverage –scar (95% CI)	23.9(17.5-30.3)	57.4 (52.9-62.4)	71.2((59.1-80.9)	34.9(31.2–38.7)
%Vitamin A supplementation in past six months (95% CI)	87.7(83.0-92.3)	91.6% (88.5-93.9)	71.2(59.1-80.9)	57.6(53.7–61.5)
Classification of nutrition situation	**Poor**	**Normal**	**Serious**	**Critical**

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Conclusion and recommendations:

During the first quarter of 2013, nine surveys were conducted and four of the survey results indicated a normal nutrition situation. This was linked to good post Meher harvest season positive impact, associated with last year (2012) good rain performance that resulted in relatively better production performance in the assessed woredas.

However, there were woredas in both Meher and Belg dependent areas that experienced failure or below normal Meher rains that affected production and in turn food security and nutrition situation. The poor Meher performance in those woredas coupled with the delay of the 2013 Belg rains and the long dry spell in the lowland woredas of the Eastern and North Eastern parts of the country caused acute water shortage for both animal and human consumption. This contributed for the deterioration of the nutrition situation in some of the woredas that are chronically food insecure. As result, Three woredas survey results were classified as 'poor', one 'serious' and one as 'critical' and the remaining four were classified as 'normal'. The situation was particularly a concern in the surveyed woredas of Somali region due to the long dry season 'Jilaal' that resulted in serious shortages of water and Pasture.

In all the nine (9) surveys results including the survey result that was classified as critical (Adadele), the under five mortality rates were normal or below the non-emergency threshold. This is partly achieved because of the ongoing nutrition interventions particularly CMAM being implemented by the Government supported by partners/NGOs. For example, as part of the routine health care delivery system, Therapeutic Feeding Program (TFP) is being implemented in all the surveyed woredas by the government and / or NGOs covering about 600 woredas

Emergency nutrition responses were recommended and or strengthened further by nutrition cluster partners in the two woredas with the nutrition situation that were classified as serious and critical. Close monitoring was recommended and implemented in all the woredas whose nutrition situation was classified as poor.

In the rest of the woredas, it was recommended to handover the implementation of the nutrition project to the respective woreda and regional authorities. Partners were also requested to continue supporting woreda health offices with CMAM implementation as per national outpatient roll out strategy implemented by the FMoH in collaboration with partners

1.3 NUTRITION SITUATION BASED ON HOTSPOT WOREDAS

Revision of hotspot woredas list is triggered by either deterioration of food security and nutrition situation in some of the woredas or by the result from seasonal needs assessments (Belg and Meher) led by the Government (DRMFSS), in collaboration with humanitarian stakeholders.

Hotspot woredas revision is usually done at two phases ie at regional and federal levels. In phase one, the regional early warning bureau in collaboration with partners, classifies its hotspot woredas using common hotspot classification criteria. Before the hotspot classification was done in January/February , a TOT training was conducted at regional level by the DRMFS/ENCU in collaboration with WFP, FEWSNET and UNICEF between December 2012 and January 2013 (except Somali region that was done in April). A total of 50 regional early warning and health officials from 8 regions were trained. The objective of the training was to standardize the hotspot classifications process and criteria across the regions and enhance consensus between regional and federal level. The hotspot revision at regional level was completed toward the end of January, 2013 and submitted to the DRMFSS.

Phase two of the hotspot classifications usually done at federal level involves revision of the regional level classifications. Federal level revision was done by technical team on hotspot classification comprising members from WFP, FEWSNET and DRMFSS/ENCU. The revision at federal level was finalized second week of February and approved by the DRMFSS on 11th February and circulated to all MANTF members.

A total of 89, 185 and 53 woredas were classified as priority 1, 2 and 3 respectively at national level for the first quarter of the year of 2013. When compared to October 2012 hotspot list, total hotspot woredas decreased by 13.3 percent (50 woredas) from 377 in October 2012 to 327 in January 2013. However, hotspot priority one woredas increased slightly by 5.9 percent from 84 in October to 89 in January. Woredas classified as priority two increased slightly by 7.5 percent from 172 woredas in October to 185 woredas in February; while priority 3 decreased from 121 to 53 during the same period. Oromiya region had the biggest number of hotspot priority one woredas accounting for 48 percent of the total priority one in the country. The big priority one woredas in the region was associated with poor 2012 performance in East and West Hararghe zones that had the highest number of priority one hotspot woredas. Somali region ranked second accounting for about 16 percent of total priority one woredas. There was no significant different in hotspot priority one for the remaining 4 major regions that are prone to nutrition emergencies (Amhara, Afar, SNNPR and Tigray). The distribution of hotspot woredas by region in Ethiopia in January/February is shown in Table 4 below.

The revised hotspot list guide partners (government and humanitarian actors) as well as donors to plan, prioritize and allocate limited resources for implementation of emergency nutrition responses particularly in hotspot priority one and two woredas while priority 3 are usually put on close monitoring. Following the release of revised hotspot list, nutrition cluster partners expressed commitment to continue strengthen nutrition responses in 36 hotspot priority one woredas and would expand to 27 and 29 priority one and two woredas respectively. Due to the evolving food security and nutrition situation in hotspot woredas, revision of hotspot woredas was planned to be done in April, 2013.

