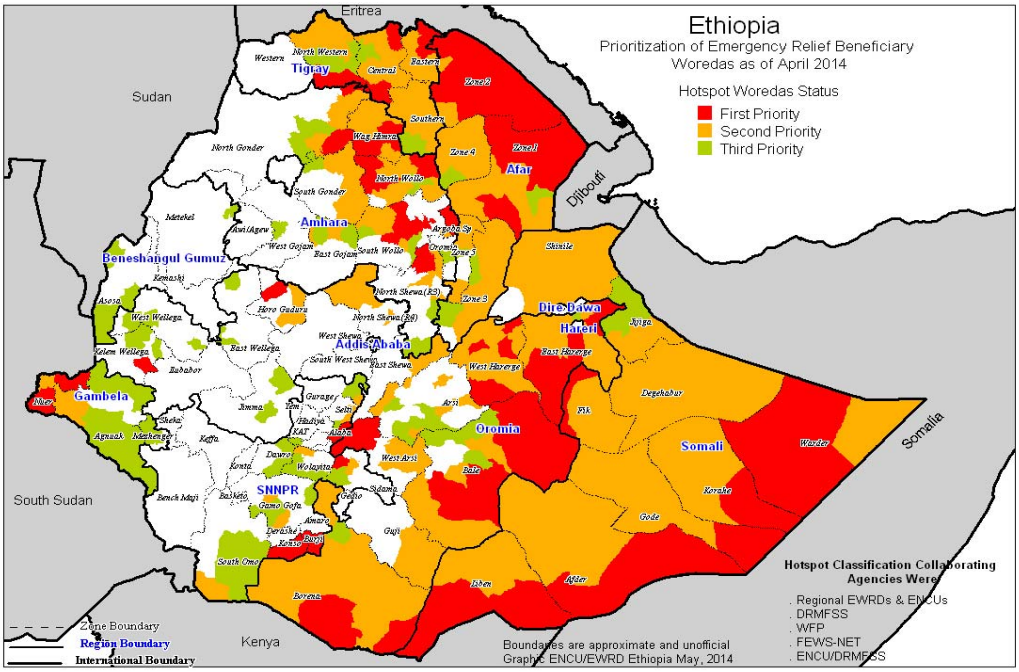
EMERGENCY NUTRITION QUARTERLY BULLETIN

(First and Second Quarter 2014)

Emergency Nutrition Coordination Unit

Early Warning & Response Directorate

(Disaster Risk Management & Food Security Sector)



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1. Nutrition situation

The emergency nutrition situation at national level is monitored by collecting and analyzing different sources of nutrition information such as TFP admissions, ad hoc and bi-annual surveys and revision of woredas's hotspot status. The nutrition situation at national level for first and second quarter of 2014 based on the above sources is described in Section one of this bulletin

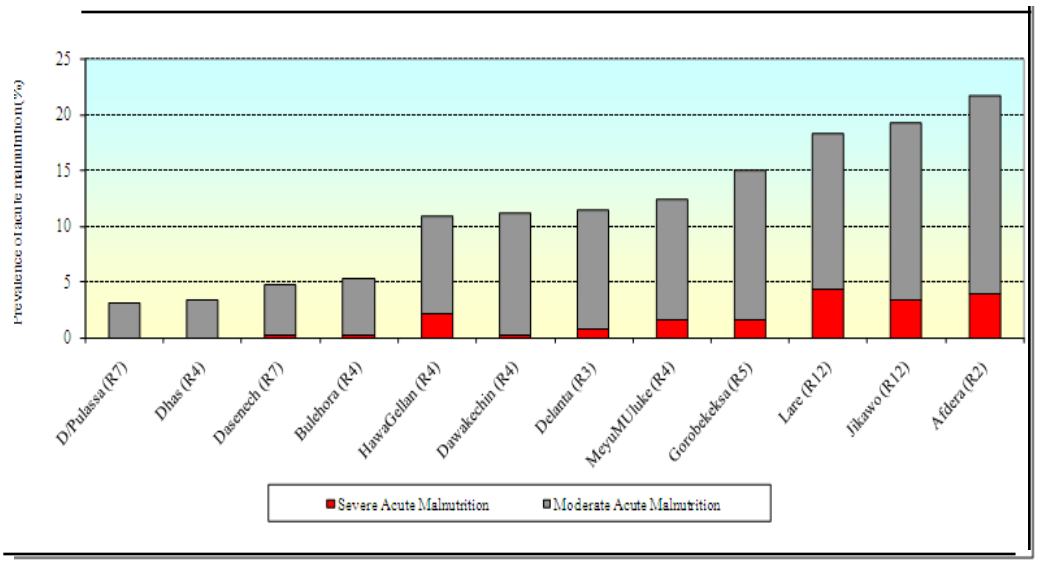

Figure 1: Ad hoc nutrition survey results from January-June 2014

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1.1 NUTRITION SITUATION BASED ON STANDARD SURVEY RESULTS

In the first and second quarter of 2014, a total of 12 ad-hoc and 21 bi-annual standard nutrition surveys were conducted in the country. The ad hoc surveys were conducted either to confirm reports of deterioration nutrition and food security situations or monitor nutrition responses or as end line to support decisions making to either continue or phased out partners support. While, the main objective of the bi-annual surveys is to provide reliable, accurate and timely nutrition data and information for early warning, risk mitigation and prevention of nutrition related emergencies in advance. It gives the government and humanitarian community the opportunity to prevent/mitigate the deterioration in nutritional status of children, well in advance and enhance children's physical and mental growth potentials; thereby fulfilling the government's DRM policy and strategy

1.2 AD-HOC AND BI-ANNUAL SURVEYS

A total of 12 standard nutrition surveys were conducted in the first and second quarters of 2014. Of the 12 surveys, two were undertaken in agrarian regions of Amhara -1 and SNNPR-1 while two surveys were conducted in the pastoralist regions of Afar -1 and SNNPR -1. The remaining 8 surveys were undertaken in the agro-pastoral areas of Oromiya -5, Gambella -2 and Somali -1 regions. The surveys were conducted by nutrition cluster partners (NGOs) that included: GOAL -3, Concern-3, Merlin-3, and IMC-2 and also by Oromiya DPPC-1.Of the twelve surveys conducted, four were carried out to confirm reports of concerning nutrition situation food security deterioration.The remaining eight were conducted to either monitor or as end line surveys following implementation of emergency nutrition responses.With respect to bi-annual surveys, a total of 21 were conducted in the second quarter of 2014 in in 6 regions (Afar, Amhara, Tigray, Oromiya, SNNPR and Somali). Four surveys were carried out in each of Amhara, Oromiya and SNNPR while three surveys were undertaken in each of Afar, Somali and Tigray regions. These surveys were conducted and coordinated by each of the respective regional ENCUs in collaboration with the regional early warning bureaus, RHBs, respective zonal and woreda early warning and health offices. In regions where technical capacity is limited, federal ENCU requested partners' technical support in survey preparations, implementation as well as report writing.

1.3 SURVEY METHODOLOGY

All the 12 ad hoc and 21 bi-annual surveys applied a two- stage cluster sampling based on the ENA SMART methodology. Clusters included in the survey ranged from 33 in Damote Pulassa to 63 in Dessie Zuria woredas depending on the respective area contexts. Special attention was given on both anthropometry and mortality sample size determination as well as on cluster and households selection depending on the survey woredas' actual situation.
To maintain survey data quality, all surveys (i.e. proposals, raw data and reports) were reviewed & validated by the FENCU of the 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 guidance and support was given to the partnering agencies to prepare proposals according to the national guidelines. Partners' assessment plans and implementations for both ad hoc and bi-annual surveys were followed up by the ENCU to ensure timely implementation and submission of survey reports.

All the ad hoc and bi-annual surveys data sets for anthropometric and mortality rates were analyzed using the ENA -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.

1.3 NUTRITION SURVEY DATA QUALITY CHECK

Quality checks on anthropometry and mortality raw data were conducted using the plausibility function of the ENA - SMART November 2013 software against the major quality criteria set for nutrition surveys for both ad hoc and bi-annual 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: Others included: WHZ distributions as measured with standard deviation, the index of dispersion, Skewness & kurtosis.

As per the major criteria, data quality check for the 12 ad hoc and 21 bi-annual surveys revealed that the digit preference score for weight height measurements generally within the recommended cut off points. The Standard deviations (SD) of WHZ for all 33 surveys were below 1.2 of which 55 percent of them had WHZZ-score below 1SD. Moments of Skewness and Kurtosis were within ± 0.2 (which is excellent) for 85 and 88 percent of all the surveys respectively. The remaining surveys are also within acceptable range of +0.4 and -0.4. Data quality check summary results of all the 33 surveys are presented in Table1 below

