



Nutritional response to the 2011 famine in Somalia

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ABSTRACT

Over the past decade Somalia has experienced an unrelenting nutrition crisis. In late 2010, early warning systems alerted of a deteriorating food security situation and continued to do so until Famine was declared in July 2011. In the build up to the famine, nutrition response from nutrition was late owing to conflicting and inadequate nutritional information, complex decision process for intervening in access-restricted *Al-Shabaab* controlled areas, and lack of agreed nutrition specific early warning triggers for action. Once famine was declared existing programs to manage acute malnutrition were significantly scaled-up and large food and cash based preventive programs were designed attempting to systematically link food security with nutrition treatment programs. This article describes what information was available and how it was used to trigger the nutrition response before and during the famine. Responses are primarily approached through a geographical lens given the variety of contexts in south Somalia and their influence on program design, but also address specific groups and needs. An attempt is made to analyze and recommend actions needed to address key factors that delayed and affected the response.

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1. Introduction

Somalia is among the poorest and most food insecure countries in the world, with some of the world's worst development indicators (UNDP, 2010). It is often portrayed as “the world's most failed state” (Anderson, 2009), with mortality and malnutrition rates among the highest in the world, particularly in the southern part of the country (Kassim et al., 2009). A multitude of international initiatives over the past 20 years have not led to sustainable progress towards peace and stability, resulting in ever-increasing vulnerability to food and nutrition insecurity, aggravated by increasingly limited humanitarian access. Prior to the famine of 2011, the nutrition response to this long-term chronic emergency had been a standard nutrition response slowly adapting to the related challenges of restricted access for international and technical staff and by increasingly relying on national nutrition actors with varying technical and programming capacities. The

need for decision-making from a distance also meant program quality suffered.

1.1. Long term trends and chronic nutrition crisis in the South

Nutrition surveys conducted since the 1980s document the chronic nature of malnutrition in south Somalia (Cambrey, 1997). Since 2001, the median Global Acute Malnutrition (GAM) prevalence has remained at Serious (10–15%) or Critical (15–20%) levels (Bush and Verster, 2010). The nutrition situation in south Somalia is generally worse than that of Puntland or Somaliland in the north, primarily due to conflict, a lack of governmental structures and infrastructure, and a progressive deterioration in humanitarian access. The National Micronutrient and Anthropometric Nutrition Survey, conducted in 2009, underlined that micronutrient malnutrition and poor infant and young child feeding practices pose a significant public health problem in Somalia (Kassim et al., 2009). Fig. 1 shows the estimated nutrition situation between 2007 and 2011, with a clear and persistent deterioration in the south, where all districts eventually exhibited a critical nutrition situation (GAM > 15%).

1.2. Build up to the famine

Nutrition indicators played a minor role in the early analysis and warning of the impending situation in south Somalia. GAM prevalence, the main indicator used in nutrition during emergencies, is

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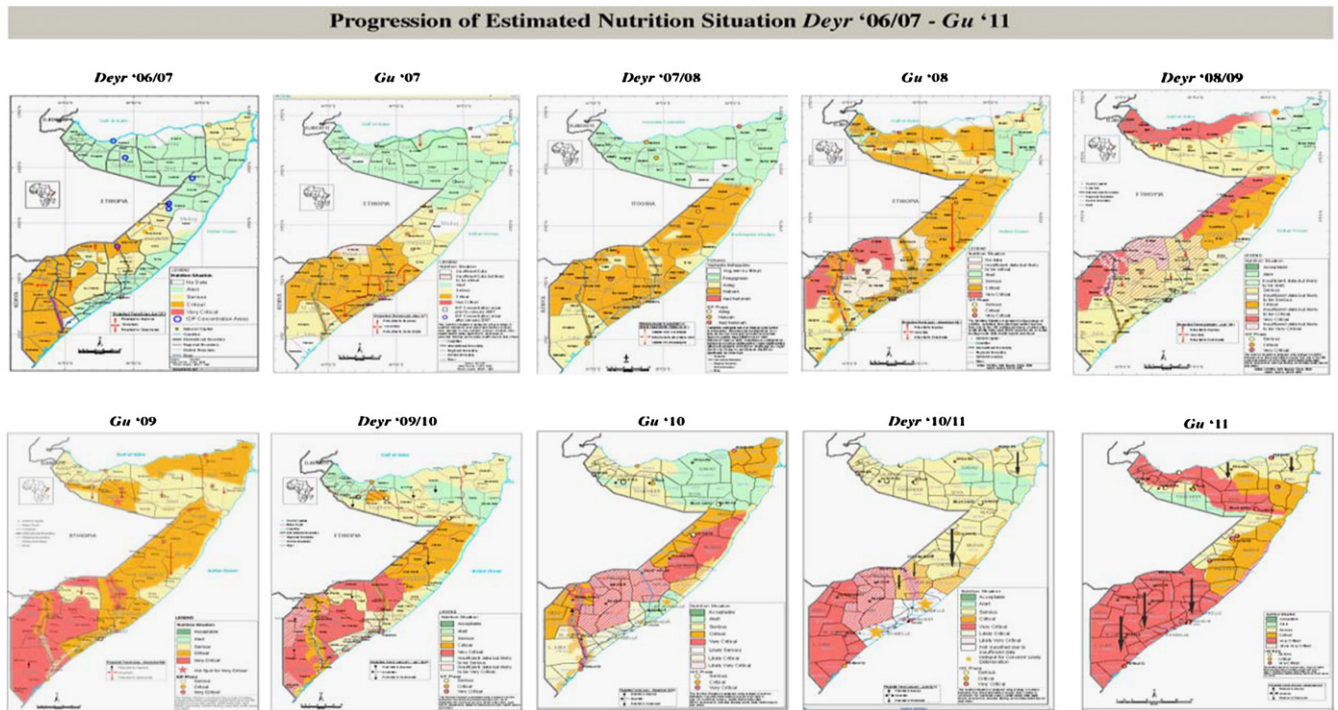