Table 4 : Distribution of hotspot woreda status by region and at national level Feb,2013

	January/February 2013 hotspot woredas			
Region	Pr 1	Pr 2	Pr 3	Total
Tigray	8	17	6	31
Afar	6	17	5	28
SNNPR	7	25	13	45
Oromia	43	40	4	87
Amhara	8	23	17	48
Benshangul -Gumz	0	3	2	5
Gambella	3	8	2	13
Somali	14	50	4	68
Harari	0	1	0	1
Dire Dawa	0	1	0	1
Total	89	185	53	327

1.4 NUTRITION SITUATION BASED ON NEW TFP ADMISSIONS

Analysis of the new TFP admissions in the past 10 years (2003 to 2012) indicate that new TFP admissions start depicting an increasing trend from February and reaches its peak in May/June coinciding with the peak hunger gap. After May/ June period TFP admissions start depicting a gradual decreasing trend toward the end of the year.

Given, the overall good Meher performance in 2012 and NMA's weather forecast for first half of 2013 and the ongoing TFP expansion by the FMOH, the ENCU/DRMFSS projected a gradual increase in TFP admissions in the first half of the year ranging from 5 to 9 percent in February and May respectively with an overall, 159,090 SAM cases (HRD estimate) see table 5 below. For the first quarter of the year, TFP admissions were projected to increase by 5 percent for each of February and March, with an overall SAM caseload of 71,303 at 80 percent reporting rate.

However, actual January to March 2013 TFP admissions did not mirror the projected increase. Admissions increased by 12 and by about 7 percent national wise in February and March respectively with an overall 67,981 TFP caseload admitted in an average of 9261 TFP sites per month with an above 89 percent reporting rate. Of the total first quarter TFP admissions, 5.4 percent of them we SAM cases with complications and therefore admitted in therapeutic feeding unit. Those without medical complications were treated in outpatient programme (OTP). The first quarter admissions constitute 95.3 percent of the projected caseload for that quarter and 42.7 percent of the January to June caseload. One could immediately see a paradox with the above relationship between actual percentage increase in malnutrition and actual caseload vis-a-vis the projected percentage increase and caseload see table 5 below. The reason is that TFP admissions continued to decrease in January from December 2012 levels instead of stabilizing at December levels as it was anticipated during the projection stage, (HRD preparation) leading to a big jump between January and February.

The ENCU also compared the 2013 TFP admissions with 2012 at national level and found that 2013 admissions are lower in 2012 by 6 percent after adjusting for TFP reporting sites associated with TFP expansion implemented by the FMOH. The distribution of TFP admissions at national and region level by month and reporting rate is summarized in Table 5 below. The overall TFP admission trend between Jan-March at national level is shown in Fig.2

Table 5: Actual TFP admissions compared with projected caseload during the 1st quarter Jan-Mar,2013

Month	Actual TFP admissions in 2012	Projected TFP admissions 2013 HRD	Actual admissions 2013	Projected % change in TFP adm (HRD)	Actual % change in TFP adm compared to HRD projection	Actual % increase Jan- June period
Jan	20,457	23,378	20,464	0	-12	
Feb	22,950	24,547	23,030	+5	-6	+12.2
March	25,376	25,774	24,683	+5	-4.2	+6.8
Apr	27,195	27,321		+6		
May	31,334	29,780		+9		
June	29,801	28,251		-5		
Total	157,113	159,090	67,981			