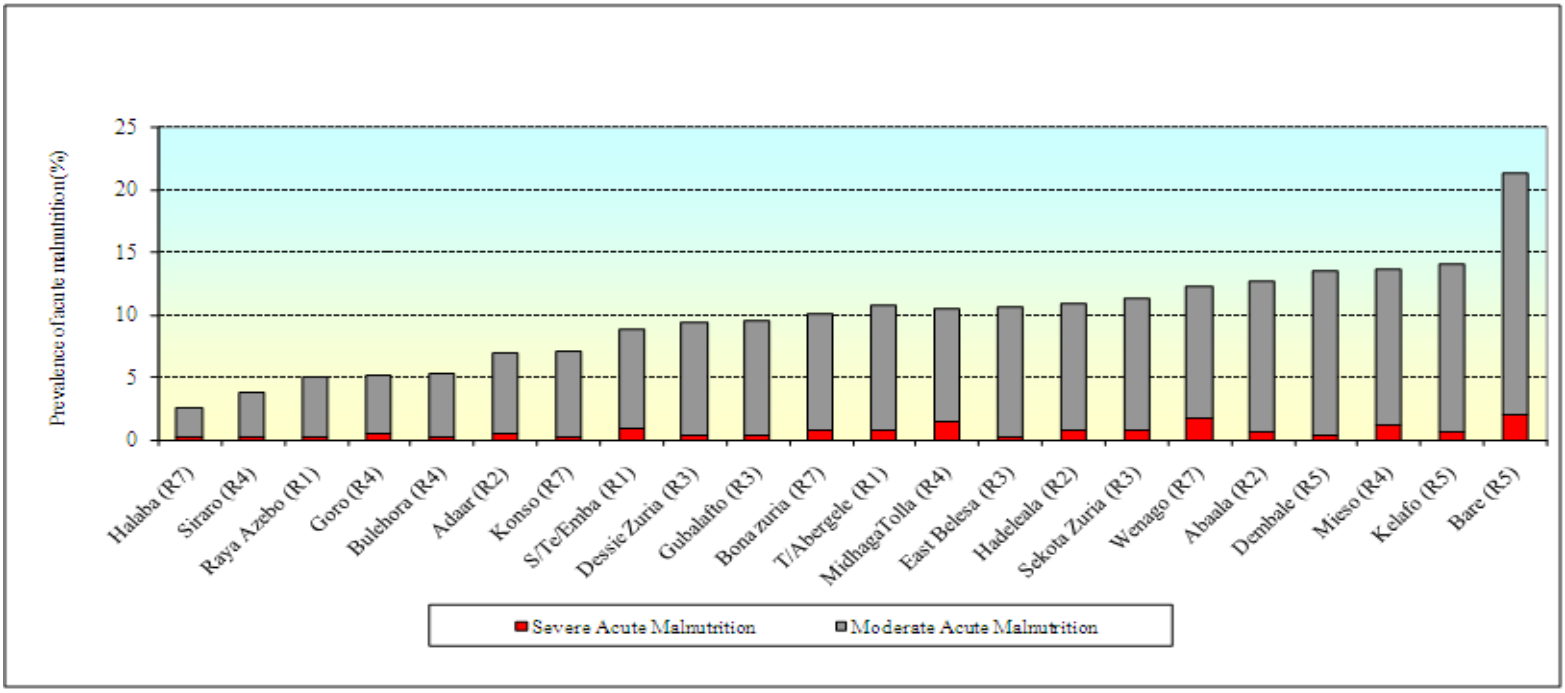

Figure 2: Bi-annual nutrition survey results from January-June 2014

Table 1: First and second quarters of 2014 Ad-hoc and Bi-annual surveys 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
Ad-hoc quality check results									
Merlin	Dhas	3	4	0.98	0.37	0.08	0.2	1	0.9
Merlin	Dawakechin	6	7	0.98	-0.03	-0.18	0.6	1.04	1.1
Goal	BuleHora	5	6	0.94	-0.13	-0.09	0.2	0.96	1.1
Concern	Dasenech	4	4	1.04	-0.11	-0.01	0.5	1.1	1.1
IMC	Damote pulassa	6	9	0.92	0.2	0.15	0.4	0.84	0.9
IMC	Meyu muluke	5	7	0.99	-0.03	-0.09	1.2	0.88	1
Concern	Delanta	5	5	0.92	0.14	0.22	0.7	0.8	0.9
Goal	Jikawo	3	5	1.11	-0.05	-0.1	2.5	0.73	1
Merlin	Gorobekeksa	5	7	1.01	0.01	0.09	1.3	1.01	1
Concern	Lare	3	3	1.09	-0.37	0.01	2.7	0.66*	1
ODPPC	HawaGellan	4	4	1.16	-0.34	-0.16	0	0.74	0.9
Goal	Afdera	3	5	1	-0.15	0.2	1.3	1.06	1.1
Bi-annual quality check results									
Tigray DPPB	S/Te/Emba	4	5	0.97	-0.24	0.01	1.9	0.87	1.2*
Tigray DPPB	T/Abergele	6	5	0.99	0.12	-0.12	1.2	0.8	0.9
Tigray DPPB	Raya Azebo	5	10	0.95	0.03	-0.07	0.3	1.05	1.1
Afar DPFSPCO+ GOAL	Adaar	5	6	0.91	-0.05	0.27	0.2	1.1	1.1
Afar DPFSPCO+ GOAL	Hadeleala	5	3	0.91	0.01	0.01	1.1	0.97	1.1
Afar DPFSPCO+GOAL	Abaala	4	4	0.92	-0.07	0.12	0.2	0.89	1.1
AmharaDPFSCO	Gubalafto	7	9	0.91	-0.04	0.4	0.6	0.91	0.9
Amhara DPFSCO	SekotaZuria	4	6	0.95	-0.13	0.07	0.6	0.97	0.9
AmharaDPFSCO	DessieZuria	6	13	0.91	0.13	0.14	0	0.85	1.1
AmharaDPFSCO	East Belesa	6	6	1.01	0.02	-0.13	0.2	0.67*	1
OromiyaDPPB	Goro	2	5	0.95	0.02	0.11	0.9	1.07	1
OromiyaDPPB	Mieso	4	4	1	-0.08	-0.05	1.3	1	1.3*
OromiyaDPPB	MidhagaTolla	4	4	1.03	-0.13	-0.01	1.8	1.15	0.9
OromiyaDPPB	Siraro	5	6	1.02	0.04	-0.12	2.1	0.72	1
OromiyaDPPB	Konso	3	7	0.94	0.05	-0.03	0.2	0.91	1
OromiyaDPPB	Halaba	3	4	0.91	0.1	0.1	0.4	0.94	1.1
OromiyaDPPB	Bona zuria	4	6	1	-0.18	-0.2	1.2	0.69	1.1
OrimiyaDPPB	Wenago	3	5	1.06	-0.26	-0.2	1.7	0.97	1.1
Somali DPPB	Dembale	4	6	1.03	-0.02	-0.26	1	0.77	1.1
Somali DPPB	Bare	6	7	1.04	0.07	-0.36	0.5	0.96	1
Somali DPPB	Kelafo	4	3	1.03	0.05	-0.14	0	1.17	1.1

Key survey findings: Ad hoc surveys

The level of malnutrition as measured by Global Acute Malnutrition (GAM) ranged from 3.1 percent in Damot Pulassa woreda in SNNP region to 21.7 percent in Afdera woreda, in Afar region. The nutrition situation in three out of the 12 surveys (one in Afar and two in Gambella) were classified at 'Critical'and four other surveys (2 in oromiya, 1 in Amhara and 1 in Somali) were classified at serious. The critical nutrition situation reported in the two woredas (Lare and Jikawo) in Gambella region were partly linked to South Sudan refugees influx in host communities; whereas the Afdera situation was partly related with the critical water shortage problem in the woreda.

Generally, about 67 percent of the surveys conducted in the first and second quarters of this year were either classified as poor serious or critical malnutrition situation in the surveyed woredas (see Table 2-4). One third of the surveys (33.3%) that were conducted reported GAM prevalence less than 6 percent and were classified as normal in the absence of aggravating factors .

The prevalence of Severe Acute Malnutrition (SAM) ranged between 0.0 percent in Damote Pulassa of SNNPR and Dhas woreda in Oromiya to 4.3 percent in Lare woreda in Gambella region. About 50 percent (6)of the surveys results reported SAM levels below 1 percent and 25 percent(3) of the survey results reported SAM levels between 1 and 2.4 percent whereas the remain 25 percent (3) results reported SAM levels between 3 and 4.3 percent.

With exceptional of Lare in Gambela region, crude mortality rates were normal in all the remaining 11 woredas. However, under- five mortality rates exceeded National and Sphere emergency thresholds in Jikawo and Lare woredas in Gambale region ranging from 0.0 in Dhas and Meyumuluke in Oromiya and also in Delantai n Amhara to 5.28 in Lare woreda in Gambella region. For remaining woredas, under-five mortality was normal. Diarrhea was reported to be among the major causes of the under- five deaths accounting for about 33 percent of the total reported causes of deaths followed by Respiratory Tract Infection (27%) and measles (20%).

The prevalence of morbidity among under- five children was between 5.1 percent in Dhas woreda in oromiya and 33.1percent in Jikawo woreda in Gambella region. The most common perceived morbidities reported two weeks prior to the respective survey periods included: Diarrhoea, respiratory tract infection/cough, fever and measles in their order of arrangement. Diarrhoea was the most leading causes of morbidity reported in most (92%) of the surveys.Measles cases were reported in Lare, Dawakech in and Gorobekeksa woredas. Control measures were undertaken by the government (FMOH/RHBs)and partners to address the problem.

Measles vaccination coverage (Measles by card + recall) was below Sphere standards of 90 percent in 9 of the surveys and only two surveys in Damote Pulassa and Delanta woredas reported above 90 percent coverage.The measles vaccination coverage (Measles by card + recall) ranged from 4.6 in Afdera to 94.8 percent in Delanta woreda. BCG coverage as estimated with presence of scar ranged between 4.1 and 77.1 percent with the lowest coverage reported in Afdera woreda in Afar region.

The vitamin supplementation coverage was below the recommended Sphere Standards coverage of 95 percent in 11 of the surveys except in Damote Pulassa woredas where it was estimated to be 97.7 percept. Summary results of the key indicators for all the 12 surveys are summarized in Tables 2,3 and 4 below.

