Consecutive years of poor rainfall in the countries of Horn of Africa (HoA) has led to the cumulative erosion of people’s assets in both pastoral and agricultural communities, undermining coping strategies and leading to greater vulnerability. The health and survival of an estimate 8.5 million people are at risk.

Avoiding unnecessary excess mortality and morbidity from malnutrition and communicable diseases among these communities is a matter of extreme urgency. The health and survival of an estimate 8.5 million people are at risk.

This regional crisis calls for a regional approach by the Health Cluster. In the Horn, the Regional Health Emergency Group (RHEG) already provides a functional platform for the Cluster Approach. WHO’s four functions in crises – assessment & monitoring, support to coordination, filling gaps and capacity building – provide a good strategic framework, focused on the common goal of reducing avoidable mortality as well as vulnerabilities at medium- and long-term.

A meeting, held from 14-15 June 2006, on the Horn of Africa crisis brought together senior staff from two WHO Regional Offices and other regional actors set the tone for a revamped Health Cluster Approach. In addition, WHO has established a regional technical Hub to support the HoA countries in the implementation of CERF-funded activities.

As a way forward, focus should be put on mobilizing additional financial resources to consolidate ongoing life-saving activities and to better prepare for future humanitarian crises. These extra-budgetary resources will finance baseline comprehensive surveys, including mortality surveys; strengthen communicable diseases surveillance and response to outbreaks; establish an information tracking system for health and nutrition; strengthen coordination and provide community-based health care services.

This Bulletin aims to provide an overview and assessment of current drought interventions by health and nutrition stakeholders in the HoA and seeks to highlight gaps and recommend solutions. We are aware of its limitations, it will improve.
Funding Gaps Hampering Life-Saving Interventions

As of 30 June 2006 (FTS) revealed that only 13% of the funds required has been disbursed. To fill the gap, the UN Emergency Relief Coordinator mobilized funds from the CERF. About US$ 30 million have been allocated, of which about 50% are for health, to allow rapid and timely implementation of critical life-saving interventions in the drought-affected countries. In the health sector, 27% of the requirements have been covered mainly by contributions from CERF (see financial contribution table below).

The lack of funding will negatively impact on the continuity of life-saving activities such as in epidemic surveillance and response, Therapeutic Feeding Centres (TFC) and Supplementary Feeding Centres (SFC) programmes, outreach Primary Health Care services, water and sanitation.

The impact of the drought and other ongoing humanitarian troubles in most countries of the HoA requires the continuation of relief operations at least until December.

These life-saving activities funded by the CERF must be consolidated to ensure better preparedness and response to potential future drought-related crises in this part of Africa.

Financial Tracking System (FTS) as of 30/06/2006
http://www.reliefweb.int/fts
Senior delegates from WHO met in a two-day inter-regional meeting in Nairobi to: (1) Assess the status of implementation of CERF grants (2) Ensure consistent approaches to the health needs of the most vulnerable populations, under a common strategic framework and along best public health practices and (3) Reach agreement on the establishment of a WHO inter-regional hub to support Country Offices in the context of the Inter-Agency Standing Committee (IASC) Cluster Approach for the implementation of drought-related interventions and promote collaboration on and information sharing of cross-border activities.

Sessions of the meeting were attended by WHO and representatives from health partners: UN agencies, NGOs and bilateral donors.

For all WHO Country Offices in Djibouti, Eritrea, Ethiopia, Kenya and Somalia, a common strategy framework covers structural inputs and expansion of WHO’s field capacity, immunization, information management, capacity building for health care delivery, outreach, cold chain and laboratories. Most countries emphasized common theme areas as cross-border operations that already include Synchronized National Immunization Days, cross-border active surveillance for polio and mapping of new cases.

Maximizing the Sub-region’s capacity in emergencies through a revamped Health Cluster approach in countries

The second day of the meeting gathered humanitarian agencies, donors and international NGOs and reflected on ways to maximize the sub-region’s capacity in emergencies through a revamped Health Cluster Approach. While the Cluster Approach does not represent a totally new blue print it is a step forward in the development of good field practices on coordination and joint programming.