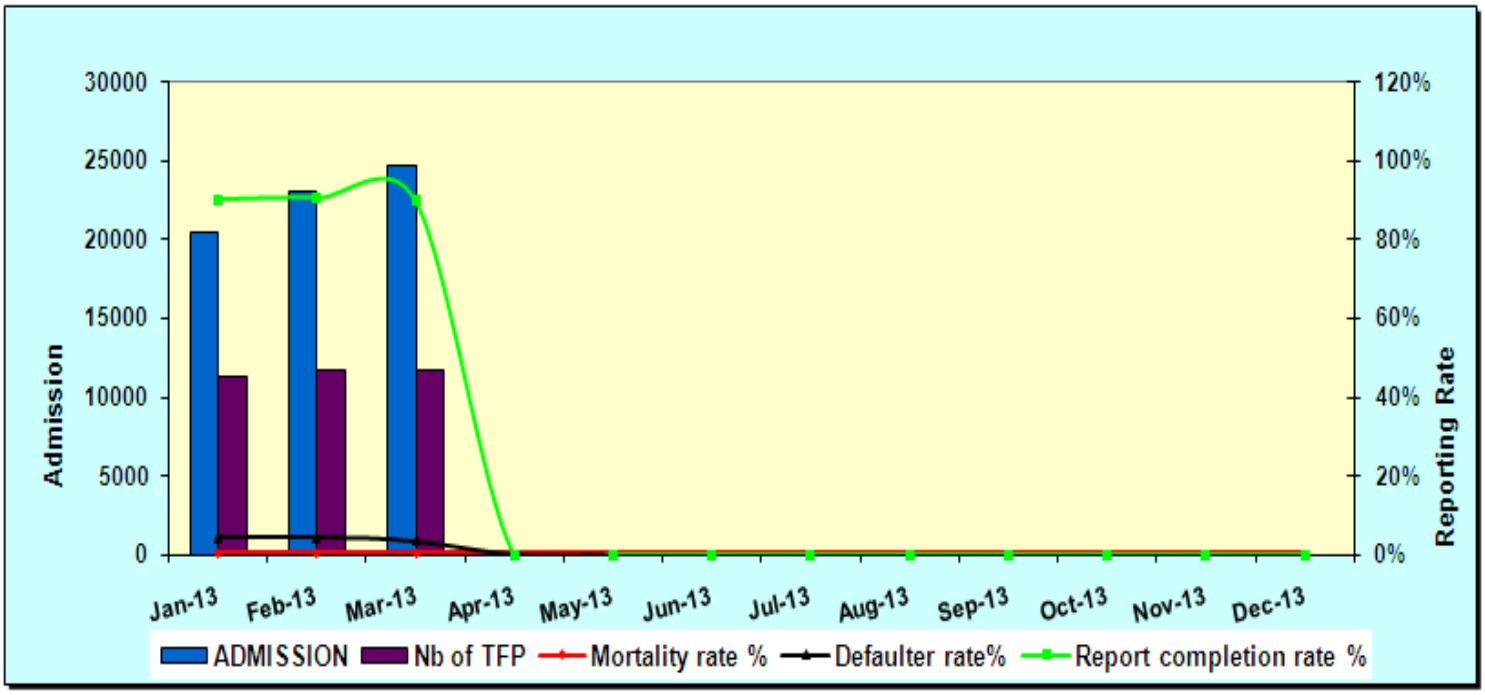

Figure 2 :Number of Admissions and Performance Indicators/TFP in Ethiopia/January to March 2013

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Regionally, TFP admissions trends varied significantly. In SNNPR, admissions increased in two months in a row; in February by 9 percent (from 4437 in January to 4835 in February) and by 67 percent in March (from 4,835 in February to 8975 in March) with over 94 percent reporting rates. Trend of SAM cases with complications were stable between January and February at around 8 percent and dropped to 6.4 percent in March as more out-patient cases were enrolled in the programme. However, numerically the number of SAM cases with complications was higher in March constituting about 68 percent of the Jan and February combined caseload.

Sharp increase in TFP admissions in March in SNNPR was linked with CHD screening associated with community mobilization and active case finding, late TSF response and deterioration of food security situation in some of the woredas. When compared to the 2012 and after adjusting for the TFP that reported in the specific months of January, February and March, new TFP admissions was found to be lower in 2013 by 37, 50 and 29 percent respectively. Overall, SNNPR accounted for 25.5 percent of total TFP admissions and about 34 percent of total SAM cases with complications in the first quarter at national level. The rest of the regions had lower monthly proportions of SAM cases with complications compared with SNNPR. TFP admissions trends in SNNPR is depicted in figure 3.

In Oromiya and Amhara, new TFP admissions fluctuated in the first quarter of the year. While it increased by 36 percent in February, it slightly decreased by March by 5 in Oromiya. Similarly in Amhara, TFP admissions increased in February by 28.3 percent and then decreased at relatively same rate in March, 26.8 percent. Thus, plausible interpretation of new TFP admissions trends at regional level in Amhara and Oromiya regions in January to March is confounded by the CHD screening conducted in February. As explained earlier, this is because; increase in malnutrition is normally expected beginning February to May coinciding with the peak hunger gap.

However, in some of the zones like East Hararghe in Oromiya region, the nutrition situation continued to deteriorate in March where TFP admissions increased by 38.6 percent from 2,025 SAM cases in February to 2,806 in March with over 96 percent of the reports collected in both months. The increase was associated with continued deterioration in food security and late emergency TSF responses in which all the 19 woredas were classified as priority one in February. Oromiya region had the biggest caseload in first quarter accounting for 38.7 percent of the total caseload at national level. The region was also leading in terms of caseload for three months in a row.

TFP admissions in Tigray were stable in February and March. In Somali, TFP admissions increased considerably by 33 percent from 1,124 in February to 1,495 in March with over about 89 percent reporting rate in both two months. Afar admissions can not be interpreted with certainty due to low reporting rates between January and March. However, deterioration of food security and nutrition situation as well as water shortage in Afar in March led to the DRMFS to increase the number of relief beneficiaries. The region also identified 17 woredas hotspot woredas that needed emergency nutrition responses. The ENCU/DRMFSS mobilized six partners (GOAL, IR, MSF Spain, SCI, AMREF and CARE) to strengthen nutrition responses in the region.

