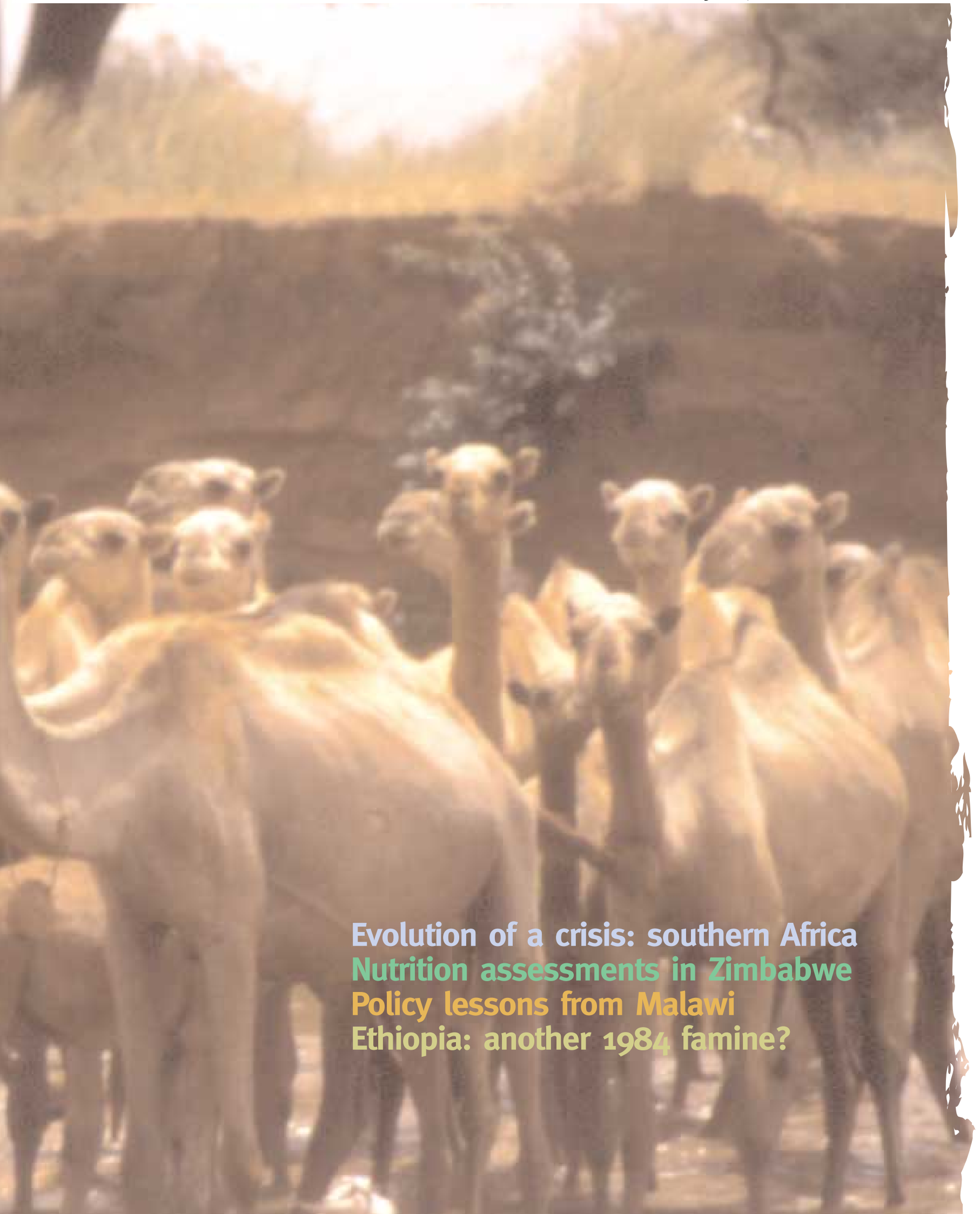


Field Exchange

Emergency Nutrition Network



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Editorial By Fiona Watson

Fiona Watson has been involved in assessment and evaluations of emergency nutrition and food security programmes for the last 10 years. She is currently a member of an ODI (Overseas Development Institute) team involved in critically reviewing needs assessment practice and its influence on resource allocation.

The politics of humanitarian needs and how needs are currently assessed are two main themes of this edition of Field Exchange. George Kararach, in his article on nutrition assessments in Zimbabwe, emphasises the political nature of the crisis in Zimbabwe and how this in turn has impacted on the way in which assessments have been conducted and interpreted. He argues that technical considerations have, in some instances, been swept away in favour of pragmatic political considerations, and he describes how the government and humanitarian community are sometimes at odds because of their differing agenda.

Zimbabwe is one of the countries affected in a far wider crisis currently hitting southern Africa. The article by Mark Wright on the evolution of the southern Africa crisis describes how, despite evidence of a deterioration in food security, the response of donors and national governments was initially sluggish. Only after intensive lobbying, and a nutrition survey which showed a large increase in global malnutrition in one district of Malawi, were the governments of Malawi and Zimbabwe willing to declare an emergency and donors prepared to react with humanitarian aid. The article highlights the fact that 'hard' evidence based on malnutrition is often required to convince the humanitarian community to act.

The article by Gaelle Fedida of MSF France also challenges how the humanitarian community defines and prioritises need, but from a different perspective. The article contrasts the case of Angola, which has very high levels of malnutrition and mortality, with southern Africa where malnutrition and mortality rates have generally not yet risen above 'normal' levels. Yet, the 'new' emergency in southern Africa has received much more donor attention and money than the 'old' emergency in Angola. The article raises an important point - that there is a global mismatch between absolute needs and the focus of donor attention.

The inequity in the allocation of humanitarian aid is the subject of various current research projects which have yielded startling statistics. For example, one recent paper¹ notes that in the year 2000, South Eastern Europe received \$185 per person compared to \$87 per person in the Democratic Republic of Congo, and less than \$50 per person in Sudan, Angola, Burundi, Sierra Leone, Tanzania, North Korea, Somalia, Tajikistan, Uganda and Guinea-Bissau.

The 'humanitarian imperative' demands that people have a right to aid whatever the reason for their plight, whether it is as a result of environmental disaster, poor governance, chronic poverty, conflict, a disease such as HIV/AIDs or any combination of these factors. As the MSF article stresses, humanitarian needs should be assessed independently, and there is a clear need for easily accessible, comparable data to increase transparency and accountability across the humanitarian system. This would lead to greater equity in response, or at least would highlight inequities.

The need for comparable data raises the question of which indicators are universally comparable and

appropriate? There has been a call to compare the rates of malnutrition and mortality in different contexts (e.g. by USAID). However, by the time malnutrition and mortality rates have risen, it may be too late to prevent a catastrophe. What is needed is agreement on early indicators of deterioration in food security and other causal factors for malnutrition, which can be used in needs assessments. Currently, several methods have been developed to assess food security. Generally, these are agency specific and have different objectives.

One of the best known methods is the Household Economy Analysis (HEA) developed originally by SCF-UK. The field article by Sonya LeJeune and Julius Holt describes how the HEA was used in Burundi to assess food aid needs for WFP. Although HEA assessments may identify the need for a range of responses, they have mainly focused on food aid needs. The method relies on qualitative data collection and assessors require a high level of training. Furthermore, nutrition data are not collected as an integral part of the HEA though surveys may be conducted simultaneously. The HEA method, therefore, is not easily replicable and doesn't necessarily link food security and nutrition information.

The Nutrition Causal Analysis (NCA) approach to assessment bears many similarities to the HEA approach. Both rely on qualitative, participatory data collection techniques, include some form of wealth ranking and rely on participants to make quantified estimates. The field article by Paul Rees-Thomas describes how the method was used in Mandera, Kenya to understand the causes of malnutrition from the population's perspective. The article highlights how this information can be used for advocacy purposes. Again, the method relies on a high level of training and does not directly link food security and nutrition information.

An innovative approach to needs assessment has been used in southern Africa and is mentioned in the articles by both Mark Wright and George Kararach. The emergency assessments were carried out in all affected countries of southern Africa by the Vulnerability Assessment Committee (VAC) in August 2002, and again in November/ December 2002. These assessments have integrated an analysis of household economy, coping strategies, dietary intake, agricultural inputs and nutritional anthropometry. The assessments are unique in their vast coverage and in the fact that they have been carried out by a group of UN agencies, NGOs, the Red Cross and others working collaboratively. Although the assessments have suffered from methodological weaknesses, they represent an attempt to improve needs assessments and so accountability and transparency in the humanitarian system. This type of initiative could help to reduce global inequities in humanitarian aid, and improve the quality of needs assessment information.

¹ Financing international humanitarian action: a review of key trends. HGP Briefing Number 4, November 2002. Overseas Development Institute (ODI).

erratum

The article in Field Exchange, November 2002, Issue 17: Scurvy outbreak in Afghanistan: An investigation by ACF and WHO, by P. Leborgne, C. Wilkinson, S. Montebault and MT Ververs draws heavily on the field report "Investigation and response to scurvy outbreak in 2 districts of Ghor province, Afghanistan (9 - 18 March 2002)" which was written by Sylvie Goossens, ACF, Yon Flerackers and Zita Weise Prinzo, WHO. The article printed in Field Exchange 17 did not adequately acknowledge the principal investigators, who wrote this report.

Field Exchange would also like to acknowledge the team members in charge of the investigation in Taiwara and

Chagcharan districts, Ghor province, Afghanistan: Dr. Yon Flerackers, epidemiologist, WHO Afghanistan; Dr. Abobkar Rassouli, National Health Coordinator, WHO, Herat, Afghanistan; Dr. Sylvie Goossens, Action Contre la Faim, Taiwara Center, Taiwara district; Dr. Naser Ahmad, Action Contre la Faim; Mr. Abdorahim Turkmanan, nurse, Herat Hospital MOPH, Herat, Afghanistan; Mr. Shiragar Naib, nurse, Herat Hospital MOPH, Herat, Afghanistan; Mrs Zita Weise Prinzo, nutrition department, WHO Geneva; Mr Gregg Friedman, general coordinator, Medecins du Monde, Chagcharan district.



Women and Children
Nutrition Centre, Khulna

Sphere standards in Bangladesh flood response

Summary of research¹

During 1998, Bangladesh experienced floods that were unprecedented in their scope, duration and the damage they caused. Although seasonal flooding is quite normal in Bangladesh, the unusual combination of excessive run-off from Himalayan snowmelts, heavy rainfall and particularly high tides in the Bay of Bengal conspired to cause abnormally severe flooding. Between late August and the end of September 1998, approximately 100,000 square kilometres (68% of the country) was flooded, with flood conditions lasting an average of 65 days.

Over thirty million people were affected by this disaster, and more than one million people were displaced to government shelters. In response, 163 local, national and international non-governmental organisations (NGOs) distributed relief items, including food aid, water purification tablets, clothing and medicines, to 2.4 million Bangladeshi families. A recently published study set out to evaluate whether the nutritional interventions during this response met Sphere minimum standards for emergencies.

A sample of fifteen agencies were analysed (two bilateral organisations, one United Nations (UN) body, one government agency, eight international NGOs and three local NGOs). Two questionnaires were administered to each agency. One was qualitative and focused on intervention criteria, rapid needs assessment, acute-phase interventions, transitions and rehabilitative phase interventions, monitoring and evaluation, disaster preparedness activities and donor response. The second was quantitative, and attempted to obtain information on number of beneficiaries, total nutritional and food

expenditure, cash grant expenditure, rehabilitation expenditure, disaster preparedness funding, staffing and total disaster response expenditure. The performance of each organisation was evaluated against the 'Minimum Standards in Food Aid and Minimum standards in Nutrition', selected from the 1998 edition of the Sphere manual.