The Cluster Approach deserves to be implemented in all the five countries of the Horn, at least as far as health is concerned, and to be supported by appropriate services at regional level in Nairobi. Work with OCHA is necessary at regional as well as country levels to maintain coordination.

Clusters cannot operate within a bureaucratic environment. All agencies need to be more inclusive in their work and involve all partners. Starting by mapping needs and capacities and identifying gaps to be addressed, e.g. strengthening agencies presence, country health clusters should formulate a plan of work in a way that allows for monitoring and follow up. Ideally, this plan should address the root cause of this crisis in the medium- and long-term and not limit itself to responding to the current emergency.

The Cluster lead should have adequate resources and technical capacity. However as last-result provider for health at the global level, and as a health technical agency mandated by its Governing Bodies to fill gaps, WHO must always be ready to take up this function at country level if no other suitable candidate is available.

Maximizing the sub-regions’ capacities in emergencies through the creation of an inter-regional hub

With the implementation of CERF-funded activities, the countries of the sub-region are shouldering an increase in their workload. WHO is establishing in Nairobi an inter-regional hub in collaboration with Health Cluster partners. The new hub is being strengthened with human and financial resources co-owned by the AFRO and EMRO Region through an agreed cost-sharing mechanism.

A key outcome of the hub will be the collection, analysis and dissemination of morbidity and mortality data in the five countries to inform decision makers and donors. The presence in Nairobi of most regional representations of partner agencies provides opportunities for regular information exchange, strategic consultations, joint planning, and technical, logistical backup and resource mobilization.
Drought-Induced Instabilities

Rainfall and Implications on Food security

Threats of widespread famine may have evaporated with the good rains in April and May. However they were not well distributed and therefore the expected improvements in the livelihoods of pastoralists and agro-pastoralists in Eritrea, Ethiopia, Kenya, Djibouti and Somalia will not occur instantly. Countries of the HoA faced with drought early in 2006 are now enduring its long-term economic, social and environmental effects. Some have described these rains as the “occasional shower”. While the return of rains will relieve stress from water shortages and improve pasture conditions and food security it is still too early to predict full recovery in countries where most of the population lives below the poverty line.

Drought and Conflicts

In Kenya there continues to be reports of livestock raids and fighting over grazing areas along the common borders of Laikipia, Samburu, Baringo districts and Turkana (north-west) now considered as one of the most affected areas. Fighting is occurring among nomadic-cattle herders. The impact of the drought may raise internal tensions to a level never experienced before. In Somalia though the urgent food needs have decreased in some regions, large pockets still remain food insecure according to WFP. Civil strife is hampering food distribution following the attack of a WFP food convoy in Dhobley district, Lower Juba.

Drought-induced population Movements

Population and livestock movements across clan, ethnic, district and national borders increase the risks of resource-based conflicts. In Somalia drought-induced movements were reported within the Lower Shabelle region as people moved to Golwanye village in Marka, villages around Afgoye and Wanle Wayne town. Multiple displacement patterns are recorded as people moved in search of water and livelihood between March/June in Lower Shabelle. Returns of displaced people to the Gedo region were also recorded. People displaced within Garbaharey and Burdhuubo district returned back to their original areas within Garbaharey district due to the onset of rains. Heavy border movements were recorded in June from Mogadishu towards Hargeisa and into Ethiopia (1500 people) and towards Dolo and into Ethiopia (370 people). Movement into Kenya (750 people) via Lower Juba through the Liboi Somalia-Kenya border, Amuma area and Madao Island was also recorded.

Long-term Economic Effects

The economic impact of the drought has led to the collapse of livestock-based economies; for example in Somalia cattle deaths had reached 20-30%, and up to 80% in Djibouti. In Kenya’s Wajir district, located 650 km northeast of Nairobi, the cost of an adult cow has fallen from 7000 kenya shillings (US$ 96) to 800 shillings (11$). Camels fetch less than 5000 shillings (68$) down from 20 000 shillings (US$ 274). According to an Oxfam report, 70% of the cattle (or 270 000 heads) perished in Kenya. Staple prices in most drought-affected areas rose. In El Wak district (Kenya) pastoralists lost up to 90% of their livestock: goats, sheep, cattle and even camels. So far CARE has cleared an estimated 15 000 carcasses from the town centre, MSF 60 000 more from surrounding areas, but countless more remain in the bush.
Health Indicators above Emergency Threshold

The vicious circle of diseases and under-nutrition needs to be broken!