Moreover, updates from partners submitted to the ENCU as part of monthly MANTF updates indicated mixed TFP admissions trends in their operational woredas in Oromiya, Amhara and Somali regions. Out of the 45 woredas supported by partners whose update was received at ENCU, 14 depicted a decreasing trend while the remaining 31 indicated an increasing trend. However the increase was described by partners as normal and expected.

Table 6: Distribution of new TFP admission and reporting rate by regions and of national level Jan- Mar,2013

Region	December 2012		January 2013		February 2013		March 2013	
	Adm	RR (%)	Adm	RR (%)	Adm	RR (%)	Adm	RR (%)
SNNPR	5507	98.7	4437	98.1	4835	96.9	8075	94.9
Oromia	7856	92.1	7178	91.1	9789	91.7	9342	91.2
Afar	2010	69.7	1793	79.9	1300	71.3	1209	64.2
Amhara	4098	88.8	3859	89.7	4951	89.5	3624	89.0
Tigray	1182	92.3	1728	86.9	850	82.3	890	83.7
Somali	2084	86.7	1372	60.5	1224	88.9	1495	89.7
Gambella	71	89.3	45	65.9	43	65.9	48	73.2
Ben/Gumuz	44	94.5	52	61.2	38	61.2	-	-
Addis Ababa	14	100	-	-	-	-	-	-
Dire Dawa	-	-	-	-	-	-	-	-
Harari	-	-	-	-	-	-	-	-
Total	22,866	92.0	20,464	90.3	23,030	90.8	24,683	90.1

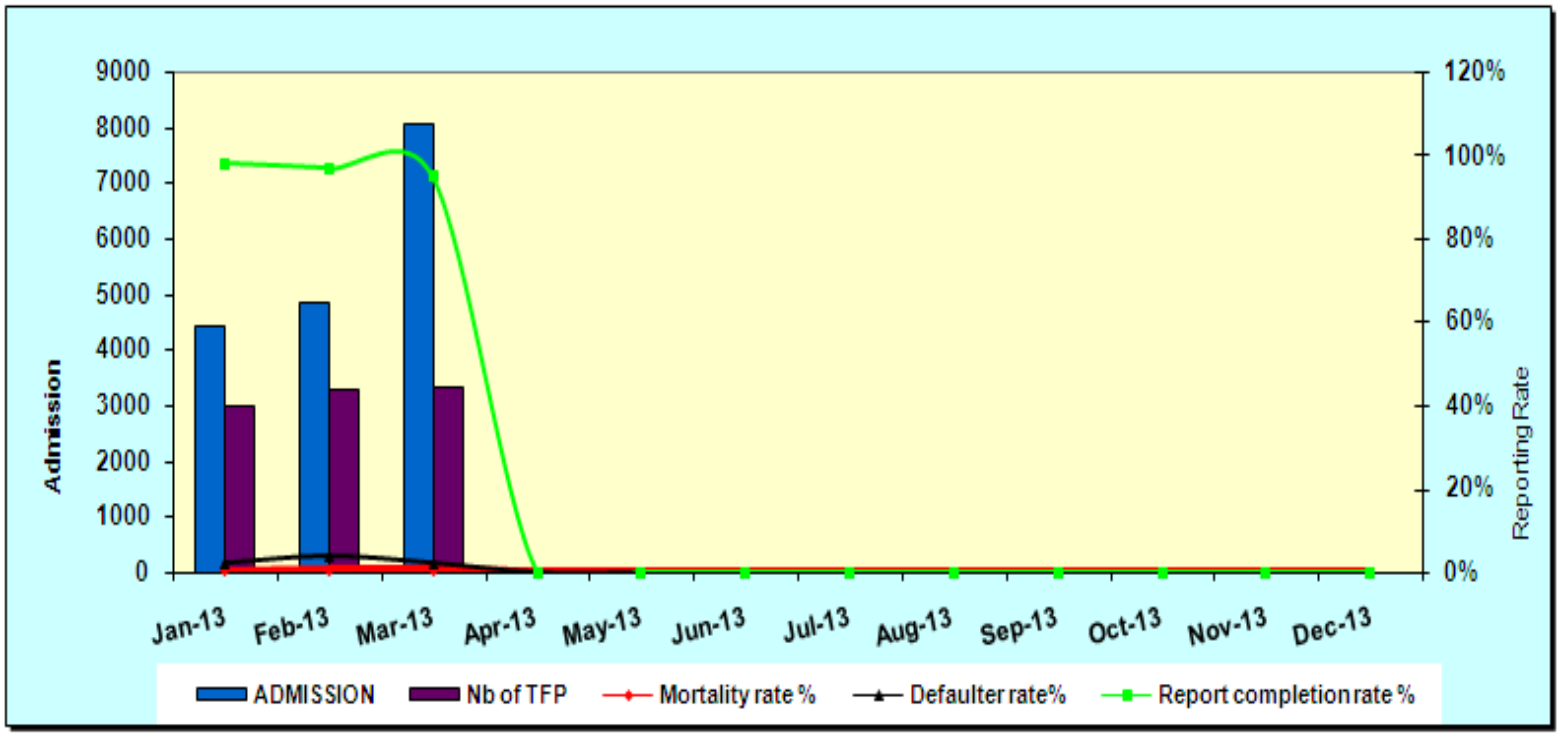


Figure 3: Number of Admissions and Performance Indicators/TFP in SNNPR/January to March 2013