Of those agencies assessed, 83% targeted the most vulnerable groups and three-quarters (75%) of agencies performed some form of ongoing monitoring and evaluation. Methods for identifying vulnerable people varied from the simple to the sophisticated, depending on the agency involved. Half of the agencies assessed nutritional status before providing assistance. However, fewer than half - 42% in each case - collected beneficiary feedback on the intervention, monitored local markets for how the importation of new food sources affected local prices or businesses, or sought local participation in their relief efforts. One-third of agencies had an existing disaster preparedness plan. Only one agency had made an assessment of the impact of their response, despite the fact that many had participated in a 'lessons learned' workshop. It should be noted that conditions identified as pre-requisites by the Sphere project for application of the minimum standards were present in the Bangladeshi context, i.e. sufficient resources, access to affected populations and common goals amongst agencies.

One of the main findings of the study was that lower capacity agencies were less able to meet the Sphere standards, presumably because they lacked appropriately skilled personnel, technical capabilities, operational experience and access to resources. Only

the best funded were able to meet the majority of standards assessed. The authors of the study suggest that Sphere, as a potential co-ordinating framework, may be able to help address this issue by enabling agencies to share core competencies. A prerequisite for this approach is interagency planning and donor funding for the co-ordinating mechanism, as well as incentives for agencies to participate. One danger identified by the study authors was that, by insisting on minimum standards, smaller, less funded and lower capacity agencies might be discouraged from participating in disaster response.

Particular challenges facing Sphere implementation, the paper concluded, are those which require ongoing commitment of energy and resources. These include building avenues for local participation, disaster preparedness and mitigation, and developing tools for co-ordination of response and impact assessment. However despite these challenges, the authors argue that Sphere has further value in articulating a breadth and depth of technical standards in a way that is relevant and useful to an extraordinary variety of humanitarian disaster situations, and for a great diversity of agencies, organisations and individuals. By linking them to the humanitarian imperative, Sphere universalises these standards and focuses disaster response on the human dignity of affected populations.

¹ O'Donnell M.R, Bacos D, Bennish M.L (2002). Nutritional response to the 1998 Bangladesh flood disaster: Sphere Minimum Standards in Disaster Response. *Disasters*, Vol 26 (3), pp 229-241

Policy lessons from Malawi

Summary of report¹

In May 2002, ActionAid commissioned a piece of field research as a contribution to the debate in Malawi about the ongoing food crisis. The research aimed to contribute to a dialogue among stakeholders around interventions that will protect Malawian lives and livelihoods. Both short-term initiatives, specifically in the context of another poor harvest in 2002 and the possibility of an *El Niño* event in 2003, and longer-term strategies to generate sustainable livelihoods and reduced vulnerability to production shocks,² were considered. The research team included staff from the Institute for Development Studies (IDS) Sussex, ActionAid, the Agricultural Policy Research Unit at the University of Malawi, Concern Universal, and the Malawian CISANET (Civil Society Agriculture Network).

From January to April 2002, between 500 and 1,000 people died of hunger or hunger related diseases in southern and central Malawi. As with all famines, the explanations fell into two clusters: 'trigger factors' (livelihood shocks and response failures) and 'underlying causes' (factors that create vulnerability to livelihood shocks). Similarly, the famine, like others, may be viewed as the product of 'technical' and 'political' factors combined.

Trigger factors

The 'technical' explanation: The famine followed a sequence of unfortunate events, namely production failure, information constraints, a depleted food reserve, import bottlenecks and unaffordable high food prices. During February and March 2001, localised flooding in the central and southern regions triggered a food production shock. This reduced maize production from 2.5 million metric tons (MT) in 1999/2000, to 1.7 million MT in 2000/01, and created a national maize deficit of 273,000 MT. The magnitude of the food gap was underestimated by both the government and donors, primarily due to methodological errors (exaggerated forecasts of roots and tubers production) which over-compensated for the maize gap.

The Strategic Grain Reserve (SGR) had been sold, leaving the government and donors unable to implement food distribution programmes in good time. Transport bottlenecks caused fatal delays in the arrival of food imports, in particular, congested roads, the diversion of food trucks to Zimbabwe and Zambia, a train derailment at Beit Bridge and capacity constraints at Nacala and Beira ports in Mozambique. Because of limited supplies and food marketing liberalisation, maize prices rose from MK4/kg at harvest time (June 2001) to over MK40/kg (January 2002).

The 'political' explanation: The famine was caused by negative synergies between government and donor policies and practices. The International Monetary Fund (IMF) instructed the Government of Malawi to sell the SGR, in order to repay a debt of MK1 billion incurred by the National Food Reserve Agency during set up as a quasi-independent agency. The IMF insists, however, that it advised the government to reduce the SGR from 165,000 MT to 60,000 MT - not to sell it all.

Private traders profiteered from the sale of the grain reserve, by buying maize cheaply and hoarding it until prices rose, before reselling it for exorbitant profits. Donor-government relations were strained at this crucial time, because of donor allegations of economic mismanagement and governance failures. The donors delayed responding to the food crisis

while they obsessed with finding out what had happened to the SGR. If the grain was still in-country, it could be released onto the market. If politicians had profiteered from its sale, however, they should own up to this.

Underlying Causes

The underlying cause of the current food crisis in Malawi is the steadily increasing livelihood vulnerability of this predominantly rural population. Contributing factors include:

- intensifying pressure on land, accelerated by rapid population growth
- declining soil fertility associated with falling application of agricultural inputs
- strictly limited off-farm and non-agricultural income generating opportunities
- the HIV/AIDS pandemic, which is decimating the labour force and raising household dependency ratios
- government policies that favour urban populations and the business sector, including the commercial estates, to the relative neglect of smallholder agriculture
- economic liberalisation measures that have undermined farmers' access to inputs and eliminated consumer subsidies and food price stabilisation interventions.

The year 2002 was widely perceived as worse than the more severe drought of 1991/92, mainly because ten years ago, the agricultural marketing parastatal (ADMARC) had depots in the most inaccessible rural communities and made food available at affordable prices. Malawi has entered an extremely vulnerable 'transition' phase between state regulation -when ADMARC controlled agricultural marketing, input supply, and food prices, and full liberalisation - where food supplies and prices are wholly market-determined.

Lessons learned

Two sets of factors intersected to produce the 2002 famine, vulnerable livelihoods and weak institutions.

Livelihood vulnerability can only be addressed through socio-economic development. In particular this requires pursuing policies that, directly or indirectly, raise the incomes of poor households and diversify or stabilise their food sources, to reduce food security risks. Direct measures include employment creation programmes and enhancing access to agricultural inputs (one example, which achieves both objectives, is inputs-for-work). Indirect measures include education to improve the prospects of young Malawians finding non-farm employment, thus reducing their dependence on rain-fed agriculture.

Institutional vulnerability can best be addressed through institution-building and strengthening government capacity to design and implement sound, pro-poor policies. However these are longer-term measures. The immediate priority facing Malawi is to prevent a similar catastrophe in the coming agricultural year, which again is predicted to be a deficit year. Three key policy areas to target are the management of the SGR, the future of the Starter Pack programme, and the right to food.

Strategic Grain Reserve

The appropriate functions and stock level of the SGR must be negotiated and agreed between the

Government of Malawi and its donor partners. Three key questions remain unresolved:

- What is the appropriate stock level for the SGR in order to meet national food security objectives at reasonable cost? Opinions range from 60,000 MT to 180,000 MT, or enough grain to meet 3-9 months of national consumption needs.
- Should the SGR be used to intervene in the market, e.g. to stabilise prices counter-seasonally, by buying grain at harvest and selling this grain during the 'hungry season' at cost - or should it function purely as an emergency buffer stock?
- If the SGR is to fulfil food security functions, it must be adequately capitalised. But should it be subsidised or should it be used for cost recovery?

However these issues are resolved, there is little disagreement that the SGR must be managed in a transparent manner and be subjected to regular independent audit.

Starter Packs

Since the early 1990's, the main constraint on agricultural production in Malawi has been limited access to inputs (fertiliser, seeds, credit). In this context, the Starter Pack - or Targeted Inputs Programme - makes an important contribution to the national harvest and household food security. Distribution of Starter Packs was restricted to 1 million households last year, but this year will be expanded up to 2.5 million households. However, the Starter Pack cannot be seen as a substitute for a more holistic agriculture and food security policy. The long-term solution lies in promoting production through extending access to inputs.

The Right to Food

The right to food means making adequate food available and affordable to all Malawians at all times. The allegation that private traders deliberately purchased SGR maize cheaply, to then resell it at excessively high prices during the food shortage, is an extremely serious accusation. Profiteering from hunger violates the basic human right to food, as well as the constitutional provision to guarantee access to adequate food for all Malawian citizens. Civil society must be involved in any future policy decisions that impact directly on household food security. A sensitisation campaign is needed to inform people about their right to food, and their right to hold politicians accountable if the right to food is violated.

It is hoped that the lessons learned from this research will assist in identifying more appropriate and timely interventions in the future, as well as reducing vulnerability to future food crises.

For further information, contact Sakou Jobe Country Director, ActionAid Malawi, email: sakouj@actionaidmalawi.net, or Edson Musopole, Africa Policy Co-ordinator, ActionAid Regional Office, email: edsonm@actionaidmalawi.net. The author of the report, Stephen Devereux, can be contacted at the Institute for Development Studies, Sussex, UK, email: S.G.Devereux@ids.ac.uk

¹ State of Disaster: Causes, Consequences and Policy Lessons from Malawi. ActionAid report, commissioned by ActionAid Malawi and written by Stephen Devereux, June 2002

² A 'shock' is a term often used in food security analysis which describes factors or events that may affect sources or influences of household income and food supply



Handgrip strength measurement in the Chabilissa II camp, Tanzania 1995

Nutritional status and handgrip strength in older refugees

Summary of research¹

A recent study set out to demonstrate the relationship between nutritional status and handgrip strength in older Rwandan refugees. The nutritional status of older people has been related to functional ability and strength, and handgrip strength is the most common assessment method for upper extremity muscle strength.

Nutritional status is particularly relevant to the survival of older refugees and their dependants. Older refugees can be a particularly vulnerable group, as living conditions are harsh and social networks may have broken down, yet consideration of older age groups amongst refugees is rare. Indeed, in Bosnia-Herzegovina, undernutrition was found to be absent among children whereas the prevalence in older adults was 10-20%. Similar figures of undernutrition have been demonstrated in older Rwandan refugees.

This particular study was set in a Rwandan refugee camp located in the Karagwe district of north-western Tanzania, and took place between 1995-96 (post-emergency phase). A total of 413 men and 415 women, aged 50-92 years, participated in the study. Weight, height, mid upper arm circumference (MUAC) and triceps skinfold measurements were obtained using standard techniques. For participants with visible kyphosis (curvature of the spine), height was estimated from armspan measurements using regression equations developed from non-kyphotic subjects within the same sample. Handgrip strength was measured using a mechanical handgrip dynamometer. Information regarding physical activity and health status was obtained through interviews and clinical screening.

The study observed that about 40% of the sample (of whom two-thirds were female) lived without a partner. The prevalence of under-nutrition was 19.5% in men and 13.1% in women and was higher in those over sixty years of age for both sexes. The older refugees were still quite active in the camp. More than 70% were engaged in work in kitchen gardens and light household activities, while 42% took part in heavy household activities, such as fetching water and firewood. Men performed heavy household tasks and undertook paid labour significantly more often than women.