Reduced food intake and lack of varied diet, leading to malnutrition and micro-nutrient deficiencies (e.g., vitamin A) will result in increased morbidity and mortality, particularly from communi-cable dis-eases. Disease, in turn, will aggravate nutritional losses.

High Malnutrition Levels in all Countries

The situation in all countries is above the emergency threshold (footnote: i.e., more than 10% of children suffering from acute malnutrition).

A total of 44 nutritional surveys conducted in Eritrea, Ethiopia, Kenya and Somalia focused in the most drought-affected areas. Thirty-two of the surveys showed acute malnutrition rates among children under five at and above the critical threshold of 15% indicating an emergency according to the UNICEF June 2006 Nutrition Update.

In Somalia, nine surveys undertaken between January and May in five regions show rates of GAM that range from 15% to 27% with Gedo region showing the highest GAM rate.

In Eritrea, nutritional assessments in three drought-affected regions showed levels of GAM ranging from 11% to more than 20%.

The situation in Ethiopia has not been documented recently; however surveys conducted in January and February 2006 showed alarming levels of acute malnutrition with GAM and SAM (Severe Acute Malnutrition) rates ranging from 18.6% (Cherati town) to 23.5% (Denan in Gode Zone) and from 1.4% to 3.9% respectively. In Djibouti, a rapid assessment conducted in February 2006 showed alarming results with GAM estimated at 28% and SAM at 10%.

Interlinked causes of the vicious circle

• Poverty
• Food insecurity
• Inadequate maternal & Child care
• Insufficient health services
• Unhealthy environment

Global Acute Malnutrition (GAM) at almost 30% (Marsabit, Isolo, and El Wak/ Mandera District), which, according to the report, is at the brink of a humanitarian disaster.

In Kenya, three out of 15 surveys show levels of Global Acute Malnutrition (GAM) at almost 30% (Marsabit, Isolo, and El Wak/ Mandera District), which, according to the report, is at the brink of a humanitarian disaster.
Humanitarian Coverage

It is important to provide a good idea of the proportion of the affected populations that is reachable and actually reached by humanitarian relief. Standard working definitions for these parameters need to be developed, and could be:

- **Reachable population**: humanitarian actors have unrestrained access in a neutral and impartial manner to the affected population
- **Reached population**: humanitarian actors are running major relief programmes in the affected population (‘major’ defined as including all of the following types of intervention: food, nutritional rehabilitation, health, and water and sanitation components)

If data are available (hopefully from OCHA), staff should calculate the following indicators, to be presented in a table:

- **Potential humanitarian coverage**: affected population that can be reached by humanitarian aid / total affected population
- **Operational humanitarian coverage**: affected population reached by humanitarian aid / total affected population that can be reached
- **Overall humanitarian coverage**: affected population reached by humanitarian aid / total affected population

**Table**  Current humanitarian coverage of affected populations. mm, yyyy.

<table>
<thead>
<tr>
<th>Country and area</th>
<th>Number affected</th>
<th>Number reachable</th>
<th>Number reached</th>
<th>Potential humanitarian coverage (reachable/affected)</th>
<th>Operational humanitarian coverage (reached/reachable)</th>
<th>Overall humanitarian coverage (reached/affected)</th>
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**For more details and ideas:**

Communicable diseases remain the major cause of morbidity, regardless of the drought situation. Malaria, acute respiratory infections, diarrhoeas and some epidemic-prone diseases such as cholera, meningitis (Ethiopia and Western Kenya) and measles are major causes of morbidity and, although no accurate mortality survey is available, probably of mortality in the five countries. Children under five are most affected by those diseases (refer to country figures graphs).