TSF Distribution Site

ENCU

During the first quarter, TSF responses were implemented in a total of 55 woredas (NGOs 40 and WFP 15) in four regions: Somali, Amhara, Afar Oromiya on part of the NGOs[1] and Tigray and SNNPR with respect to WFP. Altogether, WFP and NGOs enrolled a total of 79,272 moderately malnourished under-five, pregnant and lactating women between January and March constituting 14.1 percent of the 564,000 projected in the HRD. Of the total beneficiaries about 53 percent were under-five children and the remainder was pregnant and lactating women. WFP alone reached 51.3 percent of the total TSF beneficiaries and the reminder were enrolled by NGOs.

There are two reasons for low coverage of TSF beneficiaries compared to the HRD projection. First, WFP TSF response in February and March in hotspot priority 1 woredas was delayed due to long transport tendering process in the regional early warning bureaus. Second, TSF beneficiaries enrolled by NGOs decreased from 18,094 in January to 10,438 in March as several of the NGOs projects were phased out. The difference in TSF beneficiaries between NGOs (40 woredas) and WFP (15 woreda) lies in their mode of beneficiaries identification. While WFP beneficiaries are identified following community based screening done by the respective regional health bureaus, the NGOs beneficiaries are identified based on routine monthly screening at health facility level. The distribution of TSF beneficiaries between January and March is summarized in the Table 7 below.

Table 7: TSF Beneficiaries in January to March enrolled by WFP and NGOs in 2013

	January,2013			February,2013			March,2013			Total
Partner	< 5	PLW	Woredas	< 5	PLW	Woredas	< 5	PLW	Woredas	
NGOs[1]	9,655	8,439	40	3,491	6,612	34	5,909	4,529	28	38,635
WFP	22,809	17,828	15							40,637
Total	32,464	26,267	55	3,491	6,612	34	5,909	4,529	28	79,272

TFP and TSF admissions outlook for the April to June

Based on the January to March TFP admissions, the ENCU project that admission in TFP programmes will continue to increase between April and June reaching its peak in May with slight decrease in June as it was observed in 2011 and 2012. The rate of increase will vary per region, depending of evolving food security situation, implementation of planned and ongoing emergency nutrition responses by government and partners in hotspot woredas and CHD/EOS screening for under-five, pregnant and lactating women.

The ENCU/DRMFSS in collaboration with partners will continue to closely monitor the evolving nutrition situation using a combination of monitoring systems (ie TFP admissions, revision of hotspot woredas, ad hoc and bi-annual surveys that are scheduled to be implemented in the six region during the second quarter of 2013.

[1]Merlin, GOAL, SC, CONCERN, Mercy Corps, IMC, WVE, Plan International, Islamic Relief,Care and ACF

2. NUTRITION RESPONSE

Emergency nutrition responses implemented by the government and partners and overall performance of TFP during the first quarter in hotspot woredas is summarized below.

2.1 Emergency nutrition response strategies

In order to avoid late initiation of emergency nutrition responses (June-September) observed in 2012 after peak admissions in May, the ENCU/DRMFSS in collaboration with OCHA/HRF organized a meeting in December 2012 with all partners and agreed: 1) to conduct situation analysis between December and January 2013 in collaboration with regional early warning bureau. 2) Ensuring continuity of emergency nutrition responses where situation demands and avoiding phase out and phase in approach. 3) OCHA/HRF committed to accelerate funding of emergency nutrition responses to avoid phase out and phase in and 4) Guidance for the situation analysis was prepared by the ENCU and shared with partners.

The ENCU and HRF reviewed the situation analysis prepared by partners and recommended either proposal be developed or further improvement be made in consultation with regional early warning and health bureaus.

Advocacy for timeliness of emergency nutrition responses was conducted to the regional early warning and health bureaus as well as with partners in SNNPR by ENCU in collaboration with OCHA/HRF, WFP and UNICEF. Similar advocacy meeting were conducted in Afar and Oromiya regions. The following common strategies for timely emergency nutrition responses were agreed with regional officials: i) Understanding of the implication/impacts of late responses on the current and long term health and nutritional status of children on growth, development, education and productivity, ii) Early commitment from partners to strengthen nutrition responses in hotspot woredas iii) conducting joint situation assessments in collaboration with regional early warning bureaus and reaching consensus of the nutrition situation in the respective woredas and how it was likely to evolve between January to June iv) Joint proposal development with regional officials/joint implementation of emergency nutrition responses v) Understanding of the nutrition cluster review and donor fund process vi) Timely MOU signing and vi) timely implementation of emergency nutrition responses (ie timely: screening, sharing of screening results, hotspot classification, delivery of supplies and following the national guidelines for emergency nutrition responses).