Reported health problems were mainly of a chronic nature, such as dentition and vision problems, non-specific poor general health (self-reported), poor mobility and depressive symptoms. Women were significantly more likely to suffer from these problems than men.

The study found that handgrip strength was significantly higher in men compared to women (30.3 versus 22.3) and was significantly lower in each older age group in both sexes. Handgrip strength was positively correlated to calculated body mass index (BMI) and arm muscle area (AMA). Individuals with poor nutritional status (BMI < 18.5) were 1.75 times more likely to have impaired handgrip strength compared with those of adequate nutritional status. After controlling for potential confounders (sex, age and height), BMI still remained a significant contributor to the variation in handgrip strength.

The main conclusion of the study was that nutritional status is associated with handgrip strength, independent of sex, age and height in this refugee population. This may indicate that underweight older people are likely to have more difficulties in functioning independently in the community. The author states that good functional ability is an important attribute in refugee camps, where people are not self-sufficient and caring behaviour is often diminished. Especially in unstable situations, where many young adults may have died and families may have been split up, independent older people still have an active role to play in maintaining family life and well-being, and in the wider community. Therefore it is essential that older people remain in good nutritional and general health condition for as long as possible. The author of the study suggests that further research is needed to investigate if improving nutritional status can actually lead to better functional ability.

¹ Pieterse S (2002). The association between nutritional status and handgrip strength in older Rwandan refugees. *European Journal of Clinical Nutrition*, Vol 56, pp 933-939

Infant feeding in emergencies

Summary of research¹

The public health importance of infant feeding in emergencies has been highlighted in countries such as Iraq and Bosnia where feeding infants with breastmilk substitute is common practice. Although there are few epidemiological studies on the impact of emergencies on infant feeding, many anecdotal reports of adverse health outcomes exist. The displacement of such populations has created new dilemmas for aid workers on how best to assess and support feeding practice.

During the 1999 Kosovo Crisis an opportunity arose to research humanitarian interventions in infant feeding in the Former Yugoslav Republic (FYR) of Macedonia.

Indicators, recommended by international health and nutrition organisations for assessing infant feeding practice, were compiled and analysed to evaluate their consistency and applicability for use in surveys of emergency-affected populations. These included measures of breast-feeding status, use of artificial feeding, anthropometric status and morbidity. In addition, health and nutrition status surveys performed on the resident or refugee population of Kosovo during the years 1996-1999 were reviewed to compare their use of infant feeding and morbidity indicators.

Comparison of standard indicators

Indicators recommended by the World Health Organisation (WHO), UNICEF Multiple Indicator Cluster Survey (MICS) Indicators for Global Reporting, Wellstart International Expanded Programme on Breastfeeding (EPB) and Measure Demographic Health Surveys (DHS) were compared. This revealed a number of inconsistencies, both in target population and measurement method.

For example:

- The recommended age-group in which *exclusive breastfeeding* rate was measured varied between less than four months (WHO, UNICEF), and less than six months (EPB, DHS), thus limiting comparability of data.
- The standard indicator for *timely complementary feeding*, recommended by both WHO and UNICEF, refers to breastfed infants only. Thus in a population where a proportion of the infants are solely artificially fed, they would be excluded from this assessment.
- There is currently no specific definition of diarrhoea for infants under six months. The WHO standard definition of acute watery diarrhoea (three or more loose stools in 24 hours) closely resembles the minimum number of stools normal for an effectively breastfed infant (three or more stools in 24 hours).² This greatly limits the interpretation of morbidity data in young infants.
- *Timely initiation of breastfeeding* is not included as a MICS global indicator and definition varies between DHS and WHO, and Wellstarts EPB.

Use of indicators during Kosovo crisis

The use of recommended indicators during the Kosovo crisis was inconsistent, with many non-standard indicators and methodologies used instead.



Above and below: standard feeding indicators do not adequately assess artificial feeding practices of a population. Refugee camp, FYR Macedonia, 1999
© ANDY SEAL



For example, a large inter-agency nutrition and health survey, carried out in seven refugee camps in FYR Macedonia in 1999, included no standard indicators on infant feeding, while an infant feeding and weaning survey of the returned population in Kosovo included only one recommended infant feeding indicator. Seven of the reviewed surveys measured exclusive and predominant breastfeeding rates, however only two actually used the 24 hour recall method as recommended by the WHO.

Age-groups for which feeding and morbidity data were gathered also varied widely and infants under six months were often not included in anthropometric or feeding practice assessments. In some cases, feeding practice of young infants was inferred from data gathered from older infants and young children.

These limitations did not prevent comparison, interpretation or conclusion on infant feeding practice in survey reports. Conclusions appeared to be based

on field perceptions and experiences rather than on actual data collected.

Discussion

The authors suggest that the inconsistencies observed may reflect a lack of awareness by personnel of current recommendations. The widespread use of non-standard indicators may also reflect gaps in the scope of current assessment tools in emerging emergency situations. Although many standard infant feeding indicators have been developed and are widely used in non-emergency settings (e.g. UNICEF Baby Friendly Hospital Initiative), in reality they have not yet been operationalised in the context of emergencies. Also, current indicators have been developed particularly to assess breastfeeding practice but few recommend how to assess the extent and nature of artificial feeding in a population. The use of a number of non-standard indicators in Kosovo may have reflected a need to assess artificial feeding

Factors influencing deviance in growth of children in rural West Bengal

Summary of MSc Thesis¹
By Chandrashekhar Pandey and Rosalyn O'Loughlin

This study may have some relevance to emergency situations where there is variation in the growth performance of children enrolled in emergency selective feeding programmes (Ed).

The term positive deviance has been used to identify children who ‘...grow and develop well in impoverished environments where most children are victims of malnutrition and chronic illness’.² Negative deviants grow at the lower end of the growth spectrum and median growers grow at or around the median of the growth spectrum.² The aim of a recent study was to identify the child-care, feeding behaviours and other factors associated with positive deviance in a deprived rural Indian community in order to improve the maternal and child health and nutrition programme run by the Child In Need Institute (CINI). **Methods**

A comparative study method was used. Growth velocities were calculated for a sample (n=737) of children, who had been enrolled at birth in the CINI programme in 1998 or 1999 (n=1500) using monthly weight recordings from 6 to 24 months. Children were classified based on growth velocity as either positive deviants >0.6 Z scores, median growers <0.3 to >-0.3 Z scores or negative deviants <-0.6 Z scores.¹ The final sample drawn from these groups was 233. Interviewer administered questionnaires were conducted with primary carers of this sample in April 2002 and additional information was obtained from child health cards. Analysis was carried out using Pearson’s chi-square and trend tests.

Results

The response rate was 97.4% (n=227). Morbidity data was recorded for 90.6% (n=211) of children over the 19 month period. Two thirds (67.8%) of these had at least one episodes of illness. Negative deviants were significantly more likely to have been ill, and to have been ill more frequently than positive deviants or median growers. There was an increasing trend from positive deviants to negative deviants in the number of episodes of fever, chest infection and diarrhoea (table 1).

Table 1: Child morbidity history over 19 months by the three nutritional groups.

	Positive No. (%) (n=72)	Median No. (%) (n=65)	Negative No. (%) (n=74)	Total No. (%)	Chi squared test, p value
Episodes of illness (n=211)					$\chi^2 = 35.4$, df 4 p < 0.0001
No sickness	33 (45.8)	24 (36.9)	11 (14.9)	68 (32.2)	
1-2 episodes	34 (47.2)	36 (55.4)	36 (48.7)	106 (50.2)	
>2 episodes	5 (6.9)	5 (7.7)	27 (36.5)	37 (17.6)	
Episodes of fever (n=210)			(n=73)		χ^2 tr = 6.0, p < 0.01
None	49 (68.1)	37 (56.9)	35 (47.9)	121 (57.6)	
One or more	23 (31.9)	28 (43.1)	38 (52.1)	89 (42.4)	
Episodes of chest infection (n=210)					χ^2 tr = 15.8, p < 0.0001
None	52 (72.2)	41 (63.1)	29 (39.7)	122 (58.1)	
One or more	20 (27.8)	24 (36.9)	44 (60.3)	88 (41.9)	
Episodes of diarrhoea (n=210)					χ^2 tr = 15.5, p < 0.0001
None	56 (77.8)	46 (70.8)	34 (46.6)	136 (64.8)	
One or more	16 (22.2)	19 (29.2)	39 (53.4)	74 (35.2)	

A significantly higher proportion of negative deviants who were ill in the two weeks preceding the study attended an unqualified doctor during illness compared to median growers who were more likely to attend a qualified practitioner ($\chi^2 = 9.4$, df 1, p = 0.002). No significant differences were found between the three groups in knowledge, attitude and practice of the primary carers or socio-economic backgrounds.

Policy implications and further research

The principal finding, that negative deviants were more likely to have recurrent illnesses, have important implications for planning intervention programmes to combat the problem of poor growth. CINI uses a system of community health workers to provide health education and follow-up for sick children. The Integrated Management of Childhood illness, a WHO / UNICEF initiative, emphasises training of community health workers.^{3,4} This is recommended as an appropriate tool to introduce into the CINI programme. Training should concentrate on early detection of illness, giving appropriate nutritional advice and understanding growth charts. Further research is needed in order to understand whether negative deviance is a cause of, or an effect of, illness and why the primary carers of negative deviants are less likely to take their ill child to qualified health personnel.

Acknowledgments

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- 4 WHO. Integrated management of the sick child. Bulletin of the World Health Organisation 1995;73(6):735-740

practice, for which standard indicators do not exist.

Although the benefits of appropriate infant feeding in terms of child survival are well known, the evaluation of aid impact in terms of morbidity and mortality may not be practical or feasible in emergencies. Impact indicators, such as morbidity and anthropometry, have particular constraints when applied to young infants. Furthermore, there may be many indirect influences on infant and child feeding practice in an emergency situation. Monitoring of the entire aid process is necessary to evaluate impact, assign responsibility and encourage accountability. In particular, there is a need to broaden the field concept and practice of evaluation to include process indicators (e.g. number of mothers enrolled in a breastfeeding programme) and outcome indicators (e.g. breastfeeding rates) of infant and child feeding practice.

Recommendations

The authors conclude that during the Kosovo crisis, an inconsistent approach to assessment and monitoring prevented conclusions being drawn about the effectiveness of the international response in protecting infant health and nutrition.

Suggestions to improve future monitoring are made, including:

- Recommended outcome indicators and sampling strategies for assessing infant and child feeding practice should be developed and included in emergency field manuals for health, nutrition, logistics and donor personnel.
- The scope of existing standard indicators is not sufficiently comprehensive to address all feeding issues in emergency situations, particularly in relation to artificially fed populations. Further development and field testing of standard indicators for this population group is necessary if appropriate and comparable assessments are to be made.
- Ultimately, the presence of experienced key personnel in the field is essential to implementing international recommendations and guidelines. This requires significant improvements in field technical support and, where resources permit, early field positioning of an infant and child feeding co-ordinator in emergencies.

