July 2003 Issue 19

Field Exchange

Emergency Nutrition Network

Destocking in Ethiopia

HIV/AIDS Home Based Care in Zimbabwe

Community Based Therapeutic Care

Ambulatory TFC in Afghanistan

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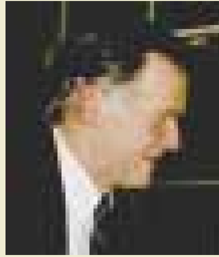


Field Exchange salutes John Kevany

co-director of the ENN, who died unexpectedly on Easter Sunday this year.

John was instrumental in the search for an institutional location and funding for the ENN. Based in the Dept. of Community Health and General Practice, Professor John Kevany immediately recognised the need for the ENN and set about convincing others in the Irish Dept. of Foreign Affairs and Trinity College Dublin that this was an initiative worthy of support. Both institutions took his advice so that the ENN was established in the Dept. of Community Health and General Practice,TCD with core funding from the Dept. of Foreign Affairs. John's involvement in the ENN did not end there. He became one of the three ENN Directors and was an invaluable source of advice, support and encouragement for all ENN activities.

John's ability to catalyse initiatives was evident throughout his professional life. He was full of ideas and could think his way around most challenges. John was a facilitator who shared knowledge and experience willingly.

John Kevany began to take a particular interest in malnutrition in developing countries soon after qualifying in medicine in the mid-1950's. He started work with Pan American Health Organisation (PAHO the regional office of WHO for the Americas) as an advisor in nutrition through the 1960's. This interest – itself stimulated by Abraham Horwitz, his long time friend and director of PAHO – continued on his return to Dublin to take up his academic career in Trinity College. It then led to his many contributions to World Bank projects in this area, first based full time in Washington in 1984-86, then as a frequent contributor to programme development. In 1988 Dr Horwitz appointed John Chair of the United nations Advisory Group on Nutrition, where he continued to press for effective action that helped people – and showing a renowned impatience with abstract discussion. In this role he provided a sure touch in nudging the conglomerate of international agencies towards actually achieving some improvement in the lives and welfare of poor people, especially women and children.

As the central force of the MSc in Community Health, he inspired interest and application from those with overseas international health interests. Many former students currently involved in overseas work benefited from his tenure in the Department of Community Health and General Practice. In the department, John represented the very best of academic tradition by prioritising the search for knowledge and at the same time catering for the needs of students. His admirable qualities were continually on display in his willingness to share and build on a huge base of knowledge and experience, his accessibility, and his willingness at all times to motivate, to help and to support.

John was the true mentor - he infected his students with his own enthusiasm for public health and justice. That influence lives on within the Department of Community Health and General Practice and in the work of many organisations in Ireland and overseas where graduates of the Department are now placed. It has percolated into the policies and programmes of the Health Boards in Ireland, Pavee Point, the Emergency Nutrition Network, Oxfam, Ireland Aid, the International Federation of the Red Cross, the London School of Hygiene and Tropical Medicine and many other organisations.

When John retired from TCD he continued as one of the ENN Directors. He also became more involved in working on HIV and AIDS for Ireland Aid. Over the last five years he was hugely influential in helping to shape the Irish Government's policies in the field of public health and HIV/AIDS and in determining Irish Government priorities for investing in health needs of developing countries.

His life was characterised by a profound understanding of the multiple causes of ill health and a huge commitment to bringing about the changes necessary to redress these. In 1996, in an article in the British Medical Journal, he wrote "The world's biggest killer and the greatest cause of ill health and suffering across the globe is extreme poverty. The effects of poverty on health are never more clearly expressed than in poor communities of the developing world… The scale and persistence of these problems is a blunt reminder of an international obligation ignored."

These words perhaps give us some insight into the extent of John's commitment to the cause of international health. This is further reflected in a lifetime spent in Ireland, in Africa, in South America and in Asia and working with like minded colleagues in Trinity College, in the World Bank and in the Pan American Health Organisation.

The essence of all John's qualities is perhaps best captured in a single word – integrity.

John was a dedicated family man and will be missed most of all by his wife Rose, daughters Sophie Seana and Sabrina, his son Sebastian and step-son Peter.

This tribute to John Kevany draws on the reflections and memories of a few of John's close professional colleagues (Dr V.O'Neill, Dr. J Mason, F O'Reilly and J Shoham) during a long and illustrious career.

This issue of Field Exchange is dedicated to Prof. John Kevany (ENN Director) who died on 20th April 2003. John was instrumental in establishing the ENN. Given John's significant work with Ireland Aid in the area of HIV/AIDS it is fitting that this issue features prominently in this Field Exchange.

A field article by Hisham Kogali from IFRC describes the massive HIV/AIDS problem in Zimbabwe and the implementation of a home based care programme (HBC) for people living with HIV/AIDS. At the end of 2001, there were approximately 780,000 AIDS orphans in Zimbabwe while an estimated 2,300,000 people were infected by HIV/AIDS. The HBC programme, which IFRC began implementing as far back as 1988, aims to address the problem through information dissemination, improved access to care and provision of support through activities like income generation, agricultural projects and food distributions. The programme has recently been implemented against the backdrop of drought and increased food insecurity. There have been many challenges, which have in turn led to important lessons that should prove useful for other agencies working in similar contexts.

This issue also carries summaries of a number of recent publications specifically related to HIV in food crises and emergencies. Perhaps the most controversial of these is a paper written by Alex de Waal, who describes what has been occurring in southern Africa as a 'new variant famine'. De Waal argues that the HIV/AIDS pandemic in the region is leading to a new type of famine, as households suffer through the 'squeeze' on sick adults, higher dependency ratios and reduced life expectancy. Normal coping mechanisms are overwhelmed and when faced with drought and crop failure, people become locked into strategies which are less productive. De Waal predicts that this could lead to famines with levels of starvation never seen before. The implications of this are a need for massive aid and long term welfarism, and a shift away from purely child-focused interventions. While this is very much a 'think piece' with no supporting data or evidence for its main conclusions, the ideas are compelling and disturbing.

A less controversial review, published by the Overseas Development Institute (ODI), examines how emergencies exacerbate vulnerability to HIV. The review contains a number of recommendations in areas of policy making, risk assessment, programming decisions with regard to vulnerability to sexual violence and exploitation, and provision of health care. Implications for staff training are emphasised. A central theme running through the review is that HIV is a cross cutting issue and HIV activities need to be integrated into existing programme channels, rather than addressing the problem in stand alone, isolated HIV programmes.

A move towards such integrated programming is reflected in a WFP policy document on HIV highlighted in the news section. Recently endorsed by WFP's Executive Board, critical recommendations include i) WFP will incorporate HIV/AIDS concerns into all programming categories and ii) when HIV/AIDS threatens food security and influences mortality in ways similar to other disasters, WFP will consider HIV/AIDS as a basis for a protracted relief and recovery operation (PRRO). Also in news, FAO/WHO have recently published a manual on nutritional care and support for people living with HIV/AIDS . It contains practical recommendations for a healthy, well balanced diet in countries or areas with low resource bases, and aims at improving nutrition in home based settings.

A second theme running through this issue of Field Exchange relates to assessment methodologies for identifying and justifying appropriate non-food aid interventions in food crises. Two experiences are described in this issue. The article by Dereje Tieke describes CARE's livestock de-stocking programme in Ethiopia following a protracted drought. The programme appears to have been highly successful in that it reduced livestock asset loss, led to sustainable meat processing and reduced pressure on rangeland. Many lessons were learnt during the programme, including the unanticipated ability of local systems to 'bounce back' and return to livestock holding rather than sale, once the situation improved. Valuable lessons are also highlighted in the summary of a published paper about a seed multiplication project in southern Sudan. As the project evolved, lessons emerged over the inappropriateness of the selected seed varieties, and it became clear that implementing agencies had not drawn sufficiently on local information during project planning. Both experiences demonstrated how much more there is to learn about the implementation of such projects.

It may, in part, be this steep learning curve which creates a tendency to opt for more tried and tested interventions based on food aid provision. A recent Groupe Urgence Rèhabilitation Dèvelopment (URD) evaluation in Afghanistan (page 17), criticised the use of 'blue print' food aid programmes, like supplementary and therapeutic feeding. Factors contributing to this type of 'unimaginative' programming were identified as urgency to respond, donor pressure to yield results, competition between agencies for funds and visibility, and lack of staff with nutritional experience and knowledge of Afghanistan. Similarly, a recent review of livelihood assessments in situations of chronic conflict and political instability (SCCIPI) (page10) found that assessments were mainly used to identify the need for food aid. The reviewers suggest that this may be due to limited scope for supporting livelihood strategies in SCCIPI, fear of fuelling conflict, funding constraints (programmes fall between relief and development) or agency mandate (most agencies focus on a limited number of specific interventions). The authors conclude that, even in SCCIPI, there is often much scope for livelihoods programming and that this should be addressed by needs assessments.

This conclusion was reinforced at a recent WFP technical meeting on emergency needs assessment (page27). A number of donors present at the meeting expressed concern that agencies conducting assessments often overestimate food aid needs, citing southern Africa as an example, while the potential for non food aid interventions is not adequately examined or justified in assessments and resulting proposals. At the same time, donors admitted that their confidence in assessment findings depended, to some degree, on the reputation of agencies and demonstrated use of a recognised methodology.

The tendency amongst some agencies to rely too much on standard food aid responses in emergencies may be underpinned by assessment methodologies which have not been developed adequately to identify the need for, and appropriateness of, other types of intervention, e.g. market support, livestock off-take, agricultural support, etc. This is worrying as in some situations, non-food aid responses to food crises are probably more appropriate in terms of timing, cost-effectiveness and longer term impact. This is a bit of a 'chicken and egg' scenario as strengthening emergency needs assessment methodologies in terms of identifying scope for non-food aid interventions is to a certain extent dependent on experience of implementing these types of programmes. Perhaps what is needed at this stage is more of a commitment to engage in the process of strengthening ENA methodologies. The one area where assessment methodologies for non-food aid interventions appear to be developing are 'seeds and tools provision'. A recent review , summarised in this issue, concluded that many seeds and tools programmes are automatic 'knee jerk' responses to the post-emergency phase, yet such programmes are often unnecessary. The authors propose a methodology called 'seed profiling', which should help determine whether such programmes are necessary and workable. It is precisely this type of analysis and methodological development that is urgently required for the many other types of non-food aid interventions which are periodically piloted, but rarely implemented, on any scale in food emergencies.

Jeremy Shoham

Federation of the Red Cross and Red Crescent, 2002

Red Cross volunteers train carers in households to look after people living with HIV/AIDS

HIV/AIDS

Home Based Care in Zimbabwe

By Hisham Khogali

Federation of the Red Cross and Red Crescent, 2002

Hisham Khogali is currently the Senior Food Security Officer of the International Federation of the Red Cross and Red Crescent. Prior to this, Hisham worked for Oxfam as a Food and Nutrition Advisor and has worked for MSF-Holland in various countries in Africa and Asia.

The support of the Zimbabwe Red Cross and British Red Cross to the programme, and the contribution of Jane McAskill to this review, is gratefully acknowledged.

In this article, Hisham describes a home based care programme for people living with HIV/AIDS in Zimbabwe, highlighting constraints as well as areas for further development.

Federation of the Red Cross and Red Crescent, 2002

Red cross ' Care Facilitators' are involved in training carers in households to look after people living with HIV/AIDS . They are also involved in food distribution

Across Zimbabwe, the level of infection and illness associated with HIV/AIDS is contributing to a dramatic rise in poverty levels. A recent assessment[1] of people and households living with HIV/AIDS suggests that there has been an increase in widows, widowers and orphans. The assessment, moreover, showed that greater time was spent on caring for the sick, and that households were facing increased medical costs, as well as reducing spending on household requirements. Migration is also on the increase, with movement of people from rural to urban areas in search of treatment, and from urban to rural areas in pursuit of a cheaper life-style. At the same time, households have a deteriorating dependency ratio, characterised by a low number of healthy adults relative to people living with HIV/AIDS (PLWHA), children and elderly.

This experience of the impact of HIV/AIDS on households in Zimbabwe is supported by estimates[2] that, by the end of 2001, 2.3 million people were infected by HIV/AIDS in Zimbabwe. One-third (33.7%) of all adults aged 15-49years were estimated to be infected, with 200,000 deaths due to HIV/AIDS. By the end of 2001, Zimbabwe had approximately 780,000 orphans (children under 15 years who have lost one or both parents to HIV/AIDS).

Integrated Aids Project

As early as 1988, the Zimbabwe Red Cross (ZRCS) recognised the increasing vulnerability of households, with the start of the Integrated AIDS Project (IAP) which focused on prevention. As it became evident that the numbers of HIV affected households was growing, Home Based Care (HBC) was developed in 1992. The IAP now focuses on three main areas including:

- Prevention of transmission of sexually transmitted diseases (STDs) and HIV/AIDS
- Care and support for PLWHA and their affected families
- Advocacy

The goal of the IAP is to "reduce the incidence of HIV/AIDS and its consequences among vulnerable groups in Zimbabwe through information dissemination, access to care and support". The programme reaches some 10,000 chronically sick clients[3] in their homes and has registered over 35,000 orphans and vulnerable children (OVC).

There are currently 22 HBC projects across the eight provinces of Zimbabwe. The Zimbabwe Red Cross trains volunteers recruited from the community, often themselves infected with HIV, to become care facilitators. These volunteers then support households with PLWHA in various ways including hygiene training for infection management, promoting key health and nutrition messages, as well as work to reduce the stigma associated with HIV/AIDS.

Often the clients of home based care lack basic needs such as food, shelter and clothing - a key weakness of the programme identified prior to the current crisis. In order to meet these needs, the ZRCS started to distribute food to the HBC clients. However, due to funding constraints, this was erratic and often not enough to meet the ever-growing needs.

As a result of the political and drought induced crisis in Zimbabwe, the ZRCS was able to appeal for food provision for HBC clients and their household members in order to reduce the impact of the drought and political crisis on these particularly vulnerable households. The monthly ration currently provided is shown in Table 1, which reflects the extra nutrient needs of HBC clients.

Table 1 Monthly food rations to Home based Care clients and household members

Monthly ration	Maize meal	Bean	CSB	Oil	Sugar
HBC Client	10kg	4kg	2kg	1.5l	1kg
Household Members	10kg	1.8kg	3kg	0.6l	

As well as food provision, some of the HBC projects have support groups. These groups can be active through small income generating activities, as well as agricultural projects such as poultry production and home gardening. These support groups also act as an important means of psychological support by enabling people to talk and share concerns and ideas, while on a practical basis allow the sharing of costs for funerals.

HIV, food security and vulnerability

Although it is recognised that HIV/AIDS crosses wealth groups, it is clear that the poorest households in communities are the most vulnerable or at risk. The very poor have less access to HIV/AIDS information, may resort to prostitution to access money or food and have a poorer health and nutrition status. These are all factors that increase their vulnerability. At the same time, those better off may be vulnerable in that they have the resources to pay for multiple sex partners[1].

Poorer HIV/AIDS affected households have a higher dependency ratio, with a lower number of healthy adults. They have less access to relatives in urban areas and abroad, while the gifts they receive are smaller in size and less regular than better off households. Poorer households also tend to have less access to regular employment, pensions or property and medical services. They have less access to nutritious food than better off households - a key factor in prolonging the lives of infected individuals.

The drought and political crisis in Zimbabwe exacerbated the impact of HIV/AIDS on clients of the HBC programme and their household members, by reducing access to food from production in rural areas, as well as in some urban areas, and through food price inflation. It has resulted in household members having to spend longer looking for sources of money or food and reduced the value of pensions, savings and the social welfare system as a result of inflation. Poor households with PLWHA have tried to cope by relying more on wild foods in rural areas and on casual labour and petty trade as income sources. Some have joined public works programmes, such as food for work, whilst others are trying to access social welfare programmes. Rural households may have more care and support available from relatives while urban households may be able to rely on support from relatives in urban centres or abroad. Table 2 provides a comparison of urban versus rural HBC project areas in Marondera and Chivi, in 2002.

Improving programming

While recognising the important and necessary role of food aid for PLWHA and household members, the HBC programme continues to struggle with a number of key issues including targeting, improving medium to long-term food security and capacity to meet food needs.

Targeting

The HBC project aims to target the most vulnerable, i.e. the poorest households with PLWHA. Although difficult, this has been more effective in urban areas where HIV testing is more available and can be combined with needs assessments by Social Welfare. In rural areas, testing was not available so that selection was based on clinical symptoms in the absence of a clear clinical case definition. This has meant that some vulnerable households without PLWHA have been included in the programme.

A recent assessment[1] proposed the following criteria for targeting in the absence of HIV/AIDS testing:

i) *"Clear evidence (medical card) of a combination of recurring infections associated with HIV/AIDS"*, including

- constant diarrhoea
- herpes
- persistent coughing /recurring TB
- swollen lymph nodes
- kaposi sarcoma
- "permed hair"

ii) People undergoing TB treatment. TB patients

Table 2 Comparisons between two projects areas (urban vs. rural)

Urban – Marondera	Rural – Chivi
Family composition	
Family sizes slightly smaller in urban areas, particularly amongst middle and better-off wealth groups.	Rural households may be more likely to have a second wife.
Access to land	
Only a proportion of the population has access to land for cultivation. Some of the poor/very poor may have small plots allocated by the municipality.	All have access to land and many have small vegetable gardens.
Access to food	
Families usually purchase food. Urban eat more matemba* and have limited access to wild foods.	Usually a significant proportion of food comes from production and the balance comes from purchase. Households became more dependent on food purchase because of drought. Wild foods improve access to vitamins and minerals.
Better access to food through the HBC from ZRCS, DAAC[1]. This is better targeted to the very poor.	Less access to food via HBC. This district received food aid from CARE. Middle wealth groups until recently got more food than the poor, or very poor.
Sources of income	
More varied, particularly for the poor and very poor. Formal employment more important for all wealth groups except the very poor.	More dependent on casual/agricultural labour and gold panning. More limited access to markets.
The public works programme is limited to a maximum of 3 weeks per year for any person.	Once a person has registered for public works programmes, they can stay on the programme indefinitely.
Type of clients	
Through screening of clients, more people have been tested for HIV/AIDS, reflecting the proximity of testing centres. Easier for wives to choose to go for testing – do not have to consult the community. 75% estimated to have been tested HIV/AIDS positive – the balance show typical signs and symptoms	Targets all people who are terminally ill including the old and the disabled. Identification of clients more dependent on symptoms. Few people have been tested – less access to testing centres due to distance, cost and time. May also reflect cultural issues of having to have husbands/ families permission to go for testing. Three-quarters (75%) estimated to have signs/symptoms of HIV/AIDS, the remainder being elderly, disabled etc.
Both projects target the poor and very poor – but there is greater emphasis in the urban population	
Access to services	
Access to services – health, education is generally easier in the urban setting.	More support in rural areas from extended family.

*Matemba: a type of fish
[1]DAAC: District Aids Action Committee

Source: MacAskill et al, 2002

Federation of the Red Cross and Red Crescent, 2002

should, however, be weaned off the programme at the end of treatment unless clear evidence exists of HIV/AIDS infection.

Work continues with the ZRCS to try to improve targeting in order to use scarce resources more efficiently, while recognising the implications of stigma and discrimination associated with HIV/AIDS.

Improving medium to long term food security

The home care programme has recognised the need to identify strategies that target the medium to long term food security of other household members. For example, orphans and vulnerable children are often left without the knowledge and skills base to undertake agricultural production at a time when labour is in increasingly short supply.

Less time is available due to the time spent on care for the ill. There is therefore a need to develop methods of less labour intensive production, whilst maintaining the nutrient quality of the food produced.

Poor households also lack access to employment and are often depleting assets to access curative services for PLWHA. Increasing access to income could play a key role in improving food security.

The current programme has small income generating, poultry and home gardening activities, which contribute more in terms of social and psychological support than to the food security of households. A challenge for the Zimbabwe Red Cross lies in how to improve the food security of affected households while not overburdening the capacity of volunteers.

Capacity

Resources for the current food distribution of the HBC programme are funded through an Emergency appeal by the International Federation of the Red Cross and Red Crescent. The expectations raised by the intervention will require forging partnerships between the ZRCS and multilateral and bilateral donors in ensure a continuous supply of food
.

As food provision remains an important part of the HBC, the ZRCS are faced with a fundamental challenge, namely, the capacity of the existing volunteer base to meet food needs and provide for an increasingly diverse set of priorities within the HBC. This means that volunteers are stretched to their limits.

Conclusion

Home based care for people living with HIV/AIDS provides a unique opportunity for the ZRCS to access vulnerable households. These households are, however, vulnerable in both the short term as well as the long term. Although current efforts are focussed on addressing the acute food crisis as a result of the drought and political crisis in the country, it will be important to pilot and support the development of programmes that address longer term vulnerability.

A fundamental concern remains over the increasing workload of volunteers, coupled with the concomitant increase in needs of clients and their households. The HBC programme will therefore need to consider the possibility of increasing its volunteer base through a recruitment drive, or develop food security programming in an independent, though integrated, way to address the needs of PLWHA and their household members, including orphans and vulnerable children.

Lastly, it is clear that the crisis in Southern Africa, including Zimbabwe, is not "business as usual" for the humanitarian community. The Zimbabwe Red Cross, amongst other National Red Cross Societies in the region, recognises the need to develop an integrated multi-sectoral programme in support of households and communities affected by HIV/AIDS.

For further information, contact Hisham Khogali, email: Hisham.Khogali@ifrc.org

[1]MacAskill J, Chinyangarara E, Dimbo K, Maxwell Phiri, M Tambudzayi T, 2002. Assessment of the impact of the drought and HIV/AIDS on HBC clients in the Chivi rural Project area and in Marondera urban project area.

[2]Source: UNAIDS/UNICEF/WHO estimates

[3]The term chronically sick clients is used in order to reduce the risk of stigma associated with HIV/AIDS

Community Based Therapeutic Care

Summary of published research[1]

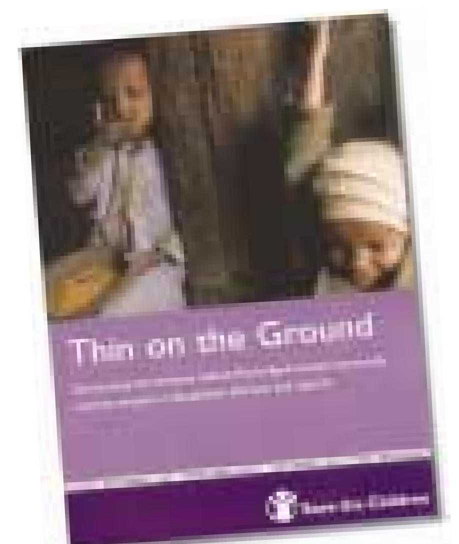
Bedawacho Woreda is a district in Ethiopia, 350 km south of Addis Ababa, which had suffered three years of drought. A nutritional survey by Concern Worldwide found that 17% of children aged 6-60 months were moderately malnourished (weight-for height less than -2 z scores) and 5% were severely malnourished (weight-for-height less than –3 z scores). In response, Concern Worldwide started a decentralised dry supplementary feeding programme (SFP) from ten distribution points, located at government-run primary health-care clinics or health centres.