Table 2: First and second Quarter of 2014 Results in Oromia region against key indicators

Key indicators	Surveyed woredas in Oromiya region				
	MeyuMuluke	BuleHora	Dhas	Dawakechin	HawaGelan
Survey date	11 -16 Mar 2014	8-22,Mar 2014	18-23, Feb 014	14-20,Feb 2014	3 -8 May 2014
Survey objective	End line	End line	Monitoring	Monitoring	Monitoring – emergency
Study design	572 children from 35 clusters	525 children from 39 clusters	487 children from 36 dusters	808 children from 49 clusters	431 children in 36 clusters
% GAM Z-Score (95 % CI)	12.3 %(9.6 - 15.6)	5.3%(3.7-7.7)	3.3 %(1.7 - 6.3)	11.2% (8.9-14.0)	10.9% (7.9 – 14.9)
% SAM Z-Score (95 % CI)	1.6 % (0.7 - 3.3)	0.2% (0.0-1.4)	0.0 %(0.0 - 0.0)	0.2 % (0.1 - 1.0)	2.1 % (0.9 – 4.7
% Kwashiorkor	0.0	0.0	0.0	0.0	0.2
CMR Death/10,000/day (95 % CI)	0.03(0.00-0.27)	0.07(0.01-0.55)	0.0 (0.0 - 0.0)	0.08 (0.02-0.37)	0.10 (0.03-0.32)
U5MR Death/10000/day (95% CI)	0.0	0.38 (0.05-0.78)	0.0 (0.0 - 0.0)	0.12 (0.02-0.90)	0.45 (0.11-1.88)
Major causes of U5MR	0	Accident and Unknown	0	Measles	Fever and ARI
% Morbidity	14.3%(11.43-17.2)	23.0%(19.6-26.9)	5.1%(3.15-7.05)	5.2%(3.67-6.73)	27.1%(22.9- 31.3)
Major illnesses or symptom	Diarrhoea and ARI	Diarrhoea, ARI and Fever	ARI	Measles, ARI and diarrhoea	Diarrhoea, ARI& Fever
% Measles coverage by card (95 % CI)	0.0	12.7% (10.0-16)	6.5%(4.5-9.3)	4.2%(2.9-5.9)	19.3 % (15.7-23.50)
% Measles by card + recall (95% CI)	56.0%(51.7-60.2)	49%(44.5-53.5)	69.1%(64.6-73.2)	60.8%(57.2-64.2)	72.3%(67.7-76.5)
% BCG coverage – scar (95% CI)	35.3%(31.4-39.4)	33.3% (29.3-37)	73.1%(68.9-76.9)	35.4% (32.1 38.8%)	48.5%(43.7-53.3)
%Vitamin A supplementation in past six months (95% CI)	85%(81.787.7)	55.2% (50.9-59.5)	75.6%(71.5-79.3)	74.4%(71.2-77.3)	65.9%(61.2-70.3)
Classification of nutrition situation	Serious	Normal	Normal	Poor	Serious

Table 3: First and second Quarter of 2014 survey Results in Amhara and SNNP Regions against key indicators

	Amhara		SNNPR
Key indicators	**Delanta**	**Damote Pulassa**	**Dasenech**
Survey date	6-15 June, 2014	14-24 Jan 2014	1–9, Mar 2014
Survey objective	Endline	Endline	Monitoring –emergency
Study design	441 children from 43 clusters	516 children from 33 clusters	576 children from 40 clusters
% GAM Z-Score (95 % CI)	11.4%(8.5 - 15.0)	3.1% (1.8-5.4)	4.7 % (2.8 - 7.7)
% SAM Z-Score (95 % CI)	0.7% (0.2 – 2.2)	0.0	0.2 % (0.0 - 1.3)
% Kwashiorkor	0.0	0.0	0.0
CMR Death/10,000/day (95 % CI)	0.25(0.10 -0.60)	0.18(06-0.55)	0.27 (0.11-0.63)
U5MR Death/10000/day (95% CI)	0.00 – 0.00	0.50(0.03-1.52)	0.82 (0.27-2.49)
Major causes of U5MR	0	Unknown	Diarrhoea, ARI
% Morbidity	7.5%(5.04-9.96)	10.1 %(7.5-12.7)	13 %(10.25- 15.8)
Major illnesses or symptom	Mumps, diarrhea, eye infection	Malaria, diarrhea and ARI	Diarrhea, ARI, Malaria
% Measles coverage by card (95 % CI)	14.8% (9.4 –20.20)	21.2%(13.7 - 30.9)	6.5%(2.7-6.6)
% Measles by card + recall (95% CI)	94.8%(92.1 –97.4)	94%(89.7 - 96.6)	50.8%(46.4-55.1)
% BCG coverage –scar (95% CI)	58.5%(52.2 –64.8)	77.1%(71.2-82.2)	13.4%(10.8-16.5)
%Vitamin A supplementation in past six months (95% CI)	94.1%(89.8-98.3)	97.7%(94.5 - 99.0)	84.7%(81.5-87.5)
Classification of nutrition situation	**Serious**	**Normal**	**Normal**

Table 4: First and Second Quarters of 2014 survey Results in Afar, Gambella and Somali Regions against key indicators

	Afar		Gambella	Somali
Key indicators	**Afdera**	**Lare**	**Jikawo**	**Gorobekeksa**
Survey date	2-17 April 2014	5-12May 2014	8-29 May 2014	15-20 May 2014
Survey objective	Monitoring – emergency	Monitoring – emergency	Monitoring	Monitoring
Study design	536 children in 42 clusters	515 children in 40 clusters	553 children in 42 clusters	560 children from 34 clusters
% GAM Z-Score (95 % CI)	21.7% (17.8-26.2)	18.2 %(14.5 - 22.5)	19.2% (16.1-22.6)	14.9 % (11.6-18.9)
% SAM Z-Score (95 % CI)	3.9% (2.6-6.0)	4.3 %(2.8 - 6.6)	3.3% (2.0- 5.3)	1.6 % (0.8- 3.1)
% Kwashiorkor	0.0	0.2	0.2	0.2
CMR Death/10,000/day (95 % CI)	0.28(0.11-0.69)	1.39(0.87 –2.22)	0.58 (0.34-0.99	0.24 (0.10-0.61)
U5MR Death/10000/day (95% CI)	0.79(0.23-2.63)	5.28(2.72 –10.02)	2.64 (1.46-4.72)	0.35 (0.08-1.40)
Major causes of U5MR	Diarrhoea, malnutrition	Diarrhea, measles, ARI,	Fever and diarrhoea	Measles and diarrhoea
% Morbidity	22%(18.6-25.8)	20 (16.7-23.8)	33.1(29.2-37.2)	23.1%(19.6-26.6)
Major illnesses or symptom	Diarrhea, ARI and fever	Diarrhea, measles, Malaria	Diarrhoea, fever and ARI	ARI,Diarrhoea and Measles
% Measles coverage by card (95 % CI)	1.5%(0.7-3.1)	0.2%(0.0-1.3)	0.6%(0.1-1.8)	7.5%(5.5-10.2)
% Measles by card + recall (95% CI)	4.6%(3.0-6.9)	42.6%(38.2-47.1)	56.0%(51.7-60.3)	53.7%(49.3-58.0)
% BCG coverage –scar (95% CI)	4.1%(2.7-6.2)	4.9%(3.2-7.2)	12.1%(9.6-15.2)	28.9%(25.2-32.9)
%Vitamin A supplementation in past sixmonths (95% CI)	10.6%(8.2-13.6)	81.5%(77.9-84.8)	41.6%(37.5-45.8)	50.4%(46.1-54.6)
Classification of nutrition situation	**Critical**	**Critical**	**Critical**	**Serious**

Bi-annual surveys results

The level of malnutrition as estimated by Global Acute Malnutrition (GAM) ranged from 2.5 percent in Halaba Special woreda in SNNPR to 21.2 percent in Bare woreda, in Somali region. Only in Bare in Somali, the nutrition situation was classified as 'Critical'. In five woredas with GAM ranging from 10.8 to 14 percent, the nutrition situation was classified as serious in the presence of aggravating factors; while it was classified as poor in seven woredas constituting 29 percent of the total woredas surveyed. The remaining eight surveys (38% of the total) GAM levels were estimated to be below 10 percent and their nutrition situations were classified as normal in absence of aggravating factors.

SAM prevalence was below 1 percent in 81 percent (17 surveys) ranging from 0.0 and in Halaba Special and Konso woredas in SNNPR to 2.0 percent of Bare woreda in Somali region; and only in 4 (19 %) woredas, SAM prevalence was estimated to be between 1 and 2 percent.

Crude and under-five mortality rates were normal in all the 21 surveys falling far below the national and Sphere standards. As in the case of ad hoc surveys, diarrhoea was the major causes of the under five mortality which accounted about 21 percent of the causes of deaths followed by Respiratory Tract Infection (RTI) and measles.

The prevalence of morbidity among under- five children ranged between 6.6 percent in Dambale to 32.7 percent in Bare woredas of Somali region. The most common perceived morbidities reported two weeks prior to the respective survey periods included: Diarrhoea, fever and ARI/Cough in their order of arrangement. Diarrhoea was the most leading causes of morbidity in 18 (86%) of all the surveys. There was no any major disease outbreak reported as public health significance in the surveyed woredas except measles cases reported in Sekota Zuria and East Belesa woredas of Amhara region three months before the surveys. Immediate control measures were undertaken by the government in collaboration with Partners to address the problem.

Similarly, Measles vaccination coverage (Measles by card + recall) was below Sphere Standard of 90 percent in 8 and above 90 percent for the remainder. The measles vaccination coverage (Measles by card + recall) ranged rom 5.9 percent in Hadelela of Afar to 97.9 percent in Halaba Special woreda in SNNPR.

The vitamin supplementation coverage was below the recommended standards of Sphere standard of 95 percent in 14 of the surveys where as it was above the recommended target in 7 of the surveys. The highest point estimate for the vitamin 'A' supplementation coverage was found in Halaba special woreda (97.5%) whereas the lowest was estimated in Hadellela woreda (32.7%). Summary results of the key indicators for all the 21 BAN surveys are presented in Table 6 to 11 below.