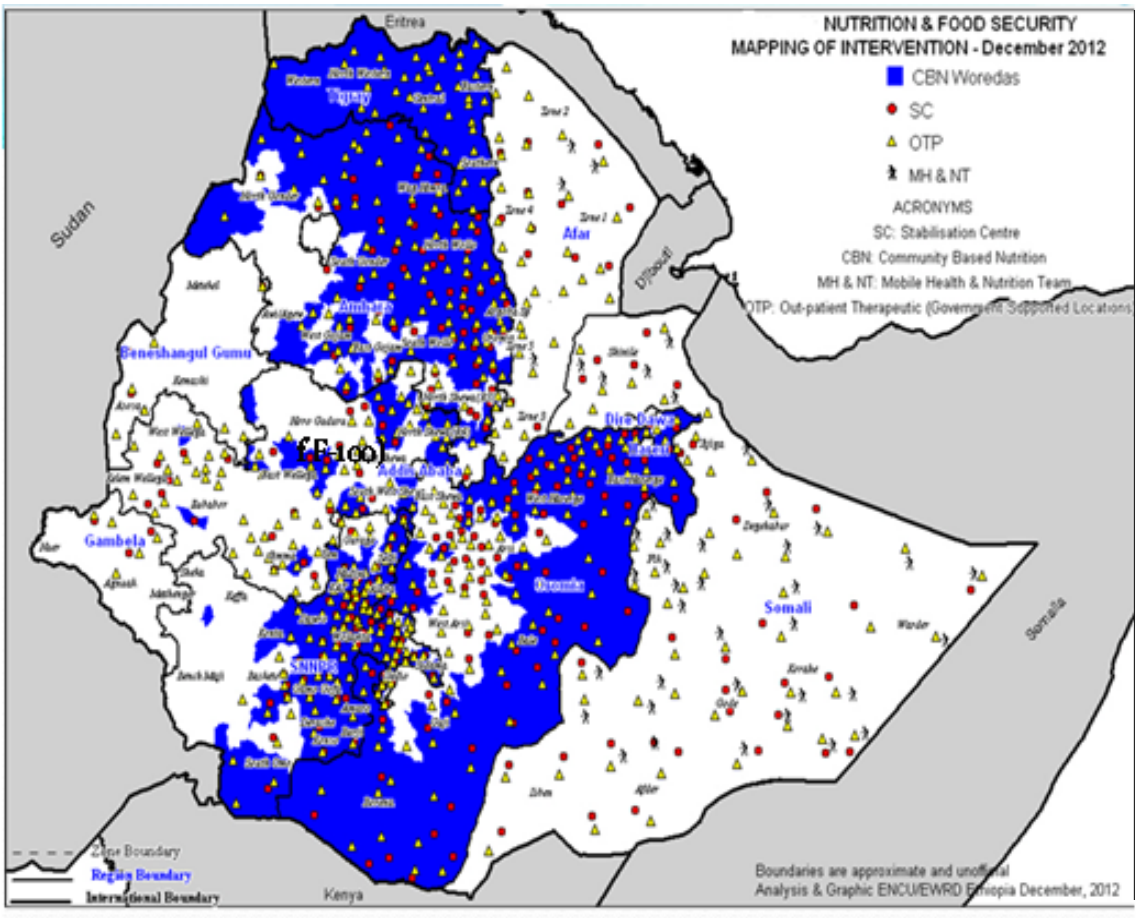
In additional, the ENCU coordinated development of SOP for implementation of targeted supplementary feeding programme in Ethiopia for priority 1 and priority 2 woredas. The ENCU also in collaboration with partners (NGOs, UN agencies and FMOH) developed a guidance on the minimum human resources that should recruited by NGOs supporting government (FMOH/RHBs) in implementing CMAM in hotspot woredas in agrarian and pastoralist contexts. Both the SOP and guidance on CMAM human resources capacity support were still being finalized.

2. 2 COVERAGE OF EMERGENCY NUTRITION RESPONSES IN HOTSPOT WOREDAS

Following the release of the revised hotspot woredas list, the federal ENCU mobilize nutrition cluster partners through the MANTF forum to initiate and/or strengthen nutrition responses in hotspot woredas in the regions. Building on earlier situational analysis, partners expressed commitment to continue strengthening emergency nutrition responses in 36 and committed to expand in 27 out of 89 priority 1 woredas. Similarly partners committed to continue supporting 52 and expanding to 29 new hotspot priority 2 woredas. On its part WFP expressed commitment and was responsible to implement TSF in all priority 1 woredas unless NGOs present in the woreda had the capacity to do so.

Implementation and coverage of emergency nutrition responses were regularly monitored by both regional and federal ENCU in particular the six regions (SNNPR, Oromiya, Afar, Somali, Amhara and Tigray) prone to nutrition emergency. The implementation of emergency nutrition responses in hotspot woredas within four weeks after the release of the hotspot woredas list were tracked and updated from time to time.