During the first weeks of the feeding programme, 160 children were identified as severely malnourished. The children were dispersed across the Woreda district, much of which was inaccessible. Ideally, their treatment would have commenced with several days in a phase-1 unit. However inpatient care facilities were not available in the district, and the regional government did not want agencies to set up new therapeutic feeding centres. Consequently, patients were treated as outpatients attending only once-per-week at clinics or distribution sites.

Between October and January 2001, patients were enrolled at any one of the ten supplementary feeding programme (SFP) distribution points. Inclusion criteria were a weight-for-height ratio of 70% or less, or bilateral pitting oedema. One outpatient therapeutic feeding

Thin on the Ground

By Louisa Gisling, SC UK



programme site was set up at each of the ten SFP sites. Each participant in the outpatient programme returned weekly to their closest site in order to receive food and a medical assessment. Every fortnight during the SFP distribution, the outpatient participants were examined and supplied with a two week ration of Farmix and a weekly supply of ready-to-use-therapeutic food (RUTF). On the weeks between the SFP, children were examined by local clinic staff and given a one week ration of RUTF. Outreach workers followed up patients at home once or twice a week. They checked children's progress and referred ill children back to the clinic.

On admission, patients were given an oral dose of vitamin A, mebendazole and folic acid. Patients received a 5-day course of co-trimoxazole. Dehydration was treated with ReSoMal. On alternate weeks, patients received folic acid orally. At admission, an educational message sheet was discussed with groups of patients' mothers. The message was reinforced by the community outreach team during home visits. Education focused on the feeding regimen and on reducing the risk of complications arising from severe malnutrition. Patients were discharged to the SFP if their weight-for-height was more than 75% for two consecutive weeks and they did not have infectious disease.

A retrospective cohort study was conducted on the outpatients between September 2000 and January 2001 involving clinical records for 170 children aged 6-120 months[2]. The children had either marasmus, kwashiorkor or marasmic kwashiorkor. Outcomes were mortality, default from programme, discharge from programme, rate of weight gain and length of stay in programme.

The study found that 144 patients recovered, seven (4%) died, eleven (6%) were transferred and eight (5%) defaulted. Median time to discharge was 42 days, days to death (14) and days to default (14). Median rate of weight gain was 3.16 g/kg/day. Amongst patients who recovered, median rates of weight gain were 4.8 g/kg/day for marasmic patients, 4.03 g/kg/day for marasmic kwashiorkor patients and 2.7 g/kg/day for kwashiorkor patients.

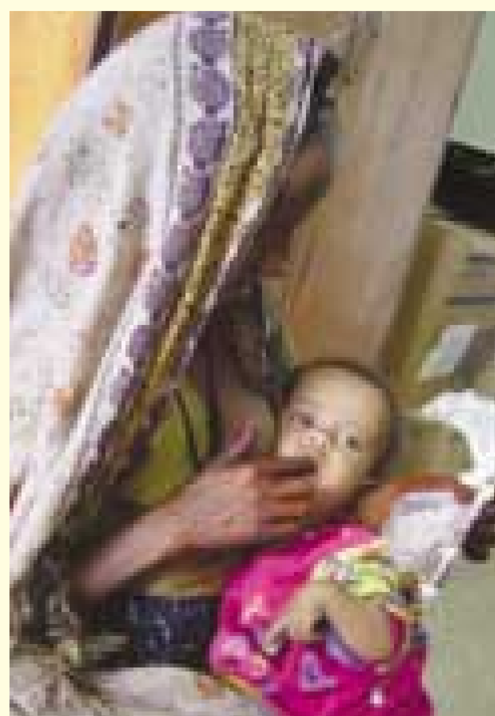
Outpatient care exceeded internationally accepted minimum standards for recovery, default, and mortality rates. Time spent in the programme and rates of weight gain did not meet these standards. However, caution is required in interpretation of these data. For example, weight gain was calculated in relation to when oedema was first assessed as having disappeared and as there was weekly weighing, this may not have been accurate. Furthermore, as dangers of acquired infection were less (malnourished patients were not removed from home environments and congregated), length of time in programme is of less significance. Also, slow response was probably caused by sharing of food rations. However, it may also have reflected poor dietary composition of the ration, and formal controlled tests for effectiveness of RUTF in oedematous patients are needed. The default rate was low, indicating that outpatient care was acceptable to participants.
No data for programme coverage were collected. which the authors of the study believe was a serious omission and should take place in subsequent evaluations of this type of programme.

Among the authors conclusions were the following:

◆ Outpatient care could provide a complementary treatment strategy to therapeutic feeding centres but further research is needed to compare the effectiveness of outpatient and centre based treatment of severe malnutrition in emergency nutritional interventions.
◆ Marasmic kwashiorkor patients are very vulnerable and have a high risk of death and complication. These patients require the intensive care, monitoring and cautious F75 based feeding regimens of phase one therapeutic care which are not possible in outpatient treatment. In the absence of a RUTF designed for phase one treatment, outpatient feeding should be run in conjunction with suitable inpatient facilities.
◆ The reasonable response to this type of treatment indicates that only severe cases (marasmic kwashiorkor or those with complications) require inpatient care, which need last only a few days. Phase one centres could, therefore, be smaller and more basic than conventional therapeutic feeding centres, easier to construct and less resource intensive.
◆ An advantage of combining outpatient feeding with phase one centres it that the outpatient element can be started immediately and begin rehabilitating people while the phase one centres are being built.
◆ Small centres, where patients stay for only a few days, have lower risks of nosocomial infections, decrease disruption to carers, and release emergency funding to strengthen local health infrastructures.

[1]Outpatient care for severely malnourished children in emergency relief programmes; a retrospective cohort study. S. Collins and Kate Sadler. The Lancet, vol 360, Dec 7th, 2002

[2]Children aged 6 - 120 months were included in analysis since reasonable weight-for-height tables exist for this group and children in this age-group were treated in the programme (10%, n=16, were over 60 months of age). Personal communication. Dr Steve Collins, 30.05.03


S. Collins 2003

Malnourished Child being fed with ready-to-use therapeutic food (RUTF)

Questioning the evidence behind World Bank-funded community nutrition projects in Bangladesh, Ethiopia and Uganda, key findings of the Save the Children UK report, Thin on the Ground, were presented at the UN Standing Committee on Nutrition meeting in Chennai, India in March 2003.

The report was written by Save the Children UK to publicise the findings of a study into the effectiveness of nutrition projects funded through World Bank IDA loans. All the projects use the growth monitoring and promotion approach as one of their key components. The study showed that because of problems with both the design and implementation of these projects, it is extremely unlikely that they can be really effective in addressing problems of malnutrition in the poorest countries.

In Bangladesh, Save the Children UK conducted a cross-sectional survey comparing areas included in the project with non-project areas. This investigation cast doubt on the effectiveness of the project and found no difference in the rates of malnutrition between project areas and non-project areas despite six years of implementation. The survey also showed that growth monitoring charts were poorly understood by mothers and that supplementary feeding had limited effectiveness, especially for very young children.

In Uganda, no evaluation of the project's impact over the past four years has been made public. In spite of this, plans to open up new areas to the project are being discussed. In Ethiopia, Growth Monitoring and Promotion (GMP) is a high-risk intervention, since the strategy has never been evaluated in such a resource-constrained environment and in the absence of a functioning health system. In all three countries, the per capita cost of the projects exceeded per capita investments on health services.

The report calls on the World Bank, and other donors, to cease opening up new areas to the projects until independent reviews have been completed, to explore the cost-effectiveness of alternative approaches to malnutrition, and to increase accountability in the design, monitoring and evaluation of projects.

The report has already stimulated a lively controversy. SC UK have posted the report on http://www.nutritionnet.net, to promote a transparent and wide-ranging debate on this issue within the professional nutrition community. There are clearly different experiences and professional opinions in relation to large scale nutrition programmes. We need to capture and analyse this range of experience to help establish how best to tackle the enormous problems of malnutrition in the poorest countries.

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Donors in humanitarian action: changing roles, trends and issues

Summary of a published review[1]

The changing role of donor governments in the management of humanitarian assistance is the subject of a recent ODI[2] Humanitarian Policy Group (HPG) briefing paper. Based on field studies, documentary reviews and case studies of official donors in the United Kingdom (UK), Denmark, Canada and the United States as well as ECHO[3], it identifies the implications of observed trends, and proposes an agenda to define 'good donorship' in the humanitarian sphere. The main findings of the study are summarised here.

In 1990-2000, official humanitarian aid flows doubled both in real terms, from 2.1 billion dollars to 5.9 billion dollars, and as a proportion of official development assistance, from 5.83% to 10.5%. Bilateral donors accounted for over 90% of official humanitarian aid spending. These data show a move away from multi-lateral methods of disbursing assistance in favour of bilateral channels. Multi-lateral aid refers only to aid which is not earmarked and is channelled through multilateral institutions such as the United Nations (UN) and the World Bank. All other aid, including earmarked assistance to the UN, non-governmental organisations (NGOs) and the Red Cross movement, and funds spent by governments themselves, is technically bilateral aid.

Factors accounting for the apparent bilateralisation of aid spending include:

- Spending on supporting refugees in donor countries is defined as bilateral aid. In 2000, 38% of bilateral aid was spent in this way.
- The introduction of new mechanisms of resource mobilisation. All contributions to the Consolidated Appeal Process (CAP) are earmarked and thus bilateral.
- Greater earmarking of contributions to the UN organisations and increased direct contracting of NGOs and of military and paramilitary providers.

The expansion in the range of potential partners through which official aid might be channelled has made the choice of partner more complicated. It is, however, unclear whether donors have sufficient capacity to appraise and monitor contracts, particularly given the increase in direct contracting with NGOs and in earmarked funding.

Issues of accountability are further complicated by the lack of universally accepted performance indicators, which means that donors are allowing their partners to define and monitor their own programmes. This will make it difficult to assess the overall effectiveness of a particular donor's humanitarian aid programming.

Donors have paid relatively little attention to how they, themselves, are held accountable for the impact of their decisions. Internationally, there is no mechanism of global governance to monitor and regulate the use of official humanitarian assistance, no concensus regarding what a good donor profile is, and no systematic documentation of good practice.

With the partial exception of the UK, the countries looked at in the study have paid little attention to humanitarian assistance, either through parliamentary questions or via committees. Audit reports have been confined largely to issues of financial probity and the conduct of specific operations.

Few independent evaluations of donors humanitarian aid programmes have included assessments of the policies and procedures of donors themselves.

Underpinning these problems of accountability and performance is the fact that the main objective of official humanitarian assistance has become increasingly unclear. At its simplest, it is about meeting life-saving needs. However, over the past decade additional, sometimes competing, objectives have emerged, including promoting development and conflict reduction. Thus, the idea of humanitarian aid as a distinctive form of assistance, governed by principles of impartiality and neutrality, is being eroded. In particular, its independence from the foreign policy of donor states is threatened.

There has been little discussion as to what constitutes a good humanitarian donor. Establishing such an agreement would be timely. Humanitarian aid flows are increasing, humanitarian decision-making is becoming more complex and sensitive and the framework

Viability of an ENN research initiative

Summary of pilot study findings[1]

Over the past decade, there has been a concerted effort to improve active learning and sharing within the humanitarian sector. In the nutrition sector, research has led to significant advances in emergency programming, however there remains a considerable shortfall in the evidence base of emergency interventions. Opportunities to engage in formal research activities are often not capitalised upon, while informal operational data is typically under used and poorly shared within the sector. Whilst the ENN captures a substantial amount of relevant research, evaluation and programmatic experiences through the preparation and publication of Field Exchange, based on it's current modus operandi it cannot be exhaustive in this process.

Recognising the need for complementary initiatives to minimise information loss within the nutrition sector, a preliminary proposal was developed by the ENN aimed at prompting and sharing research in the emergency food and nutrition sector amongst humanitarian agencies. Such an initiative would involve supporting agencies to undertake analysis, write up and dissemination of research and would culminate in a trade fair/ research workshop. In order to investigate the viability of the proposed ENN workshop, a pilot study was undertaken to assess research activity within a cross-section of humanitarian agencies, to identify obstacles to research and to participation in an ENN workshop initiative, and to identify the resources necessary to implement the project.

Between March and September 2002, a cross-section of humanitarian agencies and academics were targeted with a questionnaire on research interests and activity, supported by phone and email contact. From 22 agency contacts, eight questionnaires were returned, significant feedback given by an additional four agencies, and reasons for incomplete information offered by six agencies. Amongst academics, fifteen questionnaires were returned, while a further 26 of those contacted gave significant email and/or telephone feedback. As the study progressed, potentially relevant initiatives, institutions and individuals were identified and investigated. A web-based literary search for evidence to support the proposal, to identify any complementary initiatives, and to investigate issues raised by the respondents was also carried out.

Overall, the agency and academic response to the proposed research initiative was positive and welcomed. This study confirmed that a substantial amount of formal and informal research exists in the emergency food and nutrition sector, at various stages of completion. Such research includes unanalysed or underused data sets from project monitoring, qualitative surveys, programme reviews, evaluation findings, and protocol-led research. Research findings were more often shared internally or with a limited external network of contacts, and less frequently entered the wider public domain. Agencies typically relied on routine data collection and retrospective analysis to answer research questions, while recognised opportunities for planned operational research were not capitalised upon.

A number of significant, but surmountable, obstacles were identified which may at least partly account for poor information sharing and research processes within aid organisations. These included lack of designated funding, time constraints, lack of expertise, lack of processes within agencies to encourage data analysis or 'deeper' reflection on programme implementation and problem solving, and poor capacity and confidence in statistical analysis, the publication process, and writing up of these findings. Dilemmas over the ethics of research in emergencies were a concern of many agencies, while information sensitivity – both politically and in terms of securing donor funding – also discouraged open information sharing. Both academics and agency staff expressed concerns regarding the quality of accumulated data, which currently impedes analysis and may detract from embarking on new initiatives. Agencies who responded were willing to share research findings in an ENN forum, but the majority felt that they should have the ultimate say over how and whether information was used.
Academics were available and willing to offer technical expertise in a wide variety of nutrition competencies, which complemented the operational activities and research interests of the agency respondents. Many felt it was critical

for measuring donor performance is weak, undermining accountability and the trust necessary for positive relations between donors and their partners.

The authors of the study advocate three core principles which might provide the basis for such a discussion. These are:

◆ A commitment to international humanitarian law and principles
◆ A commitment to needs-based programming
◆ Predictable and adequate funding.

Systems to measure humanitarian need and monitor the allocation of resources need to be more robust, and the predictability and adequacy of official funding needs to be strengthened. This could be achieved by a number of initiatives, including encouraging the development of multi-year funding arrangements, and ensuring that in major emergencies, additional and adequate funds are made available, and that funds are not simply reallocated from elsewhere.

It is also important to invest in systems to monitor adherence to good practice by, for example, strengthening the capacity and engagement of parliamentary committees and audit offices, and ensuring regular independent evaluations of donor programmes and policies and system-wide evaluations.

[1]Macrae. J (2002): The changing role of official donors in humanitarian action; a review of trends and i ssues. HPG Briefing. Number 5, December 2002. Overseas Development Institute

[2]Overseas Development Institute

[3]European Commission-Humanitarian Office (ECHO)

that academics were involved with agencies in the early stages of research planning and all were willing to share research findings in an ENN forum.

The study concluded that the proposed ENN research workshop is a viable and necessary project. Strategies to deal with the practical constraints to emergency research activity are necessary, and must take into account the factors at individual, agency and sectoral level that may encourage or impede information sharing. Whilst funding is critical to supporting any research activity, funds alone are unlikely to be sufficient stimulus for research initiation and information sharing. Given the ENN's 'neutral' position in the aid sector and active involvement in emergency nutrition, an ENN research initiative could prove to be the peer-led catalyst of change required to stimulate open and equal knowledge sharing amongst agencies in the nutrition sector.

A full copy of the report is available online at www. ennonline.net, or contact ENN at: fiona@ennonline.net

On the basis of the pilot findings, a proposal is being finalised to support an ENN-led research workshop. A consultative meeting will be held by the ENN within the next six months to establish contact between interested agencies and academics and to identify research opportunities, with a view to establishing a scheduled plan of activity (Ed).

[1]Nutrition research in emergencies: an investigation of the feasibility of an ENN research workshop, Pilot study report, Marie McGrath, Jeremy Shoham, Fiona O'Reilly, Emergency Nutrition Network (ENN), March 2003,

Bags of wheat seed are returned to Concern by seed beneficiaries, Caliomamo, Angola

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Assessing seed systems in relief operations

Summary[1] of published paper

Existing guidelines on emergency seed provisioning contain very little practical advice on how to determine whether or not relief seed inputs are needed by farmers affected by conflict or natural disaster. An increasing number of studies show that some emergency seed interventions have very little impact, relative to their high costs. Furthermore, the rationale on which such projects are based is now coming under question. Contrary to assumptions, farmers seed systems are remarkably resilient, even in the face of severe disasters.

A recent article describes a method, Seed System Profiling (SSP), which can be used to compile information about the ways in which farmers manage the seed of various crops. When used in conjunction with an assessment framework, SSP allows for better understanding of the impact of a disaster on the seed system (see box 1).

Box 1

Questions to ask when developing a Seed System Profile

◆ What crops and crop varieties are planted by farmers, and how are these used (for food, for sale, as forage, etc)?
◆ What are the main features of the cropping system, i.e. in what ecologies are the crops planted, what is the cropping calendar for the different crops and crop types, and who is responsible for the various agricultural tasks?
◆ For each crop, do farmers normally save the seed from the previous harvest? How is seed saved and what are the main constraints?
◆ If seed is not saved, how do farmers normally acquire the seed for the different crops (where, through what means, from whom)?

The paper describes how, in Somalia and Mozambique, seed assessments work from the premise that seed is needed following harvest failure. Data collected are merely used to calculate the quantities of seed required and how these should be targeted. Data on access to seed are not considered, even though there may be mechanisms through which seed can be acquired from local traders or other farmers.

How farmers use different crops and different varieties can provide important information relating not only to the availability of seed, but also to the understanding of the dynamics in cropping systems due to insecurity and changing market conditions associated with disasters. For those crops that are sold, planting material may be available to farmers in local markets, either as grain that can be used as seed or as seed/planting material. Farmers tend to take much greater care of the seed of crops that are not normally sold. Also, farmer seed specialists who are able to maintain the seed of different varieties of crops, even under very extreme crisis conditions, often exist within communities thus providing a source from which other farmers can acquire seed that they themselves may have lost.

An SSP can be used as a baseline to both predict and understand the impacts of disasters on seed systems. Variables necessary for assessing the need for seed system support following an emergency include,
- the features of the crisis (type, timing, duration, scale and intensity)
- socio-economic impact on local populations (displacement, changes in household composition)
- functioning of local markets
- the mobility of both farmers and traders (in relation to security and transport systems)
- the assets available to farmers, including their ability to draw on existing social networks.

The ways in which these different types of information can be used are summarised in a step by step framework outlined in the paper. The SSP, together with the framework steps, can be used to identify the strengths and weaknesses of seed systems affected by disaster, and highlight appropriate interventions. Ideally, the SSP should be developed prior to a disaster, but can also be developed during the course of a protracted emergency or following an acute disaster.

The methodological approach described in this paper is presently being tested on a pilot scale and further refined in Mozambique, where conventional seeds-and-tools interventions, implemented for many years, are now being questioned by some agencies.

[1] Longley C (2002). Do farmers need relief seed? A methodology for assessing seed systems. Disasters, 2002, 26(4); pp 343-355

Credit Joyce Kelly S.Sudan 2000

Fishing under the watchful eye of the militia waiting to collect the 'Tax'. When was the last 'normal year' for South Sudan, at war for almost two decades.

Livelihood assessment approaches in emergencies

Summary of published review[1]

A recent paper published by the Overseas Development Institute (ODI) reviewed emergency livelihoods assessment approaches in situations of chronic conflict and political instability (SCCPI).

The reviewers describe how SCCPI are associated with a parallel economy centred on conflict, a high degree of violence and a weak or failed governance environment. The severity of the impact depends on the nature of war strategies, the war economy and the accountability and effectiveness of local institutions and processes. Vulnerability is, to a large extent, determined by social and political status. In such situations, the aim of livelihood strategies often becomes limited to ensuring food security or survival. Strategies frequently include a return to subsistence, illegal, criminal or immoral activities.

The paper suggests that an adapted livelihoods framework, which establishes links between SCCPI and impact on livelihoods, may provide the basis for assessing livelihoods in SCCPI.

The framework can be adapted in a number of ways, for example:

- Considering war strategies, the impact of war and the political economy together with the governance environment, in order to identify livelihood options and risks and the need for protection of vulnerable groups.
- Recognising the limited goals and options for livelihood strategies in SCCPI and developing a new way of analysing and interpreting the types of strategies used by people in response to SCCPI.

The key strengths of livelihoods approaches, in general, are that they consider all elements essential for people to make a living not only in the short term, but also to contribute to longer-term well-being. The approach aims to be participatory and identify interventions according to people's own priorities. The review found that livelihood approaches used in SCCPI focus in particular on food security as an outcome, and assess livelihood strategies at the household or community level. Few include an analysis of political vulnerability or the processes at a macro-level.

None of the livelihoods assessments reviewed were able to elicit information on the war economy. There are several challenges in conducting livelihoods assessments in SCCPI - mainly due to problems with access and insecurity, differences in, and homogenisation of, livelihood strategies compared to stable situations, and an increased potential for bias. Many assessment approaches rely on the identification of a 'normal' year with which to compare food and income sources after a certain shock. This is rarely possible in protracted conflict situations. Agencies have made adaptations to approaches and methods to address these difficulties. These adaptations include the categorisation of the population according to political, security or displacement factors (rather than livelihood groups) so as to define groups with similar means of accessing food. It also includes a greater emphasis on secondary information, triangulation, and combining qualitative and quantitative information.

In current practice, the main use of emergency livelihoods assessments is to determine the need for immediate relief, usually food aid. This may be because the scope for supporting livelihood strategies at community level is limited during violent conflict, due to fears of causing harm, funding constraints (activities fall between relief and development) or agency mandates (most agencies focus on a limited number of specific interventions).

The review argues that a focus on relief and asset delivery, and assessments to identify the need for this, only address people's economic vulnerability. For such interventions to be effective, there is a need for the protection of vulnerable groups to allow them to hold onto both existing assets, and those provided or created through assistance. The implication for assessments is that the causes of political vulnerability need to be examined in order to determine how to protect populations.

The authors conclude that the scope for livelihood support at household or community level may be limited during violent conflict or insecure situations. However, there is a wide range of unstable situations ranging from violent conflict to sporadic banditry. When violent conflict has ceased, options for livelihood support increase. An understanding of the nature of SCCPI and of livelihood options in each situation is necessary to determine the feasibility and appropriateness of livelihood support.