¹ McGrath M, Seal A, Taylor A (2002). Infant feeding indicators for use in emergencies: an analysis of current recommendations and practice. Public Health Nutrition: 5(3), 365-372
² Evidence-Based Guidelines for Breastfeeding Management during the First Fourteen Days, International Lactation Consultant Management (ILCA), 1999

Angular stomatitis and riboflavin status

Summary of published paper¹

Between 1990 and 1993, fear of persecution led 83,000 ethnic Nepalese to flee from Bhutan to refugee camps in Nepal. Between December 1998 and March 1999, reported cases of angular stomatitis (thinning or fissuring at the mouth angles) increased six-fold, from 5.5 to 35.6 cases per 1000 per month. The highest rates were found in children and adolescents. This increase followed the removal of a fortified cereal from food rations, withdrawn in January 1999 due to programme constraints. Consequently, the riboflavin content of the daily ration fell from less than 0.6 mg/day to 0.4 mg/day, well below the WHO recommended amounts of 1.35-1.8 mg/day for adolescents.

Angular stomatitis (AS) has classically been linked with deficiencies of riboflavin, other B group vitamins and iron. Potential functional consequences of riboflavin deficiency in humans include decreases in motor skills and attention span, and reduced absorption or utilisation of iron.

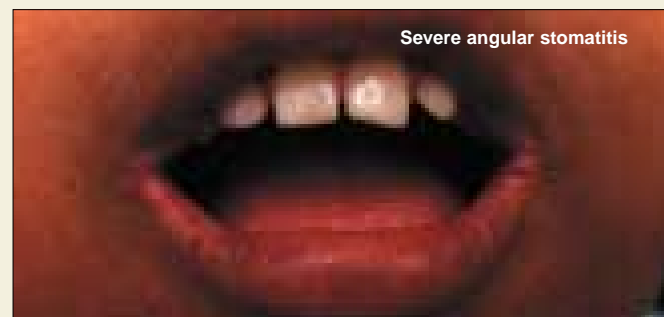
In October 1999, 463 adolescent refugees were randomly surveyed to assess the prevalence of AS and the prevalence of low concentrations of riboflavin, folate, vitamin B-12 and iron. Interviews and physical examinations were made and blood samples taken. Biochemical measures were used to determine whether riboflavin status was associated with AS and to assess the potential of using AS as a screening measure for low

riboflavin concentrations. Riboflavin status was assessed using the erythrocyte glutathione reductase (EGR) activity coefficient (EGR is a riboflavin dependent enzyme).

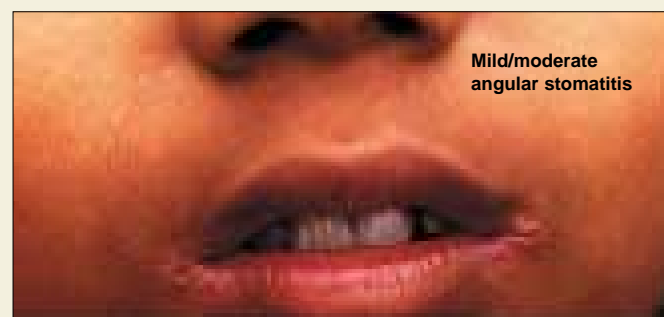
The main findings of the survey were that AS was common (26.8%), the prevalence of low riboflavin concentration was high (85.8%) and riboflavin status was associated with AS. Adolescents with AS had significantly lower riboflavin concentrations than did adolescents without AS.

The authors of the survey concluded that AS was a good screening measure for low riboflavin concentration. It had a high specificity and positive predictive value (PPV) but a low sensitivity in detecting low riboflavin concentration. Because PPV increases with the prevalence of the condition, the PPV would be expected to be lower where prevalence of AS is lower. The high PPV in this survey (89%) shows that AS can be used in conjunction with other relevant nutrient data, e.g. data on the nutrient composition of the food basket, as a surveillance tool to indicate marginal riboflavin concentrations in refugee or displaced populations. The low sensitivity of AS, however, limits its utility as an individual screening measure for low riboflavin concentrations.

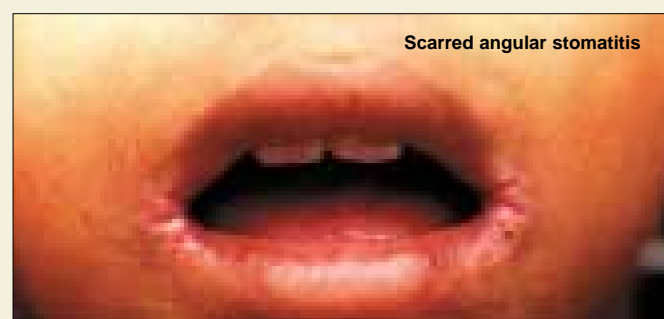
¹ Blank H et al (2002). Angular stomatitis and riboflavin status among adolescent Bhutanese refugees living in south-eastern Nepal. *American Journal of Clinical Nutrition*, vol 76, pp 430-435



Severe angular stomatitis



Mild/moderate angular stomatitis



Scarred angular stomatitis

Pictures taken by research team members from UNHCR, WFP & LWF Nepal

Mental health in emergencies

Summary of published papers^{1,2}

Field Exchange has previously run articles on the need to address the mental health of war affected populations and to consider the possible link between mental health, economic well being and future food security. The importance of mental health care during and following conflict appears to be increasingly recognised by humanitarian agencies. For example, during 1995 in the former Yugoslavia, 185 mental health projects were being operated by 117 organisations.

A recent article in the *Lancet* addresses the issue of improving psychosocial survival in complex emergencies. It illustrates how mental disorders are difficult to measure and hence there are few robust data that quantify their prevalence in war-affected populations. Additionally, there are inadequate comparative data on the prevalence of these disorders in stable low-income countries.

Many mental health programmes have provided counselling services based largely on tools developed in a western cultural context and have focused on the prevention and treatment of post-traumatic stress disorder. Recently these services have been criticised for focusing on the medical disorders of individuals and failing to recognise that war and displacement are collective experiences that warrant community responses.

Some researchers urge aid agencies to focus on supporting the adaptive responses of communities to deal with widespread grief, anger, loss of identity and

helplessness. These emotions are normal human reactions that are most commonly addressed through religious and cultural rituals, attention to continued economic survival, and family cohesion. Ensuring a lasting peace is probably the most effective external intervention to support community restoration. Others may include support for rituals (such as reburials), employment, restoration of governance and a process to ensure justice.

Public health programmes are often initially overwhelmed by the task of reducing morbidity and mortality from infectious disease, malnutrition and injuries. Thus, a phased approach to mental health would include an assessment of mental illness using culturally appropriate tools, a study of community coping mechanisms, support to the community adaptive systems and home-based care of the mentally ill through local community based organisations.

An example of community based mental health support was described in the same issue of the *Lancet*, through the work of the Amani Trust in Matabeleland, Zimbabwe. This local, non-governmental, organisation rehabilitates survivors of torture and of organised violence in the western half of the country. Until 1987, civil war had raged in western Zimbabwe since independence, during which time 10,000-20,000 people are estimated to have died. The Amani Trust initially approached communities expecting to offer counselling services, in keeping with the western expectation that post-

traumatic stress disorders would be the most prevalent problem. However, it proved better to move away from one-on-one psychotherapy and instead, use traditional community conflict resolution, belief systems and public truth telling to restore social fabric after community destruction.

This community approach is reflected in Amani's involvement with exhumations. Ancestral spirits are hugely important in regional belief systems in Zimbabwe. For an ancestral spirit to protect a family, it needs an honourable funeral and a ritual in which it is officially inaugurated as an ancestor. The main request made to Amani by community leaders and families in rural districts has been for an intervention to appease the aggrieved spirits of people who had been murdered and buried in unacceptable graves. This is how Amani first became involved in exhumations and for four years since, has been working with the same communities in five adjacent villages in Gwanda district. Using longitudinal case studies of communities and families, Amani assess the consequences of exhumation and reburial from cultural, psychological, individual and group perspectives. The overwhelming perception of families and community leaders is that the process had been both healing and progressive.

¹ Toole M (2002). Improving psychosocial survival in complex emergencies. *The Lancet*, Vol 360, September 14th, pp 869

² Eppel S (2002). Reburial ceremonies for health and healing after state terror in Zimbabwe. *The Lancet*, Vol 360, September 14th, pp 369-370

Minimum standards in post-emergency phase

Summary of online published paper¹

In the acute phase of complex humanitarian emergencies, assessment data on service delivery and health outcomes for interventions are increasingly being gathered to develop an evidence base for policies. However, for the post-emergency phase, there has been little equivalent study and no comprehensive programme guidelines currently exist. A recent study aimed to identify associations between age-specific mortality and health indicators in displaced people in post-emergency phase camps, and to define the programme and policy implications of these data. It was hoped that the findings would initiate a dialogue on minimum standards for displaced people during the post-emergency phase of complex humanitarian emergencies.

Between 1998 and 2000, the study team obtained and analysed retrospective mortality data for the previous three months in 51 post-emergency phase camps in seven countries. The team also completed field trips of 6-8 weeks duration to the following countries: Azerbaijan, Ethiopia, Myanmar, Nepal, Tanzania, Thailand, and Uganda. Inclusion criteria for camps were: displaced people residing in the camp during the post-emergency phase, less than 5% change in population size during the 3 months prior to data collection, camp population at least partly dependent on outside organisations for food aid and health care, and functioning health-information system.

Multivariate regression analysis was carried out using 18 independent variables that affect crude mortality rates (CMRs) and mortality rates in children younger than 5 years (U5MRs) in complex emergencies. The results were compared with recommended emergency phase minimum indicators.

The main findings were that recently established camps had higher CMRs and U5MRs, and fewer local health workers per person, than did camps that had been longer established. Camps that were close to the border or region of conflict, or had longer travel times to referral hospitals, had higher CMRs than did those located further away or with shorter travel times. Camps with less water per person and high rates of diarrhoea had higher U5MRs than did those with more water and lower rates of diarrhoea.

The results support some policies and programmes that are already being implemented, such as provision of a minimum quantity of water and an emphasis on diarrhoeal disease prevention and treatment. Sphere recommendations include at least 15 L of water per person daily for drinking, cooking, and personal and domestic

hygiene during the emergency phase of a complex humanitarian emergency. However, in the post-emergency phase, displaced people need water for more than just survival as they return to aspects of settled lifestyles, such as agriculture, livestock care, and building. In this study, provision of more than 20 L per person daily of water was associated with lower mortality rates in children. Hence the minimum standard for water supply may need to be higher than 20 L in the post-emergency phase.

The study also identified factors whose importance has not been sufficiently prioritised in guidelines and standards, such as the number of local health-care workers per person and the distance that camps are situated from a border or area of conflict.

A consensus between international humanitarian organisations, taking into account budgetary constraints, will be necessary to establish optimum staff levels in post-emergency camps. Current Sphere recommendations should be reassessed, since it is likely that more health workers are needed in an emergency, than in a post-emergency phase camp.

The authors recommend that programmes in complex emergencies should focus on indicators proven to be associated with mortality. Humanitarian organisations often provide similar services in the emergency and post-emergency phases of complex humanitarian emergencies, despite increasing evidence and consensus that needs differ between these phases.

Research is needed to establish evidence-based policies and programmes with the objective of reducing mortality in displaced people living in post-emergency phase camps. Sphere standards describe indicators and minimum standards for the emergency phase of complex humanitarian emergencies, but a comprehensive and practical set of minimum standards for key indicators needs to be developed for displaced people in post-emergency phase camps.