The disease surveillance system is being strengthened to provide data from drought-affected districts. In some countries, like Ethiopia and Djibouti sentinel surveillance sites have been set up to allow rapid response. However existing IDSR (Integrated Disease Surveillance and Response) reports give a picture of the situation in drought-affected regions.

In Somalia, no major outbreaks of communicable diseases were reported besides polio. However assessment missions with health partners were carried out during the last week of June to confirm the report and investigate the cause of an outbreak of watery diarrhoea (W/Diarrhoea) with associated deaths reported in Afmadow district, Lower Juba region during the second week of June. An initial report from the WHO District Polio Officer confirms 26 cases among children under five with four deaths. The WHO Office in Mogadishu is preparing to send emergency medical supplies (oral rehydration salts, Ringer Lactate, IV solutions, chlorine tablets, etc.) to the affected area. Social mobilization efforts are also under way. Malaria continues to be a high burden of morbidity in Somalia and is aggravated by the low coverage of public health centres throughout the country’s three zones.

Results collected from sentinel sites show a sharp increase in the number of cases ranging from 6726 cases in the first quarter of 2005 to 10 882 during the first quarter of 2006. The proportional morbidity among children under five shows that diarrhoea, malaria and measles are the major causes of morbidity (figure 1).
In Eritrea, the cases of bloody diarrhoea (B/Diarrhoea) reported in communities in Southern Red Sea Zone in 2006 reached critical levels in January. The outbreaks can be linked to shortage of drinking water in those communities. No outbreak of other diseases has been reported as of 25 June 2006. Respiratory infections are the major cause of morbidity (figure 2).

Since 4 May 2006 and as of 18 June, cholera cases have been reported from Kakuma refugee camp in Turkana district, Kenya. Fourteen more cases were reported this week, bringing the cumulative total to 93 cases (14 culture-confirmed) and one death (figure 3). The main risk factors for the outbreak were inadequate sanitation facilities for the refugees—the pit latrines were swept away by heavy rainfalls in April—and the high influx of refugees from Sudan (currently experiencing a severe cholera outbreak). Case management, health education, epidemiological surveillance (mainly cross-border at Logichogio), water supply and sanitation, new refugees screening activities were implemented.
Following the short rain, Mandera district was affected by a dysentery outbreak (206 cases with 13 deaths, CFR 6.30 %) (Figure 4). Thanks to curative and preventive measures this outbreak lasted only 2 weeks (14-27 May 2006). Drought-affected districts also reported measles cases from January to March 2006.

In Ethiopia, meningitis and measles outbreaks were reported with a peak in March 2006 (136 measles cases and 103 meningitis cases reported in Oromia and Somali provinces in March. Diarrhoea remains the major cause of morbidity in Borena region. Malaria remains low in most of the health institutions despite an increase in Teltelle woreda. Drought-affected areas have experienced an increase of diarrhoea and malaria cases with the short rains. Sentinel surveillance set up in Moyale, Teltelle and Yabello Health Centres show a decrease in the last two weeks of June. Indoor Residual Spraying (IRS) and distribution of insecticide-treated nets in Teltelle after a peak detection of malaria cases seem to have contributed in the decline observed in the trends (figures 5 and 6). No outbreak has been detected in drought-affected area in Djibouti. The Report from Djibouti city showed diarrhoea diseases is also a major cause of morbidity.

- Significant improvement noted on the number of diarrhoeal cases.
- The number of malaria cases has started to decline following the indoor residual spraying and distribution of nets.
- The decline in the diarrhoeal cases is also maintained.
- Malaria and diarrhoeal cases maintained at low level in Yabello.
The lack of vital information providing evidence on the human suffering due to the impact of the drought led humanitarian agencies to give priority to the strengthening of information systems.

Good information management is paramount in averting potential regional outbreaks including Avian Influenza, meningitis and polio. Threats of such outbreaks are real in the face of unfavorable information policy to set up an early warning and rapid response system.

Inter-agency needs assessments and evaluation missions were conducted in the drought-affected areas of the five HoA countries to update programmers on the design of efficient relief operations.