[1] Jaspars. S and Shoham. J (2002). A critical review of approaches to assessing and monitoring livelihoods in situations of chronic conflict and political instability. Working paper 191. Overseas Development Institute, December 2002

Monitoring the international code in west Africa

A paper and recently summarised editorial[1,2]

Violations of the International Code of Marketing of Breastmilk Substitutes have been previously reported in Field Exchange[3]. A paper and editorial summary recently published demonstrates how Code legislation does not, in itself, ensure Code adherence, and highlights the shortfall in monitoring mechanisms that currently exist. Given the challenges facing policy makers and aid practitioners regarding infant feeding and HIV/AIDS, particularly in environments where artificial feeding may be practised and commercial companies are active, e.g. Southern Africa, upholding the Code should go some way towards realising appropriate and informed decision-making regarding infant feeding choices. (Eds)

HIV/AIDS and emergencies:

analysis and recommendations for practice

Summary of a published review[1]

A Humanitarian Policy Network paper recently reviewed issues related to HIV/AIDS and emergencies. The paper states that the link between emergencies and HIV vulnerability is essentially two-fold. First, the vast majority of humanitarian crises take place in countries were rates of HIV infection are already high, which means that pre-existing risks of infection and discrimination are significant. Secondly, the destruction, disruption, dislocation and displacement that emergencies typically cause can exacerbate vulnerability by increasing the risk of infection among affected populations. For example, loss of livelihoods might cause women to turn to sex work, or rates of sexual abuse by armed groups might increase.

Despite these links, HIV is not generally seen as a priority in emergency operations. The author of the paper states that in failing to take HIV into account from the earliest stages of planning and implementation of an emergency response, humanitarian

A recent paper has reported on the findings of a multi-site cross sectional survey in two west African countries (Burkino Faso and Togo), to monitor compliance with the International Code of Marketing of Breastmilk Substitutes (the Code). While the value of breastfeeding in infant health and growth is well recognised, the authors highlight how contact with western health practices, exposure to mass media, and aggressive marketing of breast milk substitutes (BMS) risk undermining sound practice. Whilst countries are encouraged to enact the Code into national legislation, few west African countries have done so.

The study involved staff at 43 health facilities and 66 sales outlets and distribution points, 186 health providers, and 105 mothers of infants aged 5 months, in 16 cities. Investigations were interview and questionnaire based. Significant and comparable levels of code violations were observed with (Burkina Faso) and without (Togo) regulating legislation. Examples included violations of code labelling standards (forty companies), donations of breastmilk substitutes to six health facilities (14%), distribution of donated BMS free of charge to mothers, promotional gifts to five health facilities (12%) and special marketing displays at 29 sales and distribution points (44%). Most (90%, n=144) health providers had never heard of the code, and over half of mothers (63%, n=66) had never received any counselling on breast feeding by their health providers.

The authors concluded that legislation must be accompanied by effective information, training, and monitoring systems to ensure that healthcare providers and manufacturers comply with evidence based practice and the code.

Wider implications of this study were considered in an editorial in the same issue. First, how should compliance with the code be monitored effectively to reduce continuing violations? The authors suggest that of the three international models of monitoring that currently exist[4], the Interagency Group on Breastfeeding Monitoring (IGBM) protocol (in draft) has the greatest application and should be endorsed by the international community.

Secondly, regarding appropriate training of health workers in the protection and support of breastfeeding, the authors emphasis the importance of periodic and systematic training of workers, and suggest drawing on the evidence base and experiences of the UNICEF Baby Friendly Hospital Initiative (BFHI).

Thirdly, the authors consider how to combine support for breast feeding, with recognition of the risk of maternally transmitted HIV infection. They propose that in most poor countries affected by AIDS, the risk associated with bottle feeding is higher than the risk of mother to infant transmission of HIV infection, a fact that needs to be reiterated to decision makers, since manufacturers of breast milk substitutes may capitalise on HIV infection as a reason for formula promotion. In addition, the World Health Organisation (WHO) recommendations[5] require maternal access to credible information, quality care, and support, to facilitate informed decisions regarding infant feeding. Whilst governments and the WHO code are central to ensuring breastfeeding protection, the editorial concludes that a better way of monitoring and enforcing its application, in both industrialised and low income countries, must be identified.

[1]Monitoring compliance with the International Code of Marketing of Breastmilk Substitutes in west Africa: multi-site cross sectional survey in Togo and Burkina Faso. BMJ 2003;326:127, 18th Jan

[2]Editorial. Monitoring the marketing of infant formula feeds BMJ 2003; 326:113-114, 18th Jan

[3]See Field Exchange Issue 8, Infant feeding in emergencies: recurring challenges, and Issue 10, Infant Feeding Practice: observations from Macedonia and Kosovo

[4]1) WHO Common Review and Evaluation Framework (WHO/NUT/96., 2) the International Baby Food Action Network (IBFAN) Monitoring Forms Manual (email ibfanpg@tm.net.my), 3) Interagency Group on Breastfeeding Monitoring (IGBM) protocol currently in draft (www.scfuk.org.uk/development/links/IGBM.htm

[5]United Nations Administrative Committee on Coordination/Standing Committee on Nutrition. Nutrition and HIV/AIDS. Nutrition policy paper no. 20. In: Geneva: ACC/SCN, 2001. http://acc.unsystem.org/SCN/

practitioners may be, unwittingly, exacerbating levels of infection.
The review sets out a series of recommendations to redress this situation, which include:

Policy Making

Agencies providing a humanitarian response need to revise existing policies and strategies to take account of issues raised by HIV. Disaster preparedness policies need to recognise HIV as a priority. This might include establishing the prevalence of HIV infection in an emergency affected or prone area.

Risk Assessment

This should include an assessment of the vulnerability to HIV of affected populations and aid workers. Particular attention should be given to the composition of the displaced and surrounding host population to establish, for example, whether they are mostly women and children, single women, unaccompanied children or armed men. As part of a wider risk assessment, agencies should also determine which factors might heighten people's HIV vulnerability, and which should be targeted with specific interventions, e.g. cultural beliefs, attitudes and practices concerning sexuality and sexual health, whether illicit drugs are being used, etc.

Decisions/practices influencing vulnerability to sexual violence or exploitation

Where displacement has occurred, risk of sexual violence should be taken into account, for example, when planning accommodation and temporary shelter.

Decisions/practices influencing power relations

Men with decision-making powers, and those who control accommodation design, food resources and future opportunities (e.g. employment, refugee entitlements and visa concessions), often barter these for sex. Rape at the hands of the men who police a relief operation is common and redress rare. Relief agencies do have an opportunity to influence structures that affect women's HIV vulnerability. For example, agencies can ensure that displaced women are involved in decisions about accommodation design and layout, and that women have some measure of control over how resources are distributed and the running of the relief site.

Provision of Health Care

There are many HIV-related concerns that should inform health care practice. These include ensuring the safety of blood transfusions, HIV-free surgical and other skin piercing instruments, and measures that minimise the risk of HIV infection from needle-stick injuries or clinical waste. Measures that minimise risk of HIV infection through sex, and the provision of the same standards of care for people with HIV related illness as for other sick people, should also be considered.

Implications for humanitarian agencies

Organisations need to address the underlying factors that heighten people's vulnerability to HIV in emergencies. To do this, agencies may need to review the preparation and training they offer staff and volunteers. Staff and volunteers will need a thorough understanding of the specific vulnerabilities to HIV of all refugee and displaced people, and more particularly of women, young girls and young boys. Staff may also need help in overcoming their own fears and prejudices towards people infected with, or affected by, HIV.

At an international level, agencies need to foster more discussion with and between organisations, so as to encourage the development of clear, user-friendly and easily applied guidelines and policies.

The key argument of the review is that HIV needs to be seen as a cross-cutting issue, with implications for existing relief programmes and modes of responding to an emergency. HIV considerations need to be integrated into these already-existing channels, rather than being addressed in a 'stand-alone' isolated HIV programme. If this is to happen, an accurate understanding and strong commitment from senior managers is required at strategic and policy levels. This needs to be accompanied by sufficient financial and personnel resources to ensure that such policies are acted on in every emergency situation where HIV is present, or potentially so.

[1]Smith, A (2002). HIV/AIDS and emergencies: analysis and recommendations for practice. Humanitarian Practice Network (HPN) paper, No 38, Feb 2002

Seed security in southern Sudan

Summary of published paper[1]

Jack Harlan Collection: Royal Botanic Gardens, Kew

Seeds-and-tools programmes have been widely implemented throughout southern Sudan as a means of increasing the population's food security. This has included transporting surplus grain and seeds from Western Equatoria - an area of plentiful rainfall, fertile soils and relative security - to food deficit and assumed seed-defict areas in other southern provinces.

Three seed projects were set up in Western Equatoria with the primary objectives of reducing the costs of seed relief assistance, obviating problems of quality that had been experienced with imported commercial seed, and institutionalising production of quality seeds and seed self-sufficiency within southern Sudan. Based on fieldwork in Western Equatoria, Bahr-el-Ghazal and the Lakes province from 2000-2001, a recent paper describes issues relating to seed security in southern Sudan and examines the three local-level seed production projects.

The main research question was to determine whether the relief seed distribution model, multiplying seed in western Equatoria for distribution in Bahr-el-Ghazal and Lakes, addressed the needs of farmers. The research comprised of a review of the agricultural research literature from southern Sudan, a formal household survey and a series of informal interviews and focus group discussions with farmers, local leaders and project staff.

The main findings of the study were as follows:

Impact of the relief schemes

The schemes undoubtedly injected cash into the local economies of the areas where they operated. However, after two non-governmental organisations (NGOs) had been forced to withdraw support from two of the schemes, contract farmers were unable to sell their seed surpluses. The only market for seed was that provided by relief agencies, showing the resilience of local farmers seed systems even under chronic disaster conditions.

A major problem was the choice of crops and varieties and the assumption that because the seeds were being grown within southern Sudan, they were local and hence adapted. The seed schemes in western Equatoria multiplied Serena sorghum. This is a non-photo period sensitive variety that matures in three and a half months. The variety, which was developed as an early maturing commercial crop, could therefore be harvested before the main crops were ready. Yet despite repeated distribution of relief seed of this variety to farmers in southern Sudan, they have largely continued to plant seed of their own preferred local varieties.

A detailed review of agricultural research in southern Sudan found several references to the fact that imported varieties of traditional crops indigenous to the area were either inferior to, or no better than, local varieties. The fact that three seed multiplication schemes multiplied seed of a variety that was known to be inferior to local germplasm from as far back as 1979, underscores the need for humanitarian agencies to draw upon all available information before embarking upon humanitarian interventions.

Alternative interventions

In such situations, the best source of seed of adapted varieties is the farmer seed system itself. Many seeds-and-tools projects now procure seed from within the very same communities where it is to be distributed. One approach that has been used is seed vouchers and seed fairs[2].

A weakness of the farmer seed system in areas like southern Sudan is the absence of any effective mechanism to link the farmer seed system to sources of new germplasm that would normally come from research, trade networks and the formal seed sector. Interventions can provide an opportunity for relief agencies to inject small quantities of seed that would permit farmers to test and experiment with new crops and varieties. Where unknown seed has been introduced, farmers have shown their willingness to test and experiment with the new varieties. There have been notable successes, e.g. 'UN okra' and a type of groundnut known as 'Mr Lake' - named after the colonial officer who first introduced the variety. The fact that Serena sorghum was not taken up should have been noticed and acted upon.

A main conclusion of the paper was that the creation of artificial markets based on relief needs, as was the case with the seed multiplication schemes in Western Equatoria, is not sustainable in the long term. There is value in strengthening what already works and treating farmers as potential clients, rather than embarking on the more common and unsustainable supply-side interventions.

[1] Jones et al (2002). The need to look beyond the production and provision of relief seed: experiences from southern Sudan. Disasters, 2002, 26 (4), pp 302-315

[2] Field Exchange, Issue 15. CRS seed vouchers and fairs-an innovative approach to help farm communities recover from disaster. p22

NGOs and the private sector

Summary of unpublished report[1]

Recent research, carried out by an intern at Concern Worldwide, has examined the costs and benefits of public-private partnership, involving the non-governmental organisation (NGO) sector. The aim of the research was to better prepare and guide public actors in potential collaborations.

NGOs and the private sector have recently initiated a remarkable, though precarious, movement away from confrontation and towards dialogue and co-operation. Collaborative efforts are sought out and desired on the part of both the business sector and NGOs. The relationships between NGOs and their business partners are varied. Public private partnerships include activities such as fundraising or 'resource mobilisation', negotiations for lower product prices, research collaborations, consultations or discussions, arrangements to implement codes of conduct, corporate social responsibility marketing projects, and contracting out public services.

The main findings of the study were as follows:

Negative aspects of partnership

- Private sector actors may be using the interaction to gain political and market intelligence or advantage, in order to gain political influence and/or a competitive edge.
- Private sector actors may desire access to new 'untouched' markets to which the NGO has access. This compromises NGO legitimacy, credibility, and focus.
- Private sector actors may use the relationship to set the global public agenda.
- Private sector actors may offer research and development and access to information that is biased towards market effectiveness and profit rather than philanthropic or ethical motives.
- Private sector actors may recognise the appealing reputation and credibility associated with an NGO and seek interaction based on image-boosting.
- Private sector actors may seek out cost-effective, technical solutions to complex problems.
- Private sector actors may prove to be an inappropriate choice when corporate image

clashes with NGO objectives and motivations.

◆ Private sector actor involvement may undermine NGO control and principles in partnership programmes.

◆ Private sector actor involvement may divert programme interests towards decidedly corporate interests.

◆ Private sector collaboration may require an exclusive or limited relationship, binding the NGO to certain loyalties and limiting available support from other agencies and/or corporations.

◆ Private sector donations may be available under certain caveats or requirements that bind the NGO to those caveats.

Positive aspects of partnership

◆ Private sector actors may provide critical amounts of financial support.

◆ Private sector actors may award grants or donations without criteria for use or other restrictions.

◆ Private sector interactions increase availability and access to various contacts, political influences and technical expertise.

◆ Private sector actors may develop internal and external organisations for education, awareness and advocacy.

◆ Private sector actors may initiate and develop policy-making opportunities for the NGO.

Conclusion

Vast amounts of funding become available to NGOs as a result of collaboration, partnership, or donation relationship with the corporate sector. This may be funding that would otherwise be entirely unavailable to the NGO. Partnership relationships depend on the characteristics of the individual actors and the specific initiatives being co-ordinated for collaboration. It is necessary, however, that the positive and negative outcomes are equitably and appropriately evaluated and analysed prior to partnership. Understanding the private sector and its motivations, calculating potential positive and negative effects, and determining whether benefit exceeds cost may provide NGOs with guidelines and strategies for developing a positive, beneficial, and rewarding relationship with the business sector.

[1]Doing Business with 'Big Business': Profit Motive, Philanthropy, and Public Private Partnerships. By Ellen J. Johnson, Concern Intern via Boston University, April 2003.

[2]Richter, Judith. (2003). 'We the Peoples' or 'We the Corporations'? Critical Reflections on UN-Business 'partnerships'. IBFAN/GIFA: Geneva. p17.

FAMINE CRY: IRAQ

May 5, 2003

Dear Field Exchange

As we prepare to mount a colossal humanitarian intervention in Iraq, we should be circumspect and humble about our past food-aid operations in Afghanistan, Sudan, Somalia, Ethiopia and other countries where an over-reaction of food imports has done more harm than good.

Even in the short term, it is imperative that we do everything possible to restore the agricultural self-sufficiency of Iraqis and not deepen a cycle of dependency. Although as many as sixty percent of Iraqis had received rations distributed through the Oil for Food Program, this food parcel was not the primary or sole source of family nutrition; it was more often a supplement. Since the initiation of the Oil for Food Program in 1997, there had been measurable improvements in malnutrition and even a rise in obesity. The twelve years of international sanctions and economic embargo on Iraq have made the Oil for Food Program a necessary food provision program. Iraq had been effectively isolated from the outside world. In anticipation of this war, the Baathist regime had been stockpiling foodstuffs for several months. Moreover, indigenous grain production in Iraq had begun rebounding over the past two years. Individual families were stocking their household pantries with reserves for months before the initial bombing began.

In our enthusiasm to prevent unnecessary suffering in Iraq, we are about to repeat the very same mistakes that other huge food logistics enterprises have made. When it comes to food handouts, our guild is slow to learn.

The most common occupation in Iraq is farming. More Iraqis derive an income from agriculture than from the oil industry. Support and promotion of Iraq's agricultural economy will be as critical to Iraq's recovery as will be its petroleum reserves. In addition, the large-scale unemployment in Iraq is creating a security problem that only meaningful vocation can remedy. Iraq has some of the most fertile land in the Middle East - hence "the Fertile Crescent" - and this land is copiously irrigated by the Tigris and Euphrates Rivers. Throughout the past decade, Iraq has been a net-exporter of dates and other produce. Are huge grain exports from affluent western countries to Iraq such a good idea? What the Iraqi farmer needs is re-establishment of trade links, restoration of international commerce, and the end to over a decade of economic isolation. What they need is trade, not aid.

The colossal exports of US and European-grown cereals does less for the subsistence farmer in Iraq, Afghanistan, or southern Africa than it does for the corporate interests of agribusiness and the modern western farmers receiving subsidies from their affluent governments. U.S. agricultural groups have been lobbying the Bush administration for months to ship American grown commodities to Iraq as this represented a new foreign export market for its surpluses.[1]

Large exports of grain from prosperous western countries to poorer ones - cynically referred to in the field as 'wheat dumping' - permits agribusinesses to legitimately dispense of the extraordinary surpluses of food that highly mechanized and subsidized western farmers produce. This is a supply-side solution and is not necessarily driven by demand. We should, rather, be exporting tools, irrigation technology, high-yield seeds, fertilizers, and technical expertise.

The nutritional challenges and interruptions in food supply in Iraq do not constitute a famine nor does it justify an over-reaction of food imports that may well compete or distract from efforts to increase local food production. Since food has become financially out of reach for people because of inflation, loss of income, and disruption of livelihoods then these root causes must be addressed, not only their symptoms. Cash-for-work programs and direct market-stimulus interventions that promote supply and drive prices down are effective antidotes to food crises. Employment programs, vouchers, and small cash grants given directly to displaced families—referred to as 'cash transfers'—are often effective, although still somewhat revolutionary and controversial among aid agencies that are used to distributing food rather than money. The injection of cash into a local market stimulates demand. Markets react by generating supply. Food suppliers will be attracted to the situation and beneficial transactions between food surplus areas and food shortage areas will be made.

Not unlike any large-scale commodity distribution program, a successful cash transfer project will require an experienced market analyst to monitor prices and effectively re-balance supply and demand variables and, ultimately, increase transactions on both sides. Although direct cash interventions are not a panacea, in many food crises this radical approach might be the most humane and intelligent gesture of compassion.

If the international community responds to Iraq as a famine - as we did in Afghanistan and numerous other humanitarian tragedies - the result will be the same: depression of market prices for locally grown commodities, disincentives for farmers to grow food, conversion of farmland to more profitable cash crops (read opium poppy), micro- nutrient deficiencies from eating unbalanced aid rations, and dependency on foreign food imports.

When the senior UN official said that the US should be "sending ships of wheat to the Persian Gulf along with ships of soldiers", did he even realize the irony of this statement? Although the coalition forces dropped bombs on Iraq, it would be cruel to dump our surplus wheat on them as well.

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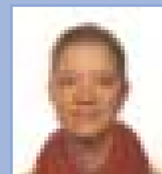
Emmanuelle Lurquin, 2002 Maimana, Afghanistan

Malnourished infant with mother wearing burka

Ambulatory treatment of severe malnutrition in Afghanistan



By Emmanuelle Lurqin

Emmanuelle is a paediatric nurse and since 2000, has worked with MSF Belgium on nutrition programmes in Angola, Burundi, and Afghanistan. She is currently working with MSF Belgium in the Ivory Coast.

During 2002, the author spent nine months in Faryab province, Afghanistan working as a nurse with MSF Belgium on the nutrition programme. This article describes her experiences in ambulatory care of severely malnourished children.

Faryab province is in a remote and poor area in the north of Afghanistan. There is little infrastructure, a high risk of disease outbreaks such as cholera and measles, and malnutrition is endemic. Communities have limited access to health care and education. MSF has been present in the province since May 1997, with programmes focused mainly on primary health care, nutritional interventions and responding to medical emergencies.

Following many years of war and more than three years of drought, Afghanistan was facing a food crisis situation. According to a WFP food security assessment carried out in July 2001[1], Faryab was one of the worst affected provinces of the country. A number of evaluations[2] demonstrated that the food security of the population was extremely weak, and that there was extensive malnutrition as well as outbreaks of scurvy. Impoverished families had lost their land. Families who had land could not cultivate it because they had no seeds or they had lost their animals. A lot of cattle died during the drought. The quantity and quality of food aid distributed in the province was inadequate and vulnerable people in remote areas were not being reached.

The population used different mechanisms to cope with the situation. Some families sold personal belongings, including livestock and land, in order to get money to buy food. Some families even had to commit their daughter to marriage at an earlier age than usual in order to secure income. Many families resorted to loans from the wealthy while many men moved to towns or to Iran in order to find employment.

At the time of writing this article (January, 2003), the food situation remained precarious and the political and security situation unstable. MSF were operating five feeding centres in the province with an average of 2,200 beneficiaries (moderately and severely malnourished children and pregnant/lactating women).

Rationale for ATFC

A number of constraints made the implementation of a conventional 24-hour therapeutic feeding programme problematic in Faryab province:

◆ Cultural values and practices in Afghanistan determined that the freedom of women was still very restricted. They could not leave their home for long periods and were required to spend long periods at home undertaking domestic or agricultural tasks, as well as caring for their children and husbands. It was not acceptable for women to spend a night outside their houses and they would have to be home before dark. It was, therefore, extremely difficult to ask mothers to stay overnight with their children in a therapeutic feeding centre (TFC).

◆ Accessibility to health centres was very difficult in this mountainous remote area. The roads were of very poor quality, which meant a mother had to walk an average of four hours to the feeding centre, and another four hours to return home. During the winter, the situation was worse as the roads were muddy or snowy.

◆ It was not easy to find educated people in this rural area and it was very difficult to employ women, since they were frequently not allowed to go out and work.

More recently, there has been much discussion in the literature about community based therapeutic feeding programmes for treating severely malnourished children.
Potential advantages of this approach are that it allows a decentralised programme thereby ensuring better coverage, it increases accessibility and acceptability and does not undermine family units. However, intensive medical/nutritional care and monitoring are much more difficult in outpatient treatment. Furthermore, individually tailored dietary regimes are impractical. Also, individually tailored dietary regimes cannot be employed.

Given the constraints of a 24 hour therapeutic feeding programme, and bearing in mind the advantages and limitations of community-based care, MSF opted to implement an Ambulatory Therapeutic Feeding Centre (ATFC).

Ambulatory care approach

This ATFC approach in Faryab involved malnourished children attending a feeding centre on a weekly basis. The feeding centres in Faryab province enrolled both moderately (supplementary feeding) and severely malnourished children. Admission criteria were based on weight-for-height (W/H), mid-upper arm circumference (MUAC), presence of oedema, or children transferred from the supplementary feeding programme. All malnourished children under 130 cm were eligible for admission.

Medical treatment

A complete physical examination, including a health and nutrition history, was undertaken for each child. Where possible, physical examination by a doctor was carried out weekly. Systematic treatment was administered according to standardised protocols, and any additional diagnosis individually managed. All children received measles vaccination.