¹ Spiegel P, Sheik M, Gotway-Crawford C, Salama P (2002). Health programmes and policies associated with decreased mortality in displaced people in post-emergency phase camps: a retrospective study. *The Lancet*. Published online November 19, 2002. <http://image.thelancet.com/extras/01art11089web.pdf>

Supplementary feeding in Zimbabwe

Summary of research¹

During the periods 1992-3 and 1995-6, a child supplementary feeding programme (CSFP) was used in Zimbabwe to combat child malnutrition associated with times of drought. Evaluations in the past have concluded that the CSFP was effective in preventing an increase in malnutrition among children under five years, especially during the 1992-3 period. However, such evaluations made only cursory use of available household survey data. A recently published article based on a more detailed analysis of household surveys presents evidence that contradicts previous findings.

The objectives of Zimbabwe's CSFP included feeding vulnerable children, so as to maintain or improve the nutritional status of children under five in drought affected areas and to assist in averting starvation-associated child deaths. The CSFP aimed to provide children aged 6-59 months in all target areas with a nutritious meal that met 40% of daily energy requirements and 88% of daily protein needs. The official daily ration consisted of 66g of maize meal, 20g of groundnuts, 20g of beans and 12 ml of cooking oil. The programme comprised of wet feeding for five days a week, with local mothers providing the labour and water for cooking and cleaning up. Government and NGO officials managed the distribution and storage of CSFP rations.

Four nation-wide household surveys had previously been carried out in Zimbabwe, one occurring at the beginning or towards the end of both programme periods (1992-3 and 1995-6). Three of the national surveys were implemented by government ministries with support from UNICEF, while the fourth was a poverty assessment study. Re-analysis of these surveys set out to establish the following:

- the level of coverage of children under five in drought affected areas during the two programme periods
- the extent to which the CSFP reached children from poor and nutritionally vulnerable households, and how did this coverage compare to coverage of children from better-off households
- the proportion of malnourished children who actually got fed by the CSFP.

In order to check whether children from poor households got CSFP benefits, several poverty indices were developed, based on income poverty, consumption poverty and asset poverty. Assessment was questionnaire-based, although specific content varied from one survey to another. Using mid upper arm circumference (the anthropometric index available in three of the four household surveys), the proportion of currently malnourished children receiving supplementary feeding was calculated.

CSFP coverage

In establishing the CSFP coverage level (table 1), re-analysis observed that:

- CSFP coverage was lower earlier in the life cycle of feeding programme and rose towards the end.
- Coverage was higher and more evenly spread in the 1992-3 period- the worst of the two droughts.
- CSFP coverage was patchy, with between one-quarter and two-fifths of areas without feeding programmes.
- Even within those areas covered, large numbers of children were not receiving supplementary feeding.

On the positive side, the regularity of supplementary feeding of beneficiary children appeared high.

Table 1 CSFP coverage of children under five according to household surveys, 1992-3 and 1995-6

Date of survey	Proportion of under fives in CSFP for all rural areas	Proportion of under-fives in CSFP where CSFP operational
October 1992	37.6%	45.7%
March 1993	68.2%	69.0%
Late 1995	23.9%	39.5%
March 1996	28.0%	44.5%

Targeting vulnerable children

With the exception of the March 1993 survey findings, half or more of under-fives from poor and nutritionally vulnerable households were not enrolled in supplementary feeding. Coverage of children from these households was lower in 1995-6 compared to similar periods in 1992-3. Even in areas where CSFP was operational, large numbers of children from poor and nutritionally vulnerable households did not receive supplementary feeding. It is not clear whether under-fives from poor households found it easier or harder to access supplementary feeding than did children from non-poor households - the evidence is mixed. What is clear is that the probability of children receiving or not receiving supplementary feeding was not particularly different between poor and non-poor households.

CSFP impact on nutritional status

The areas where CSFP was operational were not necessarily where levels of malnutrition were highest. Record keeping at feeding points on children's nutritional status before, during and after supplementary feeding was extremely haphazard. Large numbers of malnourished children were not in supplementary feeding, even in areas where CSFPs were operational. Less than half of malnourished children surveyed early in the life-cycle of both programmes were in supplementary feeding. Even at the height of programme coverage in March 1993, one-quarter of children were not receiving feeding in operational areas. Furthermore there was some evidence that malnourished children were less likely to be in the programme than other children. This could mean that the programme was effective or that malnourished children had less access. However, the reasons why children, even malnourished or poorer ones, did not attend remains obscure. One possible explanation put forward has been the opportunity cost to mothers.

Conclusions

A comprehensive evaluation of the CSFP impact on nutrition in Zimbabwe is not possible. No data were collected at feeding points and no information is available on the regularity or quantity with which individual children were fed. Furthermore, it is inappropriate to move, as the original evaluators did, straight into the analysis of impact indicators, while bypassing important questions about how many children got fed and what their socio-economic and nutritional status was.

The re-analysis does show that the 1992-3 CSFP should be distinguished from its successor in 1995-6. Overall, programme coverage was higher in 1992-3, as was the proportion of malnourished children who received supplementary feeding, especially in the latter part of the programme's life cycle. However, the success of the 1992-3 feeding programme was at best a qualified one. Even during peak coverage around March 1993, almost one-third of children, and one-quarter of all malnourished children, were without supplementary feeding.

Children who were enrolled in the programme tended to get five meals a week and amongst these, there is some evidence that feeding did provide nutritional benefits.

In essence, evidence from the household surveys casts considerable doubt on previous evaluations, in particular claims that CSFP played a major part in controlling malnutrition rates and preventing famine in Zimbabwe in 1992-3 and, especially, in 1995-6.

¹ Munro L (2002). Zimbabwe's child supplementary feeding programme: a re-assessment using household survey data. *Disasters*, 2002, 26 (3), pp 242-261

Disparate responses to need in Southern Africa

By Gaëlle Fedida

Since 1993, Gaëlle Fedida has worked in humanitarian aid in a wide variety of countries, including Croatia, Burundi, Cameroon, Congo Brazzaville and Afghanistan. Now based in Paris, she is in charge of the Food Aid Programme for MSF France operations. In this article, the author describes how recent experiences in Angola and Southern Africa have led her to challenge how the humanitarian community define and prioritise need in emergencies.

Since 1995, MSF France has had a food aid cell at their headquarters in Paris. The role of the food aid programme is to analyse underlying or complicating factors influencing MSF relief operations and, where possible, formulate operational food strategies. Areas currently under scrutiny include Sudan, Ethiopia, Kenya and Madagascar, where there is a recurring pattern of nutritional deterioration and, consequently, of MSF food aid intervention.

Despite decades of experience in dealing with famine, and increasingly clear insights into the political factors which often trigger mass starvation and mortality, a dominant conceptualisation of

famine remains which relies on its explanation in terms of natural disasters (e.g. drought and HIV). It appears that political analysis still comes a poor second to the applied disciplines of meteorology and epidemiology, in terms of understanding causes and lack of solutions. This biased perception has implications for humanitarian interventions, and is reflected in our recent experiences and analysis of the Southern Africa situation.

The Angolan experience

Peace came to Angola in April 2002. As a result, MSF gained access to a population that had previously been held captive by the fighting. In



Blanket food distribution in
Bunjei, Angola, August, 2002
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Blanket food distribution in
Bunjei, Angola, August, 2002
© GAELLE FEDDIA, MSF FRANCE



several locations, early rapid assessments¹ revealed rates of acute global malnutrition as high as 30% to 35%, while severe acute malnutrition affected as many as 15%. With 4.5 deaths per 10,000 inhabitants per day in some areas (levels far above emergency thresholds), MSF rapidly expanded its programme to operate in 12 out of the country's 18 provinces. As a result, an estimated 1.5 million people (including 570,000 displaced) had access to MSF therapeutic, supplementary and blanket feeding programmes.

The political players in Angola were quick to congratulate themselves on achieving peace, and claimed to be supporting it with food aid distributed in the camps reserved for UNITA² fighters. Overall there were an estimated 85,000 demobilised UNITA fighters, together with 300,000 relatives, in 36 government-managed camps³. Given the major political importance of the demobilisation, these camps were the first priority when international aid distribution finally began - in July for the camps in the north of Huambo province. However, for the remainder in need - the thousands of civilians who did not have sufficient connection to the troops to be classified as "families of demobilised troops" - the wait was much longer (Sept/Oct, 2002). Indeed, some were still without food distributions at the time of writing this article (Nov, 2002). Furthermore, in the camps of Chiteta and Esfinge Fazenda where MSF are operational, food distributions did not occur monthly (more likely every 45 days), and distributed rations did not meet the standard 2100 kcal requirement.

The World Food Programme (WFP) did not mobilise emergency resources to meet the urgent and growing need, i.e. no emergency operation (EMOP) was initiated. Instead, the agency expanded its on-going programme (PRRO⁴), by 120,000 recipients in June and then by a further 80,000 in late October, when at least 500,000 individuals in appalling conditions became accessible.⁵ Past experiences demonstrate that there are other agencies capable of deploying parallel food pipelines alongside WFP, particularly when there are huge emergency needs. This was not the case in Angola and, in spite of the tardiness and inadequacy of response, the WFP were the only agency to increase the volume of assistance for this rapidly evolving crisis. Whilst MSF were not dependant on WFP for resources, the absence of an adequate food distribution network initially led MSF to deploy food aid (Unimix) to meet the obvious

acute needs of the population.

The Southern Africa appeal

At around the same time but further to the east, a number of food shortage alerts were made across the Southern Africa region, and in July 2002, the WFP launched an international appeal (EMOP 10200). Worth \$507 million, they aimed to assist 10,255,880 people through a variety of food aid activities across the region, from Malawi to Lesotho, including Zambia, Zimbabwe, Mozambique and Swaziland. In Zimbabwe, the degree of economic and food insecurity did indeed reach alarming levels. However, in Malawi and Zambia, MSF did not encounter anyone starving to death. Although MSF was not operational in the drought-affected areas of Zambia, rapid MUAC assessments in the south did not reveal a problem. This view was later supported by nutrition surveys (MSF Holland) in May 2002, which found 3.5% global acute malnutrition (GAM) and 0.9% severe acute malnutrition (SAM) in the south, and 3.9% GAM and 1.2% SAM in the west⁶. Surveys conducted by Oxfam in July also showed non-emergency levels of wasting, ranging from 4.3-5.8% GAM and 1.2-1.9% SAM.⁷

In Malawi, the MSF therapeutic feeding centre in Chiradzulu, near Blantyre, did not receive any more children than usual (30-50 admissions per month), despite a reactivated screening strategy. Furthermore, rigorous and large-scale nutrition surveys since show the prevalence of malnutrition remains largely below critical thresholds, despite the claim by many that the 'hunger gap' would start by August 2002. Yet, the WFP is expending considerable energy in opening a regional office and an emergency logistics centre in South Africa, and continues to mobilise international opinion and funders for an emergency operation. Indeed, donors are responding quickly to the famine in Southern Africa, with \$362.7 million contributed to WFP since May⁸. In stark contrast, the WFP has received only \$86 million for Angola since April 2002. Experiencing peace for the first time in years, Angola is expected to redirect its oil dividends from a war economy into social services for the well being of its population as, it is argued, "the country is rich."

Analysis of aid response

What are the factors that contribute to these famine alerts in southern Africa and ultimately, lead to such

disparity of response in the face of evident need? One factor may be that the early warning systems, in operation since the 1980s and specifically intended to avert famine, are anchored in the national agricultural information systems. As a result, the most objective data are meteorological, whilst the agricultural data (estimates of cultivated cropland and of harvests) come from local ministries and are of questionable accuracy. For example, over a period of three weeks, MSF observed a 20% reduction in the official crop estimates for the 2002 agricultural campaign in Malawi, although Ministry of Agriculture field personnel had no means to conduct any studies within such a short time frame. Yet, this official information is used by relief agencies as a basis for determining the levels of food aid required. Questions must be asked about how and why this occurs.