However, critical information gaps remain due to lack of funding for surveys, and evidence is lacking to highlight the impact of the drought on the populations’ health.

Nutritional and mortality surveys were planned in the CAP but remain unfunded. Out of the five countries affected by drought only Eritrea conducted a household survey and health district profile through a compilation of health data in conjunction with the Orotta School of Medicine. This survey could be extended to the rest of the country if additional funds are made available.

The Integrated Disease Surveillance and Response (IDSR) systems which have been introduced in most affected countries are not fully reliable and need to be strengthened to provide morbidity and nutritional status data. Efforts are being made to improve the completeness and timeliness as well as the accuracy and reliability of reports. Major constraints in the establishment of a reliable IDSR are the lack of human resources and of adequate communication from the peripheral to the district and regional level. These are compounded by logistical constraints due to poor infrastructure. CERF grants have therefore been used to build national human resource capacities and to develop data collection tools and guidelines. The roll out of IDSR cascade trainings at the peripheral level is ongoing.

Challenges in the Surveillance System and data Compilation

To harmonize and reconcile information in the HoA countries is challenging because of different surveillance systems that reflect on country needs and levels of desegregation of data (district, regional, etc.), making it difficult to focus on drought-affected areas. In this context, denominators are difficult to estimate as the reporting frequency of sentinel sites or health centres vary from one month to the next. In drought-affected areas, the IDSR systems are not strong enough to capture information beyond the town level. Information collection from drought-affected areas is further complicated by the communication or geographical constraints. Timeliness and completeness of information is affected by the weakness of the national health systems.

To overcome these challenges, WHO is proposing to set up sentinel surveillance sites in some drought-affected areas. Community-based surveillance will also be integrated to outreach services. WHO has also developed collection tools to allow Emergency Focal Points to collect information on useful indicators from already existing surveillance systems and sentinel sites.

Eritrea conducted a household survey and health district profile. Data was compiled in conjunction with the Orotta School of Medicine.
At the peak of the humanitarian crisis the need for stronger coordination was felt as critical by most organizations. As the Health Cluster lead, the challenge for WHO and the Ministries of Health was to bring all national and international stakeholders in a joint planning and coordinating mechanism.

Health partners participated in the CAP and CERF projects development. However the level of coordination and collaboration decreased during the implementation phases.

CERF funds have however allowed WHO and UNICEF to strengthen the field level coordination by recruiting National and international staff and providing them with adequate logistical support.

CERF funds facilitated the coordination of all programmes addressing health issues in drought-affected areas, while simultaneously, strengthening the IASC Cluster Approach.

Health and Nutrition Clusters regional inter-agency meetings were organized in Nairobi, including UN Agencies (WHO, UNICEF, UNFPA, WFP, OCHA, FSAU/FAO), NGOs (SC-UK, Merlin, MSF-Swiss, MSF-Holland, World Vision and ACF), International Organizations and local coordination bodies. Activities carried out by the health sector partners in response to the drought and other emergencies were among the main topics discussed.
Mass polio and measles campaigns were organized in most countries of the HoA with a focus on drought-affected areas.

In Eritrea, a measles vaccination campaign and Vitamin A supplementation targeting an estimated 580,000 children between 6 and 59 months is being planned (Report from 29 May-4 June 2006).

In Somalia, the first measles mass vaccination campaign in 13 years was started in November 2005, targeting children aged 9 months to 12 years. As of May 2006, over 1.14 million children have been vaccinated (including more than 531,000 in five drought-affected regions in the Center/South Zone; close to 469,000 in the North West Zone; and more than 142,500 in the North East Zone). Additionally, more than 509,500 children under five received Vitamin A supplements. Somalia is the only country in the Horn affected by an outbreak of polio, with 211 cases confirmed since July 2005 (185 cases in 2005 and 26 since January 2006). The number of polio cases in Mogadishu has decreased from 158 in 2005 to 7 in 2006. However, the virus has spread to new regions: Gedo, Mudug, Lower Juba, Bari, Hiran, Galgadud and Middle Juba.