Nutritional treatment

Nutritional treatment was based on "ready-to-use therapeutic foods"(RUTFs) -Plumpy'nut and BP100. The quantity of RUTFs supplied per week varied, and was based on providing each child with 200 Kcal/kg/day. In addition, a supporting family ration was given to the mothers, to supplement - rather than substitute - the general food distribution. This comprised 6 kg of wheat per week, and provided an average 471 Kcal/person/day (based on a six person family). For infants under 60cm in length who were admitted to the ATFC, a support ration was given to the mother. This comprised 2.3 kg of premix (400g oil, 100g sugar, 1.8 kg corn soya blend), corresponding to 1540Kcal/woman/day.

Follow-up

After the medical consultation, the children remained as long as possible with their mother in the "TFC room". In general, the mothers were able to stay for 4 hours, during which time the nurse performed a number of tasks:

◆ checked the card of each child, measured the weight gain and investigated any cases of weight loss
◆ ensured that the child took the drugs administered (first treatment dose was given in the centre)
◆ provided standard oral rehydration salts (ORS) to each child who presented with diarrhoea (ORS given on the spot and two packets to take home).
◆ gave a cup of therapeutic milk, 'F100' , to each severely malnourished child.

Health education

The health educator attempted to ensure the carer correctly understood the advised diet and importance of the treatment, and tackled health education issues (breastfeeding, complementary feeding practices, basic hygiene rules and main diseases).

Programme review

For the period January to October 2002, clinical records for 635 severely malnourished children were analysed and a review performed using traditional TFC indicators. As this type of

Severely malnourished child with mother

Emmanuelle Lurquin, 2002 Maimana, Afghanistan

programme is relatively new and has not been implemented in many places, it is difficult to compare results with a 'norm'. However, it is considered worth sharing findings from this programme, despite difficulties with their interpretation.

Nearly half of children were admitted under weight for height criteria (see table 1), and the female: male sex ratio was 1.19. Most of the new admissions were children with heights between 60-85 cm, corresponding to 6 to 18 months (see table 2). This age profile suggests that poor breast-feeding and complementary feeding practices were significant factors in the presenting cases of malnutrition. In our experience, many mothers continued exclusive breastfeeding for longer than six months (sometimes until 2 years of age).

Table 1 Overview of admissions to ATFC

New admissions	number	Percentage
W/H<70%	307	48.3%
Transfer from SFC to ATFC	145	22.8%
MUAC <110mm (height ≥75cm)	110	17.3%
Bilateral leg oedema	67	10.6%
Readmissions	6	1%
Total	635	100%

Outcome indicators

In terms of outcome, the mortality rate of 6% was slightly higher than the MSF target of less than 5% mortality for a 24-hour TFC (table 3). An increase in June and July (19.4% mortality in July), and decreases between August and the end of the year (from 7.6% to 2.2%), most likely reflected seasonal diarrhoeal patterns. Where possible, the local team investigated causes of death. The reasons for death most commonly given by mothers were fever, diarrhoea, vomiting or cough

Table 2 Height profile of admissions to ATFC

Height	number	Percentage
<60 cm	51	8%
60-85 cm	553	87.1%
>85-110 cm	28	4.4%
>110 cm	3	0.5%
Total	635	100%

Table 3 Outcome indicators of ATFC

Proportion of Exits	Number	Percentage
Recovered	292	61.0%
Deaths	29	6.0%
Defaulters	114	23.8%
Others	44	9.2%
Total	479	100%

Defaulters

A child was defined as a "defaulter" after three consecutive absences from the centre. The high default rate in the programme (23.8%) was close to the MSF 'alarming' value for a 24-hour TFC (target <25%). In an attempt to identify reasons for defaulting, community follow-up of 29 defaulters by the nutritional team identified the following reasons, as reported by the mother:

- Ten children (34.5 %) defaulted due to illness of the child or mother.
- Seven children (24.1 %) had to accompany mothers to the field where they were cultivating land.
- Seven of the children (24.1 %) didn't return for various other reasons, e.g. not enough food distributed at centres, problems at home.
- Five of the children (17.3 %) had died.

As some of the children identified as defaulters will undoubtedly have died, the 6% mortality rate is likely an underestimate.

Weight gain and length of stay

Average weight gain in the programme was 6.1g/kg/day and the mean length of stay was 57 days, with little monthly variation. While these figures compare unfavourably with traditional TFC norms (target weight gains: 10-20g/kg/d, target length of stay: < 30 days), results really need to be compared with other similar experiences and, ideally, with norms developed specifically for this type of programme.

Programme constraints

A number of factors may have adversely affected programme performance:

- Lack of medical and nutritional follow-up of children.
- Difficulties for mothers in reaching the centres.
- Maternal level of knowledge about appropriate child caring practices and correct diets was very poor, and certain cultural beliefs handicapped the work of the centres.
- Mothers often failed to recognise whether a child was ill and would therefore not go to the health centre when it was necessary. Many of the malnourished children had a history of disease when they arrived at the feeding centre.
- The staff working in the feeding centres were not always skilled and lacked experience. MSF therefore had much training to do. Due to cultural constraints, there was also a lack of women available to work and mothers did not find it so easy to confide in male staff.
- The RUTFs are not the ideal initial treatment for severely malnourished children, especially small babies who may find it difficult to swallow[3].

Lessons learned

The ideal strategy for treatment of severe malnutrition would be inpatient care, followed by community-based care and home management. However, despite the constraints of the ambulatory approach in Faryab province, a number of positive aspects of this strategy emerged. The programme was well accepted by mothers who were motivated to come, partly because their child received a full medical examination. Interest in the health education component seemed to increase, with mothers agreeing to stay longer to receive advice. RUTF was well accepted by the children. Also, children began to respond more quickly, both medically and in terms of weight gain, following the introduction of more systematic medical examination by doctors at the end of July 2002.

Through the course of the programme, some key lessons were learned which may help to improve future programming outcomes:

- Sustained medical follow-up of severely malnourished children is essential, ideally a weekly consultation with a doctor.
- Training of staff is critical in order to maintain the quality of the programme and the dynamism of the teams.
- Health education can be vital. Malnutrition in Afghanistan is not only due to a lack of food but also due to a lack of knowledge of mothers regarding breast-feeding and complementary feeding practices, as well as cultural beliefs.
- Where there are high levels of default, teams should actively search for patients in the community to try and understand the main reasons for absence. However, this activity requires a lot of time, as well as human and material resources.
- Children with severe malnutrition should be admitted to a residential care centre for the initial treatment and closely monitored during this critical early phase. The rehabilitation phase can be conducted in a centre or at home.
- A system of community outreach workers should be organised to allow follow-up at home. The outreach workers should check the children's progress and refer the ill children back to the feeding centre or the closest clinic. They should also reinforce the educational messages discussed in the centres with the mothers. Mothers should be encouraged to disseminate the health messages inside the community.
- A system of outreach teams will also allow active screening for malnourished children, which should increase programme coverage.
- Collaboration with the Ministry of Public Health and the first-line health systems is essential.

Outstanding issues

There are a number of outstanding issues that necessitate further research.

- The composition of RUTF's (high-protein diet with sodium and iron) is not ideal for severely malnourished patients in the initial phase of treatment, especially oedematous patients. More research on the use of RUFTs for kwashiorkor patients is needed.
- Ongoing research on the cost-effectiveness of ambulatory treatment is needed. In Faryab, MSF employed an average of 12 people per feeding centre, and one local doctor working for the whole nutrition programme. The supervision of these staff required time as well as financial and material resources.
- There is a need to make the management of severe malnutrition, currently based on imported foodstuffs, more sustainable. While emergency relief programmes may be generally well funded, long-term programmes are sometimes under-financed. Even if the price of Plumpy'nut were to decrease, it would remain comparatively expensive. Production of feeds based on locally available foodstuffs is carried out in some countries but more information on these experiences is needed.

Finally, analysis of outcomes, including programme coverage, is essential for evaluating programme impact. However, to truly analyse efficacy of the ambulatory programme, further research is needed. This will require a collation and analysis of experiences in other contexts in order to refine the strategy and identify 'norms' for programme performance.

For further information, contact Sophie Baquet, Nutritionist, MSF B at email: sophie.baquet@msf.be

[1]WFP Food security assessment, Vulnerability Assessment and Mapping Unit, July 2001

[2]Nutritional survey in Qaisar and Almar districts, Faryab province, Northern Afghanistan, MSF-B, August 2001;
Nutritional survey in Qaisar and Almar districts, Faryab province, Northern Afghanistan, MSF-B, July 2002;
Vulnerability assessment in Northern Afghanistan, Faryab province and Sar-I-Pol, Epicentre/MSF-B, January 2002; Field visit report Afghanistan, Sophie Baquet, MSF-B, March 2002.

[3]RUTFs are not intended for initial treatment and are not indicated for use in young infants

Severely malnourished child with father

Emmanuelle Lurquin, 2002 Maimana, Afghanistan

Ambulatory treatment of severe malnutrition

Commentary by Dr. Steve Collins

Dr. Steve Collins is a medical doctor with a doctorate in nutrition during emergency operations. He is a director of Valid International, a company which aims to improve the quality and accountability of humanitarian assistance. Since 2000 he has been directing the CTC programme, a multi-country, multi-agency programme to research and develop Community-based Therapeutic Care.

This article describes the experiences of an MSF-B nutritional project in Faryab that was forced by cultural and geographical constraints to treat children with severe acute malnutrition as outpatients. Given the constraints and difficulties inherent in the context, the results are encouraging and many of the lessons that MSF-B have learnt are useful.

The most important of these lessons is that community-based mobilisation and profound outreach are essential in order to maximise programme impact. This is also one of the main lessons that we have learnt during the first three years of the Community-based Therapeutic Care (CTC) programme. Implicit in this lesson is the necessity to move away from 'Ambulatory/Home Treatment', towards a model of 'Community-based Care'. Ambulatory/Home Treatment is a hang-over from the therapeutic feeding centre (TFC) approach to severe malnutrition, emphasising the medicalised treatment of a severely malnourished individual, rather than the management of malnutrition as a complex socio-economic condition. Malnutrition is not a disease you catch that requires mere medical/nutritional treatment, rather it is the end-point of a complex interaction between social, cultural, economic and physiological processes. Unless project design acknowledges this multi-factorial aetiology, impact will continue to be limited by high default, poor coverage and a lack of compliance.

From the data provided, it is not possible to draw firm conclusions about the MSF-B Faryab programme. Coverage data is essential in order to examine impact. In addition, more data on those who died and defaulted (age, concurrent medical diagnoses, timing of death and attendance record) would be useful. However, the results presented appear to show that the quality of medical and nutritional treatment of those that attended was not a major factor limiting impact. Although no 'phase one' inpatient care was provided, the death rate amongst those who attended the programme was 6%[1]. This is well within the Sphere standards and similar to MSF standards for a well run TFC[2]. I would guess that this mortality rate is better than those in many of the TFCs currently operating in Afghanistan[3]. The rate of weight gain of 6.1 g/kg/day and mean length of stay of 57 days are also reasonable given the limited opportunity costs and risks entailed by being in the programme.

From the report, it appears that the main factor limiting impact is the high default rate. Overall, 48.2% of those investigated defaulted because the opportunity costs of programme attendance were perceived as greater than the benefits derived from that attendance. Another 34% defaulted because they or their carer were ill; either unable to access the programme or under the impression that the programme would not treat them adequately. Thus programme design and implementation impacted on at least 82% of defaulters. In particular, the physical access to distribution points and waiting times at distribution points, understanding of the programme, and the quality of service during consultations would have been important factors[4].

It is a shame that MSF-B do not report programme coverage. Given the reported "difficulties for mothers in reaching the centres" and the perception of high opportunity costs amongst those attending the programme, I would guess that the programme coverage was low. Low programme coverage is usually the most important factor limiting selective feeding programme impact.

I question the validity of some of the lesson that MSF-B have learnt. The lesson that all children with severe malnutrition should be admitted to residential care appears at odds with the results presented. The programme's mortality rate is already close to the MSF norms for residential TFCs, and I find it unlikely that the costs and effort of constructing residential "phase 1" care for all patients would be repaid in impact. MSF-B's first lesson includes an aspiration to have a doctor for all the weekly follow-up consultations. Given that the mortality rate amongst those attending is already low and the rates of recovery are reasonable, it is unlikely that the large human resource and cost implications of having a doctor at each distribution would achieve a commensurate increase in impact. Indeed, by diverting resources away from achieving access, coverage and mobilisation, these two "lessons" are likely to decrease programme impact.

The main limitations to impact appear to be the high default rate and the problems of access to the distribution centres (presumably coexistent with low programme coverage). Efforts to resolve these problems, rather than aspiring towards a more medicalised 'TFC approach' would be likely to be more effective. Increasing the number of distribution sites would improve access and reduce the opportunity costs of attendance. These sites could be temporary, where possible utilising existing health / social structures and mobile distribution teams. This would improve coverage, reduce default and facilitate transition towards longer-term programming. Over the past three years, experiences with Community-based Therapeutic Care in Ethiopia, Sudan and Malawi have demonstrated that with improved access malnourished cases present earlier. The clinical course of malnutrition is one of a gradual increase in severity and concurrent medical complications, therefore those who present earlier are easier to treat and the results are better.

MSF-B's other lessons (more outreach, community mobilisation, improved education, more systematic protocols and greater integration with other structures) are important steps forward. To improve sustainability and cost-effectiveness, community mobilisation can use positive role models within communities by harnessing existing capacity, whether this be traditional practitioners, traditional birth attendants (TBAs), 'wise women' etc, in addition to the more usual paid outreach workers. These are now being incorporated into CTC project design.

MSF-B's experiences in Faryab highlight important issues surrounding the management of severely malnourished children in the community. Maximising impact in these programmes requires the design of a Community-based Therapeutic Care programme specifically to address issues relevant to the care of the malnourished in their homes and villages, not ad hoc adjustments to the basic TFC model. Sending people home with RUTF, medical treatment and didactic education will not maximise the impact of these programmes. Maximising the impact of CTC requires radical changes to the prioritisation, human resources, protocols, monitoring and data collection and logistics of selective feeding protocols.

[1] Even when you add an estimate for the number of deaths amongst those who defaulted to this (114 * 17.3% = 20 deaths), the death rate is still 10%. Note that the SPHERE standard does not include the number of defaulters from TFCs that die.

[2] It is similar to the rate in Concern's pilot outpatient treatment programmes (OTPs) in Ethiopia in 2000 (see research summary, Community based therapeutic care, in this issue of Field Exchange) and Oxfam's experience in Bolosso Sorie, Ethiopia where they conducted one of the first OTPs.

[3] As there are currently 156 children in the programme and mortality rates tend to be highest shortly after admission (I would be very interested in the timing of deaths), this rate is likely to decrease further by the end of the programme.

[4] Although information on food security is not included, it is likely that this programme operated during both the planting and the harvest periods in Faryab and this would be an important factor influencing default.

The Quality Project In Afghanistan

By Christine Bousquet, Charlotte Dufour, François Grünewald, Hugues Maury, Groupe Urgence Réhabilitation Dévelopement (URD)

Pictures taken by Quality Project Team in Afghanistan, missions 1 (jul/aug 2002) and 2 (jan/feb 2003)

The Quality Project is an operational research programme implemented by Groupe URD in partnership with a network of non-governmental organisations (NGOs) and researchers, and involving a team of specialists in public health, nutrition, habitat/shelter, food security, international humanitarian law, and quality assurance. It aims at developing, testing and disseminating a self-evaluation and self-learning tool based on a questioning process throughout the project cycle. The ultimate objective of the 'tool' is to improve the service provided to beneficiaries.

In order to ground this tool in 'field' reality, the Quality Project team is carrying out missions in Central America, Afghanistan and the Gulf of Guinea with the aim of capitalising on, and learning from, aid workers' experiences, in various sectors and humanitarian contexts. A participatory approach is used, combining direct observation and project visits with interviews and focus group discussions with agency staff, national officials and beneficiaries. Feedback seminars are organised in the field and in Europe after each mission.

Two of the missions in Afghanistan have already taken place, in July/August 2002 and January/February 2003. These research missions were multi-sectoral and involved a wide range of actors (local and international NGOs, government representatives, United Nations organisations…). Areas visited included Kabul, the Shamali Plain, the Panshir Valley, the central (Bamyan), northern (Ruyi-Duab, Mazar-e-Sharif Nahrin, Pul-e-Khumri), southern (Kandahar) and eastern (Jalalabad) parts of Afghanistan.

The purpose of the field missions was to gain a thorough understanding of the range of humanitarian interventions and strategies, to identify what made projects successful or problematic, to raise issues pertaining to the quality of humanitarian interventions and stimulate a debate with agencies and key stakeholders. This summary concentrates on the nutrition sector, in light of findings in the health and food security sectors.

The nutritional situation in Afghanistan can be summarised as one of high rates of chronic malnutrition (50-60%) and micronutrient deficiencies, related to chronic food insecurity and poor dietary diversity, and relatively low rates of acute malnutrition (<10%). Acute malnutrition is usually associated with disease (notably diarrhoea) and improper infant feeding practices.

During the first mission (August 2002), field interventions seemed mostly supply-driven and relief-oriented, with a reliance on blue-print programme design (e.g. supplementary and therapeutic feeding programmes). Factors which contributed to this situation included the felt urgency to respond to the drought and effects of the conflict, donor pressure to yield measurable outcomes, competition between agencies for funds and visibility, and lack of staff with nutritional expertise and knowledge of Afghanistan. Needs assessment tended to rely essentially on quantitative data (e.g. nutritional surveys), to the detriment of qualitative information on food security, health and caring practices, and there was little consultation of potential beneficiaries.

Observed high rates of defaulters, low weight gains, and low recovery rates suggest that 'classical' nutritional interventions – supplementary feeding centres (SFCs), in particular - may not be an appropriate response in the Afghan context. Furthermore, difficulties in implementation of therapeutic feeding centres (TFCs) led agencies to resort to the distribution of Ready-to-Use Therapeutic Foods for use at home with little or no monitoring, although the effectiveness of these products is not yet proven outside TFCs nor in the absence of regular supervision [1]. Finally it seemed that monitoring rarely involved consultation of beneficiaries and was often insufficient or inadequate to inform decisions on strategy change [2].

These difficulties must not overshadow the impressive efforts made at the national level to address the structural causes of malnutrition through long-term strategies. The second mission (January 2003) highlighted how nutrition coordination, under the leadership of the Ministry of Health (MOH) and UNICEF, has played a key role in lesson learning from experiences in 2001/2002. Efforts are concerted into local capacity-building, a critical evaluation of SFCs is under preparation, management strategies for severe malnutrition are being integrated into MOH structures, and a national food security and nutrition surveillance is yielding its first results, in co-ordination with key ministries. Surveys are underway on feeding and caring practices, and non-food approaches are being considered.

The key to addressing malnutrition lies precisely in coordination, and in a strategy integrating the health and food security/agriculture sectors. These sectors, though, face similar constraints to those encountered by the nutrition sector, and the same weaknesses have been noted (supply-driven approach, little consultation...).

In health, key issues such as health beliefs and health-seeking behaviours were poorly understood, though understanding them is essential to improve health education and to develop community health strategies. Constraints included difficulty in accessing women and the lack of qualified staff, in particular female staff and in remote areas. Also, the lack of clarity concerning the future MOH's mandate and activities made it difficult for NGOs to work with, rather than as substitutes for, the government. In the food security sector, the main constraints were lack of understanding of agrarian systems (seed security, pastoral livelihoods, rain-fed systems, etc.), and poor knowledge of food and economic security and coping strategies in urban areas, which were growing rapidly with the flow of returnees and internally displaced persons (IDPs) fleeing drought-struck regions.

Humanitarian actors in Afghanistan are faced with challenges of emergency situations (IDPs, drought), reconstruction (local capacity-building) and development (long-term strategies), often with short-term means in terms of funding and human resources. These challenges are made more difficult by constraints such as the shortage of qualified human resources (few international and national staff have training and experience in nutrition, and much of the expertise is concentrated in Kabul) and a high rate of staff turnover, that makes it difficult to capitalise on lessons learnt and follow through a coherent strategy. Furthermore, the complexity and diversity of the current political and humanitarian situation makes it difficult for agencies to place themselves on the emergency-rehabilitation-development continuum, and to design strategies accordingly.

Significant progress has been made but while the world's attention is turned to Iraq, we can only hope that Afghanistan will not be forgotten and that current achievements do not collapse.

For further information, contact Groupe URD Afghanistan Quality Project Team: afganistanurd@urd.org or see the websites: www.urd.org and www.qualityproject.org

[1]Field Exchange Issue 17, Letter, Ethics of ready-to-use therapeutic foods, Charlotte Dufour, p23
[2]For more detailed information, see the website : www.globalstudyparticipation.org

Community- based targeting in Kenya

Summary of evaluation[1]

At the end of 2002, an evaluation of community based targeted distributions (CBTD) of general rations was carried out in Kenya, in order to derive lessons for it's future application in Kenya and elsewhere. The evaluation set out to determine CBTD efficacy in delivering food assistance, in an accountable and transparent manner, to households targeted according to their vulnerability from 2000-2002. CBTD effectiveness was compared with systems previously operated in Kenya and in drought emergencies in other countries.

Four districts were visited over a one month period (Mandera, Wajir, Laikipia and Turkana). Here, discussions were held with members of the District Steering Group/ District Social Dimensions of Development Committee (DSG/DSDDC), the World Food Programme (WFP), lead agencies and the Arid Lands Resource Management Project (ALRMP). The majority of district time was spent in rural areas, in focus group discussions with Relief Committees (RC) and members of the community (men and women were interviewed separately). In each district, the consultants aimed to visit all the different livelihood zones, and within each livelihood zone, select two RCs - one which had been functioning well and another which had faced difficulties. Due to time constraints this was not always possible. In Nairobi, the consultants had discussions with the national level stakeholders e.g. the WFP, government representatives from ALRMP and the Relief and Rehabilitation Department, Unicef, and representatives from lead agencies.

Main evaluation findings

The CBTD was a huge improvement compared to the previously implemented relief intervention by the Government of Kenya (GoK), which suffered from 'leakage' and the fact that the most needy did not always receive the food. However, when the Kenya CBTD was compared with the CBTD experiences in Singida and Dodoma, Tanzania, it was relatively less successful. The main reasons for this were:

◆ The poverty levels of the drought-affected areas in Kenya were considerably higher and the wealth differentials within the community were marginal.
◆ In many of the affected areas, sharing resources during times of hardship is an important cultural practice and a traditional coping mechanism.
◆ The assumption by national policy makers that not all households were badly affected by drought and so did not require food aid, was contrary to the community's perception.
◆According to the stated objectives of the CBTD in Kenya, the target population included the nutritionally vulnerable (saving lives) and those who still had assets (protecting livelihoods), and so arguably included the majority of the population within the communities.

Given these factors, it was unrealistic - and even inappropriate - to expect community elected Relief Committees (RCs) to target communities by excluding certain households. The reality of what actually happened could best be described as a blanket distribution at the community level.

There was overwhelming consensus that the community elected Relief Committee was an effective mechanism for community distributions. They encouraged community participation and transparency and were generally accountable to their community. Some RCs had, however, difficulty implementing certain components of the CBTD, such as encouraging communities to fulfill the various distribution tasks on a voluntary basis, or securing women's involvement which, at times, could best be described as tokenism. There was also some concern as to whether all the RCs (even when RCs were large in number) truly represented all the people connected to their distribution site - in particular, the mobile pastoralists, as it was impractical for them to be RCs members, and other minority groups.