Accordingly, by end of March, 96.5 percent of 86 hotspot priority one woredas in six regions were covered with OTP while TFU services coverage was 75.6 percent. TSF coverage in priority 1 woredas stood at 74.4 percent. About 86 percent of the 172 priority two woredas were covered with OTP services while TFU coverage stood at about 74.8 percent. TSF implementation in priority two woredas depend on the need along with justifications from regional early warning bureaus and therefore its coverage is usually difficult to objectively calculate.



2.3 Donor Funded emergency nutrition responses coordinated by the nutrition cluster

The nutrition cluster through ENCU and in collaboration with HRF/OCHA reviewed a total of eight (8) projects planned to be implemented in five regions (Afar, Amhara, Somali, Oromiya and SNNPR). The eight projects to be / or being implemented by six NGOs[2] covered a total of 30 hotspot woredas of which 20 of them were priority one and the remaining 10 were priority two. HRF also funded central procurement of TFP supplies for SAM management through UNICEF. The supplies were were distributed through the FMOH systems and were accessible by all partners implementing CMAM including the FMoH/RHBs.

By the end of the third quarter at total 13 of partners led by the FMOH implemented TFP services across the country covering an average of 11,684 TFP sites per month in 599 woreda of which 62 (10.3%) were supported by NGOs[3]. About 69 percent (413) of 599 woredas that implemented TFP services had a least one TFU/SC site for management of complicated SAM cases of which Oromiya and SNNPR regions accounted for 59.3 percent of the total TFU/SC sites in the country.

During the same period UNICEF distributed a total of 44,827, 308 and 392 cartons of plumpy nuts, F-75 and F-100 respectively. In additional, a total of 50,430 bottles of Amoxicillin were distributed during the reporting period.

Coverage of nutrition interventions at the beginning of the first quarter of 2013 is shown in the above map.

2.4 GAPS IN EMERGENCY NUTRITION RESPONSES IN HOTSPOT WOREDAS

One of the major gaps in emergency nutrition response in the first quarter was the delayed implementation of TSF in hotspot priority one woredas by FMo WFP in collaboration with the regional early warning bureaus. And one of the major reasons for delayed TSF response was due to lengthy transport tendering and awarding process in the regions. The DRMFSS had to intervene and the problem was sorted out.

As hinted earlier, about a quarter of priority 1 woredas (21 woredas) lacked TFU service (11 in Somali region, 3 in Afar, 4 in Oromiya and 3 in Tigray). In addition, TFU/SC services was also lacking in 45 (26.2%) hotspot priority two woredas, two third of them from Somali region. FMOH, regional health bureaus in collaboration UNICEF and NGOs continued strengthening and expanding TFP services in hotspot woreda and across the country in an effort to fill the gaps. As a result the number of TFP sites increased by 4.4 percent from 11,373 in December 2012 to 11,875 in March 2013.

[2]SCI, MC, CARE, IMC, Child Fund and GOAL

[3]MSF Holland, MSF Spain, SCI, ACF, concern, CARE, IMC, MC, Child Fund, KHI, Islamic Relief, Merlin and Plan International

2.5 PERFORMANCE OF EMERGENCY AND NON EMERGENCY TFP SERVICES IN ETHIOPIA

The standard performance indicators (cure, death and defaulter rates) are usually tracked on monthly basis by FMoH and partner implementing CMAM in Ethiopia as per FMOH monthly reporting format. The monthly reports are consolidated at health facility, woreda, regional and federal level and analyzed at the regional and by the federal ENCU at DRMFSS. Based on the 89.7 percent reports that were collected, performance of TFP services at national level continued to exceed National (FMOH)[4]and Sphere[5] standards. As it was published in previous bulletins in 2011, death rates in TFP sites under the FMOH and those supported by the NGOs continued to be below 0.5 percent at national level ranging between 0.2 to 0.9 percent in the six regions (Somali, SNNPR, Oromiya, Tigray, Afar and Amhara) .

With exception of Tigray, cure rate in all the six major regions in the entire first quarter were 80% and above with an overall national average of 86 percent and above. While overall performance is very impressive, there are a considerable proportion of SAM cases that are discharged in TFU/SC sites indicating that they stay longer than expected. UNICEF in collaboration with the regional health bureaus in some of the regions such as Oromiya conducted an assessment to establish why. The findings of this assessment will be made available to nutrition cluster partners once finalized.

Table 8 :Performance of emergency and non-emergency TFP in Ethiopia Jan-Mar 2013

Region	Total Discharge (%)	Recovery Rate (%)	Mortality Rate (%)	Defaulter Rate (%)	Other Rates* (%)
SNNP	16,288	85.7	0.3	2.7	11.3
Oromia	25,440	88.2	0.2	3.0	8.6
Somali	3,761	89.4	0.3	4.8	5.5
Tigray	3,343	82.0	0.6	4.4	13.0
Afar	2,885	86.5	0.5	7.1	5.9
Amhara	12,459	83.0	0.4	7.1	9.6
Gambela	160	82.5	3.1	5.6	8.8
DireDawa					
Ben/Gumuz	97	90.7	1.0	8.2	0.0
Addis Ababa	0				
Ethiopia	64,433	86.2	0.3	4.1	9.4

[4]Death rate<5%; defaulter rate<15% and Cure rate>75%

[5]Death rate<10; defaulter rate<15% and Cure rate>75%

*Non respondent medical transfers

3. Other technical activities implemented by the nutrition cluster coordinated by the ENCU

In addition to the coordination of emergency nutrition assessment and response, the ENCU of the DRMFSS, coordinated capacity building on hotspot classification at regional level, provided updates of emergency nutrition situation to the government and partners as well as coordinated implementation of operational study on improving nutrition situation monitoring in pastoralist contexts. The three activities are briefly described below.