Two cases were also identified in the Somali region of Ethiopia, direct importations from Somalia. Synchronized National Immunization Days (NIDs) were conducted in June 2006 in Somalia, the Somali region of Ethiopia and the North Eastern province of Kenya (commitment from all HOA countries is paramount). Further NIDs rounds will be conducted every 4 to 6 weeks until after the last polio case has been identified.

In Kenya, there is an ongoing measles outbreak with the index case traced in an un-immunized child in Somalia. The response to the outbreak revealed serious weaknesses in coordination and an overwhelmed system inadequate to respond. An emergency immunization campaign against polio and measles was conducted in 16 districts of the North Eastern and Eastern provinces and Nairobi, which were at a risk of polio infection from Ethiopia and Somalia. More than 500,000 children under five were immunized.

A mass measles immunization campaign targeting more than 1.5 million children was organized in Ethiopia’s drought-affected regions with the support of UNICEF.

Emergency Drugs and supplies

One strategy implemented throughout the HoA was to improve stocks of emergency drugs and supplies by pre-positioning adequate quantities of drugs and supplies for routine use and during disease outbreaks. While standard emergency health kits are useful for routine services, countries made available drugs and supplies based on disease profiles and assessed risks for outbreaks.

In Eritrea, three New Emergency Health Kits (NEHKs), two Diarrhoea Kits, 40 UNFPA Kits and one Trauma Kit were procured. They can treat 30,000 people for 3 months for common diseases, manage 200 cases of diarrhoea including cholera, attend to 100 interventions cases of trauma and conduct 8,000 deliveries.

In Somalia there are currently 13 NEHKs and four Diarrhoea Kits: nine are in Hargeisa (six NEHKs and three Diarrhoea Kits), one in Garowe, four in Mogadishu (three NEHKs and one Diarrhoea Kit), one in Kismayo Hospital and two in Baidoa (Bay Hospital and OPD Caritas Somalia). Distribution of in-country NEHKd and Diarrhoea Kits in drought affected regions continues.

In May 2006, Ethiopia reported that essential drugs worth US$ 20,000 were purchased locally and distributed to drought-affected woredas. Four NEHKs and 20 delivery kits were procured, while the procurement of two Cholera Kits is ongoing.

In Kenya, nine NEHKs and 36 Reproductive Health Kits were provided to the nine most affected districts. Further distribution within the districts was done in collaboration with the Kenya Red Cross.
Filling Gaps in Drought Affected Areas

Health Care Mobile Clinics

To reduce excessive drought-related morbidity and mortality among vulnerable populations without access to fixed/permanent health care facilities, HoA countries put in place outreach activities. Mobile healthcare clinics help improve access to vital health care for underserved populations such as transhumant herders who migrate between two grazing areas along well-defined routes every year; pastoralists who migrate along conventional routes but can move in different directions every year and within a given year and semi-nomads who practice other activities while retaining migration and livestock herding as their basic economy. Such services are adapted in situations of emergencies as they are more flexible. Mobile health care clinics are also suitable to cater for the thousands of internally displaced people caused by the combination of civil strife and natural disasters. The clinics will be used to complement and strengthen existing emergency health response activities provided by health sector partners. The mobile clinics or outreach services (depending on the countries) are supported by WHO and UNICEF in collaboration with partner NGOs and the MoH.

In Djibouti, refresher training for mobile units staff was done in collaboration with MoH.

In Eritrea, sustainable outreach services have been developed in two sub Zobas (districts) in Northern and Southern Red Sea. They depend on further funding.

In Somalia, health partners in drought-affected regions continue joint planning for CERF-funded mobile health units. Outreach training was provided to prepare disaster management teams recruited from health partners in Somalia and enable them to assess and respond adequately to needs. The training was implemented in Merka (Lower Shabelle region) from 10 to 15 July for nurses working in health facilities in drought affected regions of South/Central Somalia.
Capacity Building in Drought Affected Areas

Therapeutic and Supplementary Feeding Programmes

To face the high malnutrition levels reported in all HoA countries, humanitarian agencies standardized nutritional and medical protocols, improved severe malnutrition case management and provided supplementary feeding.