Reassessment of the targeting criteria and beneficiaries did not occur as extensively as planned for the following reasons:
◆ According to the communities perception, there were very few households, if any, who were receiving food aid and recovered sufficiently to no longer be considered vulnerable.
◆Limited funds were available for the reassessment exercise.
◆ Attempting to revise the registration lists every 3 months, when assessors were aware re-distribution would probably occur anyway, seemed a futile exercise.
◆ It was a huge undertaking for the communities and the implementing agencies.
◆ If unregistered new arrivals were considered to be as vulnerable as registered households, the community preferred to agree to share their food aid ration with them rather than revising the registration list.

The DSG/DSDDC proved to be an effective mechanism for co-ordinating relief activities. However, the lack of resources for GoK members of the DSG/DSDDC was a frustration and, at times, prevented them from fulfilling all of their responsibilities.

Redistribution of the food aid occurred extensively, however it was not possible in this review to discern the proportion of the food ration that was not consumed by the household but used for other purposes. The communities believed redistribution was an effective strategy to ensure all vulnerable households received food assistance and that this improved the efficiency of the targeting strategy.

[1]A review of the community based targeting and distribution system used in Kenya 2000-2002. Final report Nov 2002. Submitted by Acacia Consultants Ltd

Uganda learns from Zambian GM food controversy

Last year, Zambia's refusal to accept maize donated for the hungry[1] inflamed the debate on the use of genetically modified (GM) foods in Africa. Zambia refused to accept a donation of maize grain because the consignment had traces of GM maize and the government feared that farmers might plant the seeds and contaminate local crops. Local people later broke into the stores and stole the GM maize. A recent article in the Lancet asserts that in Uganda, most lay people consider GM food to be so dangerous that not even starving people should be fed such food. The article explains that the Uganda Consumer Protection Association (UCPA) initially argued that there is no need for GM foods in Uganda. The organisation raised fears about possible health hazards, contamination of local strains and loss of traditional farming practice of planting seeds from the previous harvest. On the other hand the Uganda National Council of Science and Technology and the National Agricultural Research Organisation, dismissed these fears as being devoid of scientific evidence.

The article points out that despite having fertile soil and good rainfall, Uganda has a high rate of malnutrition. For instance, 54% of Ugandan children have vitamin A deficiency, 60% have various manifestations of iodine deficiency and 43% of all deaths are associated with malnutrition through lack of protein in the diet. All these are problems that genetic modification of staple crops could reverse, argue supporters of GM foods. According to the author, the main lesson Uganda has learnt from Zambia is the urgent need to develop the country's capacity to handle the benefits and risks associated with genetic modification.

To date, Uganda - like most African countries - does not have a policy or law on GM food. Following months of dialogue, the UCPA has adjusted its tone. They say that legislation must be speeded up, the government and companies must be transparent and that risks should be addressed. The position of the government is that Uganda should not adopt GM crops until the appropriate legal framework is in place, but that research should proceed. The Uganda National Council of Science and Technology has drafted a GM food law, which has been sent to the government and will be discussed first by the cabinet and then in Parliament. At the same time the Council is initiating a countrywide project to raise awareness about GM foods among the general public. Officials in government have made it clear that Uganda may not be in a hurry to consume GM foods, but stress that there is urgent need to prepare for them.

Wendo, C (2003). Uganda tries to learn from Zambia's GM food controversy. The Lancet, vol 361, Feb 8th, pp 500

[1]See Field Exchange 18, March 2003. Genetically modified food in emergencies, p14

Caring for Severely Malnourished Children[1]

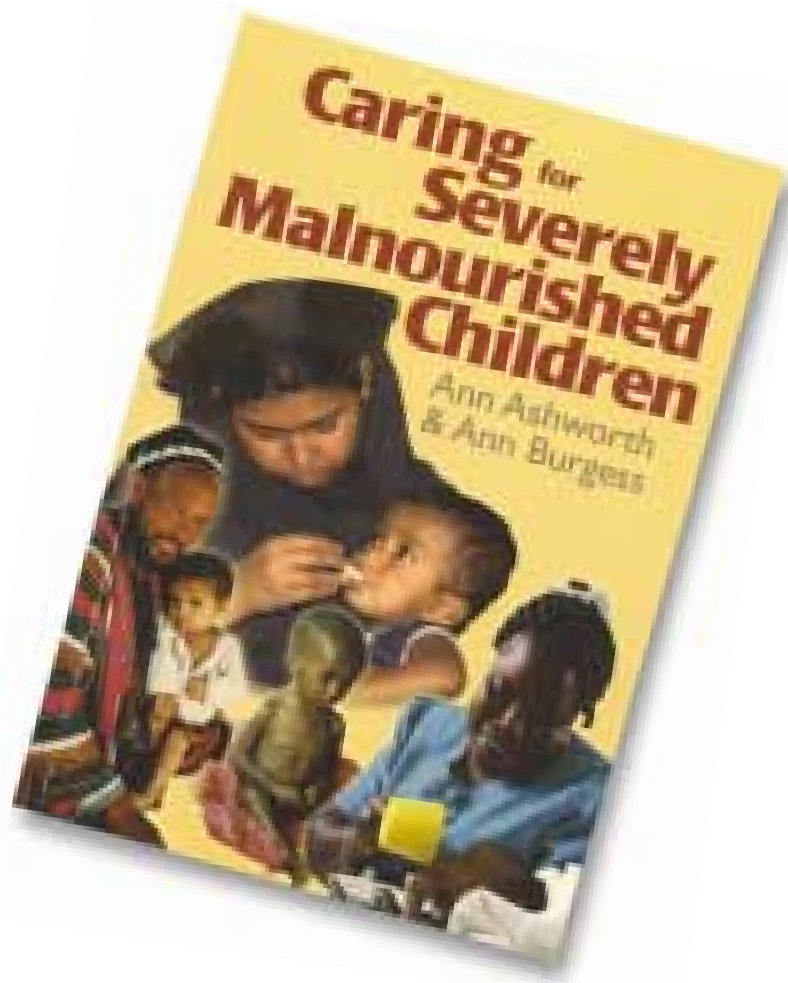
By Darryl Cowley and Professor David Morley (Teaching-aids At Low Cost)

This book describes how to manage severely malnourished children in hospitals and other health units with inpatient facilities. Based on the WHO manual for physicians and other senior health workers on the management of severe malnutrition, and the WHO-IMCI guidelines on the management of the child with a serious infection or severe malnutrition, it describes ten treatment steps and why each is important. It also highlights the supportive role that mothers and other carers should play and suggests ways to involve them in providing care.

The book was written at the suggestion of African health workers who wanted something simple, practical and easy to read. In the view of the WHO departments of Nutrition for Health and Development and Child and Adolescent Health and Development, Ashworth and Burgess have faithfully translated the original two sets of WHO science-based operational guidelines.

The book has nevertheless come in for some criticism by Prof. Mike Golden. As a result, the authors, TALC and the publisher together agreed to have the book reviewed by respected independent experts in the field of management of severe malnutrition in children.

[1]Ashworth A, Burgess A (2003). Caring for Severely Malnourished Children. Available from Macmillan Education and TALC. The book is also available on CD Rom. Sponsored by TALC (Teaching-aids At Low Cost) and the Academy for Education and Development.



ProNUTRITION and ProNut-HIV

ProNUTRITION is an information resource that supports health care providers, community health workers, policy makers, and programme managers with practical information and tools for decision-making. Information sources include discussion groups on topics of current interest, newsletters, documents on-line, links to useful web sites, guidelines, and assessment tools. Areas of emphasis include:

- Nutrition and HIV/AIDS
- Nutrition for Mothers and Children
- Nutrition and Food Security
- Malnutrition
- Micronutrients
- Nutrition in Emergencies

ProNut-HIV is an electronic forum which aims to promote constructive dialogue and to share up-to-date information, knowledge and experiences on nutrition and HIV/AIDS. People living with HIV/AIDS, front line workers, researchers, programme planners and policy makers are encouraged to actively participate and contribute to the dialogue. Expert moderators in HIV/AIDS and Nutrition facilitate the discussion. ProNut-HIV is a collaboration between SATELLIFE[1] and the Academy for Educational Development (AED).

See information and archives online at http://www.pronutrition.org. To subscribe to ProNut-HIV, write to: majordomo@healthnet.org.

[1]SATELLIFE is a global health information network which, through innovative applications of information and communication technology, aims to improve access to information. See online at www.healthnet.org

EPI INFO Training Manual for Nutrition Surveys

Save the Children UK has developed a comprehensive training manual to provide training on how to use EPI INFO specifically to analyse data from nutrition surveys. The purpose of the training manual is to provide users with the skills needed to process and analyse nutrition survey data. The focus of the manual and the practical exercises focus on nutrition data, however the skills acquired by working through this training manual will allow users to process and analyse data from other types of epidemiological surveys, not only nutrition survey data.

By the end of the training course, you should be able to:

- set up a database for nutrition survey data
- know how to set up constraints for data entry
- perform data entry
- analyse data from a nutritional survey
- report results from a nutritional survey
- produce graphical displays for anthropometric indices
- understand how to make conclusions about a population from sample estimates.

The training manual is in English and comes as a hard copy handbook with a CD ROM containing practice survey data and the EPI INFO software. This user-friendly manual can be ordered from Plymbridge Distributers at a cost of £20.00 (includes postage and packaging).

To order, please contact Plymbridge Distributers on 01752 202 301 or orders@plymbridge.com, quoting ISBN No. 1 84187 080 3

Adapted MSF nutrition guidelines on F75

Prompted by recent operational findings, MSF has decided to modify its Nutrition Guidelines to promote the use of F75 in Phase I treatment of severe malnutrition. Although nutrition academics and scientists have long advocated F75 as the safest therapeutic option, MSF has been reluctant to advocate the new protocol on the basis that there has been no proof of its efficiency in the field. The additional reduction in mortality by using F75 is not currently known, and it was felt that the use of two similar milks complicated the work and thus increased the risk of errors in milk prescription and administration.

Being compliant with many national and international guidelines, however, MSF increasingly used F75 in the first phase of treatment. Also, during the nutritional crisis in Angola (2002), MSF used F75 in its therapeutic feeding centre with positive results. National staff who were responsible for mixing and administering the therapeutic food were largely illiterate, however this had no effect on the efficiency and quality of their work. This experience proved to MSF that, provided staff are adequately trained and supervised, F75 can be implemented in an emergency situation. However, in case of an overwhelming situation and lack of human resources, lack of milk supply, or where simplification of the protocol is needed, MSF consider the use of F100 (diluted for particularly weak cases) instead of F75 an acceptable alternative.

For further information, contact Saskia van der Kam, MSF-Holland. Email: saskia.vd.kam@amsterdam.msf.org

HIV/AIDS and Food Crises: Next Steps for RENEWAL

There is some evidence and growing recognition that the spread of HIV/AIDS has increased the sensitivity of agrarian society, so that small shocks can precipitate crises for many people. A May 2003 SADC FANR study [1] suggests that the impacts of HIV/AIDS on food security, in the context of the 2002 food emergency, are strong and negative. It also suggests that these impacts are complex and require urgent, innovative and sustainable responses.

But just what is the role that HIV/AIDS is playing in the current food crises? To what extent, and in what ways, is AIDS exacerbating food crises? To what extent are food crises accelerating the spread of HIV? And what does this mean for the ways in which different people at various levels need to respond – now, and for years to come?

The RENEWAL[2] network in eastern and southern Africa is embarking on a new phase of work that will address these questions. Networks are now up and running in Malawi (HASARNET) and Uganda (HASNET) and, with this initiative, it is hoped others will form in the region. The joint purpose of these networks is to show that fresh thinking in agricultural and livelihoods research, along with development policy and concerted action, can help prevent HIV infection and lessen the impact of AIDS.

Another main purpose of this initiative is to promote convergence between humanitarian and development thinkers and practitioners around the issue of AIDS and its two-way interactions with chronic and acute food insecurity. Given the nature of the virus, and the different waves of AIDS impacts, this will be critical. Short-term relief has to be embedded within a broader vision of multi-level response.

Key concepts and principles underlying RENEWAL's focus and approach are described in a recent paper by Michael Loevinsohn (ISNAR)[3] and Stuart Gillespie (IFPRI)[4]. This, and other papers and workshop reports, are available on the RENEWAL website: www.isnar.cgiar.org/renewal. For further information, email: S.Gillespie@cgiar.org.

[1]SADC (Southern African Development Community) FANR (Food, Agriculture and Natural Resources) Vulnerability Assessment Committee (2003). Towards Identifying Impacts of HIV/AIDS on Food Insecurity in Southern Africa and Implications for Response: Findings from Malawi, Zambia and Zimbabwe. Harare, Zimbabwe

[2]Regional Network on HIV/AIDS, Rural Livelihoods and Food Security (RENEWAL) is an emerging regional network of national networks of agricultural institutions, public, private, NGO and farmers' organisations, together with partners in AIDS and public health.

[3]International Service for National Agricultural Research

[4]International Food Policy Research Institute

Malnourished Child with ready-to-use-therapeutic food (RUTF)

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Increase in the shelf-life of Plumpy'nut

Aware of the long time it can take for products to reach the field, especially in land-locked countries, Nutriset have been conducting research with a view to increasing the 'best before' date of Plumpy'nut. Through product changes, brought about by field feedback and company trials, the shelf-life of the product is due to increase from 20 to 24 months[1].

A study by Nutriset on the ageing of Plumpy'nut, when kept for two years at a temperature of 40°C, has resulted in changes to extend the life of the product, without impairing its taste, its general aspect and its nutritional qualities. Documented losses of the two most heat sensitive vitamins (vitamin A and vitamin C) during the trial, have been accounted for through a dose increase.

For more details, please contact Christelle Lecossais, Product manger, Nutriset at email: nutriset@nutriset.fr.

[1]At time of writing (May 2003), product with increased shelf-life not yet in circulation.

Revised Sphere guidelines

The Sphere handbook 2000 edition has been revised over the last year. There have been consultations in many countries in an attempt to capture people's experience and views and build consensus on minimum standards, indicators and guidance notes. The major new additions to the next edition are the new Food Security standards. These will appear in a new chapter entitled Food Security, Nutrition and Food aid, which combines the previous food aid and nutrition chapters with the new food security standards.

This new chapter has been developed by national, regional and international groups of technicians who have carefully reviewed drafts and suggested improvements. The consultations have taken place in Kenya, Ethiopia, India, Afghanistan, Malawi, Liberia, USA, Switzerland and UK and have involved about 250 individuals. In addition there has been a much wider web-based consultation.

The new handbook will be published in October 2003. It is hoped that the new edition will be more useful for field workers, be relevant to a wide variety of contexts for disaster response and ultimately contribute to greater quality and accountability in humanitarian response.

For further information or to offer feedback, contact Anna Taylor (nutrition) email: A.Taylor@scuk.org.uk, Helen Young (food security), email: Helen.young@tufts.edu, or John Solomon (Food aid), email:Jsolomon@care.org

Training in public health in emergencies

A public health in complex emergencies training programme (PHCE) is being implemented by World Education, Inc. in collaboration with the International Rescue Committee (IRC) and Columbia University. Regional partners include the American University of Beirut, Lebanon, the Institute of Public Health, Kampala, Uganda and the Asian Disaster Preparedness Centre, Bangkok, Thailand. Key topics included in the programme are:

- Context of Emergencies
- Epidemiology Weapons
- Communicable Disease
- Environmental Health
- Nutrition Coordination
- Reproductive Health
- Violence and Trauma
- Protection and Security
- Psychosocial Issues

Dates for the next three programmes scheduled are:

Beirut, Lebanon	21 July - 2 August, 2003
Kampala, Uganda	25 August - 6 September, 2003
Bankgkok, Thailand	22 September - 4 October, 2003

For more information contact: Lorna Stevens, Director, Health Training, IRC
tel: +1 212 551 3005 email: shortcourse@theirc.org
website: http://www.theirc.org/phce

WFP policy on HIV/AIDS

A policy document, 'Programming in the era of AIDS : WFP's response to AIDS/HIV', submitted in February 2003 to the World Food Programme (WFP) Executive board [1] has been approved.

The document begins with the premise that food security can be viewed as one more way to prevent the spread of AIDS and reduce its impact, and that people affected by HIV/AIDS need both treatment and food. The document notes that little work has been carried out on how food – and, specifically, food aid - can be best integrated into programmes designed to mitigate the impact of HIV/AIDS on poor households' food security.

The document states that, when associated with other inputs, food assistance in all WFP programming categories can:

- create opportunities for less risky livelihoods, and strengthen household and community capacity to respond to HIV/AIDS impact on food security, through initiatives such as food for training and food for assets
- improve and maintain human capital through nutrition programmes, food for training and school feeding
- reduce the vulnerability of families to food insecurity and malnutrition through safety-net initiatives, such as home-based care projects and mother-and-child health programmes, and initiatives targeted at child-headed households
- through partners, be used as a conduit for the dissemination of HIV/AIDS messages and information.

The board adopted the following recommendations contained in the policy paper:

- WFP will incorporate HIV/AIDS concerns in all of its programming categories - Country Programmes, Protracted Relief and Recovery Operations (PRROs), and Emergency Operations (EMOPs). Food insecurity driven by HIV/AIDS can be addressed directly through WFP programmes and WFP activities can be used as platforms for other types of HIV/AIDS programmes, such as preventative education.
- WFP will work with local and international partners, non-governmental organisations, governments and United Nations agencies to ensure that food is incorporated into HIV activities when and where appropriate. WFP will work particularly closely with UNAIDS co-sponsors and the UNAIDS Secretariat in this regard.
- WFP will adjust programming tools such as needs assessments, vulnerability analysis, the design of rations and other nutrition-related activities as information and research results become available, to reflect the new reality presented by HIV/AIDS.
- When HIV/AIDS threatens food security and influences mortality in ways similar to other disasters, WFP will consider HIV/AIDS as a basis for a PRRO, consistent with the current WFP policy on PRROs.

For further information, contact Rita Bhatia, WFP at email: Rita.Bhatia@wfp.org

[1] Executive board first regular session - 5-7th February, 2003. Policy Issues Agenda Item 4. Programming in the era of AIDS; WFP response to HIV/AIDS

Revised UNHCR operations handbook

A second edition of the UNHCR handbook, Partnership: an operations management handbook for UNHCR's partners, was issued on 27 February 2003.

The revised handbook reflects progress made in recent years, including:
- greater emphasis on results-oriented programming, as well as on enhanced measurement of impact and performance for monitoring and reporting purposes
- better integration of protection and assistance aspects of UNHCR's work, with greater involvement of UNHCR partners in protection work
- enhanced focus on creating a culture of accountability in use of resources
- emphasis on standards of conduct expected of those involved in providing protection
- better structured, more inclusive approaches to planning

A full English version is available online (http:// www.unhcr.ch), and text copies of the handbook are also available from UNHCR. The French version is under preparation. This handbook will be updated regularly, using the UNHCR website (Partnership Guides).

Suggestions for improvements to the Handbook can be forwarded by email to: hqdoshlp@unhcr.ch

RedR and IHE merger

Effective from June 2003, RedR - Engineers for Disaster Relief - and International Health Exchange (IHE) two of the UK's leading humanitarian-relief personnel organisations, have merged. By joining forces, the aim is to provide for more integrated recruitment, training and information services, and support for those engaged in humanitarian work. With a combined membership of over 2,000, the new organisation will provide training to over 1,000 aid workers each year. All existing recruitment, training and publications services offered by both organisations will continue.

IHE and emergency nutrition

The May 2003 issue of the IHE quarterly publication, The Health Exchange, has a special focus on emergency nutrition. Entitled Food for thought — challenges for nutritionists on the frontline it includes a series of articles by practitioners on topics such as emergency needs assessments, community-based treatment of malnutrition, and tackling micronutrient disorders. It also contains a nutrition resources guide, training section, and the latest humanitarian health-worker vacancies and relevant courses.

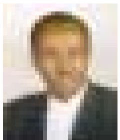
For further details, contact: International Health Exchange/RedR, 1 Great George Street, London SW1P 3AA, UK
Tel: +44 (0) 207 233 1100Fax: +44 (0) 207 233 3590 Email: info@ihe.org.uk Website: www.ihe.org.uk

Meat in drying place, Borana

All Photos: Melese Aweke, CARE Ethiopia

Destocking to improve food security in drought- prone Ethiopia

By Dereje Adugna Tieke



Dereje is an Emergency Response & Transition Program Officer for CARE Ethiopia, with sixteen years of field experience in development work and emergency relief operations.

The contribution of CARE Ethiopia in permitting the publishing of this article is gratefully acknowledged.

This article describes Care Ethiopia's experiences of a destocking programme in Ethiopia, and the lessons they learned for future similar interventions[1].

Dried and folded skin

The Borana zone in the Oromiya region of southern Ethiopia is extremely drought prone. The population of close to 1.4 million people is predominantly pastoralist, depending on the main rains from March to mid-May and short rains from September to November for water and pasture to sustain their livelihood.

Beginning in 1996, the Borana zone suffered from severe drought, followed by erratic and insufficient rains for several years afterwards. In 1998, the short (Hagaya) and main (Ganna) rains were well below normal, and the situation became extremely critical in the lowland woredas of Yabello, Dire, Arero, Moyale and Teltele. Pasture became scarce, and water points such as ponds and traditional wells dried up earlier than usual. In order to cope, the pastoralists were forced to move their livestock to less affected areas, which put excessive pressure on the limited resources of those areas. The condition of calves and milking cows deteriorated severely due to the acute shortages of pasture and water, and in general, cattle mortality was significant and rising.

In October 1999, in view of this worsening situation and in conjunction with other relief efforts, CARE Borana began pilot destocking activities at two sites, Adegelechet in the Yabello woreda and Dubluk in the Dire woreda. As the intensity of the drought became more severe, a third centre was opened at Dara in Teltele. Destocking ended in August 2000 when most of the area in the Borana plateau received rain in the Hagaya and Ganna seasons, which improved the availability of pasture and water. Improvement in the physical condition and price of livestock made the pastoralists unwilling to barter the physically 'improved' livestock for grain.

Pilot destocking project

The pilot project comprised of two complementary components: livestock destocking and dry meat processing. It was designed, in the short term, to make use of severely weakened but otherwise healthy cattle in order to reduce human mortality risk and improve the nutritional status of malnourished and vulnerable community members. Through the exchange of grain for weak but otherwise healthy cattle, food income was generated. Dried meat (quanta), produced from these animals through the meat processing activity, was distributed to children[2] and the elderly, supplementing the food rations already being received.

The project also aimed to:

- ◆ reduce the loss of assets due to the scarcity of forage and water
- ◆ assist local communities to set up their own sustainable and replicable dried meat processing plants
- ◆ assist in destocking, so that the competition for rangeland resources would be reduced and improve future livestock productivity.

During the eleven months of CARE's intervention, 1,466 weak but healthy cattle were exchanged for 118 MT of grain. From this exchange, CARE produced 6,651 kg of dried meat that was distributed to 18,069 malnourished children[2] and elderly people in 27 Peasant Associations.

It was expected that the impact of the project would go beyond mere emergency relief. Any subsequent privatisation of centres by service cooperatives or interested pastoralist/ agro-pastoralist families to produce dried meat for sale could promote sustainable off-take of animals from grazing lands.