3.1. Capacity building of regional early warning bureaus and partners on hotspot classification

Following the finalization of the hotspot guideline in 2012, the next step was to train all respective regional early warning bureaus officials and other stakeholders (i.e. health bureaus, UN agencies, NGOs) involved in hotspot classifications in the regions. The group training were conducted by the DRMFSS/ENCU in Kombolcha[6] , Adama[7] and Somali[8] locations in collaboration with WFP, FEWSNET and UNICEF between January and February 2013.

The objective of the training was to standardize and harmonize hotspot revision at regional and federal levels. The standardization and harmonization is indented to avoid complaints on hotspot status of some of the woredas after the hotspot list has been released at federal level. Overall a total of 50 participants representing regional early warning bureaus, regional health bureaus and UN agencies operational in the respective regions were trained.

3.2. Operational study of improving nutrition situation monitoring in pastoralist context in Ethiopia.

Conducting effective nutrition situation monitoring in pastoralist communities have been a challenge not only in Ethiopia but also in other countries with pastoralist communities due to the mobility nature of pastoralist life. In order to address this challenge, the ENCU/DRMFSS/FMoH in collaboration with partners through the PSMTWG and financial support from UNICEF, engaged a consultant firm (IMaCs) to conduct the study on "improving nutrition situation monitoring in pastoralist contexts".

Under the coordination of the ENCU, the PSMTWG reviewed the study framework, tools and provided guidance on the design and implementation of the study including consultations with all stakeholders from federal to community level. The study was conducted in four regions (Somali, Afar, Oromoya and SNNPR) that have significant number of pastoralist communities to ensure inclusiveness and establish better understanding of the differences in pastoralist life and mobility if any. The study is expected among other things to pin point the strengths and areas of improvement of the existing emergency nutrition monitoring system in pastoralist communities and recommend ways to improve them.

The study commenced in February and was expected to be completed in March/April. Final report was expected May/June 2013. Once finalized the main finding of the study will be published in the subsequent ENCU quarterly bulletins.

[6] For Afar, Tigray and Amhara regions

[7] For SNNPR, Oromiya, Gambella

[8] For Somali region

3.3 COORDINATION MECHANISMS AND NUTRITION INFORMATION ANALYSIS AND SHARING

Since the beginning of 2013, the nutrition situation in the first half of 2013 was predicted to be better than it was observed in 2011 and 2012. In view of this the MANTF coordination meetings were held on monthly basis. The regular MANTF meetings provided opportunities to nutrition cluster partners to share situation updates focusing on TFP admissions, completed, ongoing and planned surveys, coverage of emergency nutrition responses and updates on supplies status in their operational areas. The meetings focused on addressing key issues/challenges that were encountered by partners in their operational areas and recommendations for addressing them. The federal ENCU followed up on action points and provided feedback to MANTF members in subsequent meetings.

Two ad hoc MANTF meetings were also held following release of hotspot woredas list to give partners opportunity to express commitment to woredas they would like to strengthen responses and avoid overlap and duplication of resources. In additional a number of bilateral and TWG meetings were organized and hosted by the ENCU at the DRMFSS

The ENCU also prepared nutrition inputs included in the monthly (Jan to March) early warning bulletin published by the early warning Directorate of the DRMFSS. Several nutrition updates were also prepared by the ENCU, cleared by the DRMFSS and published in the weekly OCHA humanitarian bulletin.

Acronym

DRMFSS	Disaster Risk Management and Food Security Sector
ENCU	Emergency Nutrition Coordination Unit
ENA	Emergency Nutrition Assessment
ODPPC	Oromia Disaster Prevention and Preparedness commission
EWFSSB	Early Warning and Food Security Sector Bureau
RHB	Regional Health Bureau
SMART	Standardized Monitoring and Assessment in Relief and Transition
WHZ	Weight for Height –Z Score
SD	Standard Deviation
GAM	Global Acute Malnutrition
SAM	Server Acute Malnutrition
CMAM	Community Based Management of Acute Malnutrition
TFP	Therapeutic Feeding Programme
TSF	Targeted Supplementary Feeding
OTP	Out-Patient Therapeutic Programme
CHD	Community Health Days
MANTF	Multi-Agency Nutrition Task Force
HRF	Humanitarian Response Fund
TFU	Therapeutic Feeding Unit
FMoH	Federal Ministry of Health