In Eritrea, Nutrition and breastfeeding education was provided. For health partners in Kenya, training on severe malnutrition case management, nut surveillance & MISP for Repro Health, IDSR, Malaria case management was done. In Djibouti, an expert in nutrition and nutritional warning systems was recruited to provide technical support to MoH.

In Ethiopia, under the joint UNICEF/WFP Enhanced Outreach Strategy, targeted supplementary feeding provided 314,000 children under five living in remote parts of the Somali region with a life-saving package of interventions including vitamin A supplementation, de-worming and nutritional screening in early February.

In Kenya and Somalia, UNICEF is supporting nutritional programmes in collaboration with several NGOs.

In Eritrea, following an agreement with the Ministry of Health (MOH), Integrated Management of Childhood Illnesses (IMCI) trainings have been conducted since 20 June.

Strengthening Health Presence

In Ethiopia, the Federal MOH assigned more than 51 health professionals to the Somali region to relieve the critical shortage of human resource in the drought-affected areas. Meanwhile satellite posts for communicable disease surveillance were strengthened. All woreda health offices were provided with essential guidelines on the management of communicable diseases and guidelines on the treatment of malaria were distributed. WHO Ethiopia provided technical support to the Federal MOH, regional health bureaus and woreda health offices in the preparation of response plans, the coordination of partners and the supervision and training of health professionals. Training of trainers for 19 Woreda rapid response team members and on the job training of health professionals redeployed to the Borena Zone in Oromiya were conducted to address the critical shortage of human resources.

In Merka, Lower Shabelle, Somalia, two trainings were conducted for local health workers from various affected regions (Bakool, Banadir, Bay, Gedo, Hiran, Lower Juba, Lower Shabelle, Middle Juba & Middle Shabelle). The first was on malaria and surveillance in drought affected regions of South Somalia and the second, organized by the Health Cluster with CERF funding, on surveillance and control of communicable disease in emergencies.

In Kenya, training on disease surveillance and rapid response is ongoing since June in the nine most affected districts. WHO and the MoH also conducted training on the management of severe malnutrition, with UNFPA’s input on Reproductive Health.
Funds made available through the CERF mechanism have allowed for the quick implementation of life-saving operations in response to the drought crisis in the Horn of Africa.

However daunting challenges remain for humanitarian aid agencies in their efforts to avoid excessive mortality and morbidity and to mitigate the effects of the drought on affected populations.

One major priority for the international community is to raise additional resources to sustain the results made so far in the detection and response of communicable disease outbreaks through the establishment of disease surveillance and response systems.

Delays in the implementation of outreach services were partly due to the lack of health workers trained in emergency preparedness and response. It is therefore imperative to increase the number of capacity-building initiatives to relieve the critical shortage of human resources in the drought affected areas. Outreach services should also be strengthened with adequate logistical support.

Logistic support to outreach services remained a challenge as vehicles at the district level are insufficient in number and are generally in a poor state. Donors should be ready to accept that the concept of capacity building needs to be extended to cover all support systems, including facilities for vehicle maintenance.

National authorities’ communication networks must be improved to increase populations’ access to health services provided by mobile medical clinics.

Support to comprehensive surveys is of strategic importance in designing future interventions in times of crisis. Such surveys will guide decision-makers and health programmers in the identification of priority areas.

In the CAP Appeal, WHO’s proposal for a comprehensive survey in collaboration with humanitarian partners, research institutes and universities to provide a clear baseline in the five drought-affected countries (Somalia if security allows) remains unfunded. About US$ 500 000 was requested to implement this activity.

Through the CERF, WHO is equipping a number of key health centres (60 in Kenya; nine districts in Somalia). However more financial support is required to increase the coverage of health services provided through the outreach strategy.

In addition, health centres closed for lack of water, essential drugs, medical equipments and staff should be reopened to support outreach services.

The nutritional indicators in most HoA countries showed high levels of malnutrition rates. The implementation of community-based supplementary or therapeutic feeding programmes can make a difference in the status of malnourished children by offsetting high default rates and increasing accessibility.