1Hadelela, Abaala, Meiso, MedagaTolla and Kelafo. For Woreda level GAM, see table 8 ,10 and 11
2 Sphere project, 2011

Comparison of 2013 and 2014 bi-annual survey results:

A comparison of the nutrition situation was done between 2014 surveys and those conducted in 2013 in the same woredas during the same period. Of the 21 surveys conducted in 2014, nutrition situation remained in the same status of normal, poor or serious in 9 while it improved in 7 and deteriorated in 5 of the surveys (see table 5 below). However, there was significant difference in comparison across the regions. For example, while, all the surveys in Oromiya retained its 2013 nutritional status with insignificant changes in GAM prevalence, survey in Somali region reported deterioration of nutrition situation in two of the three woredas. Similarly, the nutrition situation improved in 3 of the 4 surveys in SNNPR as well as in 2 of the three surveys in Afar region. The woredas level comparison of the nutrition situation in 2013 and 2014 is shown in Table 5 below

Table 5: summarizes the comparison of nutrition situation in the 21 bi-annual survey woredas in 2013 and 2014

		Nutrition Status Classification	
woreda	Region	April June, 2013	April - June2014
Adaar	Afar	Poor	Normal
Hadelela	Afar	Poor	Serious
Abaala	Afar	Critical	Serious
Halaba	SNNPR	Normal	Normal
Bona Zuria	SNNPR	Serious	Poor
Wenago	SNNPR	Normal	Poor
Konso	SNNPR	Poor	Normal
Goro	Oromiya	Normal	Normal
Siraro	Oromiya	Normal	Normal
Meiso	Oromiya	Serious	Serious
MidhagaTolla	Oromiya	Serious	Serious
GubaLafto	Amhara	Poor	Poor
DessieZuria	Amhara	Poor	Normal
East belessa	Amhara	Poor	Poor
SekotaZuria	Amhara	Critical	Poor
Dambale	Somali	Poor	Poor
Kelafo	Somali	poor	Serious
Bare	Somali	Poor	critical
Raya Azebo	Tigray	Normal	Normal
S. T. Emba	Tigray	Normal	Normal
T. Abergele	Tigray	Normal	Poor

Table 6: Bi-annual surveys conducted in the Second Quarter of 2014 Results in Amhara region against key indicators

	Surveyed woredas in Amhara region			
Key indicators	Sekota Zuria	DessieZuria	Gubalafto	East Belesa
Survey date	28April to May 9/2014	24April to 11 May 2014	19-29 May 2014	7-20 May 2014
Survey objective	Surveillance	Surveillance	Surveillance	Surveillance
Study design	494 children in 56 clusters	356 children in 63 clusters	327 children in 60 clusters	646 children in 54 clusters
% GAM Z-Score (95 % CI)	11.3 % (8.6 - 14.8)	9.3%(6.6-12.6)	9.5%(6.8-13.3)	10.6 % (9.4-14.3)
% SAM Z-Score (95 % CI)	0.8% (0.3- 2.1)	0.3 % (0.0 –2.1)	0.3% (0.0- 2.3)	0.2(0.1.1)
% Kwashiorkor	0.2	0.0	0.0	0.0
CMR Death/10,000/day (95 % CI)	0.14 (0.06-0.33)	0.14(0.06-0.31)	0.13 (0.06-0.31)	0.03(0.0-0.19)
U5MR Death/10000/day (95% CI)	0.76 (0.29-2.00)	0.28 (0.04-2.08)	0.0	0.15 (0.02-1.14)
Major causes of U5MR	Measles	Accident	0	Measles and ARI
% Morbidity	12.8%(9.9-15.6)	6.7%((4.1-9.3)	12.5%(8.9-16.1)	9.0%(6.8.-11.3)
Major illnesses or symptom	Diarrhoea. ARI, Fever,	ARI, Fever & Diarrhoea	Fever, ARI, Diarrhoea	Malaria, measles, fever
% Measles coverage by card (95 % CI)	22.7%(19.0-26.3)	18.3%(14.3 - 22.5)	9.2% (6.7-13.6)	7.7%(5.6-10)
% Measles by card + recall (95% CI)	70.1 %(66-74.2%)	90.9%(87.4 - 93.3)	81.3%(76.5-85.6)	82.4% (79.7, 85.3)
% BCG coverage –scar (95% CI)	48.2%(43.7-52.4)	55.5% (50.5 - 60.8)	44.3%(38.9-49.9)	42.7%(38.9-46.3)
%Vitamin A supplementation in past six months (95% CI)	81.8%(78.3-85.2)	93.2% (90.4 - 95.8)	86.9%(82.7-90.3)	90.9%(88.5-92.9)
Classification of nutrition situation	**Poor**	**Normal**	**Poor**	**Poor**

Table 7: Bi-annual surveys conducted in the Second Quarter of 2014 Results in Tigray region against key indicators

	Surveyed woredas in Tigray region		
Key indicators	S/Te/Emba	T/Abergele	Raya Azebo
Survey date	24 April-2 May 2014	05 -14 May 2014	7-13 May 2014
Survey objective	Surveillance	Surveillance	Surveillance
Study design	574 children in 48 clusters	838children in 60 clusters	586 children in 42 clusters
% GAM Z-Score (95 % CI)	8.8 %(6.6 - 11.7)	10.7 %(8.2 – 13.8)	5.0 %(3.5 - 6.9)
% SAM Z-Score (95 % CI)	0.9 %(0.4 - 2.1)	0.8 %(0.4 – 1.9)	0.2 %(0.0 - 1.3)
% Kwashiorkor	0.0	0.1	0.2
CMR Death/10,000/day (95 % CI)	0.07 (0.02-0.22)	0.06 (0.02- 0.19)	0.08 (0.03-0.26)
U5MR Death/10000/day (95% CI)	0.00 (0.00-0.00)	0.12 (0.02- 0.88)	0.18 (0.02-1.40)
Major causes of U5MR	0	NA*	NA*
% Morbidity	7.9 %(5.7-10.1%)	14.0%(11.6-16.4)	16.0%(13.0- 18.9)
Major illnesses or symptom	Diarrhoea, ARI, Fever,	ARI, Fever, Diarrhoea,	ARI, Diarrhoea ,Fever,
% Measles coverage by card (95 % CI)	76.1%(72.6-79.6)	42.6 %(39.2-46.0)	21.1%(17.7-24.5)
% Measles by card + recall (95% CI)	93.5%(91.5-95.5)	53.7%(50.2-57.2)	92.0%(89.7-94.3)
% BCG coverage –scar (95% CI)	88.8%(86.2- 91.4)	76.3%(73.4-79.2)	67.6%(63.8- 71.4)
%Vitamin A supplementation in past six months (95% CI)	95.9%(94.3-97.5)	97%(95.9-98.2)	95.7%(94.0-97.3)
Classification of nutrition situation	**Normal**	**Poor**	**Normal**

Table 8: Bi-annual surveys conducted in the Second Quarter of 2014 Results in Oromia region against key indicators

	Surveyed woredas in Oromiya region			
Key indicators	Goro	Mieso	MidhagaTolla	Siraro
Survey date	21-26, June2014	20-25 June,2014	6-12 June ,2014	6-11 June ,2014
Survey objective	Surveillance	Surveillance	Surveillance	Surveillance
Study design	433 children36 clusters	525 children 35 clusters	435 children 35 clusters	486 children 36 clusters
% GAM Z-Score (95 % CI)	5.1%(3.1-8.2)	13.6%(10.6-17.3)	10.4%(7.2-14.6)	3.8%(2.3-6.2)
% SAM Z-Score (95 % CI)	0.5%(0.1-1.8)	1.2%(0.5-2.8)	1.4%(0.7-2.9)	0.2% (0.0-1.5)
% Kwashiorkor	0.0	0.4%	0.0	0.0
CMR Death/10,000/day (95 % CI)	0.07(0.02-0.28)	0.11 (0.03-0.33)	0.00(0.00-0.00)	0.04 (0.00-0.27)
U5MR Death/10000/day (95% CI)	0.00(0.00-0.00)	0.00(0.00-0.00)	0.00(0.00-0.00)	0.21(0.03-1.58)
Major causes of U5MR	0	0	0	Unknown
% Morbidity	12.7 %(9.6-15.8)	8.8 %(6.1-11.5)	9.4 %(6.6-12.2)	17.9%(14.3-21.5)
Major illnesses or symptom	Diarrhoea, Fever , ARI	Diarrhoea, Fever, skin disease	Diarrhoea, Fever,ARI	Fever, Diarrhoea, ARI
% Measles coverage by card (95 % CI)	4.6 %(2.9-7.2)	5.3%(3.6-7.7)	4.4%(2.7-6.9)	2.8%(1.5-4.8)
% Measles by card+ recall (95% CI)	96.1(94.3-97.9)	85.6%(82.1-88.5)	80 %(76.2-83.8)	85.4%(81.8-88.4)
% BCG coverage –scar (95% CI)	58.9%(54.1-63.5)	48.2%(43.9-52.6)	31.3%(27-35.9)	62.6%(58.1-66.8)
%Vitamin A supplementation in past six months (95% CI)	96.3%(93.9-97.8)	85.3%(81.9-88.2)	76.3%(72-80.2)	89.9%(86.8-92.4)
Classification of nutrition situation	Normal	Serious	Serious	Normal

Table 9: Bi-annual surveys conducted in the Second Quarter of 2014 Results in SNNPR region against key indicators

	Surveyed woredas in SNNP region			
Key indicators	Halaba	Konso	Wenago	Bona zuria
Survey date	08- 20 June 2014	May24- Jun. 07, 2014	08- 21 June, 2014	May. 25- Jun. 08, 2014
Survey objective	Surveillance	Surveillance	Surveillance	Surveillance
Study design	516 children in 39 clusters	532 children in 38 clusters	473 children in 38 clusters	508 children in 39 clusters
% GAM Z-Score (95 % CI)	2.5% (1.4- 4.4)	7.0% (5.0-9.7)	12.2% (8.5-17.3)	10.1% (7.6-13.3)
% SAM Z-Score (95 % CI)	0.2% (0.0- 1.4)	0.2% (0.0- 1.4	1.7% (0.7- 3.9)	0.8% (0.3- 2.1)
% Kwashiorkor	0.2%	0.2%	0.9%	0.6%
CMR Death/10,000/day (95 % CI)	0.15(0.06 - 0.35)	0.11(0.04 - 0.29)	0.16 (0.07 - 0.39)	0.13 (0.05 - 0.31)
U5MR Death/10000/day (95% CI)	0.42(0.10 - 1.70)	0.0 (0.00 - 0.00)	0.0 (0.00 -0.00)	0.20(0.03-1.49)
Major causes of U5MR	Diarrhoea	0	0	Malnutrition
% Morbidity	12.2 %(9.4-15.0)	8.4 %(6.0-10.8)	10.2%(7.5-12.9)	10.1%(7.3-12.7)
Major illnesses or symptom	Diarrhoea	Diarrhoea	Diarrhoea	Diarrhoea
% Measles coverage by card (95 % CI)	8.3%(4.5-14.9)	19.7%(13.5-27.8)	1.2%(0.5-2.8)	1.0%(0.4-2.7)
% Measles by card + recall (95% CI)	97.9 % (96.2 - 98.8)	93.6 % (90.6 - 95.7)	86.9 %(81.9 - 90.7)	87.4 % (79.8 - 92.4)
% BCG coverage –scar (95% CI)	74.6 %(64.9 - 82.4)	80.8 % (72.2 - 87.3)	59.4 %(52.2 - 66.2)	53.3 %(45.4 - 61.1)
%Vitamin A supplementation in past six months (95% CI)	97.5 % (94.1 - 98.9)	88.5 % (80.1 - 93.70	61.7 %(45.6 - 75.6)	51.0 %(37.3 - 64.5)
Classification of nutrition situation	**Normal**	**Normal**	**Poor**	**Poor**