Previous experiences

Although this strategy was new to CARE Borana, a similar one had been used by the Relief and Rehabilitation Commission (RRC)[3] and UNICEF from 1984/85 to 1987/88 at Adegelchet in the Yabello woreda. CARE took advantage of the lessons learned in this previous experience in order to design its system.

There were a number of differences between CARE's approach and that of RRC. While RRC paid cash for the cattle, CARE used a barter system. RRC viewed their intervention purely as an emergency relief project and once the pastoralists and their livestock had recovered from the drought, RRC discontinued the programme. CARE envisaged a potential longer term impact. Finally, there was no defined system in the RRC project for determining the health status of cattle to be purchased, except by visual observation. CARE assessed animal health based on veterinary examination.

Installations

CARE began operations at the Dubluk and Adegelchet sites in October 1999. The Dubluk center was established at a previous CARE camp site and only required a few additional facilities. Given that UNICEF had used the Adegelchet site in the past for the same purpose, all the required structures were in place and only required maintenance on already existing structures. In April 2000, a third center was started at Dara, Teltele and since it was a new site, all physical structures needed for the project had to be constructed.

The average labour requirement at each centre was 21 people, including five butchers (men), ten slicers (women), two herders, two guards, one supervisor/ storekeeper, and one vet technician (meat inspector)

Based on an agreement made with the Southern Rangeland Development Unit (SORDU), CARE Borana was responsible for providing a per diem to the SORDU vet technicians. These technicians were responsible for ensuring that all cattle to be exchanged for grain were healthy. They carried out ante mortem and post mortem examinations. They also ensured that basic hygiene practices were followed in the slaughtering, butchering, and meat drying processes as well as in the disposal of offal and drying of the hides. These technicians were also responsible for compiling monthly reports regarding the vet activities.

In terms of hiring non-technical labour, the project aimed to employ individuals from families who had lost their assets and cattle. Furthermore, CARE planned to develop a rotational system to train and employ additional men and women in the butchering and drying processes. In addition to their monthly salary, the employees at the sites were given organ meats, bones and any part of the animal that was good for human consumption but not appropriate for drying, in order to contribute to improving the community's food resources.

The cost for labour and construction/ rehabilitation in the three centres over the life of the project is presented in Table 1.

Destocking centre operations

Only cattle were accepted in the destocking centres since, unlike other livestock species such as shoats and camels, cattle solely graze and depend mainly on grasses for survival. This narrow feeding habit makes them the first drought victims since other species can both browse and graze, and so survive longer when pasture is depleted. Oxen and heifers were rarely brought to the destocking centres - cows predominated.

A bartering system, exchanging grain for weak but otherwise healthy cattle, was introduced as a mechanism to facilitate the exchange. All three centres used the same barter rate of 100 kg of grain per animal. This rate did not vary by season unless the animal was extremely emaciated, in which case only 50 kg of grain was paid. All interested pastoralists and agropastoralists had the right to use the service rendered by the destocking centres, as long as they brought weak, healthy cattle. Priority in bartering was given to Peasant Associations from distant areas and to very weakened cattle.

All animals were inspected by the vet technicians and had to be declared disease free in order to enter into the barter system. Post mortem examinations were also carried out prior to processing of the meat. Depending on the outcome of the examination, any infected organs would be discarded and if necessary, the entire animal rejected and burnt.

Initially the centres did not limit their bartering based on the centre's processing capacity. As a result, bartered cattle had to stay in the centres for up to 10 days before being slaughtered. While this allowed the pastoralists to barter a weakened cow before it died, the practice increased the risk of disease and death of cattle in the destocking centres. In their weakened state, the cattle were susceptible to any diseases which might be transmitted by other cattle brought for barter, or other range cattle they might come in contact with before slaughter. After two weakened cows died while being kept in the Dubluk destocking centre, the number of cattle bartered in any given day was limited to between seven and ten animals - the amount that could be slaughtered and processed on that same day. Neither of the other centres set a limit and accepted all the presenting healthy, weakened cattle.

After processing the meat from the bartered cattle, the dried meat was distributed to malnourished children and the elderly to supplement their protein intake.

Project assessment

The main findings of an assessment of the destocking programme were:

- ◆ In the three centres, a total of 1,466 weakened but healthy cattle were exchanged for 1,179.7 quintals of maize.
- ◆ Out of the 1,466 cattle bartered, 1451 (99%) were slaughtered and processed. The remaining one per cent (15 cattle) were discarded due to pre-slaughter death or post-mortem rejection.
- ◆ A total of 6,651 kg of meat was dried from the 1,451 cattle butchered.
- ◆ A total of 6,651 kg of dried meat was distributed to 18,069 beneficiaries in 27 Peasant Associations.
- ◆ The cattle hides obtained from the centres (1456) were sold to local traders and the money received was used to offset centre costs.

Shortly after the onset of the ganna or long rainy season, the number of cattle presenting to the centres began to decline sharply. Once the pastoralists saw the emergence of grass shoots and the hope of saving their cattle, they chose to keep their animals rather than barter them.

Lessons learned

One of the programme assumptions was that, even if rains were to begin in early April and certainly after the short rains predicted for October/ November, pastoralists would need to trade their weakened cattle for grain in order to feed themselves until milk production could be re-established. This was found to be incorrect. The observed reality was that as soon as rainfall conditions improved, the supply of cattle to the destocking centres declined significantly.

Destocking, as a longer-term income generation activity in this region, is not feasible. Beyond the emergency phase, it wasn't very well accepted and furthermore,the Borana diet is not heavy on meat and so offers a limited market for quanta.

Based on our experiences, a number of recommendations are made which may help to improve future programming:

- ◆ Such a programme should incorporate a support system (extension) to monitor livestock conditions and to encourage pastoralists to begin bartering their cattle before they become desperately emaciated.
- ◆ mobile destocking units could be useful so that already weakened cattle would not experience further stress by being herded to the destocking centres.
- ◆ Programme budgets should be allocated specifically to each centre to facilitate monitoring.
- ◆ A rotational system should be arranged to ensure equitable distribution of cash for work benefits, and to train men and women in the butchering and drying processes.
- ◆ Specific training should be planned for the employees of each centre.
- ◆ The duties of the supervisors of each centre should include complete documentation of meat distribution activities.
- ◆ Destocking centres should be handed over to government or private entities.
- ◆ At least one full time light vehicle is needed to support the destocking centres.
- ◆ Destocking centres should be much closer to the affected area in order to ensure that weakened cattle reach the centres before dying.

This pilot project has demonstrated that food insecurity can be ameliorated through coordination of the communities, government entities, and non-governmental organisations, and interventions such as this destocking project, could be applied to other drought-related situations.

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[1]Final Report of Borana Emergency Drought Relief Program submitted for OFDA/USAID. April 2001, CARE Ethiopia
Impact Assessment of CARE Borana Destocking Intervention. CARE Ethiopia. Fistum Berhe (Independent Consultant), March 2001

[2]Rapid nutritional assessment was carried out with full assistance from the local government. Children with a mid-upper arm circumference of less than 12cm, were supplied with dried meat rations

[3]RRC previously known as the Disaster Prevention and Preparedness Commission

Table1 Labour and construction/ rehabilitation costs at project centres

Centre	Meat processing labour costs (dollar)	Construction/ Rehabilitation costs (dollar)	Total cost of running the centre (dollar)
Adegalchat	4,446.26	2,037.97	6,484.29
Dubluk	4,629.09	4,408.82	9,037.91
Dara*	1,800.12	1,597.55	3,397.66
Total	**10,875.47**	**8,044.33**	**18,919.80**

* The considerably cheaper construction costs in Dara was mainly due to the close proximity of the centre to the construction material supply area.

Women to be employed in the center

Supplementary suckling (SS) has revolutionised management of young, malnourished infants

Diet and renal function in malnutrition

Summary of presentation[1]

Water balance in young, malnourished infants

Water is an important nutrient, required to 'carry' excess electrolytes and urea (collectively called solute) into the urine. If there is not enough water, the solute builds up in the body. Much water is lost in the breath and through the skin - the greater this insensible loss, the less water there is available to excrete the solute and the greater the water requirement. Where renal concentrating capacity is impaired, water intake becomes even more critical.

In normal infants, fever or high respiratory rate leads to increased water loss. Presence in a hot climate increases water loss, and a dry climate can lead to very rapid water loss.

Small babies are particularly vulnerable to pure water dehydration (not salt and water dehydration) because their surface area to volume is much greater than in heavier children and their respiratory rate is higher – this leads to increased evaporative loss.

In addition, malnourished infants are particularly prone to water deprivation because they have a high surface area: volume ratio, may have diarrhoeal losses (which gives both salt and water loss) and cannot concentrate their urine (see renal function in severe malnutrition).

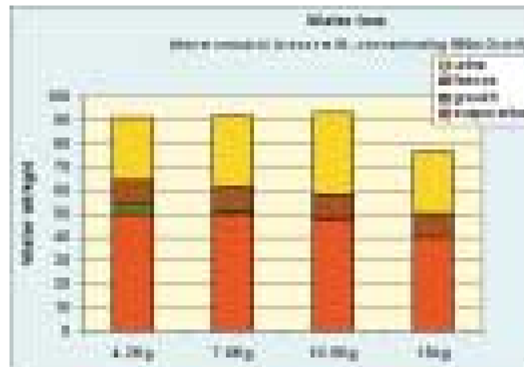
Malnourished children may be protected at home because they are often given thin watery foods, they have a low metabolic rate and so generate less heat that has to be lost. But when they get to hospital this all suddenly changes!

Evaporative water loss

Heat is lost, or 'excreted', by the body through water evaporation from the body surface. Relatively large amounts of water are required to excrete heat - 1g of water is required to lose or dissipate 0.54 kcal. Thus if 100ml/kg are lost, this will consume 54 kcal/kg. Skin lesions, which lose water in a dry climate, require extra heat generation in the body to avoid hypothermia.

Evaporative losses are at least 50 ml/kg in a normal child of 4 kg (see figure 1), and are higher in smaller infants. In investigations in Tchad, malnourished children had a water turnover of one third of body water per day (about 240 ml/kg/d) when the temperature was 43 degrees celcius and 15% humidity – 7 of 22 children in the TFC had hyperosmolar syndrome[2]. 'Fits' were often recorded as a cause of death.[3]

Figure 1: Water losses in normal children in a thermo-neutral humid environment, on breast milk, with a maximum urinary concentrating ability of 1000 mOsm/l



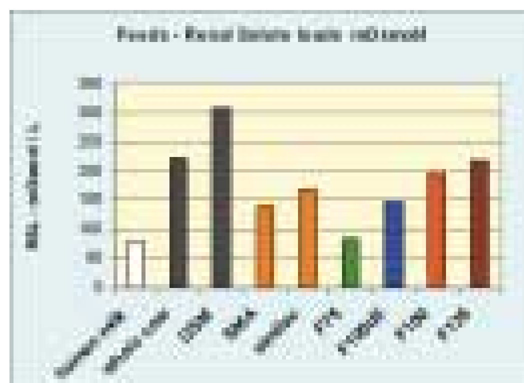
Renal function in severe malnutrition

Normal infants can achieve a renal concentration of about 700mOsm/l, malnourished infants have a mean maximum renal concentrating ability of about 450mOsm/l and some cannot concentrate their urine at all.

The renal solute load (renal osmolarity required to maintain water balance on a given intake) of diets vary greatly (see figure 2). Human breast milk has a very low renal solute load - no other diet that is satisfactory for growth comes close to breast-milk.

Using F75, small differences in intake can make a big difference to the ability to excrete solute. The higher the intake of F75, the more water there is available to excrete the solute and the lower the renal osmolarity. However if a child is not achieving an intake of 100kcal/kg/d (i.e. 130ml/kg/d), then he will be deficient in water unless extra water is given.

Figure 2: Renal solute load of various diets



It is dangerous to give ORS, which has a renal solute load of about 200 mOsm/l, to replace evaporative losses in hot dry climates.

How does this influence formula choice?

Figures 3 and 4 demonstrate the effect of dilution of F100 on renal osmolarity at various dietary energy intakes. Figure 3 reflects the urinary osmolarity that needs to be achieved at various non-renal water losses to prevent hyperosmolar syndrome, whilst taking F100. Similarly figure 4 demonstrates the urinary osmolarity, given the same non-renal losses, when taking F100-diluted (75kca/100ml)

Figure 3: Urinary osmolarity on F100 (1kcal/ml) at various non-renal water losses

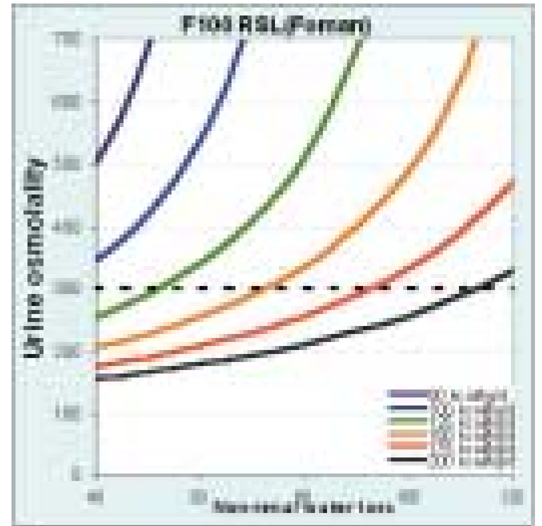
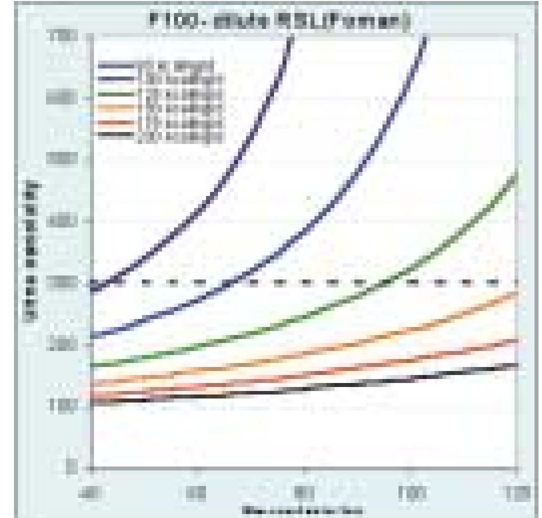


Figure 4: Urinary osmolarity on F100-diluted (0.75kcal/ml) at various non-renal water losses



These figures demonstrate that at a non-renal loss of 50ml/kg/d, with an intake of 100 kcal/kg/d (100ml/kg) from F100, the urine must be concentrated to about 420mOsm/l. With an intake of 100kcal/kg/d (130ml/kg) of F100-d, however, urine must only be concentrated to 230mOsm/kg to maintain fluid balance. With F100-d, the same renal stress as with F100 only occurs when insensible losses reach over 80 ml/kg/d.

How does this influence practice?

Up to about six months of age, birth weight is the dominant factor determining current weight, and is related to current weight up until about 18 months of age. Malnutrition in infants less than six months is predominantly due to antenatal malnutrition or prematurity – this is different from those who have become malnourished post-natally. Malnutrition in breastfed infants is almost always the result of inadequate feeding practice.

With proper management, however, breastfeeding can become perfectly adequate for the child to grow normally, and for the malnourished child to have catch-up growth on breast milk alone. The supplemental suckling technique - developed from well-established relactation methods - has truly revolutionised management of the breastfed severely malnourished child.[4]

Experiences in Burundi

In a trial of the supplementary suckling technique (SS) in Burundi in 2000, 57 malnourished infants were treated with breast-milk and SS, using F100 diluted to 75kcal/100ml. The mean admission weight was 2.7kg. Rate of weight gain was 14.6 g/kg/d and length of stay was 28 days. Overall, 12.9% abandoned the programme, and 10.5% died (six infants). Four of those who died weighed 2kg or lower - infants less than 2kg have high mortality anywhere.

Whatever supplementary formula is started with a young infant, it makes sense to continue - most infants having the supplemental suckling technique do not like to change the supplementing diet. F75 was designed for stabilisation, rather than rehabilitation and since most malnourished infants do not need a stabilisation phase, F75 is not the formula of choice in this group.

Infant formula can be safely used with young malnourished infants. However in the interests of consistency, simplicity and the risk of undermining breastfeeding by introducing supplies of infant formula, it is not recommended as the product of choice. Given the limitations of F75 and infant formula, F100-d is very much safer in any situation where there are high non-renal water losses, as in the case of the small malnourished infant. For this reason, full-strength F100 should not be used in infants under six months.

F100-d, or a return to the phase 1 diet, should also be used in older children with fever, high respiratory rates or in dry environments. Where a unit is short-staffed, which is usual, it is unsafe to rely on a diet being automatically changed when a small child has a fever or tachopnoea.

For older children (over 6 months), at an intake of 150kcal/kg/d, which is common during catch-up weight gain, F100 is perfectly safe provided that the insensible losses do not exceed about 80ml/kg/d. If a child loses appetite and refuses some feed, so that only 80kcal/kg/d are taken from the diet, then extra water should to be given - particularly if the loss of appetite is associated with a fever.

Diets of over 100kcal/100ml are likely to give hyperosmolar syndrome and should not be used.

Key issues

◆ Water is an important nutrient, but can often be limiting
◆ Fever, and high respiratory rates can increase insensible water loss
◆ Small, malnourished infants are particularly vulnerable to water deprivation
◆ Evaporative water loss in young infants is significant, especially in hot, dry climates
◆ Renal concentrating ability is impaired in the malnourished
◆ The renal solute load of the diet is critical
◆ Catch-up growth in the malnourished can be achieved on breastmilk alone
◆ Supplementary suckling (SS) has revolutionised management of young, malnourished infants
-Expressed breastmilk or F100 diluted (0.75kcal/ml) is recommended with SS
-F75 or infant formula are safe to use but have significant limitations
-Full strength F100 (1 kcal/ml) should not be used in infants less than 6months or under 4kg
-Concentrations higher than 1kcal/ml should not be used
◆ All malnourished children in desert (dry) areas should be treated with F100 diluted.

[1]Presentation by Professor Mike Golden, Renal function in malnutrition, Core group meeting, Geneva, 16-17th April, 2003
[2]Outline of hyperosmolar syndrome
[3]JC Birt. Water requirements of malnourished children in extreme hot and dry environment. MSc Thesis University of Aberdeen 1999.
[4]ME Corbett. Severe malnutrition in the infant less than 6 months – use of the supplemental suckling technique. MSc thesis, University of Aberdeen 1998

Nutrition in emergencies: SCN conference 2003

Between 3-7 March, 2003 the annual United Nations SCN (Standing Committee on Nutrition) conference was held in Chennai, India. Key achievements and plans to emerge from the nutrition in emergencies working group, are summarised here[1]

The main topic of the working group was experiences with, and research on, community based care of the severely malnourished as an alternative to therapeutic feeding centres.
Four presentations were made:
◆Update on the Community Therapeutic Care (CTC) programme—Steve Collins, Valid International
◆Social and ethical issues related to CTC—Joseph-Matthew Mfutso-Bengo, University of Malawi & Valid International
◆Experiences in CTC in North Sudan— Anna Taylor, Save the Children UK (SC UK)
◆Protocol for Home Treatment: implementation of a clinical trial in Sierra Leone— Carlos Navarro-Colorado, Action Contre la Faim (ACF)

Published experiences of the CTC project in Ethiopia are summarised in this issue of Field Exchange, whilst experiences of SC UK in North Sudan have been previously included[2] . Experiences from the clinical trial of home treatment by ACF, due to finish in July 2003, will be shared in a later issue of Field Exchange. A technical workshop, to clarify concepts and protocols in home-based treatment, is planned for October 2003 and will be reported in Field Exchange.

The working group also discussed the SMART (Standardised Monitoring and Assessment of Relief and Transitions) Project. This is an inter-agency initiative aimed at improving the monitoring, reporting and evaluation of humanitarian assistance, in order to ensure reliable data needed for making policy, funding and program decisions. A workshop, held in July 2002, produced a number of recommendations for assessing population stress:

Basic, essential indicators

Crude Mortality Rate (CMR) is the most significant public health indicator for all populations, particularly for societies in crisis, and should be included in anthropometric surveys.

Nutritional status of children under five is an essential indicator of the overall nutritional status of a population.

Sampling

Simple or systematic random sampling should be used where feasible, and the 30 x 30 cluster is recommended. All children in the sample household should be included, as well as households without children.

Reporting

A standardised reporting format should always be used, which includes all the information needed to evaluate the quality of the survey and demonstrate that the appropriate methodology has been used. Results should be provided in both Z score and percentage of the median. Findings should be interpreted in the context of the situation, including food security.

Plans over the next two years include development of the "SMART Manual for Dummies" on methodology on Crude Mortality Rate (CMR) and Nutritional Status and a pilot project to test the manual and it's implementation in Angola. More information is available on the SMART website: http://www.smartindicators.org/initiatives.htm

Discussions on training initiatives for capacity development in nutrition in emergencies, centred around an inventory of training courses in nutrition in emergencies, and a proposal to support training needs, based on an FAO assessment in Nairobi in 2001/2.
Examples of training initiatives included:
◆Tufts/WFP training: "Food and Nutrition in Emergencies"
◆Tufts/Columbia/CDC: training of UNICEF Health and Nutrition officers: "Training for Improved Practice: Public health and Nutrition in Emergencies"
◆SPHERE Project Health and Nutrition Training
Plans for 2003-4 are to support training courses at the University of Nairobi (ANP), Affad University, Khartoum, Kabul University/Ministry of Health and 1-2 institutions in crisis affected countries. Plans also include strengthening links with other working groups, establishing contact with regional training focal points and sharing and dissemination of an inventory of training materials and strategy.

Training was also referred to in discussions on infant feeding in emergencies. Produced by a core group of agencies[3] , a training module 1: "Infant Feeding in Emergencies, for relief staff" has been distributed to emergency staff and is under evaluation. A second more technical module, "Infant feeding in Emergencies, for health workers" is nearing completion pending resolution of certain technical issues by the core group .

An update on the Sphere Project was reported by Anna Taylor SCF (UK). Evaluation of the use of the first version of the Sphere Project manual has been completed, and a revision process is under way. The revised Sphere standards document should be available in October, 2003. Saskia van Der Kam (MSF Holland) reported on the progress and plans for NutritionNET[4] , which is providing an active working environment for nutritionists, with a large African participation. Plans are to increase the involvement of experts in certain field related problems.

Finally, a call was made to revive the currently inactive adult malnutrition group. Relevant research plans outlined in discussions included research on anthropometric assessment in adults, and an exploration of approaches to dealing with adult malnutrition in the context of HIVAIDS.

[1]Summary of the Nutrition in Emergencies Working Group, SCN, Chennai, March 2003. For further information, email: scn@who.int
[2]Field Exchange 16. Outpatient therapeutic programme (OTP). An evaluation of a new SC UK venture in North Darfur, Sudan (2001). p26
[3]A group of agency personnel, comprising UNICEF, UNHCR, WFP, WHO, IBFAN/GIFA, ENN and interested individuals, involved in developing and disseminating the material.
See presentation summary in this issue of Field Exchange
[4]Field Exchange Issue 18. NutritionNet: independent nutrition information exchange, by Saskia van der Kam, p15

Operational definition of a famine

Summary of workshop[1]

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Dried out sorghum harvest with barely any crops on it , Wollo.