To strengthen the weak coordination at district level, UN Agencies provided field staff (mainly in Ethiopia and Kenya) and improved logistic support to district officials.

Finally, Health Cluster members were encouraged to increase the coordination of health activities with the food and water and sanitation sectors to improve the outcomes of health interventions.
Clusters Coordination

**Food Security and Nutrition Working Group**

The group is chaired by FAO Regional Office for Emergency. In collaboration with FewsNet and FSAU, the group has developed a ICP (Integrated Food Security and Humanitarian Phase Classification) tool. A two-day technical regional analysis workshop was conducted in Nairobi (15-16 June) to discuss the improvement and implementation of this tool in countries.

**Link to the Report**

http://www.who.int/entity/hac/crises/international/hoafrica/sitreps/

Two further meetings were organized to discuss findings, way forward and nutritional surveys in the region (UNICEF compilation).

**Regional Health Emergency Group (RHEG)**

A thematic sub-group of the Inter-Agency Working Group (IAWG). A meeting on 3 July 2006, including FAO, IFRC, UNICEF, the University of Nairobi and WHO, updated on the situation in the drought-affected countries, ways forward and provided an overview of health and nutrition activities. Presentations included WHO’s bulletin and four pillars of activities, a UNICEF study on assessment of child nutrition in the Greater Horn of Africa (the reports are available at http://www.tulane.edu/~internut under “resources”).

The Regional Nutrition Advisor presented the results of the compilation of surveys from January to May 2006. Other topics of discussions included the need to integrate health and nutrition surveillance together. An integrated tool using sectorial data, like the one developed by FSAU allowing mapping of vulnerabilities taking into account different indicators, is useful. Clinic reporting system could integrate growth monitoring data. Community-based activity could also help to detected malnutrition cases and trigger a survey.

"Preparedness for the early warning system"

Countries must be prepared for emergencies and should allocate resources for preparedness. Trigger mechanisms should be strengthened and well disseminate to allow rapid and concrete actions by all stakeholders, including donors. The FSAU tool and community-based system (with organization like IFRC, World Vision…) may help in establishing this mechanism. Minimum resources should be available at local level to foster rapid response.

The group agreed on key activities to push forward (see way forward).

- **New IASC cluster approach**

Feedback from WHO Meeting on the HoA drought crisis meeting. It was decided to maintain at the regional level (East and Central Africa) the existing IAWG and thematic group. Recommendation was made to improve collaboration between Clusters to reinforce effectiveness.

- **RHEG’s Plan of Activities for the next quarter**

The next RHEG monthly meeting is planned for August 2006.
Recommendations from EPI Teams Cross border meeting for the Horn of Africa, Nairobi, 4-5 May 2006

Supplemental Immunization Activities (SIAs) for outbreak response

1. SIAs should be implemented regularly until transmission has been interrupted in the remaining endemic/re-infected countries due to low status of routine immunization and problem of accessibility in the HoA.

2. Synchronization is paramount to ensure optimal coverage of children especially in the border areas.

3. Due to the situation in Ethiopia’s Somali region (insecurity, weak surveillance, insufficient quality of SIAs) and its proximity to Somalia and Kenya, additional SIAs to cover all three countries may be required.

4. Efforts should be explored to ensure that areas that cannot be accessed from within the country are covered with the support of staff from the neighbouring countries.

Surveillance

1. All the HOA countries will carry out regular detailed analysis by sub national level with emphasis on border areas to identify surveillance gaps, take appropriate action that will be documented and reflected in the monthly update. This will include OPV immunization status of Acute Flaccid Paralysis (AFP) cases.

2. The existing HOA bulletin is a good medium for sharing information and should be widely distributed by regional and countries offices to all concerned staff.

Advocacy

1. Given the challenges in the HOA, including drought and accessibility issues, advocacy to sustain polio eradication should be enhanced.

2. In line with the prevailing and persistent funding gaps, as well as the need to continue SIAs, in countries resource mobilization efforts need to be initiated and strengthened.

Coordination

To facilitate the implementation of the TAG recommendations, an HOA meeting should be held biannually in conjunction with the TAG.

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