Table 10: Bi-annual surveys conducted in the Second Quarter of 2014 Results in Somali region against key indicators

	Surveyed woredas in Somali region		
Key indicators	Bambale	Kelafo	Bare
Survey date	20 -30 June 2014	20-30 June 2014	20 -30 June 2014
Survey objective	Surveillance	Surveillance	Surveillance
Study design	512 children in 37 clusters	701 children in 44 clusters	591 children in 46 clusters
% GAM Z-Score (95 % CI)	13.4 %(10.1 - 17.5)	14.0 % (11.2 - 17.3)	21.2 % (17.1 - 25.9)
% SAM Z-Score (95 % CI)	0.4 %(0.1 - 1.6)	0.6 % (0.2 - 1.9)	2% (1.1 - 3.7)
% Kwashiorkor	0.2%	0.1%	0.0
CMR Death/10,000/day (95 % CI)	0.07 (0.02-0.27)	0.51 (0.26-0.98)	0.03 (0.0-0.22)
U5MR Death/10000/day (95% CI)	0.00 (0.00-0.00)	0.28 (0.07-1.16)	0.16 (0.02-1.22)
Major causes of U5MR	0	Diarrhoea and fever	Fever
% Morbidity	6.6%(4.5-8.8)	21.9%(18.8-25)	32.7%(28.9-36.5)
Major illnesses or symptom	Fever and diarrhoea	Fever and diarrhoea	Fever, ARI and diarrhoea
% Measles coverage by card (95 % CI)	16.3%(13.1-19.5)	19.7%(16.8-22.6)	25.3%(21.8-28.8)
% Measles by card + recall (95% CI)	91.9%(84.7 - 99.1)	77.2% (70.7 - 84.2)	52.8% (45.8 - 60.9)
% BCG coverage –scar (95% CI)	59.9%(55.7-64.2)	37.5%33.9-41.1)	35.1%(31.3-39)
%Vitamin A supplementation in past six months (95% CI)	87.0%(84.1-89.9)	77.3%(74.2-80.4)	55.1%(51.1-59.1)
Classification of nutrition situation	**Poor**	**Serious**	**Critical**

Table 11: BANs conducted in the Second Quarter of 2014 Results in Afar region against key indicators

	Surveyed woredas in Afar region		
Key indicators	Adaar	Hadelela	Abaala
Survey date	22 – 27May , 2014	11-19 May 2014	1-10 May 2014
Survey objective	Surveillance	Surveillance	Surveillance
Study design	404 children in 36 clusters	361 children in 37 clusters	538 children in 38 clusters
% GAM Z-Score (95 % CI)	6.9% (4.4-10.8)	10.8% (7.7-15.0)	12.7%(10.2-15.6)
% SAM Z-Score (95 % CI)	0.5%(0.1-2.0)	0.8% (0.3-2.6)	0.6% (0.1-2.4)
% Kwashiorkor	0.0	0.0	0.0
CMR Death/10,000/day (95 % CI)	0.34(0.15-0.76)	0.15 (0.05-0.47)	0.07 (0.02-0.29
U5MR Death/10000/day (95% CI)	0.51(0.12-2.07)	0.53 (0.13-2.18)	0.19 (0.03-1.44)
Major causes of U5MR	Diarrhoea and Cough	ARI	Unknown
% Morbidity	15.6%(12.3-19.6)	14.1% (10.8-18.3)	18.2% (15.1-21.8)
Major illnesses or symptom	Fever, ARI, diarrhoea	Fever, ARI, diarrhoea	Fever, ARI, diarrhoea
% Measles coverage by card (95 % CI)	2.1% (1.0-4.2)	0.9% (0.2-2.8)	2.1% (1.1-3.9)
% Measles by card + recall (95% CI)	20.7% (16.9-25.2)	5.9% (3.7-9.1)	45% (40.7-49.5)
% BCG coverage –scar (95% CI)	24.3% (20.2-28.8)	1.4% (0.5-3.4)	16.5% (13.6-20.0)
%Vitamin A supplementation in past six months (95% CI)	41.8% (37.0-46.8)	32.7% (27.9-37.8)	80.3% (76.-83.5)
Classification of nutrition situation	**Normal**	**Serious**	**Serious**

The ENCU has been consolidating and updating emergency nutrition surveys conducted since 2000. Key survey findings such as GAM, SAM, Crude and Under-five mortality rates summarized and posted on the ENCU webpage on the DRMFSS website at www.dppc.gov.et. Table 12 below summarized surveys conducted from 2000- 2014.

Table 12 : Emergency nutrition Survey database 2000- present.

Region	Year															
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	**Total**
SNNPR	9	5	35	30	14	25	20	16	36	26	11	3	6	2	2	240
Oromia	3	2	20	27	22	20	14	6	9	13	20	21	17	12	5	211
Amhara	5	9	24	17	9	7	6	4	8	13	17	13	6	3	1	142
Somali	8	5	5	5	8	11	12	2	0	7	7	15	6	7	1	99
Tigray	0	0	6	7	3	3	0	8	0	4	2	0	0	0	0	33
Afar	0	0	4	5	1	6	4	2	1	1	2	4	1	3	1	35
Gambella	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2	3
Benshangul Gumuz	0	0	0	0	0	0	0	0	0	1	2	0	0	0	0	3
Harare	0	0	0	0	0	0	0	1	0	0	1	0	0	1	0	3
Dire dawa	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	2
Total	25	21	94	91	57	72	56	39	54	65	63	57	36	28	12	771

1.2 NUTRITION SITUATION BASED ON TFP ADMISSIONS AND REPORTING RATES

TFP admissions:Based on the January to May monthly TFP reports[1] , SAM admission trends at national level increased as expected in March by 6.4 percent and stabilized at around March levels in April and May with slight decease of 2 and 3.7 percent respectively. This trend was surprising since it was initially projected to depict a gradual increasing trend ranging between 5 and 9 percent consisted with the peak hunger gap in March to June as observed in previous years. One explanation could be better food security in most of the parts country following good Meher performance in 2014. Although the expected percentage increase during January to May was not observed; the overall caseload of 101,952[2] with 85.7 percent reporting rate (1.5 % higher than the projected caseload) admitted in over 11,000 TFP sites; was similar to the 100,410 SAM caseload projected for that period in the 2014 HRD.

Despite the reported Gu/Belg failure in Somali, Oromiya and parts of SNNPR (South Omo), it was not immediately reflected in increased TFP admissions at national and most of the regions between January and May. While there is a concern that this situation will soon impact on the nutritional status of children, the information gathered so far indicates that there was no unusual increase in TFP admissions yet. Given the size of the CMAM programme at national level, CMAM admissions information are usually four weeks late. This implies that even if the nutrition situation might have deteriorated fast in June, such deterioration will be captured relatively late, toward the end of July/Early August when adequate monthly reports for June will be collected and analyzed. In this regard, the ENCU of the DRMFSS projects that the overall caseloads in June and July are projected to be slightly higher than the initial projections in the 2014 HRD.

When compared with the previous years, TFP admissions in 2014 are consistently lower than those reported in the last two years (2012 and 2013) despite the relatively large number of reporting sites in 2014. Figure 3 Depicts TFP admissions trend in Ethiopia from 2011 to 2014.

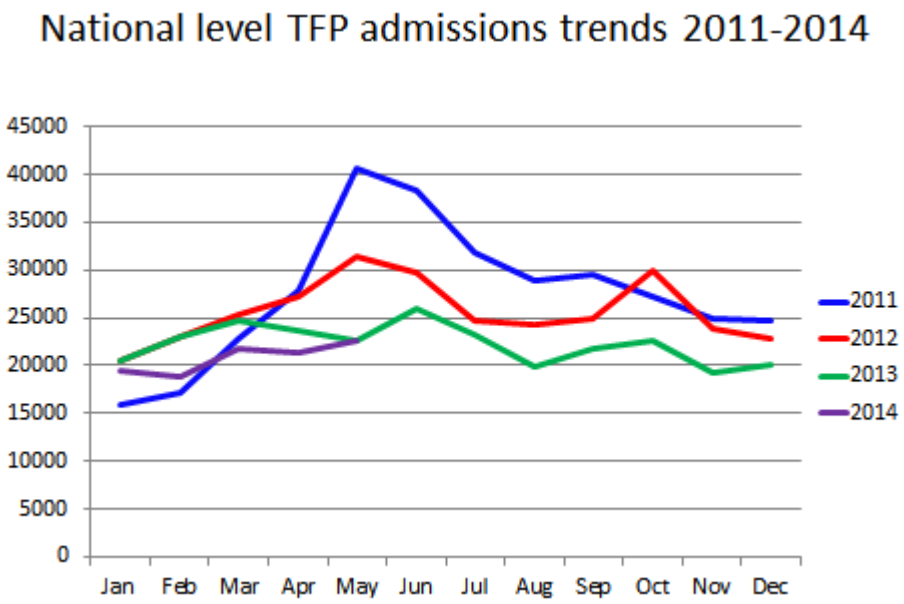

Figure 3: National level TFP admissions trends 2011 -2014

Regionally, SAM cases admitted to TFP services in SNNPR increased as expected between February and June ranging from 6 percent in June to about 16 percent in March which was within the expected national average except in March. Meanwhile the actual caseload ranged between 4,251 in January to 6,607 in June with over 95 percent reporting rates in both months accounting 25.6 percent (Jan to May) of the total caseload at national level. Despite an overall modest caseload, a number of zones (Gedeo, Halaba, Wolayita, Sidama and South Omo) reported above 20 percent increase in May. Overall, the 2014 admissions in the region remains lower than caseload reported between Jan to June in the last three years, 2011-2013 (see figure 2 below). Even for above zones except in Halaba special woreda and Sidama zones where admissions were higher in 2014 by about 29 and 27 percent respectively, the rest had lower cases than those reported in 2013.