The explanation may lie in a form of stakeholder analysis. For years, national governments have found it increasingly difficult to obtain structural economic aid. Some donors have simply put an outright halt to such assistance because of poor governance, while agencies like the International Monetary Fund (IMF) have implemented draconian control mechanisms on authorities and demanded repayment of budget amounts that have, apparently, 'evaporated without explanation'. Under these circumstances, a national disaster is the ideal occasion to generate massive funds in a short time, and compensate for the shortfall.

Donor government response may be understood in a different way. Western governments have often been notoriously difficult to convince of emergency needs, even when a high prevalence of malnutrition can be demonstrated, such as in Sudan. In some instances, this has resulted in very restricted food baskets with limited amounts of cereal. The question, therefore, must be asked - why has there been such a readiness to respond in southern Africa, where most of the data suggests that nutritional status has not declined significantly? One explanation may be that donors are trying to create regional stability, through the injection of emergency funds into the countries bordering the explosive Zimbabwe.

The explanation regarding international non-governmental organisations and United Nations agencies may be more connected with their substantial dependence on institutional financing. Declarations of "famine" are, therefore, a significant

financial opportunity for them.

There are more questions than answers here, and demonstration or proof of the above hidden agendas cannot be given. Ultimately, the disparity in response between southern African and Angola undermines the credibility of humanitarian action in the region.

The 'humanitarian imperative'

MSF do not deny that it will be especially difficult for some families in the southern Africa region to meet their food needs this year, nor that we must respond to these needs. However, it is our responsibility to question the way these needs are analysed and identified, and the way in which operations are mounted in response. There is definitely a crisis, but how large is it? Nowadays, it appears that in order to raise funds, you have to use the word 'famine', and that such famines are conceptualised in terms of causes over which we

have no short-term control e.g. AIDS and drought. Some causes may lie, more uncomfortably, closer to home. What about the responsibility of national governments to conduct a policy that ensures sufficient revenues for their rural populations? What about the sale of strategic grain reserves in Malawi and the disastrous agrarian reforms in Zimbabwe? We are presented with the indisputable argument of the 'humanitarian imperative,' which seems to mean that the 'needs' declared by authorities as arising out of natural disaster are invariably justified and therefore must be met by emergency assistance.

MSF conceives of the humanitarian imperative in another way. Needs must be evaluated in the field from an independent standpoint so assistance can be allocated impartially, i.e. according to priority needs. In 2002, this priority was clearly in Angola. Failure to make full use of good quality data, or to question data where quality is suspect, ultimately means that

responses will be determined by the internal logic of organisations and institutions. This cannot be an acceptable *modus operandi* for the humanitarian community.

For further information, contact Gaëlle Fedida, Head of Operations, Food Aid Programme, MSF France at: email: gfedida@paris.msf.org

¹ Early assessment data are from unpublished figures from MSF rapid assessments based on MUAC screening and new grave monitoring. Whilst not 'scientifically' valid methods of assessment (Ed), these data were considered to reflect observations on the ground which were later substantiated by elevated attendance at feeding programmes.

² Angolan rebel group, Unia O Nacional para a Independencia Total de Angola (UNITA).

³ OCHA estimates.

⁴ Protracted Relief and Rehabilitation Operation (PRRO)

⁵ This figure is based on interviews with Eric De Mul, head of OCHA. A subsequent USAID situation report in July 2002 increased this figure to 815,000.

⁶ Global and severe acute malnutrition rates using weight-for-height z scores.

⁷ Oxfam surveys, July 2002: Choma: GAM 5.5 %, SAM 1.9 %; Monze: GAM 5.8 %, SAM 1.5 %; Mazabuka: GAM 4.3 %, SAM 1.2 %.

⁸ WFP resourcing update, www.wfp.org

Postscript

Disparate responses to need in Southern Africa: a WFP perspective

by Judith Lewis, Coordinator

United Nations Regional Inter-Agency Coordination and Support Office in Southern Africa (RIACSO)

WFP Regional Director for East & Southern Africa

The United Nations World Food Programme (WFP) has worked for over 20 years in Angola delivering food aid to the neediest people, even during the country's darkest days when heavy fighting meant food had to be airlifted to millions of embattled hungry people. In recent years, WFP has fed, on average, one million Angolans each month, most of whom are internally displaced due to 27 years of fighting. Throughout our presence in Angola, WFP has always stood by the Angolan people and strived to reach the country's poorest.

As a result of the ceasefire agreement between the government and UNITA rebels on April 4, 2002, WFP gained access to 60 new areas. These included so-called Family Reception Areas, where families of ex-UNITA soldiers were entitled to receive food aid as part of a chance to start a new life. More than 400,000 women, children and the elderly received food in these areas. Six months later in December 2002, WFP distributed food to former UNITA fighters.

Now, hundreds of thousands of people are returning home to start rebuilding their lives, and WFP is assisting them with basic food rations. We expect the number of people we feed to reach about 1.9 million in the near future. However, several obstacles will continue to hamper efforts: near non-existent infrastructure such as derelict roads, bridges and airstrips, millions of land mines, and most poignantly, scarce funding.

When the peace treaty was signed, WFP seized the opportunity to move food quickly to help stabilise the population. The fastest way to expand the number of people we feed was to extend our current Protracted Relief and Recovery Operation (PRRO) document. Preparing a new Emergency Operation (EMOP) would have taken longer, and at the end of the day, hungry people don't care what the piece of paper is called, as long as they can eat. And that's the bottom line. Our goal is to move food fast and efficiently to those who need it. WFP distributes 85 percent of all food aid in Angola, an indication of the continuing confidence donors and the humanitarian community have in our ability to do the job quickly and effectively.

In Southern Africa, more than 15 million people across six countries require food aid. Although the situation is extremely severe, we have never declared the region a 'famine' zone. This is because the crisis is not one of widespread malnutrition, but rather one of acute food shortages exacerbated by AIDS. WFP's response is intended to save lives and preserve livelihoods so that people recover more rapidly once the acute emergency is over and are less vulnerable to future crises.

Millions of people are unable to access their staple food, maize. This is either because they lack the purchasing power or because maize is simply unavailable. This makes them vulnerable but does not mean that every single one of them is in imminent danger of starving to death. Unfortunately many people survive by taking a variety of extreme measures, such as selling off their meagre assets, taking their children out of school to work, eating potentially-poisonous wild fruits, migration and prostitution. Due to insufficient food aid, desperately hungry people across the region have resorted to these measures to stay alive, initiating a downward spiral of deprivation, extending the current crisis well into the future.

The current crisis has been triggered by erratic weather patterns, structural economic problems, and, in Zimbabwe's case, the land reform process among others. These factors have been clearly highlighted in every WFP document issued since the agency became involved in the crisis. As the world's biggest humanitarian agency, WFP strives to act before people are pushed over the coping threshold. Our job is to respond to emergency situations before emaciated images appear on television screens around the world. WFP's intervention has already saved millions of people from starvation.

However, one of the biggest challenges facing WFP and other relief organisations is the HIV/AIDS virus, which is wiping out an entire generation of productive men and women across southern Africa. In some countries, the agricultural sector has been so hard hit that recovery from the current food crisis could be delayed. Simply put, if you don't have people to plant crops, there's not going to be anything

to harvest or eat. That's why WFP's response aims to address the impact of HIV/AIDS, as well as provide food to those who have nothing to eat.

WFP and its partner organisations work hard to get assessments right. Three were carried out across the region last year, and a fourth is planned for April/May. The last assessment in December involved a team of more than seven internationally respected organisations, including the Regional Assessment Committee of the Southern Africa Development Community (SADC), FEWSNET¹, Save the Children, the International Federation of the Red Cross, UNICEF, Food and Agricultural Organisation and WFP on a regional level, and on country-specific assessments, OXFAM, World Vision, Care, and in Mozambique only, MSF. Local and donor governments also participated at many levels. These 'rolling assessments' under the auspices of SADC are highly sophisticated and involve the analysis of a variety of issues, including both food and non-food criteria. This unique process involves hundreds of researchers interviewing thousands of people.

To further ensure transparency, not all assessment partners are involved in the implementing process, and therefore, have no self-interest in the outcome. WFP then bases its humanitarian response and programming on assessment findings.

It would be interesting to have more information about the diversity of the assessment teams and the extent of fieldwork undertaken by MSF to reach the conclusions expressed in their article. More to the point, it is unfortunate that MSF has decided not to join the group of agencies that has been working together to devise and conduct assessments in the region in order to help strengthen analysis, but instead, has chosen to remain on the outside, and criticise.

¹ FEWSNET: Famine Early Warning System Network

ALNAP Annual Review 2002

The ALNAP Annual Review 2002¹ provides a synthesis of the principal findings and recommendations of evaluations of humanitarian action, completed and made available to ALNAP in 2000-2001. Encompassing 46 evaluations and 9 syntheses, it identifies crosscutting issues and trends and the learning and accountability challenges for those within the humanitarian sector, whether practitioner, policymaker or evaluator. The synthesis also highlights the humanitarian sectors repeated failure to learn and implement lessons from past experience.

The central theme of the review is *learning* within the humanitarian system, including mapping of current learning mechanisms, an analysis of their strengths and weaknesses, and key constraints to learning. It also reviews learning mechanisms from other sectors that might be adopted or adapted to meet the specific characteristics and learning needs of the humanitarian sector. The quality of individual evaluations is assessed using the 'ALNAP Quality Proforma'. This highlights the strengths and weaknesses of current practice from conception and design, through the evaluation process, to the dissemination of findings and implementation of recommendations.

One of the main sectors evaluated was food aid and emergency agriculture (19% of the reports). In general this sector met the short-term objective of 'feeding mouths', and successes were usually qualified. Problematic areas identified were ration levels and inadequate attention to disadvantaged groups, such as women and children. Water and sanitation, and health interventions were also successful in meeting their short-term objectives. Shelter, and in particular housing, was the least successful sectoral emergency intervention.

In general, the evaluation reports tell of a job well done, however a number of generic weaknesses within the humanitarian system are described by the review. Overall, the quality of evaluation reports was unsatisfactory. In particular, evaluation reports were poor at explaining why interventions were successes or failures. Other problematic areas included failure to integrate short-term emergency objectives with longer-term plans, poor co-ordination, limited



exploration of building on indigenous coping strategies and the need to improve monitoring.

Some keys to success were identified, including dedicated staff, good needs assessment, and the ability of international non-governmental organisations (NGOs) to work with well-established partners. Dedicated staff were identified as central to the success of humanitarian action. However they were often hindered by agency institutional systems typically fraught with poor communication, ineffective staff capacity building and inadequate training.

A number of examples of good learning practice were highlighted in the review, such as the development of common networks and sources of learning, e.g. Reliefweb, Humanitarian Practice Network and ALNAP. However, while the evaluation mechanism is well established in the humanitarian sector, weakness lies in a failure to distinguish between learning and accountability approaches to evaluation. For example, external, independent evaluations (which may be undertaken primarily for accountability purposes) are often not considered conducive to learning at individual and team levels, while outside criticism is often handled defensively rather than constructively.