Fig. 1. Progression of the estimated Nutrition Situation Deyr 06/07–Deyr 11/12.

Source: FSNAU, personal communication. *Progression of the Estimated Nutrition Situation Deyr'06/07–Deyr '11/12.* Nairobi: Food Security and Nutrition Analysis Unit, Food and Agriculture Organization of the United Nations.

an outcome and therefore has poor predictive value. The actual build-up to famine was first anticipated by non-nutrition indicators such as the climatic impact of La Niña, price developments, and estimated food availability (FEWS NET, 2010). Access restrictions meant only three livelihood zones could be surveyed in south Somalia during the Deyr 2010/11 seasonal assessment (FSNAU, 2011a), as opposed to 15 normally. Still, surveys reported GAM prevalence of 25.3–30.7%.

As critical as these results were, such prevalence are observed almost every season in some parts in Somalia (FSNAU, 2009, 2010). Even when reviewed in conjunction with other related information, they were not extreme enough to trigger more than an elevated seasonal scale-up to nutrition programming. In an environment where key indicators regularly surpass internationally defined crisis levels, such extreme data tends to be normalized, reducing the impact of the EWS in Somalia. As described later, it is postulated that the trigger to organize a major nutrition response was also influenced by the timing of these spot estimates in a situation where nutrition surveys are normally conducted bi-annually, but nutrition status appears to have deteriorated from crisis to famine levels in a matter of 2–3 months.

Between the Deyr and Gu assessments⁵ where representative surveys are normally conducted throughout the country, secondary surveillance data such as price movements (FSNAU Monthly Market Updates), population movements (UNHCR Population Movement Tracking), and disease outbreaks (Health Cluster monthly bulletin) are used to monitor trends. Regular nutrition information for decision-making between these FSNAU assessments is usually

gathered from a compilation of FSNAU updates, NGO program reporting and nutrition center admissions rates. Even in the best of times nutrition centre reports are a weak tool for early warning or surveillance with only major changes giving enough confidence to make decisions. Health data is very poor and lacks many critical indicators like mortality. Between February and June 2011, decision-makers were getting conflicting messages. Nutrition center reports showed an increase in admissions until March in a pattern similar to that seen in many other difficult seasons in south Somalia, and a decrease afterward consistent with seasonal pattern. Field reports varied in their urgency, with some very dramatic and others uncertain about the severity and scope of the situation, all compounded by lack of access, making it very difficult for experienced technicians to judge the situation directly.

The only nutrition survey between the Deyr'10/11 and Gu'11 assessments was in Mogadishu. For the first time in five years, a representative nutrition survey was conducted in six districts of the capital in April 2011. The survey reported a better-than-expected situation with GAM and SAM prevalence standing at 15.6% and 1.7% respectively, warranting a critical classification by FSNAU (FSNAU, 2011c). Over the past five years, the Mogadishu nutrition situation had been classified as Very Critical by FSNAU based on rapid assessments and secondary data analysis (FSNAU, 2011b). In retrospect, it is clear that the situation in Mogadishu did not reflect the deteriorating situation in the rest of the south. When the nutrition data is cross-referenced with IDP influx information this may have been due to the reduction in new arrivals at the beginning of 2011. The Population Movement Tracking System (PMTS) of UNHCR showed a marked reduction in the numbers of IDPs coming to the capital from neighboring regions between the first and the second quarter of 2011. Movement to the capital only resumed in a dramatic manner in July 2011 with an 81% increase in arrivals registered between the second and third quarter of the year, with a recording of 27,500 arrivals in July alone (UNHCR, 2011a).

⁵ The Deyr rains occur from October to December and correspond to the timing of the "Deyr seasonal food security and nutrition assessment". Between April and July, the Gu rains correspond to the second bi-annual assessment led by FSNAU. Data for the Deyr assessment are collected in November and December with results become available in January and publically released in February whereas the Gu assessment is done in June and July and results become available in August.

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