[1] June reporting rate is still very low trailing at 53 percent with 11,299 caseload
[2] Average SAM caseload per month at national level from January to May was 20,391

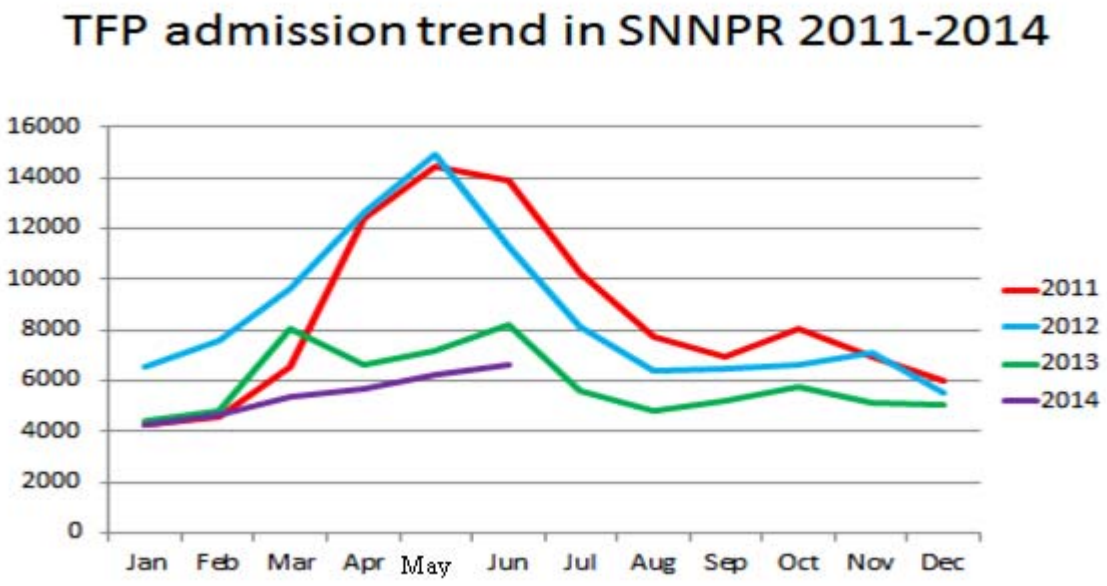

Figure 4: TFP admission trend in SNNPR in 2011 -2014

In Amhara, TFP admissions reached its peak in March with 4052 SAM cases then depicted a decreasing for consecutive two months up to May. In June, new TFP admission increased by 24.6 from 3,087in May to 3,846 with over 93 percent reporting rates in both months. Overall, SAM caseload in the region from January to June stood at 22,647 with over 93 percent reporting rate. The increase in June was associated with Child Health Days (CHD) screening that was conducted in the region, poor food security in some of the hotspot woredas and expected lean season. However, admissions increased in North Shewa zone by 38 percent in May associated with late reporting and expected lean season.

In Oromiya, the January and May period reporting rates fluctuated between 90 and 66 percent and therefore confounding description of new TFP admission trend during the first five months of the year. The June monthly TFP reports were yet to be received while the May reporting rate was also still low,trailing at 65.9 percent. Despite the low reporting rate in May (65.9%), Oromiya accounted for 40.5 percent of the total national January to May caseload. Note also that, the May 2014 admissions were 7.9 percent higher compared to those reported in May 2013. While admissions in zones such as Borena and Bale and West Arsi reported stable admissions in May, East Hararghe and Arsi reported increase of 7.6 and 10 percent respectively. However, concerning nutrition situation were reported in a number of woredas in Arsi zone like Jeju, Deksis, Limu Bilbilo, Sure, Rode and Guna and Adaba, Dodora and Gedabasasa in West Arsi. in view of reported concerning nutrition situation, rapid nutrition assessments were conducted by GOAL during the first two weeks of July to guide decision making regarding appropriate nutrition responses

TFP admissions trends for Somali, Afar and Tigray cannot be described with certainty due to low and fluctuating reporting rates between January and June. However, during the first quarter where reporting rate were above 80% in Tigray, TFP admissions decreased during the first quarter of the year; and was generally described as stable throughout the January to June period. Similarly, despite fluctuating reporting rate in Somali Jan to May TFP admissions from 24 woredas supported with Mobile health and nutrition teams (MHNTs)[3] indicated a stable nutrition situation in those woredas.

Based on the available reports, Somali, Afar and Tigray regions altogether accounted for 16.2 of the total caseload at national level with 5.6, 6.2 and 4.4 percent respectively. However, nutrition surveys conducted in the Afar, Somali and Gambela regions reported deterioration of nutrition situations in the assessed woredas (see section 1). The distribution of new TFP admissions by month and region between January to May is presented in Table 13 Below

3 Implemented by the Somali Regional Health Bureau funded by UNICEF

Table 13 : Monthly new TFP admissions from January to June 2014 by region

Month	Jan		Feb		Mar		Apr		May		Jun		Total	
Region/Adm	Adm	RR%	Adm	RR%	Adm	RR%	Adm	RR%	Adm	RR%	Adm	RR%	Adm	RR%
SNNPR	4251	95.5	4639	95.7	5371	92.3	5678	94.5	6232	97.3	6607	98.0	33778	95.5
Oromiya	7530	90.2	7321	74.5	8936	83.6	8987	87.8	8513	65.9				
Amhara	3919	93.2	3728	91.7	4502	93.3	3570	94.7	3087	93.3	3846	95.9	22647	93.7
Somali	1218	80.4	1101	66.6	1105	78.3	1400	81.3	868	62.0			5692	61.6
Tigray	1093	81.4	763	81.8	731	80.3	852	79.7	734	75.5	333	46.9	4506	74.2
Afar	1371	74.8	1355	52.2	1119	73.0	856	52.7	1097	58.4	513	36.8	6311	58.0
Others*														
Total	19377	90.0	18907	83.1	21764	86.6	21343	88.5	20561	80.5	11299	53.0	113251	80.3

- no reports received from other regions

1.3 NUTRITION SITUATION BASED ON HOTSPOT CLASSIFICATION

During the January to June 2014, hotspot woredas lists at regional and national levels were revised twice, in February and April/May period. In both two rounds of hotspot classifications, the revision was done in two phases, first at regional and finalized at federal level.

In the first phase, the DRMFSS requested all the Regional Early Warning Bureaus to revise the September 2013 hotspot list that was still used until January and February 2014 and submit to the DRMFSS. The revision at regional levels involved partners operational in the respective regions and the overall process was led by the respective Regional Early Warning and Response Bureaus.

After submission to the DRMFSS, the federal team that comprises key stakeholders in hotspot classifications from WFP VAM unit, FEWS NET and DRMFSS/ENCU, reviewed the regional classifications. Where necessary the federal team upgraded or downgraded some of the woredas hotspot status depending on the latest information available at federal level. There were no major discrepancies between regional and federal classifications, since similar guideline and criteria were used in the process of hotspot classifications at both levels. In few instances where discrepancies was noted, the respective regional early warning bureaus were consulted before the revised hotspot list was submitted to the DRMFSS management for approval and sharing with all MANTF members and other stakeholders.

In view of the 2014 good Meher performance, the February hotspot list classified 68 woredas as priority one, 202 priority two and 65 priority three making a total of 335 hotspot woredas. Compared to the same period in 2013, hotspot priority one decreased by 23.6 percent from 89 to 68 in 2013 and 2014 respectively. However, the number of hotspot woredas priority two and three increased by about 9 and 22.6 percent respectively reflecting better food security situation as well as nutrition situation in most of the woredas.

Despite that the overall number of hotspot priority one to three remained relatively stable at 334 in April, priority one increased slightly by 10.6 percent from 68 in February to 76 in April. Increase in priority one woredas is usually expected during this period of the year, as the peak hunger gap and food insecurity period (March to July) commences. When compared with hotspot list in 2013, the 2014 priority one woreda dropped by about 33 percent compared to 113 that were classified in 2013 during the same period.
On the other hand, priority two decreased also slightly by 10.5 percent from 202 in February to 181 in April as some of the woredas were upgraded to priority one. With respect to priority three, it increased by 11.6 percent from 65 in February to 77 April/May as it was expected. The map on first page shows the April 2014 distribution of hotspot woredas at the national level.

In both rounds of hotspot classifications, the revised hotspot woredas list provided guidance to all humanitarian partners in planning, mobilizing, prioritizing allocation of limited resources and implementation of emergency nutrition responses in hotspot woredas, especially in priority one and where needed in priority two. For example, following lack of TSF resources for priority one from WFP, the DRMFSS requested JEOP TSF resources be allocated to the 76 priority one hotspot woredas based on the April hotspot list.

Table 14 summarizes the February and April hotspot priority one to three woredas classification list in 2014.

Table 14: summarizes the February and April hotspot priority one to three woredas classification list in 2014.

Region	February 2014			Apr/may 2014		
	Pr[4]1	Pr2	Pr3	Pr1	Pr2	Pr3
SNNPR	4	10	14	4	9	18
Oromiya	25	75	8	27	57	20
Amhara	10	26	14	13	26	12
Somali	9	55	3	15	49	4
Tigray	9	13	9	5	20	4
Afar	8	16	8	9	16	6
DD	0	0	1	0	0	1
Harai	0	0	1	0	0	1
B/Gumuz	0	0	3	0	0	4
Gambela	3	7	3	3	3	6
Total	68	202	65	76	181	77

[4] Pr stands for hotspot priority

2.1 Nutrition outlook in July to September 2014

In view of the reported poor performance of the 2014 Belg rains in a number of zones particularly in Oromiya and Somali regions, ENCU project that TFP admissions during the July to September period will be higher that the projected in the 2014 HRD. The caseload is likely also to be higher than those reported in in 2013 if emergency nutrition responses are not implemented in a timely manner with good coverage of the combination of nutrition responses (TSF, TFP and relief). Admissions are also likely to increase associated with the increased community mobilization and active case finding in partners current operational areas and expansion areas.