Several constraints to learning in the humanitarian sector were identified, in particular lack of clarity as to intervention objectives and desired outcomes, and poorly defined responsibilities and relationships between individuals, teams and organisations. In addition, high rates of staff turnover create a severe obstacle to learning and knowledge transfer, while mechanisms for cross-organisational learning are poorly developed. Short-term funding, pressure to maintain low overheads and competitive behaviour amongst organisations vying for profile and fund access, were considered the major barriers to effective learning by, and within, the sector.

Possible areas for action identified in the review include:

Within organisations

- Assessments of current organisational practices in learning, knowledge management and training
- Development of programmes to support learning and knowledge management
- Need to commit to and prioritise learning, and work towards culture of learning and self-critical reflection.

Across sector

- Concerted action to reduce high staff turnover
- Improved resource provision for learning and development of mechanisms to increase cross-organisational learning, such as the Groupe URD (Urgence Réhabilitation Développement) approach used in Central America and ALNAPs Learning Support Office in Malawi
- Setting up of an annual sector award mechanism for instances of outstanding learning practice
- Development of an electronic library for the sector.

Copies of the ALNAP Annual Review 2002, Humanitarian Action: Improving Performance through Improved Learning can be ordered from the ALNAP Secretariat, ODI, 111 Westminster Bridge Road, London SE1 7JD or alnnap@odi.org.uk at £15 per copy (£12 to ALNAP members).

¹Active Learning Network on Accountability and Performance (ALNAP). Established in 1997, is an international, interagency forum working to improve learning, accountability and quality across the humanitarian sector. Details of ongoing ALNAP activities, new developments and publications can be found on ALNAP's website <http://www.alnnap.org>.

International Code of Marketing of Breastmilk Substitutes

The International Code Documentation Centre will hold its annual training course on implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly Resolutions in Penang, Malaysia from 14 to 23 September 2003.

Intended for policy makers within national governments, the aim of the course is to support governments in writing laws and other measures to implement the International Code.

Details and an application form can be found on the International Baby Food Action Network (IBFAN) website at <http://www.ibfan.org/english/activities/training/icdc01.html>

Medicine in conflict

A recent supplement to The Lancet, entitled *Medicine in Conflict*, examines some of the effects of conflict on individual health and human rights. It makes no attempt to be comprehensive, but presents an array of personal experiences of those working in conflict zones.

Topics range from mental health in Afghanistan and East Timor, food shortages in North Korea, and reproductive health in emergencies, to gender-based violence in refugee settings, the link between war and infectious diseases, and the reality of bioterrorism.

The supplement is available free online, at <http://www.thelancet.com/journal/supplement/vol360/iss1/> *Medicine in Conflict*. The Lancet, Vol 360, Issue 1, supplement (2002)

Famine relief and health care

The number of deaths caused by the ongoing drought in southern Africa could be greatly reduced by improving basic health care, according to the World Health Organisation (WHO). It argues that rainfall failure has triggered a crisis in healthcare systems that were already suffering from long-term deterioration. Some countries in the region, such as Malawi and Mozambique, are running health care systems on a budget of \$10 per person per year, so shortages of essential medicines and other health supplies in health centres are common. Low salaries and difficult working conditions for health care workers have led to a 'skills drain', says the WHO. It suggests that countries, as well as distributing food aid, need to strengthen their capacity to provide health care in the worst affected areas. Improving access to drugs and increasing staff levels are key recommendations.

Vass A (2002). Famine relief must also tackle health care. *BMJ*, Vol 325, 17th August 2002, pp 355

Genetically modified food in emergencies

An editorial in the *Lancet* draws attention to the rapidly emerging issue of using genetically modified (GM) foods in emergency programmes. It highlights the Zambian government's decision to allow maize donated by the United States of America (USA) to spoil in warehouses because it is genetically modified, despite the food crisis in the country. President Mwanawasa has even called GM maize 'poison', saying he is not prepared "to use our people as guinea pigs". In some areas, citizens have rioted and looted to get at the food.

According to the editorial, lack of safety is just one of the charges flying back and forth. Officials in the USA view the arguments as baseless, pointing out that the donated food is the same as what Americans have been eating for years. But critics claim that the USA is promoting biotechnology companies, using the UN to do its protectionist bidding, and offloading surplus food it cannot sell.

Potential advantages of GM foods, achieved through improved crop protection, include insect and virus resistance and herbicide tolerance. Public health might be improved by a greater supply of hardier strains, or by products that have been enriched with vitamins and minerals. Disadvantages are that GM foods may threaten biodiversity and decrease the richness and variety of food. Also, farmers may become dependent on chemical and biotech companies through the use of sterile seed or chemical products that would have to be purchased annually. Health concerns include allergenicity and gene transfer, especially of antibiotic resistant genes from GM foods to cells or

bacteria in the gastro-intestinal tract. Furthermore, 'outcrossing', or the movement of genes from GM plants into conventional crops, may pose indirect threats to food safety and security.

The editorial states that recipients have legitimate worries about being bullied into accepting something they perceive richer nations to have rejected. According to the World Health Organisation (WHO), all GM foods currently used have been assessed for safety and "are not likely to present risks for human health". But the editorial questions how sound this evidence base actually is and suggests consumers are probably right to be sceptical at the moment. Regulation varies from country to country, with no international regulatory system, and GM foods are produced in many different ways. WHO rightly cautions that foods must be assessed on a case-by-case basis and by mid-2003, the international food code (created by the Codex Alimentarius Commission) is expected to spell out specific principles for evaluating individual GM foods. The editorial concludes that if these principles incorporate rigorous scientific analysis, particularly of indirect effects on human health, and if they take a holistic approach toward integrating the disparate effects of GM foods, including their social and ethical aspects, they will be an important step towards strengthening the evidence for safety. Such evidence must be widely communicated to people in the developing and developed world alike.

Lancet (2002): How safe is GM food? Vol 360, No. 9342, 26 October 2002, editorial, pp 1261

Ethiopia, Dried out maize harvest with barely any crop on it
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International Summer School in Forced Migration 2003

7 - 25 July 2003: Oxford, UK

This three-week residential course provides a broad understanding of the issues of forced migration and humanitarian assistance. Participants examine, discuss and review theory and practice, and develop communication and analysis skills useful for the workplace. Designed for managers, administrators, field workers and policy makers in humanitarian fields, it combines lectures and seminars with small group work, case studies, simulations and individual study.

Course fees are £2300 sterling (incl. B&B accommodation, lunches, tuition fees and course materials).

For more information, contact the Summer School Administrator at Refugee Studies Centre, Queen Elizabeth House, University of Oxford, OX1 3LA, UK. Tel +44 (0)1865 249745 or email: summer.school@qeh.ox.ac.uk

Nestlé's demands on Ethiopia

The Swiss multi-national food giant, Nestlé, committed last week what may be the public-relations blunder of the decade, according to a commentary in *The Lancet*. Nestlé shocked many by demanding from Ethiopia return of US\$6 million that the company feels it is owed as "a matter of principle". In 1986, Nestlé bought the parent of a German company which the Ethiopian government had nationalised in the 1970s. The government had offered Nestlé US\$1.5 million (at today's exchange rates) as compensation, but the company, using the exchange rate at the time of nationalisation, says the debt is now US\$6 million.

The situation was brought to light on December 18 2002, in an Oxfam press release highlighting Nestlé's demand. US\$6 million would, Oxfam argued, provide safe water for 1.5 million families or anti-diarrhoeal medicines for 750,000 children in one of the poorest countries in the world. In response, there appeared to be some mellowing of the company's position, but not the principle that a debt was outstanding. Nestlé said they would invest any repayment proceeds in Ethiopia in a project that will benefit the country. Last year, Nestlé made profits of US\$3.9 billion.

McNamee, D (2002). Commentary, *The Lancet*, Vol 361, Jan 4, 2003, p12

HIV/Aids, livelihoods and food security

With increasing concerns regarding the impact of HIV/AIDS on people's livelihoods, there is growing need to re-orientate agriculture, food and nutrition security programs to take account of HIV/AIDS, and to fill critical gaps in our knowledge where these exist. RENEWAL - the Regional Network on HIV/AIDS, Rural Livelihoods and Food Security - is a capacity development/action research initiative based in east Africa, which aims to foster proactive linkages between national agricultural and public health organisations, and between academia and policy makers.

The preparatory phase of this initiative is currently under way in Uganda and Malawi, involving national multi-sectoral stakeholder workshops that, in turn, generate priorities for action and for targeted research. Action research studies, focused on at least one of the priority areas and directly involving local partners, are selected and funded out of an Action Research Fund (ARF). Findings will be discussed in subsequent policy workshops. The initiative is facilitated by the International Service for National Agricultural Research (ISNAR) and the International Food Policy Research Institute (IFPRI).

See the project website for more details (www.isnar.org/renewal) and the IFPRIs website for two linked essays on AIDS and food security (www.ifpri.org/).

NutritionNET: independent nutrition information exchange

By Saskia van der Kam, chairperson of NutritionNet, and headquarters nutritionist in MSF Holland.

Psychosocial training for aid workers

The Refugee Studies Centre, University of Oxford, has released a revised second edition of their psychosocial training module, *The Refugee Experience*. The 30-hour module, with associated resources, is designed to facilitate the training of humanitarian assistance workers in response to the psychosocial needs of refugees. The module targets the development of critical competencies in the planning, implementation and evaluation of psychosocial programmes. Materials also deal with community participation, and communication and helping skills for humanitarian workers.

A range of topics are covered, including:

- the effects of modern day conflict on civilians
- a cross-cultural understanding of the experiences of refugees
- an insight into gender issues for refugees
- the particular plight of refugee children.

The module is available on the web, free of charge:

<http://www.forcedmigration.org/rfgexp>. A printed version (two manuals) and CD-ROM may also be available where web access is limited.

The Psychosocial Group at the Refugee Studies Centre has also produced an online inventory of unpublished literature that allows ready access to project-related documentation, exemplifying key methods and principles of psychosocial interventions. In addition, a research guide on psychosocial assistance in aid and conflict has been developed which looks at key issues, interventions and research, and includes a review of literature not otherwise available electronically. See the guide online at www.forcedmigration.org.

For further information on any of these resources, contact Maryanne Loughry, Refugee Studies Centre, Queen Elizabeth House, University of Oxford, 21 St Giles, Oxford, OX1 3LA, UK
email: maryanne.loughry@qeh.ox.ac.uk tel: +44 (0)1865 270268

Evaluations of emergency nutrition programs have repeatedly illuminated the need for improvement in several operational areas including inter-agency co-operation, communication, transparency and shared ownership of interventions. Humanitarian players need to share information and experiences in order to assure timely and appropriate action in nutritional crises.

Attempts have been made to improve communication between nutritionists, field workers and policy makers. Whilst successful, the three-year run of NGONUT - a moderated e-mail exchange of ideas, question and answers between nutritionists - illuminated the need for a more extensive forum of information exchange and dynamic debate, and a demand for improved access to grey literature and distance learning modules. NutritionNET, which is a web-based interactive platform, was created in response to these needs.

The aims of NutritionNET are to increase the quality of nutrition and food security interventions by promoting:

- Coherent and consistent inter organisational policies
 - To contribute to policy discussion
 - To promote transparency in decision making on all levels
- Context specific guidance for standards and strategies
 - To share context specific program strategies and protocols
 - To share lessons learned from field experiences
- Capacity building in developing countries
 - To promote professional information flow accessible in developing countries
 - To promote networking between individual professionals and organisations
 - To disseminate information of field staff, expert groups, policy makers
- Active participatory learning
 - To participate in problem-solving
 - To facilitate subject specific in depth discussions and build data bases
 - To contribute to product (food, materials) development
 - To stimulate debate



including different perspectives e.g. disciplines

- Discussions and dissemination of information in 'grey' literature.