A one day workshop was held on March 14, 2003 by the Institute of Development Studies (IDS) Sussex, with the aim of developing an operational definition of famine. Convened as a follow-up to an IDS 2002 conference on famine, it was attended by a group of academics, donors, agencies and the ENN.

Four cases were highlighted to focus discussion. Ethiopia (1984) was unanimously declared a famine while Iraq during the 1990s, Ethiopia (2000) and Malawi (2002) were more equivocal. The ensuing discussion highlighted factors to consider in defining a famine, including:

◆ Labelling a crisis 'a famine' tends to elicit donor response, but conversely may result in donor fatigue if 'over-used'. Thus, operationally, the word may need to be used selectively.
◆ Response to famine involves political calculations, i.e. donors tend to respond through media and international pressures as well as geo-political considerations, rather than solely to objective information on need.
◆ Should a definition account for what victims themselves believe famine to be?
◆ How many deaths have to occur before the term famine is used? Should the term be used broadly, or 'saved up' or for extreme circumstances?
◆ An operational definition should be about 'early warning, response and accountability' and establishing criteria to determine whether a current situation is a potential future famine. Current early warning systems appear to be 'too late'.

Need for an operational definition of famine

An operational definition of famine was deemed necessary in order to strengthen the following:
◆ Accountability and transparency to the beneficiaries of donors, local, national and international community, and all levels of government

◆ Advocacy - to present a coherent message, set and order priorities for action and to broaden understanding of food crises at all levels

◆ Response - to promote understanding/common framework for better, faster, co-ordinated response

◆ Early warning mechanisms - by including indicators that could identify different levels of food insecurity, using a more standardised and comparable approach than current early warning systems.
Identified limitations of developing an operational definition included:

A static definition may restrict responses until a situation is finally defined as a famine, when intervention may be too late. Also, it may focus responses on food at the expense of other sectors, or even at the expense of other food-related, non-famine disasters.

Politics and accountability.

An operational definition may provide excuses for donors and agencies not to respond to situations unless a situation is labelled as famine, and could be subject to political manipulation and misuse.

Difficulties in establishing indicators.

It may prove difficult to reach consensus on one operational definition, e.g. how to take into account cultural differences, different target audiences (donors/NGOs), etc.

Following a review of existing famine definitions and group discussions, consensus was achieved on the following issues:
◆ An operational definition required a verbal description of famine which revolved around access to food, with tools to generate appropriate responses to certain situations. It was felt, however, that this would be extremely difficult to achieve.
◆ All famines can be measured by outcome indicators, such as nutrition, malnutrition and mortality, but numbers and severity will differ from famine to famine. Similarly, all famines can be measured by process indicators, but the endpoint (mass death) does not have to occur before the situation is labelled a famine.
◆ Agreeing a timeframe in which a famine occurs is essential for operational usefulness - an acute event will require an emergency response, whereas a developing situation (famine process) will require longer term strategies.
◆ Responses to famines inevitably tend to be guided by the politicisation of events and media publicity.

Outstanding disagreements/ambiguities included whether a famine was a process or event, what time-frame should be included in an operational definition, for whom the definition was designed, and whether economic and social factors should be taken into account in determining causality.

Strengths and weaknesses of definitions

The strengths and weaknesses of recent definitions/frameworks of famine (Howe and Devereux[2], Banik[3]), which involved gradation or scales, were discussed. It was suggested that scaling risks implies different, mutually exclusive, levels of famine. Also, the type of information included (malnutrition, mortality) may be difficult to gather, tended to be outcome focused or may only become available when the famine is well advanced. It was countered, however, that early warning mechanisms, as well as some aid agencies, have the capacities to collect timely key data. Alternative (qualitative) forms of criteria/indicators exist or could be developed for earlier stages. Even if certain data could only be obtained if/after a famine has occurred, it may still be used as a determination of accountability, for future advocacy and improved response.

Despite these issues, the concept of scale or gradation was deemed a useful one, since it includes the idea of a "threshold" which is crossed when a famine crisis occurs, and gives some focus to the process as well as the "event" of famine. Indicators that point to the likelihood of a famine were considered necessary, so that preventative steps may be taken. However in reality, it was considered difficult to mobilise resources for "prior stages of famine" and donors will need to be convinced that "something special is happening". Critical to a definition is how, and who, will determine that the "threshold" has been crossed?

Workshop conclusion

An operational definition was not agreed at this meeting, but key attributes of a definition were, with suggestions for taking the process forward.

Given the high levels of emergency situations and crises, an operational definition was considered a matter of extreme importance. Consensus building was necessary to approach a common position amongst stakeholders and with significant input from donors early on in the process. Gaps in the process as it stands need to be identified, with action points, eg conducting regional case studies on famine threshold issues.

The workshop was deemed successful in gaining operational insights into academic frameworks that are being generated, and giving momentum to taking the process forward through a wider consultation with stakeholders and decision-makers.

For further information, contact Stephen Devereux, IDS Sussex, University of Sussex, Brighton, UK. Email: S.G.Devereux@ids.ac.uk

[1]Report and minutes of "Operational Definition of Famine Workshop" IDS Sussex, Friday 14 March 2003

[2]Howe, Paul and Devereux, Stephen, 2002. Notes towards an operational definition of famine. Mimeo: Institute of Development Studies, Sussex.
[3]Banik, Dan, 2002. Democracy, drought and starvation in India: Testing Sen in Theory and Practice, PhD thesis submitted to The Faculty of Social Sciences, University of Oslo. (Chapter 3: Refining Sen (1):Operational definitions of famine and related terms)

Technical consultation on Emergency Needs Assessment

Summary of proceedings of meeting[1]

The World Food Programme (WFP) initiated and organised a technical consultation on emergency needs assessments (ENA) in Rome between 12-14th of March 2003. The meeting was funded by UK-DFID[2] in the context of its 'strategic partnership' with WFP. The technical consultation was principally facilitated by an ENN member of staff. The meeting was unique in that it brought together a large number of donor agencies (users of ENA) and non-governmental organisations (NGOs) that conduct assessments (producers).
The goal of the meeting was to strengthen partnerships in preparing sound, credible and comparable emergency needs assessments (ENAs) and ensure relevance to food aid decision-making.

More specifically, the meeting aimed to:
◆Strengthen the ENA process by increasing the understanding of how and why ENAs are implemented and the needs of information users.
◆ Identify and define capacities, competencies and challenges
◆ Strengthen linkages between ENA and other stages of the project information cycle: baseline data collection, early warning, monitoring and evaluation
◆ Explore scope for more partnerships and complementarity in conducting ENAs.
The focus was on food crises arising from natural disasters, conflict/displacement (complex emergency) and market-induced emergency. In fact, discussion was largely dominated by considerations relating to major slow-onset food crises, with particular focus on the current situation and operation in Southern Africa.

Weaknesses seen by donors in assessment and related agency proposals, included inadequate details on affected people and needs at sub-national levels, not enough specifics on methods, sources and actual need (submissions are mainly descriptive), recommendations not always linked to analysis, and objectives not specific enough (no clear overall intervention strategy).

The following general points emerged from the short presentations made by the representatives of UK-DFID, USAID[3], EuropeAid and the Netherlands:
◆ There are inevitable difficulties when different agencies provide different figures for numbers of people and/or food requirements for the same areas, and it is difficult to compare 'needs' and establish priorities between countries.
◆There is widespread concern among donors that food aid needs are sometimes over-estimated, while the potential for other non-food aid interventions is not adequately examined – assessments focus too narrowly on food aid, and the currently assessed needs for food aid are 'overwhelming'.
◆Donors' confidence in assessment findings and associated recommendations depends largely on the reputation of the agency (or individual), the demonstrated use of a recognised methodology and, to a lesser extent, evidence of community involvement.

Working groups discussed a number of topics including:
◆ comparability and minimum data sets
◆ regional approaches and the roles of governments and regional bodies
◆ lives/livelihoods and distinguishing between acute and chronic needs
◆ markets and the roles of the private and public sector
◆ principles and competencies for ENA.

The main recommendations to come out of the meeting were as follows:
Market and macro-economic aspects need more attention, but the methodologies and capacities for more in-depth investigation of these areas are lacking within the humanitarian aid community. Other organisations with relevant expertise (e.g. IFPRI[4] , World Bank) need to be involved.

There can be no standard methodology for all ENAs in all situations, but standards for ENAs need to be established and, if possible, criteria for choosing appropriate methodologies in different types of situation.

Whenever possible, the government and humanitarian agencies (UN and NGO) should agree on a methodology appropriate to the local situation and then work together on joint or complementary/coordinated assessments, using the agreed methodology, covering all potentially needy population groups. In situations of conflict and contested governance, agencies should assure coordinated assessments independent of the national and other local authorities.

National capacities should be developed, and regional coordination be encouraged.

On how to move forward….
Technical workshops should be organised as soon as possible to:
◆ develop the minimum information set for assessments/requests
◆ review possibilities for a minimum set of baseline information for disaster-prone areas and populations
◆ review outstanding technical issues and seek agreement on general principles in relation to sampling, distinguishing transitory and chronic food insecurity, assessing market aspects, and other issues that may be identified
◆ document good practice in assessment and analysis in different contexts, including the skills and other resources required
◆ examine options for non-food aid responses to food insecurity, and how to adapt assessment and analysis procedures to identify such options

Arrangements should be established for pre-assessment consultations among agencies and donors. (This could be extended to include more general assessment-related consultations among WFP, FAO and donors).

The process proposed by FAO and WFP to include donors and other institutions in reviewing and enhancing the CFSAM process should be supported.

E-forum(s) – email or Web based – should be established to continue the dialogue in relation to food-related emergency needs assessments and to facilitate follow up on specific technical and process issues.

Consideration should also be given to organising an evaluation of food security assessment approaches/methodologies – the similarities, differences, comparative strengths in different contexts, costs and the effectiveness of actions taken based on their recommendations, and the piloting by WFP and NGOs of market interventions and cash-based alternatives to food aid.

For further information, contact Marie France Bourgeois, WFP on email: MarieFrance.Bourgeois@wfp.org

[1] Based on draft proceedings. See contacts for more information.
[2] Department for International Development
[3] United States Agency for International Development
[4] International Food Policy Research Institute

Jeremy Shoham facilitates the workshop in Rome

ENN/GIFA project

Summary of presentation[1]

The Core Group[2], composed of UNICEF, UNHCR, WFP, WHO, ENN and GIFA/IBFAN have developed and disseminated module 1[3] on Infant Feeding in Emergencies. Module 2 is nearing completion, and has a greater technical component to support health and nutrition staff operating in emergency situations to assist mothers with infant feeding in emergency settings.

Between 16 and 17 April, 2003 a meeting was held by the Core Group[4], hosted by UNHCR, Geneva, to identify the key steps necessary to finalise the training modules. Presentations were made by ENN, on a recent collaborative project with GIFA to support the development of the modules, and by Professor Mike Golden, on the use of diluted F100 in infants under six months.

Key steps necessary to complete the modules were identified. The management of malnutrition in infants less than six months emerged as an outstanding issue which requires a wider consultation outside the Core Group.

In order to strengthen the development of the training modules, a project was developed between the Geneva Infant Feeding Association (GIFA) and the Emergency Nutrition Network (ENN) to evaluate the application of Module 1 to date, and to collate field experiences (in the form of case studies) of agencies involved in infant and young child feeding in emergencies to support module 2. Key findings were reported to the Core Group at a two day meeting (15-17 April, 2003) in Geneva, and key issues to emerge are summarised here.

Evaluation of Module 1

Information was collected through email and phone interview on the use of the module, its value and if there was a need to update/revise it. Four key user groups were targeted - the Core Group involved in the development of the training module, individuals who downloaded the material from the website, institutions involved in humanitarian training courses and key organizations involved in emergency nutrition interventions.

Since April 2001, over 1000 sets of module 1 training material have been disseminated to agencies and institutions. The material had been used in both formal and informal training by agencies, institutions and individuals. The ENN site has proved a significant distribution mechanism. Overall, 158 individuals from 20 different countries, representing at least 12 different international organisations, have downloaded material from the site.

All sections and training modules were used to varying degrees. However there was a call for more detail on supporting appropriate feeding practices, more focus on complementary feeding issues and more guidance on the challenges of infant feeding and HIV/AIDS. More case studies were also requested, with more updated information on recent or current emergencies and situations, e.g. displacement of large numbers of unaccompanied children.

Although module 1 was devised for non-technical staff, technical staff, e.g. health and nutrition workers, largely used the material. Those contacted felt the material could be marketed and targeted better. Some were not aware that the material was still available, while others felt it would be worthwhile investing in training of trainers to realise the full potential of the module.

The majority felt that translation would be premature until the modules had been finalised, however material had already been locally translated into Arabic, Spanish and Portuguese.

Based on this evaluation, it was recommended that the necessary steps to finalise module 2 should be taken. Both modules need to be appropriately marketed and targeted to emergency staff.

Field experiences

A variety of experiences and case studies were constructed. Experiences were gathered from staff currently working in a variety of countries, including Burundi, Liberia, Afghanistan, Sudan and Sierra Leone.

During the course of gathering field material, a number of issues emerged which were highlighted at the meeting.

First, a number of experiences touched on topics that were not extensively dealt with within the current draft of the training material. These particularly related to small scale (e.g. orphanage feeding) and large-scale (e.g. Iraq situation) interventions, where artificial feeding was a significant part of the emergency response.

Secondly, a critical issue emerged regarding the most appropriate management of malnourished infants less than six months – an area already identified by the Core Group as lacking in evidence. A number of field practices were identified, with individual experiences and effectiveness of interventions varying between countries and programmes. A comparative review was made of recommendations/field practice, to identify common ground, gaps, and conflicts, review the supporting evidence and determine the implications for the development of technical guidance within module 2. Protocols and practices from MSF (Afghanistan and Burundi), ACF (Afghanistan, Liberia, Burundi), Merlin (Sierra Leone), Concern (Bangladesh), and recommendations from MSF, ACF, WHO and the Ethiopian Framework for severe malnutrition were included.

Examples of specific differences between protocols and practice regarding infants less than six months included:

- Different supplementary milks used in addition to breastmilk, including F75 and F100, diluted F100, and infant formula.
- Various admission criteria, with permutations on weight and height criteria as well as reported age, medical and clinical criteria.
- Differences in discharge criteria, most significantly whether anthropometric targets were included or not.

The majority of guidelines (i.e. MSF, ACF) aimed to re-establish breastfeeding in the severely malnourished young infant, if necessary using supplementary suckling, and relied on breastmilk to achieve subsequent catch-up growth. In contrast, draft WHO recommendations for severely malnourished infants less than six months advise that breastfeeding cannot be relied upon for treatment. Supplementary milk (F75 during stabilisation, F100 during rehabilitation) is recommended by WHO before each breastfeed, which they feel is necessary to ensure the survival of the severely malnourished infant.

The evidence

Varying sources and levels of evidence supported current recommendations and practice. Most of the field activities and agency protocols that were reviewed have been guided by the ACF guidelines[5], developed on the basis of documented interventions in Liberia[6] and operationalised in many programmes since. In many cases, however, reported evidence based on programme experiences has not been fully documented, or has not been widely disseminated. Also, the context of emergency programmes has a significant influence on outcomes and is critical in interpreting effectiveness of interventions.

Evidence behind technical sources of guidance is also variable. The lack of substantial research in this area means that limited data may be given a higher credence than they merit. As it stands, there is scope for considerable confusion as to appropriate practice in the field. Conflicting recommendations may undermine the perceived value of guidance, and have a detrimental effect on the management of malnourished infants.

On the basis of this study it was recommended that artificial feeding of infants is addressed in greater depth within the technical guidance of module 2. It was suggested that resolution of issues regarding the management of malnutrition in young infants is critical, but requires involvement of a wider network of technical experts and practitioners outside the Core Group. An urgent consultation involving agencies active in the field and technical individuals/bodies is required to achieve consensus.

[1] Presentation, ENN/GIFA project, Marie McGrath, Core Group meeting, Geneva, 16-17 April, 2003
[2] A group of agency personnel committed to taking forward the process of improving practice in infant feeding in emergencies through the development and dissemination of appropriate training materials
[3] Infant Feeding in Emergencies, Module 1 for emergency relief staff. Draft material developed through collaboration of: WHO, UNICEF, LINKAGES, IBFAN, ENN and additional contributors. March 2001
[4] In addition to the Core Group members, also attending were Professor Mike Golden, Dr Andy Seal (Institute of Child Health, London), Rebecca Norton (Terre des Hommes) & Felicity Savage.
[5] Assessment and Treatment of Malnutrition in Emergency Situations, Manual of Therapeutic Care and Planning for a Nutritional programme. Written by Claudine Prudhon*, published by Action contre la Faim (2002)
[6] Field Exchange, Issue 9, Infant feeding in a TFP, MSc thesis, Mary Corbett, p7

'New variant famine' in southern Africa

Summary of presentation paper[1]

A paper, presented to a SADC[2] Vulnerability Assessment Committee (VAC) meeting in Victoria Falls in October 2002, has argued that the famine currently gripping Southern Africa during the era of HIV/AIDS may represent a new and unfamiliar kind of famine, with implications for new roles for international assistance agencies. The paper describes the commonly understood characteristics of so called 'normal' or 'old variant' famines and compares these with what is happening now in HIV/AIDS endemic areas.

'Normal' famines show a number of demographic changes. Mortality is overwhelmingly concentrated among the very young and the very old, and more men than women die. The number of births declines and there is a fall in the dependency ratio. There are also economic and livelihood components. Resistance to drought amongst rural small holders is established through diversification of activities and hedging against risk. Adult household members also learn a range of skills to enable them to resist drought. These include specialist knowledge about drought resistant seeds, how to enable animals to survive, etc.

Households develop a range of coping strategies which are designed to enable them to return to their former livelihood. These are different to 'survival strategies' which are designed to preserve the lives of its members, but at the cost of abandoning former livelihoods for ones that are less desirable and less productive. For example,

◆ adults cut back on their food intake and suffer the pangs of hunger
◆ people - predominantly women - use their expert knowledge of wild grains, berries and roots to gather alternative foods
◆ food stores are consumed and excess livestock are sold
◆ better-off relatives and friends are sought to provide support
◆ asset sales
◆ amassing debts
◆ casual labour and income generation
◆ seeking relief.

The success of these strategies is based upon several factors including, the level of assets that the household possesses, the dependency ratio in the household, social networks, and skills and experience, especially among women.

What has changed with HIV/AIDS?

The paper examines the effect of HIV/AIDS in terms of four phenomena:

◆'The double burden of care'
◆ The squeeze on adults
◆ Higher dependency ratio
◆ Lowered adult life expectancy

'The Double Burden of Care'

Rural Africa has borne the costs of supporting and caring for people living with HIV and AIDS in the rural areas, and also of those who had been employed in the formal sector.
The economic strategies of private sector and government institutions faced with the illness and death of employees has generally been to shift the burden by:

◆ Withdrawal of benefits, including health care, pensions etc.
◆ Outsourcing of services, shifting to subcontractors. By these means, a company is no longer obliged to provide for so many employees.
◆ Selective packages for the skilled, where key staff members may be given treatment and care packages while the less skilled are excluded.

The Squeeze on Adults

In 'old variant' famines, adults could live on one meal a day, growing desperately thin but still surviving and working, and making sure that their children survived. Adults who are living with HIV or AIDS, including those who are on anti-retroviral treatment, simply cannot go hungry. With their immune system compromised, cutting back consumption means they will fall sick with any number of diseases and be unable to work and care for children.

Higher Dependency Ratio

HIV/AIDS increases the dependency ratio. The premature death of adults means that fewer adults are available to support the same number of children, while 'well' adults may have to support sick adults within the household and from the extended family. This leads to a collapse in the labour endowment of the average household with the following consequences:

◆ a shift from high labour to low labour crops. This implies a decline in productivity and nutritional value.
◆ a reduction in marketing.
◆ high-input, high-return livestock (e.g. cattle) will be supplanted by those that require less labour but are less productive (e.g. goats).
◆ high labour, high return income-generating activities (e.g. craftwork, such as producing mats) will be supplanted by those that require less time and labour (e.g. commercial sex work).
◆ children will be called upon to work.

Furthermore, asset and networking strategies will become strained with their time limits becoming exhausted. After a while, households become locked into a downward spiral and abandon the prospects of 'bouncing back'.

Lower Adult Life Expectancy

HIV/AIDS has cut a decade or so off adult life expectancy in AIDS-afflicted countries, and more so in the worst affected. This has far-reaching impacts through reduced asset accumulation, costs of staff turnover, and loss of skills.

What happens when coping strategies break down?

In 'normal' famines where coping strategies remain intact, mortality may rise from a baseline of 15 per 1000 per year, to 30 or 40 per 1000 per year. In situations where there are no coping strategies left, we may see that rarest of phenomena – mass starvation. This kind of famine has never occurred in peacetime in Africa in recent history. According to de Waal, famine is displaying new characteristics, rarely seen before and which he describes as 'New Variant Famine'.

Implications for assistance

If correct, this analysis has far-reaching implications for international assistance to the famine-afflicted societies in southern Africa. Massive aid will be needed, and may require long-term welfarism, since the problem will not be resolved when the rains come. Interventions will need to include adults, not just children.

This new kind of famine will require new, improved monitoring tools. For example, dependency ratios are likely to be a major predictor of vulnerability, and adult mortality and nutritional levels should be measured as well as child nutritional levels.

Finally, strategies for rehabilitation, recovery and development will need to be carefully designed in the context of limited labour supply, lowered adult life expectancy, and the limited capacity of institutions.

[1]New Variant famine in southern Africa. Presentation for SADC VAC meeting, Victoria Falls, 17-18th October, 2002. Alex deWaal.
[2]Southern Africa District Committee (SADC)

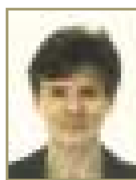
FAO funded fodder distribution for elderly beneficiaries living in rural areas, Serbia.

Margie Rehm

Better understanding vulnerability in Serbia

The breakdown of traditional family support had increased the vulnerability of the elderly

Margie Rehm



By Kate Ogden

Since July 2000, Kate Ogden has been a food security advisor in ACF headquarters, Paris. Previously she spent three years working in food security and nutrition with ACF in Sierra Leone, Liberia, Chechnya and Kosovo.

The significant contributions of Yuve Guluma, Carole Lambert, Isabelle D'Haudt and Margie Rehm to the experiences of this article, and the work of the Serbia programme team, are gratefully acknowledged.

This field article describes ACF's experiences[1] in Serbia where vulnerability assessment findings were used to inform, and hopefully influence, activities and social policy at a local and national level in Serbia.

Action Contre la Faim's (ACF's) mandate is to tackle malnutrition, especially in situations where food security is threatened by man-made actions - situations of war, economic crisis, or civil unrest - or by natural catastrophes. This was the basis of ACF's decision to intervene in Serbia in mid-1999, with possible areas of intervention including supporting refugees, the displaced, minority groups, and vulnerable Serbians, assisting in reconstruction, and the re-launch of economic activities in the most vulnerable zones.

In the early 1990's, the socio-economic situation in the Former Republic (FR) of Yugoslavia, traditionally based on industry, mining and agricultural activities, began to deteriorate. The difficult transition from being a Communist state in 1991, was subsequently followed by a disintegration of the FR of Yugoslavia culminating in war in Bosnia and Herzegovina. There was alleged mismanagement of state funds, large numbers of refugees and displaced persons in the country and declines in agricultural production. The situation reached its climax at the end of the 1990's, with the 1999 Kosovo crisis and NATO (North Atlantic Treaty Organisation) intervention.