Given the reported poor performance of belg rains in some of the Belg dependent areas in Oromiya, Somali, Afar and SNNPR (South Omo), the number of hotspot woredas will increase considerably and put more pressure on TSF resources that is already scarce. In view of this, ENCU of the DRMFSS is calling upon donors to fund CMAM (TFP and TSF) live saving emergency nutrition responses to prevent unnecessary increased in acute malnutrition and associated preventable deaths.

2. COVERAGE OF EMERGENCY NUTRITION RESPONSES IN HOTSPOT WOREDAS

This section summarizes emergency nutrition responses in hotspot woredas based on the revised hotspot woredas between January to June 2014 and performance of emergency nutrition response implemented by the government supported by nutrition cluster partners.

2.1 EMERGENCY NUTRITION RESPONSE STRATEGIES THAT WERE EMPLOYED

Based on the monthly updates from the regional health bureaus (RHBs), TFP services were implemented in over 600 woredas in the by FMOH through the regional health bureaus in the country. From January to June 2014, NGOs supported the FMOH in strengthening emergency nutrition responses (ie TFP) in 94 woredas equivalent to 28 percent of 334 hotspot woredas based on the April hotspot classification. UNICEF support in terms of supplies (RUTF, F-100, F-75 and routine drugs for SAM management) and capacity building and monitoring on CMAM implementation was done throughout the country.

ENCU has been and continues to closely monitor TFP services in priority one and two hotspot woreda especially in the six[1] regions prone to emergency nutrition situation in order to identify gaps and request the government (RHBs/FOMH) and partners to fill them. By the end of June, OTP and TFU/SC coverage in the 73 hotspot priority one woredas in the six regions stood at 99 and 85 percent respectively. Similarly, OTP and TFU/SC services coverage in 178 priority two woredas in the six regions was also high with 94 and 74 percent in that order. Most of woredas without TFU and OTP inpriority two woredaswere in Somali region partly due to some of them being recently established. The Somali RHB in collaboration with UNICEF and partners operational in the region was planning to establish TFU services where is currently missing. It also is important to note that, out of 55 woredas in Somali region where OTP services are currently provided, 24 of them are reached through mobile health and Nutrition Teams (MHNTs)[2] funded by UNICEF. MHNTs were also being implemented in four woredas by Afar RHB also funded by UNICEF.

2. 2 STRENGTHENING EMERGENCY NUTRITION RESPONSES IN GAMBELLA AND AFAR REGIONS

Due to below normal Daada rains (December/January) in Afar at the beginning of the year and refugees' influx in Gambala, the nutrition situations in these two regions were closely monitored by the ENCU of the DRMFSS in collaboration with UNICEF and partners. In view of the below normal rains and critical nutrition situations reported in selected woredas in April/May 2014 in Gambela and Afar, the Federal ENCU of the DRMFSS mobilized partners to strengthen emergency nutrition responses in the hotspot woredas in the two regions. In this regard, 7 of the 9 priority one woredas were supported by NGOs in strengthening emergency nutrition responses in Afar region. For example, while, GOAL was covering two woredas , it also funded SCI that commenced strengthening emergency nutrition responses in four woredas in the region (Dupti, Dalol, Afdera and Eldaar woredas) funded by OFDA. AMREF also commenced nutrition responses in three hotspot woredas. A coordination mechanism established in 2011 lead by the Afar RHB is strong. In order to further strengthen coordination of the emergency nutrition responses in Afar, the FENCU visited and attended two regional health and nutrition coordination meetings chaired by the RHB.

In Gambela, ZOA agreed to strengthen emergency nutrition response in Akobo woreda (priority one) and was preparing proposals for donor (OCHA-HRF) funding. GOAL continued to strengthen emergency nutrition responses in three woredas (Jikawo, Wantua and Makouy) while Concern strengthened emergency nutrition response in Lare woreda funded by GOAL/OFDA. Plan International also expressed commitment to strengthen nutrition responses in Jor and Itang woreda and was still was in the process of preparing proposal for donor funding. A multi-agency Nutrition Task Force-MANTF) was activated/formed at regional level to coordinate emergency nutrition activities in Gambela region under the initiative of UNICEF at regional level and federal ENCU. The meetings at regional will be chaired by the regional health and early warning bureaus.

[1] Afar, Amhara, Oromiya, Somali, SNNPR and Tigray

[2] Implemented by the Somali Regional Health Bureau

2. 3 PERFORMANCE OF TFP BOTH HOTSPOT AND NON HOTSPOT WOREDAS IN THE COUNTRY

The TFP performance is monitored on monthly basis by the respective RHBs and ENCU at the DRMFSS by analyzing standard performance indicators (Cure, death and defaulter rates) and compared against National and Sphere standards.The analysis is stratified by region and also consolidated at national level.

Based on the monthly TFP reports available at the ENCU, a total of 109,423 SAM cases were discharged from over 11, 500 TFP sites (OTP and TFU/SCs) in the six regions with an average cure rate of 88.3 percent ranging from 86.6 in June to 88.9 percent in February; well above the national and Sphere standards thresholds of 75 percent. Death rates were very low across the six month ranging from 0.2 in May to 0.4 percent in March with an overall average of 0.3 percent. Similarly, defaulter rates were very low ranging from 3.9 in January to 2.3 percent in May. Both death and defaulter rates were far below the National[3] and Sphere standards[4].

Regionally, there were no significant differences in cure and death rates performance indicators across the regions despite that Tigary and Amhara recorded cure rate slightly below the national average (see Table 15 below.The defaulter rate in Somali region (6.2%) in the last six months, despite being relatively stable at regional level, was 58 percent higher than the national average, possibly due to the mobility of the pastoralist communities in search for water and pasture for their livestock. The consolidated performance indicators disaggregated by region between Januarys to June is summarized in Table 15 below based on the overall reporting rate reported in Table 14 above.

Table 15: Performance of TFP in Ethiopia between January and June 2014 by region

Region	Total discharge (n)	Recovery rate %	Death rate (%)	Defaulter rate (%)	Other rates[5] (%)
SNNPR	32,416	89.3	0.3	1.5	3.4
Oromiya	38,811	89.3	0.2	1.9	1.2
Somali	4,935	89.8	0.5	6.2	0.6
Amhara	23,455	84.5	0.3	5.6	5.8
Afar	5,101	91.6	0.2	4.6	0.9
Tigray	4,696	85.9	0.3	4.2	4.1
Other regions	-	-	-	-	-
National level	109,423	88.3	0.3	3.0	2.9

3 National (FMOH) death rate cut off point <5% and defaulter rate cut off point is<15%.

4 Sphere standard for death rate<10% and defaulter rate is <15%

5 Non respond and medical transfer

2.4 TFP supplies

A total of 108146, 1903,1566 and 142524 cartons RUTF, F-100, F-75 and bottles of Amoxicillin syrup respectively were distributed by UNICEF to respective regional health bureaus throughout the country during the January to June period. The supplies were used for management of severe acute malnutrition in over 12,000 TFP sites across the country. NGOs operational in the respective regions and hotspot woredas accessed the all the above TFP supplies through the regional health bureaus. For those NGOs that expected increased use of TFP supplies in their operational areas associated with community mobilization were requested to inform UNICEF at regional and federal level in a timely manner so that additional supplies could be provided in that regard.

In order to have better understanding of the TFP supplies in the communities, ENCU tracked TFP supplies availability in NGOs operational areas from January to June. The TFP supplies were consolidated and feedback was provided to all MANTF members during monthly nutrition cluster coordination meetings. Based on the update received from NGOs during that period, most of them reported adequate supplies of RUTF, F-100 and F-75 and in view incidences shortage of routine drugs were reported in some partners operational areas. The shortage were immediately addressed by sending additional supplies to fill the gap.

2.5 TSF responses in hotspot woredas

During the January to June period, TSF was implemented in a total of 82 woredas across the country of which 60[6] were covered by WFP and 22 by NGOs. Based on monthly TSF reports consolidated by ENCU from both WFP and NGOs, a total of 298, 521 MAM cases (51.3 percent children under-five 48.7 percent pregnant and breasting women in 82 woredas were enrolled in TSFprogramme during the reporting period. About 91 percent of the total caseload were reached by WFP in collaboration with the regional early warning and health bureaus and the reminder by NGOs.

Due to lack of resources, TSF responses in priority one woredas following the February and April 2014 hotspot classification rounds was not implemented as expected. In order to address this challenge, the DRMFS in collaboration with WFP discussed with USAID and managed to secure and relocate JEOP TSF resources that were meant for relief assistance to 53 priority one woredas. This support increased TSF response coverage from 18 to 71 woredas; of which 15 of the 18 were already TSF beneficiaries through WFP piloted monthly TSF. In order to cope with the available resources for 71 woredas, the early waning and response bureaus in Somali, Afar and Oromiya were asked to reprioritize priority one woredas that should received TSF.

In view of this Somali and Afar dropped one woreda each while Oromiya, was not able reprioritize the three woredas due to concerning food security and nutrition situations priority one woredas. In order to avoid further deterioration of food security and nutrition situation and fill the TSF response gap in Oromiya region, the DRMFSS allocated its own limited TSF resources for three priority one woredas in Bale zone; enabling all the 27 priority one woredas in the region to have resources for TSF responses.

However, due to various reasons including delayed screening and transporting challenges, only 47 (56.7 percent) out of the 74 priority one woredas for which resources were available were implementing TSF by end of June. Similarly, TSF was also being implemented in 24 priority two woredas through the monthly TSF distribution piloted by WFP in collaboration with Regional Early Warning and Health Bureaus in four regions of SNNPR, Tigray, Amhara and Oromiya.

[6] 44 of the 60 were WFP piloted TSF and the remaining were priority one woredas

Table 16: Moderately malnourished under-five, Pregnant and Lactating women enrolled in TSFP January to June 2014

Month	Jan to Mar			Apr-Jun		
	<5children	PLW	No woredas	<5 children	PLW	No of woredas
WFP[7]	95,201	94,904	60	43,072	37,348	49
NGOs	11,363	9,508	20	3655	3,470	2
Total	106,564	104,412	80	46,727	40,818	51[8]

2.6 DONOR FUNDED EMERGENCY NUTRITION RESPONSE PROJECTS

Between January and June 2014, a total of 10 HRF emergency nutrition response projects covering 21 woredas were reviewed by the nutrition cluster under the coordination of the ENCU and recommended for HRF board's decision and funding. One out of the 10 projects was rejected by the HRF board as the respective partner failed to demonstrate capacity for implementation of the project. The nine projects are implemented by NGOs[9] in five regions[10] covering a total of 19 hotspot woredas of which 13 are priority one and 6 are priority two.

