Coordinating a Complex Emergency Nutrition Response in pastoral communities of Somali Region, Ethiopia 2017

ETHIOPIAN Nutrition Cluster presentation
GNC Annual Meeting
10th October 2017
Content

• **Context**: Somali Region - demographic, health system, key child nutrition and health indicators; national and regional CMAM programme scale

• **2017 nutrition situation** - SAM trend 2011 to 2017; Zonal SAM Burden; MAM response

• **Pillars for response coordination** - what works and challenges

• **Key challenges**

• **Way forward**
Ethiopia: Hotspot priority woredas (as of June 2017)

- Hotspot woreda classification is derived from expert judgment using six multi-sector indicators that are agreed upon at zonal, regional, federal levels.
- Hotspot matrix is the basis for OTP, TSF programming across the country.
- Hotspot matrix is often used as a proxy for IPC.

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Final boundary between the Republic of Sudan and the Republic of South Sudan has not yet been determined.

Creation date: 7 Jul 2017  Map Doc: M11_HS_ETH_070517_A4  Sources: NORMC/Encu  Feedback: ocha-eth@un.org  www.unocha.org  www.reliefweb.int  Prepared by: OCHA
Average monthly admissions 2010-2016: 1788
Average monthly admissions 2017: 7,512
Ethiopia - Somali Region
SAM Admissions
January - August 2017

Source: ENCU TFP database (August). The above map is for illustrative purposes only. The map uses admin boundaries of the previous 68 Woredas with data adapted from the 93 new woredas. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations or partner organisations. Created: 02 October 2017
Ethiopia - Somali region
Nutrition Partner Presence
Woreda-level

Source: ENCU TFP database (August). The above map is for illustrative purposes only and uses admin boundaries of the previous 68 Woredas with data adapted from the 93 new woredas. The boundaries, names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations or partner organisations. Created: 03/10/2017
MAM Treatment: January – August 2017

Modality
- Monthly TSFP by NGO in 60 woredas (out of 83 P1) (WFP IN 50, USAID/FFP in 10)
- WFP/Disaster Preparedness & Prevention Bureau (DPPB) distribution in 23
- Mobile health and nutrition teams (MHNT) – in remote communities and IDPs
- BSFP: October-December 2017 – planned for 45 priority woredas (WFP/DPPB/NGO)

<table>
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<tr>
<th></th>
<th>U5</th>
<th>PLW</th>
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<td>WFP</td>
<td>288,875</td>
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<td>USAID/FFP</td>
<td>32,169</td>
<td>38,322</td>
<td>70,491</td>
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<td>TOTAL</td>
<td>321,044</td>
<td>307,889</td>
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Nutrition incident command post: Pillars

- **Coordination and Nutrition**: IM - RHB, DPPB-ENCU, UNICEF, GNC
- **Case management**: RHB, WHO, UNICEF, WFP, NGO*
- **Surveillance**: RHB, WHO/CDC, UNICEF, NGO*
- **Supplies and logistics**: RHB, DPPB, WFP, UNICEF, WHO, UNOPS
- **WASH**: Regional Water Bureau, UNICEF, OXFAM, IRC, SCI
- **Community mobilisation/SBCC**: RHB, UNICEF, NGO*

* NGO: MSF Holland, MSF Spain, SCI, Mercy Corps, AAH, GOAL, IRC, IRE, CWW, (Care)
ICP & Pillars overview

**Working well**

- Jan-August: 59,729 children with SAM, 321,044 MAM U5, 307,889 PLW with AM were treated; performance standards maintained
- **Govt lead** weekly ICP with representation from all agencies and read out from all pillars
- **Scaled up deployment** of international and national staff across all agencies
- **Integrated Operation Strategy** developed from a 90 day plan
- **Tools** in use: capacity matrix, mapping and 4W
- Priority needs and targeting managed across sectors rather than in silos (WASH, HEALTH, FOOD, NUTRITION, Protxn, Ed) with cross cutting C4D

**Challenges**

- **Complex** health, nutrition and drought emergency across the entire region.
- **AWD 2016-17** capped by June, resurgence in Sept; **Disease outbreaks**: measles, AJS +
- **Context**: expansive area, little infrastructure; few INGO with capacity and experience in the region
- **Sanitation**: 16% of IDP have access to latrines; 36% IDP sites still rely on water trucking
- **Govt structures** at zone and woredas level often weak and under staffed; 26 new woredas and 2 new zones low administrative set up
ICP & Pillars overview