When the current Serbian government was formed on 25th January 2001 (democratically elected and internationally recognised), it inherited a country ravaged by war – a bankrupt state, devastated economy, dilapidated institutions, limited civil confidence, and a suspicious international community. Despite the government's programme of economic reforms, the unemployment rate rose by almost 50%, bringing with it a significant decrease in official incomes and growth of the 'grey' or 'informal' economy. The latter became the means of subsistence for the larger part of the population, with at least one million people engaged in this volatile sector either on a full or part-time basis.

Yugoslavia's complex social welfare system, operating through Centres for Social Work, nominally provided services for destitute persons and families, physically and mentally handicapped persons, 'broken' families, alcoholics and drug addicts, and elderly persons without relatives to care for them. Social welfare was paid to families earning income below the level of social security (so-called MOP[2]), others were eligible for child allowance, maternity benefits, foster family allowance, disability allowance and placement in a social welfare institution. In 1986, around 3% of the population received services from this system. During the economic crisis of the 1990's, the number of users decreased due to low and irregular payments such that the system effectively became irrelevant as a coping mechanism for the poor.

Vulnerability assessment

Programme activities - providing complementary food and non-food items to social institutions and subsequently, the wider population - meant that ACF soon became very familiar with the social situation in the country. All of the interventions adopted the Ministry of Social Affairs' social welfare categories for the 'needy', focusing particularly on MOP and institutionalised beneficiaries. However, through programme monitoring and additional surveys, ACF found that categorisation of eligible beneficiaries in this manner did not always best accord with those suffering from food insecurity. To better understand vulnerability, ACF undertook further investigations which culminated in a vulnerability assessment towards the end of 2001.

The main objectives of this assessment were:
- to identify sub-categories within or outside of the social groups already recognised and assisted by the Serbian Ministry of Social Affairs
- to identify who, amongst these sub-categories, were the most socio-economically vulnerable
- to assess if special programmes addressing vulnerable group needs would be required, in addition to the anti-poverty measures that the Ministry was planning to initiate.

It was recognised that the findings of the assessment needed to be effectively used and shared with organisations active in Serbia, as well as the Ministry of Social Affairs.

The study period ran from November 2001 to April 2002. A participatory methodology was used, supported by secondary data sources for orientation, to help determine trends and ranking of the most vulnerable socio-economic groups, as well as provide indicators of their vulnerability.

Key informant interviews were held to identify vulnerable groups and refine types of questions and issues for discussion. Four round table discussions were organised with key informants from academia, government, non-governmental organisations (NGOs), and civil society. These meetings worked at developing indicators of vulnerability for the four vulnerable groups identified during the preliminary stages of the assessment. They also examined ways of registering vulnerable households so that assistance could be effectively channelled to them through local, national, and international structures.

Focus group discussions were held to collect information on the social and physical environment of vulnerable groups and to assess the level of community support provided.

Individual household interviews were conducted in fifty randomly selected households for each vulnerable group, using semi-structured interviewing techniques to collect qualitative and quantitative information.

A novel aspect of the methodology was to

involve indirectly the municipalities and control groups. This involved a detailed community questionnaire, sent to every municipality in Serbia in an attempt to collect and map information on differences in socio-economic infrastructure between municipalities and communities. The aim was to locate the whereabouts of vulnerable groups in the overall population, as well as to compare local authority perceptions of different vulnerable groups. The community questionnaire also provided an opportunity for local community representatives to contribute to the formulation of programme recommendations (data from 76 municipalities and 442 local communities were analysed).

Two control groups, comprising thirty families registered for social support (excluding Roma, single female-headed and isolated rural households), and thirty 'average[3]' Serbian households were interviewed. All information from these sources was cross-checked.

Vulnerable groups

The assessment findings identified six vulnerable socio-economic categories in Serbia. Some of these fell within the existing social welfare criteria but were not distinguished as a separate group.

Single female headed households

Women did not have equal entitlements to men with respect to job opportunities, pay, ownership of real estate and decision-making positions in government and the business sector. The period of economic crisis had widened the gender gap and this category was generally stigmatised by society. Opportunities for obtaining employment, already limited and primarily in low-paid or unskilled jobs, were even lower for women over 35 years of age or if they had school-aged children.

Roma

This group remains one of the most vulnerable groups in Serbia, based on indicators of standards of hygiene, health, food, education, employment, shelter, etc. The low educational level of the Roma meant they had little employment, or worked in low-paid and unskilled jobs in the informal or formal labour market.

Refugees

There were approximately 400,000 refugees from Croatia and Bosnia Herzegovina who lived in absolute poverty and had been hit much harder by the economic crisis than the general population. They had limited access to land, credit, and social assistance and those who worked were usually involved in 'grey' economy activities. Major donor agencies and international organisations were planning to reduce their assistance to refugees in the coming 12 to 24 months. This was anticipated to have a significant impact on refugees and other vulnerable groups who currently relied heavily on this assistance.

Elderly Rural Agricultural Households

In addition to average pension payments being low (the rationale for which was based on the assumption that these households were capable of working and were self-sufficient through agricultural production), payments were irregular for more than a year. Health costs, late pension payments and exclusion from grey economy activities (due to the age barrier) had increased the vulnerability of elderly households. The breakdown of traditional family support, due in part to the migration of youth and working adults from rural areas to urban centres, had increased the vulnerability of rural elderly households.

Internally Displaced Persons (IDPs)

There were approximately 200,000 IDPs, mostly residing in Central Serbia and originating from Kosovo. Approximately one-quarter of IDPs were living below the lower poverty line and were particularly affected by the economic crisis. Many IDPs had difficulties obtaining work documents showing a valid termination of employment from their former employer (which would enable them to register for employment benefits). Perceived comparative advantages (some well-founded) of IDPs over refugees in regard to access to job opportunities, social welfare, property claims, and unemployment benefits, had led to neglect of this group. Of particular concern were the Roma IDPs, since a large number had been left out of the official registration process due to lack of documentation. The majority of Roma IDPs, rejected by residents of collective centres, local communities, and unassisted by municipality authorities, tended to live in appalling conditions in 'cardboard cities' in separate parts of local Roma settlements.

Redundant Workers

It was difficult to assess accurately future trends in the socio-economic status of the Serbian 'unemployed'. The collapse of industry and the restructuring of the economy in Serbia were causing thousands of people hired by state companies and banks to lose their jobs. A social plan, adopted in March 2002 by the Serbian government, sought to protect the redundant workforce through the transition period.

Informing social policy

As a result of the assessment and in consultation with members of the identified vulnerable groups and key informants, ACF put forward a number of recommendations. The needs for each of the four main vulnerable groups: Roma, single mothers, isolated rural elderly and refugees, were defined in terms of urgent short-term needs, additional short-term needs and longer-term developmental needs.

Recommendations were made for social policy to emphasise specific reforms that could promote better social care of the most vulnerable, including recommendations for Ministry of Social Affairs and other ministries, as well as for Reform of National Social Laws & Policy and Reform of the Local Social Network.

Wide-reaching programming recommendations were also made for NGO and Local Association Level in the areas of food security/nutrition, water and sanitation, hygiene, training, advocacy and campaigning. The proposed activities ranged from fulfilling the most basic of needs, i.e. food, hygiene and shelter, through education and vocational skills development, to campaigning for women's rights and advocating for allocation of resources for medical home care.

Once the assessment report was completed, it was presented and disseminated in a number of ways. A principal aim of dissemination was that the report should be read by all key national players in the Serbian social field (ministries, donors, World Bank 'Poverty Line Assessment', NGOs) and used as an element in programming and resource allocation decisions, including the design of a new social welfare system.

The Ministry of Social Affairs endorsed its conclusions before it was disseminated to bilateral donors. There was a presentation of key results at the 'Princess Katarina' meeting, a forum for humanitarian and social agency actors. The assessment was posted on the ICVA site[4] and a detailed presentation and discussion was held with humanitarian actors. The document was received positively at the various presentations, giving a strong indication of the utility of assessment.

Promoting social change

Arguably the reason why such analysis had not been carried out previously was that criteria for vulnerability were already clearly defined by the government and were being used for targeting humanitarian assistance. There was, therefore, reluctance to re-visit a vulnerability analysis, coupled with the political implications of doing so. Previous macro-level analyses focused on economic indicators of development, creating a false homogeneous picture of poverty in Serbia and obscuring the true picture of vulnerability as determined by social, cultural and geographic factors.

Vulnerability in Serbia remains fluid and volatile and will partly depend on social and economic trends during this transition period. Positive developments in job creation, unemployment benefits, increased social assistance, recognition of socially excluded groups, targeting of the most vulnerable households, successful economic and social reforms, and funding for programmes, will all play a major role in the fight against poverty in Serbia. The system inherited from the previous government has many faults and has neglected to identify hidden poverty. Hopefully, current and future reforms, along with political will, should create mechanisms for improved identification and targeting of those in the population with special needs and will aid in the development of appropriate programmes addressing these needs and the social complexities associated with them.

However, although these needs are considerable, they pose no direct threat - outside of a high level of poverty - to the overall food security of the Serbian people. Since a key aspect of ACF's mandate is to tackle food insecurity of populations, the decision was taken to phase out of Serbia but not without ensuring maximum dissemination and understanding of the assessment, and in particular highlighting the existence of the hidden vulnerable. The degree to which the assessment findings are acted upon remains to be seen but the involvement of the Ministry and municipalities during the survey gives the results and recommendations an added value, credibility and 'ownership'.

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[1]Vulnerability Assessment in Serbia (excluding Kosovo). Identification of vulnerable socio-economic categories with special needs. ACF Mission in Serbia. May 2002
Vulnerability Assessment: Belgrade, Kraljevo and Nis, Serbia (excluding Kosovo and Metohija). ACF, May 2001

[2]MOP : Materijalna Obezbedjenje Pomoc, or Financial Aid for Social Cases

[3]It was extremely difficult, (due, in part, to the grey economy) to delineate socio-economic classes in Serbia. In between an elite and well-off minority and an extremely poor population, there was an apparent homogenous middle grouping (i.e. no recognised distinct middle, lower middle, or upper middle class). Therefore, the term "average" was used to define a stratum of the population, which were not considered poor but perceived as having a living standard considered to be "normal" at that point in time.

[4]International Council of Voluntary Associations

Margie Rehm

Activities included fulfilling basic food needs

Sixty years of Oxfam

Interview by Jeremy Shoham.

Name	Oxfam GB
Address	Oxfam House, 247 Banbury Road, Oxford OX2 7DZ, UK
Telephone	+44 (0)1865 312610
Email	oxfam@oxfam.org.uk
Internet site	www.oxfam.org.uk
Year formed	1942
Director	Barbara Stocking
UK volunteers	approx 23,000
HQ staff	approx 700
Overseas staff	approx 800 international, 1,500 locally recruited
Annual income (2001/02)	189.4 million

Nick Roseveare (Deputy Director of the Humanitarian Department) and Susanne Jaspars (Food Security and Nutrition Co-ordinator) were interviewed for Field Exchange at Oxfam's headquaters in Oxford. Nick has worked for Oxfam for 15 years with ten years posted in Africa and five years at headquarters. Susanne has only recently joined Oxfam in her present post but has worked for Oxfam in Darfur in 1989-90 and been involved in Oxfam evaluations in Turkana and Red Sea Province in the late nineties. She was also Food and Nutrition advisor at headquarters for ten months in 2000.

Oxfam evolved out of a small action committee of Oxford based academics, church activists and Quakers who got together to raise funds for emergency relief during the allied blockade of Nazi occupied Greece in 1942. The Greek population were suffering appalling food shortages and high levels of malnutrition. Oxfam quickly realised that what was most needed was a change in Government policy to allow urgently needed food supplies to pass through the Allied blockade. Their lobbying helped to bring this about. As Nick pointed out, this shows how Oxfam was dealing with the complexities of relief and military conflict from its inception. Their development agenda came later.

Nick talked about critical moments in Oxfam's history. Biafra, which was very much a man-made famine, presented the challenge of attempting to provide relief without fuelling the conflict and at the same time, maintaining a perception of impartiality. Another pivotal moment was Cambodia/Kampuchea where Oxfam rapidly implemented and managed a large-scale water and sanitation (WATSAN) programme and imported substantial amounts of rice to meet acute food shortages after the overthrow of Pol Pot. WATSAN interventions have remained a specialist area of intervention for Oxfam who have continued to maintain a high profile in this sector.

The Sudan/Ethiopia programmes, following the 1984 famine, were also turning points. The scale of these programmes, involving resident populations, was far larger than any previous interventions and marked the growth of Oxfam activities in the horn of Africa. This was followed by the Great Lakes emergency in the wake of the genocide in Rwanda and work in the politically charged Goma refugee camps. Nick described this as a period of 'Oxfam's loss of innocence'. After ten years, during which the highest profile and most organisationally demanding responses were related to dealing with natural disasters, Oxfam (along with the entire humanitarian community) were suddenly plunged into the political and moral maze of refugee camps harbouring large numbers of ' genocidaires' with questions of 'who to feed' – flagging the importance of the separation of humanitarian and political roles. The experience showed how Oxfam could successfully 'scale up' at speed and provide a technically rigorous programme. However, there was a huge cost as the efforts stretched the organisation to the full and meant that other activities/programmes were less supported.

Bosnia, Kosovo and Afghanistan continued to pose complex challenges, especially in terms of the overlap between humanitarian and military action. Co-option of the humanitarian agenda and loss of humanitarian independence were constant threats and Nick admitted that Oxfam might have made some poor compromises. 'In Kosovo, Oxfam were probably unwittingly co-opted into the political agenda".

Shailan Parker/Oxfam

Gujarat, India 2002.Cash for work: workers, usually a group, gets paid 100 Rupees per bras-ie a square 10ftx10ftx1ft deep. The dug out area creates a shallow pond, and the earth is piled up to make an embankmet; both these will help to conserve soil and water when the drought breaks.Oxfam's cash for work programme is enabling many families to survive.

Susanne explained how there are currently four food and nutrition advisors based at headquarters, as well as two regional food and nutrition advisors. There are also five nutrition humanitarian support personnel (HSPs) who spend most of their time in the field, for anything up to 6 months, to support programmes. They undertake a variety of activities including assessments, establishing programmes, technical support in-country and programme management. In the seventies and eighties, Oxfam's primary nutritional activities were selective feeding programmes and nutritional surveys. In the eighties, Oxfam also became involved in general food distribution. Selective feeding programmes were carried out by Oxfam health staff, nutritional surveys by nutritionists, and general food distribution by programme managers. This was followed by a period in the early nineties when WATSAN became more prominent.

In the early 1980s, the health unit produced a practical guide on selective feeding and also the widely used Oxfam feeding kits. At the same time, nutritionists in the field were using a broad approach to nutritional surveys, which included an analysis of the underlying causes of malnutrition.

Involvement in food distribution in the mid-eighties was the first time that Oxfam promoted food aid for livelihood support, in this case 'food for recovery' in Red Sea Hills in Sudan. The late 1980s and early 1990s was also a period when Oxfam began implementing community based food distribution in South Sudan, Uganda, and Kenya.

Gradually Oxfam renewed its focus on food and nutrition, following the appointment of a food and nutrition advisor in 1996 in the humanitarian department. Discussions with Oxfam's policy department, and experience in the field, consolidated thinking around food security and livelihoods programming which led to Oxfam's livelihoods approach to food security in emergencies. This includes assessing risks to livelihoods as well as to lives, and combining a variety of food security interventions to ensure adequate access to food and to protect livelihoods.

In 2001, Oxfam commissioned a year long review of its response to food crisis which culminated in new guiding principles for response to food crisis. The impetus for the review was recognition of the changed internal and external environment, i.e. a large increase in the size and variety of Oxfam's food and nutrition programming, and the changing nature of emergencies and donor practices. The new guiding principles (see box) reflect Oxfam's increasingly confident assertion of a livelihoods approach to food crisis. Two key aspects of this policy were i) Oxfam would consider a range of food security and livelihood interventions tailored to the severity of food crisis and how livelihoods are affected, and ii) Oxfam would move out of therapeutic feeding and wet supplementary feeding by establishing Memoranda of Understanding (MOUs) with other agencies who could pick up these types of programme in emergency situations. As Nick reflected, " it is difficult to leave specialist sectors behind but the fact that we can is perhaps a measure of Oxfam's confidence and maturity". Oxfam have recently piloted an MOU for therapeutic feeding with ACF in the Red Sea Province.

Susanne explained that a lot of her team's work involves implementing the new guiding principles for response to food crisis. The food and nutrition team is currently developing guidelines on food security assessments, cash for work, livestock interventions in emergencies and food distribution programmes. She is also forging closer links with the livelihoods team in Oxfam's policy department. One of the first activities will be a short briefing paper on how Oxfam's activities in food crisis, market access and fair trade fit together to address livelihood insecurity.

Nick believes that one of Oxfam's strengths is that it is a 'thinking' agency. However, he also believes that this tendency to deeper analysis can create conflict and lead to problems of balance. "As Oxfam's understanding and analysis of humanitarian need becomes more sophisticated and incorporates principles like impartiality, codes of conduct, vulnerability reduction and gender awareness, there are inevitable costs in terms of intervention speed and scale" - "the best jewellers take months to fashion a quality gem, but often what is actually needed is the High Street jewellery store – quick and easy". Nick felt that they got the balance in Gujurat wrong as "Oxfam wanted too comprehensive and integrated a response which meant that they tried to do too much and this simply became unmanageable in a rapid onset emergency".

Advocacy is another area where Oxfam exhibits strengths and weaknesses according to Nick. "Oxfam are hugely influential and have, for example, addressed the Security Council on several occasions. Our influence has grown even more since the inception of Oxfam International. However, there is often a conflict between speaking out and consequences for humanitarian action on the ground. This is not always an easy tightrope to walk".

Nick explained how the intrinsic ethos for most people who work for Oxfam is the need to address both poverty and suffering, and to address the causes of both. Clearly, this creates programmatic tensions within the organisation and some degree of 'schizophrenia'. Staff are, however, passionate about their work. "The roots of the agency were (and still are) in campaigning – originally about food needs in Greece. This has been a continuing theme. The annual Oxfam 'fast' has run for decades, while the 'Hungry for Change' campaigns and 'Grain of Hope' food shipments to Africa were activities in the 1980s and 1990's respectively. Oxfam is still a movement of people. It has over 23,000 volunteers with a constituency of approximately 700,000 people giving more than two pounds a month through direct debit. Many of Oxfam's activists are high profile people, e.g. Chris Martin (lead singer of ColdPlay) sports a 'fair trade' tea shirt on gigs'. Although Oxfam is renowned for its high street shops and these provide a major public 'face' of the organisation, much of the considerable income generated by these outlets is absorbed by the high level of overheads in the retail sector, and fundraising has moved on to develop other areas. A major source of Oxfam income is now individual members of the public who give small but regular amounts (some also give a great deal) and are the key to Oxfam's stable resource base.

With some prior knowledge of Oxfam and the benefit of these two interviews, I found myself reflecting on the significant contributions that Oxfam has made over the past 60 years in the humanitarian sector, and in particular to practice in the emergency food and nutrition sector. There is a unique culture within the organisation – especially with regard to the depth of analysis. However, as with all agencies, Oxfam faces challenges and internal contradictions, which in part stem from the very things that make the agency unique.

Oxfam (GB) Guiding Principles for Response to Food Crises

1. Food crises are an acute cause of human suffering and the severest crises lead to excess deaths. Oxfam's humanitarian mandate makes it imperative that Oxfam acts.

2. Adequate food security and nutrition is of utmost importance to save lives as part of an emergency public health response.

3. Livelihood support is essential to help people achieve improved food security and nutrition both in emergency and development contexts, and to reduce vulnerability to food crises in the long term.

4. The effectiveness of response to food crises is improved by emergency preparedness.

5. The identification of appropriate interventions to respond to food crises should be based on an analysis of the nature and severity of food insecurity. This should include an analysis of vulnerable groups and of diversity (including gender) at all stages of food and nutrition programming.

6. Oxfam will focus its emergency food security and nutrition programming on non-food alternatives and general distribution of free food aid; areas in which it has a comparative strength. Where Oxfam has no comparative strength (in therapeutic feeding), it will support other agencies to respond.

7. There is a range of different interventions to respond to food crisis, both food aid and non-food alternatives. A combination of different types of interventions is frequently the most effective.

8. Commitment on the part of States affected by food crises, donors and the UN, is required to ensure that everyone's right to adequate food is met.

[1]The Guiding Principles for Response to Food Crisis comprises eight policy principles. In the full document, specific policy points are included under each policy principle, and guidance notes relevant to the principles and policy points are included at the end of the document. A separate Strategy Paper sets out how the Guiding Principles can be implemented. For more information about the Guiding Principles, contact Susanne Jaspars. Email: sjaspars@oxfam.org.uk

Infant Feeding in Emergencies Core Group Meeting, April 16-17 2003, UNHCR-Geneva.
Clockwise from left to right
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◆ Zahra Mirghani (UNHCR), ◆ Mike Golden (consultant)

People in Aid

Groupe Urgence Réhabilitation Développement (URD) in Afghanistan.
Clockwise from left
◆ Hugues Maury,
◆ François Grünewald and Charlotte Dufour,
◆ Christine Bousquet.

Technical consultation on Emergency Needs Assessment Rome between 12-14th of March 2003. Left to right
◆ Chris Leather (OXFAM), John Seaman (Save the Children)
◆ Hishan Koghali (IFRC), Tim Frankenberger (TANGO)

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On the cover
An SPF distribution point, Kombulcha, Ethiopia.
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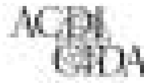

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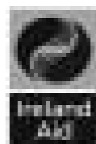

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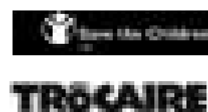

The Emergency Nutrition Network (ENN) grew out

of a series of interagency meetings focusing on food and nutritional aspects of emergencies. The meetings were hosted by UNHCR and attended by a number of UN agencies, NGOs, donors and academics. The Network is the result of a shared commitment to improve knowledge, stimulate learning and provide vital support and encouragement to food and nutrition workers involved in emergencies. The ENN officially began operations in November 1996 and has widespread support from UN agencies, NGOs, and donor governments. The network aims to improve emergency food and nutrition programme effectiveness by:

- providing a forum for the exchange of field level experiences
- strengthening humanitarian agency institutional memory
- keeping field staff up to date with current research and evaluation findings
- helping to identify subjects in the emergency food and nutrition sector which need more research

The main output of the ENN is a quarterly newsletter, Field Exchange, which is devoted primarily to publishing field level articles and current research and evaluation findings relevant to the emergency food and nutrition sector.
The main target audience of the
Newsletter are food and nutrition workers involved in emergencies and those researching this area. The reporting and exchange of field level experiences is central to ENN activities.

The Team

Fiona O'Reilly (Field Exchange production editor) and Jeremy Shoham (Field Exchange technical editor) are both ENN directors. Between them Jeremy and Fiona have decades of experience working in the area of food and nutrition in emergencies.

Marie McGrath is a qualified paediatric dietician/nutritionist. She has an abundance of experience in emergencies, working previously with Merlin and carrying out research with SC UK.

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