Meanwhile, ENCU mobilized partners funded by ECHO and OFDA to strengthen emergency nutrition responses covering 22 and 41 hotspot woredas respectively, in six regions in the country (Afar, Amhara, Somali, SNNPR, Oromiya, and Gambela). GOAL in consultations with the ENCU of the DRMFSS jointly prioritized hotspot woredas where emergency nutrition responses should be strengthened using OFDA/GOAL resources. This is a very good practice that should be emulated by other donors. Such consultation and collaboration will ensure that the available limited resources are allocated to hotspot woredas where support is needed most.

2..7 GAPS IN NUTRITION RESPONSES

1) Inadequate of TFP resources for likely increase caseload, 2) Lack of TSF resources for priority one woredas, given that hotspot priority one will increase during the July 2014 hotspot revisions and 3) Limited resources to fund NGOs for strengthening emergency nutrition responses in hotspot woredas with the impending deterioration in food and nutrition situation in Somali, Oromiya and other pocket woredas that will be recommended by the Belg assessment. 4) 11 out of the 73 priority one woredas in the 6 region had no TFU/SC services.

2..8 CHALLENGES IN RESPONSES

Security and delayed clearance hindering timely initiation and monitoring of emergency nutrition projects in particularly in Somali region.

[7] May were received from 34 woredas and June update were yet to be received from WFP

[8] Do not sum 80 and 51 woredas as WFP supported woredas in 1st quarter and continues into 2nd quarter

[9] AMREF Afar, CARE, IMC, Child Fund, KHI, Concern, SCI

[10] Afar-, Oromiya, Amhara, SNNPR and Tigray

3. OTHER TECHNICAL ACTIVITIES COORDINATED BY THE ENCU

3.1. Nutrition Causality Analysis (NCA) Study in East Hararghe Zone, Oromiya region

Following increase in acute malnutrition in East Hararghe zone in 2013 that accounted over 27 percent of the total caseload in Oromiya region, a Technical Working Group[1] was formed in August 2013, under the coordination of the ENCU of the DRMFSS at federal level with two objectives. First, to identify the main challenges that affected implementation of humanitarian responses on acute malnutrition and document lessons learnt. Secondly, to conduct a study in order to better understand the causes of acute malnutrition in the zone and recommend appropriate responses.

Lessons learnt[2] workshop was conducted in October 2013 during which the main issues/challenges and lessons learnt were documented . Meanwhile, the TWG prepared TOR for Nutrition Causality Analysis Study that was advertised at national and international level. ACF was selected by the TWG to conduct the study with funding from OCHA-HRF. ACF employed NCA methodology developed in partnership with WFP, Tufts University, IRD and University of BRISTOL. The methodology has four phases: i) Preparatory phase, ii) developing hypothesis to be tested for causes of acute malnutrition with stakeholders at East Hararghe zone in this case including literature review, iii) Gathering of evidence both qualitative and quantitative and validation of the results and iv) identifying the highest priority causes and recommendations from stakeholders. In the case of Ethiopia, the TWG recommended an additional step to that included stakeholders' workshop to discuss the results and recommend appropriate interventions to address the causes.

The study was conducted between March and July 2014. During phase two of the study, a total of 14 hypotheses were agreed tobe tested in stakeholders workshop involving participants from community, woreda, zonal , regional and federal level. After completion of the data collection, same stakeholders' workshop at zonal level was held in East Hararghe; and the study findings were shared and validated. The study findings were then reviewed by the TWG before presented to the final workshop at federal level during which a number of appropriate interventions were discussed and recommende. The study findings will guide partners operational in the zone in planning and implementing appropriate responses to address the causes of malnutrition. ACF is still finalizing the NCA study report and once is ready will be shared with all stakeholders including donors that may fund implementation of the proposed interventions.

3.2. HISTORICAL (2008-2013) HOTSPOT WOREDA ANALYSIS

The ENCU of the DRMFSS analyzed hotspot lists that were published by the DRMFSS from 2008 to 2013. The objective was to map Vulnerabilities in terms of emergency nutrition situation reflected in frequency of a woreda being classified as either hotspot priority one, two or three or combination of the three hotspot status over the above mentioned period. The analysis is also intended to guide humanitarian partners and long term development initiatives to prioritize resources in the most vulnerable woredas.

The analysis was categorized into five[3] groups and it identified 68 woredas that as very highly vulnerable, 93 as highly vulnerable while 125 were categorized as moderately vulnerable. Of the 161 most Vulnerable woredas (5 and 4 catagoris), Oromiya, Somali and Amhra regions accounted 30, 28 and about 14 percent respectively. The remaining regions accounted the remaining 29 percent. In order to address long term emergency nutrition related vulnerabilities, the ENCU of the DRMFSS recommend that more focus be given to the 161 which were either priority one or twoin the last five years -2008-2013 (category 5 and 4) and to a less extend priority three for half of the 14 rounds/tme .

1 DRMFSS/ENCU, EHNRI, FMOH, IMC, GOAL, CARE, CRS, WVI,Oromiya DPPC, Regional Health Bureau, UNICEF, WFP, OCHA, FAO

2East Hararghe Main issues and lessons learnt workshop summary report, November 2013

3 5= Very highly vulnerable, 4=highly vulnerable, 3=moderately vulnerable, 2=slightly vulnerable, 1=very slightly vulnerable

3.3 CAPACITY BUILDING ON CMAM COVERAGE ASSESSMENT

Between 2008 and 2013, a number of CMAM coverage assessments were conducted by NGOs[4] implementing in different parts of the countries using various methodologies such as S3M, CSAS and SQUEAC. Unfortunately there was no such capacity at ENCU to support other partners who needed to conduct similar assessments in their operational areas. ENCU also did not have the capacity to provide guidance in terms of reviewing partners' proposals and CMAM coverage results to determine quality and validity of the CMAM coverage assessments as well as create common understanding and harmonize coverage assessments in the country.

In order to fill this gap and harmonize coverage assessment in the country, the ENCU[5] requested technical support from the Global Nutrition Cluster (GNC) in 2012 so that partners and the ENCU are trained on implementation of CMAM coverage assessments in the country. This request coincided with GNC and Coverage Monitoring Network (CMN) second phase planned training in 2014 in which Ethiopia was among the countries prioritized for the training.

In view of this, CMAM coverage training was organized by ENCU in collaboration with GNC and CMN early July 2014 in Addis Ababa. A total of 33 participants from Regional ENCUs based in the respectiveregional early warning bureaus, NGOs, and UN agencies were trained by CMN facilitators focusing on the following three objectives: Firstly, to enable partners to plan, coordinate and evaluate the quality of coverage assessments. Secondly,jointly develop an understanding of the existing technical capacities and opportunities for implementing coverage assessments in Ethiopia. Thirdly,to develop country-specific action plans for scaling-up/rolling-out coverage assessments.

The training was very much appreciated by the participants as it used a combination of training methods, presentations, interactive mapping and discussions. The above three objectives were achieved. A country level action was prepared by the participants. In order to facilitate action plan implementation, oversee and coordinate all CMAM coverage activities in the country, it was recommended to establish a CMAM coverage assessment technical working group (TWG). One of the agreed actions was to develop a national guideline on coverage assessment and CMN agreed to continue providing technical support in this regard

3.4 A NEW HOTSPOT GUIDELINE PUBLISHED BY THE DRMFSS IN MAY 2014

The new guideline on hotspot guideline was published by the DRMFSS in May 2014. The development of the guideline involved consultations and inputs from most stakeholders participating in hotspot classification at federal and regional levels. The final consultations were made in stakeholders'[6] workshop that was held in April 2014 in Nazareth town, in Oromiya region. The aim was to harness their experience and challenges and reach consensus how they can be addressed and reflected in the guideline. It is important to note that the recommended indicators in the hotspot classification guideline are multi-sectoral, drawing on indicators from health, nutrition, agriculture, food security, market information, water and sanitation and Education among others.

The main objectives of the guideline are first, to broaden the understanding of all humanitarian partners the process involved in hotspot classification in the country. Secondly, to harmonize and standardize framework for analyzing and classifying hotspot woredas in the country and thirds, reduce subjectivity in hotspot classification at all levels. The ENCU at the DRMFSS is very optimistic that the new guideline will significantly improve the hotspot classification process both at regional and federal levels, guide mapping of vulnerability and allocation of limited resources to areas most in need.

3.5 NUTRITION CLUSTER/ENCU CHALLENGED BY HUMANITARIAN RESPONSE FUND-HRF (OCHA)

In the last five years (2008-2013), FMOH with support from partners[7] has been rolling out CMAM services through the HEP. SAM management services have been brought closer to beneficiaries as they are now available in most of the health facilities in the country. However, there are hotspot woredas that from time to time need support from NGOs to strengthen emergency nutrition responses especially during the peak hunger gap (April to August).

Given that, TFP performance indicators (cure rate, death and defaulter) are far better than the national and Sphere standard thresholds and also the fact that geographic coverage of the services is larger; the nutrition cluster has been challenged by HRF whether the current NGOs' approach to supporting the government in strengthening CMAM during emergency is still appropriate and sustainable especially in the wake of shrinking funding from donors.

In order to address this challenge, the nutrition cluster has formed a TWG[8] that is planning to start the discussions, think beyond the box and respond to the challenge in terms of recommending the best way forward. It is expected that by end of 2014, a new approach to supporting CMAM responses may be recommended once agreed by all stakeholders including the FMOH.

[4] Concern, IMC, GOAL, Merlin

[5] The DRMFSS unit coordinating all nutrition cluster activities in Ethiopia

[6] DRMFSS/ENCU, 10 Regional early warning bureaus, WFP, UNICEF, FEWS NET

[7] UNICEF, WHO and NGOs implementing emergency nutrition projects in different parts of the country

[8] EHRNI/EPHI, FMOH, UNICEF, WFP, SCI, IMC, GOAL, ENCU/DRMFSS, Concern, OCHA-HRF, WHO