Working well
• Innovative approach brought in to **bridge the staff gap** - UNOPS project
• SAM-MAM **nutrition commodities** secured to the end of 2017 by UNICEF, WFP
• Plan for **integration** of core services at woredas level (Food, Nutrition, Health, WASH)
• **New initiative** planned to boost CMAM skills, mentoring and supervision – phased approach in key zones (NGO, RRT/UNICEF,WHO)

Challenges
• Massive **deficit in health staff** to effectively manage scaled up quality CMAM services in all 83P1
• **GFD performance low** - timely distribution of full GFD ration has not been achieved across all P1
• **Monitoring** of food response has been challenging
• Needed long term solution for **WASH** - 20 deep boreholes with water scheme development $
• **Sanitation** challenging – utilization and access to latrines in host and IDPs
• Shortfalls in **PHC essential drugs**, SC kits and drugs being used beyond their purpose creates SC drug shortfalls
ICP & Pillars overview

Working well

- **Scale up of NGO partners** now 76 out of 83 P1 with full CMAM, many with MHNT
- **National protocols** for SAM/MAM management; updated AWD/SAM management guidance
- **MHNT** UNICEF scaled up to 29 RHB MHNT, NGO 25+, WHO plan for 11 new MHNT
- Innovative - **Rapid response/Medical mobile teams** planned for re outbreaks (WHO, RHB)

Challenges

- **IDP influx** now circa 200,000+ drought (and conflict) affected IDP – many now drop out pastoralist with no opportunity to restock or return to origin
- **NGO capacity** to deploy sufficient technical staff to gap fill RHB shortfalls, skill base low, strategy weak and slow to get up to speed; variation across MHNT quality and services
- **International cut offs** for AM not endorsed, late detection of AM, risk of complications high
Key challenges

• Impressive gains in CMAM service expansion but static service coverage remains suboptimal and below national targets. Lack of sufficient trained health staff – rapid response difficult.

• Lack of and low quality nutrition information for surveillance and performance tracking (low quality screening, no surveys) makes projection of needs and planning difficult.

• Inexperienced NGO partners took time to recruit sufficient new staff due to limited budget (vehicles) and availability (visas for internationals)

• Low SAM-MAM continuum of care - MAM services provided beyond OTP/health facility reduces effective links
Key challenges

• Difficult to deliver integrated package of WASH-FOOD-HEALTH & NUTRITION services to the most vulnerable (the bundle)

• HEALTH: Disease outbreaks (AWD, measles, AJS) compromised the health service capacity to manage the swell in acute malnutrition

• WASH: Low coverage of latrines in IDPs, access to safe water low; immediate need for water trucking – at expense of investment in medium and longer term gains to be made by scale up of deep borehole drilling and developed water schemes

• FOOD: Difficult to manage Timely distribution of full ration GFD difficult each month; not well coordinated with partners managing TSFP; new challenge posed by switch to cash in 67 of the 83 P1

• Insecurity: Border conflict recently caused influx of conflict IDPs into the region - new needs, risks and high vulnerability. Deployment of non-Somali staff now questioned.
Way forward

• Govt and partners develop a **surge approach** (set of triggers and response) to guide rapid response scale up in **pastoral context**.
  • Rapidly deploy health workers with **primary health care and nutrition expertise** from within and outside the region

• Improve pastoral health strategy to include:
  • **Outreach strategy** mobile teams from functional health centres reach remote community within catchment of health facility.
  • **MHNT** important - triggers to scale up/down needs to be defined
  • **RRT** with mobile medical staff to be part of the pastoral H&N services
    • Clinical skilled staff for maternal, EPI, IMNCI and SAM/MAM/screening, as break through response to disease outbreaks, for surveillance & treatment

• Initiatives to support **CMAM capacity building** within pre-service training (HW/HEW) with IMNCI, strong CMAM component and mentoring/supervision on the job

• **Supervision and surveillance system** to include H&N- breaking silos

• WASH need to **invest for longterm impact**- in water scheme development, deep boreholes for community and institutions
Way forward

• Supply system management to be lead by Govt with greater accountability

• IM: use of mobile technology to address the reporting lag and improve accuracy

• Reestablish the nutrition information system for the region – timely targeted nutrition surveys; nutrition information management skills cascaded to woredas level with frequent checks on quality assurance

• Explore use of protection rations for SAM clients to reduce sharing, promote better recovery

• Incorporate approach to rapid scale up and H&N response in pastoral in the pending National AM Guidelines

• ICP & Multi-sectoral Pillars with key agency representation in each – brings technical expertise and better cross learning to promote integration and better targeting

• Durable solutions and recovery strategy – to be developed protecting livelihoods, bringing alternatives for pastoral drop outs
Emergency Nutrition Coordination Unit

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