As a working area rather than a pure reference site, participants actively contribute and respond to new information and commentary, and can create their own discussion groups/clusters. Shared information may range from the latest news about emergencies and technical details on micronutrients, to questions from the field and dilemmas about food security strategies. Moreover, professionals can advertise their skills and identify potential colleagues, job vacancies and courses.

The benefit of a virtual meeting place is that it is open to participants who are not part of the humanitarian aid 'inner circle' of nutritionists. It also gives professionals from aid-recipient countries the opportunity to participate in programme decision-making and implementation, and help develop context sensitive strategies and programme accountability.

There are a number of characteristics of NutritionNET, which set it apart from many other websites:

Pure interactivity: Participants work without the input of a committee or board to check the value or quality of information. Specific expert groups may, however, be convened and work effectively and safely, governed by internal quality control.

Subject driven: NutritionNET is a platform to develop broader issues around nutrition and food security. It is hoped that it will evolve into a regular first point of query for all those involved in nutrition and food security interventions.

User ownership: Responsibility for the operation and management

of NutritionNET lies completely with participants themselves.

Transparency: Processes are transparent, since all information and debates are directly shared on the website.

Independence: There is no particular school of thinking promoted and all views are equally represented, without panel censorship or donor influence (there is a broad funding base).

The challenge of sharing

As a meeting place and a working area, NutritionNET must be treated as a safe zone. Participants should be able to challenge each other and examine problems from different angles, without being held accountable or personally criticised. There is no such thing as a 'wrong' answer, but only interaction, exchange and learning. Content quality is controlled by participants who take the initiative, or not, to respond.

During this first six months of NutritionNET's existence, there has been much interest and use of information available on the site. However there is a greater hesitancy in contributing information. This may reflect fear of exposing lack of knowledge with implications for personal and professional reputation. While this caution may be understood, it is only through the contribution of participants that nutritional experience and knowledge will accumulate and become available to others. With the development of NutritionNET, sharing information is now more of a mental challenge than a physical or logistical one. Can YOU rise to this challenge and dare to share?

Join Nutritionnet at <http://www.nutritionnet.net> or for further information or comment, contact Saskia van der Kam, Nutritionnet Chairperson, email: saskia.vd.kam@nutritionnet.nl

Shared experiences of Southern Africa crisis

Summary of meeting

By Marie McGrath (ENN)

On November 5th, 2002 a meeting was convened by MSF Belgium on the nutritional situation in Southern Africa. Representatives from Save the Children UK (SC UK), Oxfam GB, Action Against Hunger (AAH), MSF International, MSF Luxembourg (MSF Lux), MSF Belgium (MSF B), MSF Holland (MSF H), MSF France (MSF F), MSF UK, MSF Switzerland (MSF CH), and the Emergency Nutrition Network (ENN) were present.

The impetus for the meeting was a growing perception that conflicting information was emerging regarding the nature and severity of the situation in Southern Africa. The purpose of the meeting was to share analyses and agency perceptions of the crisis, to identify and explore any differences, and to build a common understanding - with the aim of making recommendations for the future.

To set the scene, an overview of the Southern Africa crisis was presented by MSF B. This was followed by a number of country-specific reviews by different agencies, around which there were considerable discussion and debate. The afternoon session focussed on perspectives of the Angolan situation.

Country reviews¹

In terms of anticipated food shortages and populations affected in Southern Africa, it was estimated that one-quarter of the population, nearly 14.5 million people, in six countries (Zimbabwe, Mozambique, Malawi, Zambia, Lesotho, and Swaziland) were in need of food aid for the period September 1, 2002 to March 31, 2003.² In Angola, an additional 1.4 million people were considered in need.³

Summaries of agency experiences in Mozambique (MSF Lux), Zambia (MSF H), Zimbabwe (SC UK) and Malawi (Oxfam GB) highlighted, to varying degrees, increased livelihood vulnerability, declining food security, but relatively low levels of malnutrition. MSF-Hs review of the situation in Zambia, for example, highlighted the considerable shortfall in maize supply, both through aid networks and government sources - a situation complicated by Zambia refusing genetically modified maize in October. At the time of the meeting, nutrition surveys⁴ had demonstrated relatively low prevailing levels of malnutrition. While MSF expected "pockets" of deterioration in nutritional status, Oxfam GB's experiences from the south were that coping mechanisms were already stretched (due to crop failure), and the hungry season had started early. Although the rates of global acute and severe acute malnutrition found in July 2002 were not at emergency levels⁵, they were higher than expected. Oxfam GB also described how HIV/AIDS was also impacting on the population's ability to cope, and risk of infection was increased as women resorted to sex to secure food or income.

How information was interpreted varied between agencies. Based on their experiences in Mozambique,

MSF Lux expressed doubts over the predicted numbers in need and did not consider the situation a crisis, despite reports of deteriorating food security. However, SC UK suggested that there was considerable variation between the north and south of the country. This view was shared by Oxfam GB, who voiced that the anticipated poor harvest and increasing vulnerability of the population warranted immediate preventive interventions.

The multi-sectoral and often complex influences of individual country situations were highlighted in reviews of both Zimbabwe (SC UK) and Malawi (Oxfam GB). SC UK's experiences in Zimbabwe highlighted how climatic, economic, political and social factors - not just land reform issues, had all contributed to the emergency. Although prevalence rates of malnutrition have varied⁶, SC UK felt the prognosis until March 2003 was poor, with limited expectations for the winter harvest (estimated 40% reduction) and increasing government-imposed limits on NGO operational space. Meeting immediate food needs was only a stop-gap, and did not address the underlying political and social reforms necessary to prevent the situation recurring - a point made by MSF, and reflected in SC UK and Oxfam GB's outline of activities in regional advocacy and livelihood support.

In Malawi, Oxfam GB described how chronic poverty, HIV/AIDS, erratic weather patterns (leading to two consecutive poor harvests) and a steady decline in national food security had all contributed to a crisis of livelihoods. Shortfalls in WFP funding (Emergency Operation (EMOP) only 50% funded), and limited supplies of expensive agricultural inputs were also compounding the issue. Estimates suggested that 28.5% of the population (3.25 million people) would be in need of food assistance for the period December 2002 and March 2003⁷. Although malnutrition and mortality rates were low⁸ at the time of the meeting, Oxfam GB felt that multi-sectoral interventions were essential to prevent further deterioration.

Outlining their recent experiences in Angola, MSF described how, following the April 4th ceasefire, there was suddenly access to a population which had been largely inaccessible for 3-4 years previous. Numbers presenting to MSF centres dramatically increased and, between May and June 2002, MSF B doubled the number of feeding centres (30,000 patients). Further indications of the scale of the situation were reflected in a UN assessment in April/May 2002, which estimated 500,000 to 800,000 people were affected by malnutrition. Also, a retrospective mortality survey, conducted in the famine areas by Epicentre, showed that the situation had passed the emergency threshold for almost a year.

By November 2002, the situation in Angola had stabilised (malnutrition rates had fallen), but high mortality rates and poor vaccination coverage persisted. A lack of harvest in 2002, considerable

shortfall in the food pipeline supply to Angola, and inadequate funding of the WFP EMOP (27% funded) all contributed to an ongoing emergency situation. Furthermore, resettlement and closure of the Family Quartering Areas (FQAs)⁹, strongly promoted by the Angolan government, was placing agencies under considerable pressure to meet the needs of an increasingly dispersed population.

Topical issues

Throughout the day's proceedings, a number of issues emerged which were debated at length, in particular, MSF's experiences in Angola, how different agencies quantify and define a crisis, the politicalisation of resource allocation in humanitarian response, and how information is communicated and interpreted in a complex emergencies.

The Angolan situation

Regarding Angola, MSF voiced strong opinions regarding the humanitarian response to the recent crisis there. In particular, they felt that:

- * There was an unacceptably slow international response to this major crisis.
- Delivery of essential aid to the population was delayed by 4-6 weeks, due to lengthy UN negotiations at higher levels. In contrast, MSF had secured earlier access through negotiations at a provincial level.
- There was a lack of initiative and diversity amongst NGOs, with many operating as a homogeneous group within the UN system. According to MSF, this problem persists and could lead to a loss of NGO neutrality and impartiality.
- The WFP failed to grasp the scale and the urgency of the crisis and although the WFP experienced genuine financial and logistical constraints, MSF feel these did not entirely account for their slow reaction.
- Considering the UN shortfall, more NGOs should have become involved in food distributions.

In response to the criticisms levied, a number of agencies outlined their activities, which reflected that Angola was a serious consideration for them even before the current crisis. SC UK outlined their strong advocacy role e.g. through the British Overseas Agencies Group (BOAG), demonstrating that Angola has always been high on their agenda. It was also countered that strong co-ordination within the UN system had made several actions possible in Angola, particularly in light of the limited resource capacity of some agencies. In terms of food supply shortfalls, one unofficial source suggested that WFP were so pessimistic about meeting targets that they were approaching petrol companies to lobby donors for funds, as any deterioration in the Angolan security and food security situations might compromise access to oil.



Defining a crisis

MSF's field experience of relatively low levels of malnutrition, which they initially thought might prove contrary to others, was shared by all those present. Based on these criteria, MSF felt the situation was not at crisis level. However, SC UK, Oxfam GB and AAH felt that elevated rates of malnutrition were not a pre-requisite for defining a crisis situation.

'Promising' a famine

There were a number of interpretations of the appropriateness of the Southern Africa appeal, the level of crisis in Southern Africa, and whether the crisis should have been defined as a famine. Both MSF and AAH felt the use of the term 'famine' risked promising the world starving millions, while in reality, it has proved very difficult to predict the outcome of the current fragile situation in Southern Africa. Furthermore, MSF suggested that potentially "crying wolf" at this point risked exhausting capacity to mobilise funds and response when a "real" emergency actually occurred. A case in point, they felt, was the Angolan situation which due to the Southern Africa appeal, did not receive the level of attention that it warranted.

MSF also suggested that indicators of one type of nutrition assessment approach should not be used to describe or predict scenarios that they cannot accurately measure. Thus, a food security assessment could not predict a famine with certainty.

A different perspective was held by other agencies, such as SC UK and Oxfam GB. Rather than promising a famine, they felt the Southern Africa appeal anticipated a famine and could therefore be seen as 'a preparedness measure'. As such, it was justified in securing resources to act before the nutritional situation deteriorated.

Communication

The meeting questioned the extent to which NGOs should use the media, and considered possible repercussions for other operations. For example, MSF felt that the NGO instigated media attention around

the Southern Africa appeal negatively influenced coverage of the Angolan crisis.

All agreed that accuracy and transparency were essential in any communications around an emergency. However, questions remained regarding the aid communities' capacity and required strategies to maintain attention and mobilise resources for chronic emergencies.

Politics

Considerable criticism was levied by MSF at the UN in Angola, in particular at how the UN framework for operation allied humanitarian intervention and response too closely with political goals. MSF suggested that since NGOs were co-ordinated by the UN system, they risked losing their own impartiality and neutrality. Furthermore, the high level of UN funding in Angola gave them considerable control over agencies, which may have discouraged freethinking and action.

Donor reluctance to fund interventions in Angola was cited as a problem by all agencies. Apparently, many donors needed evidence of clear benefits before committing funds and also argued that responsibility lay with the Angolan government to use its resources to support its people. Many of those present at the meeting felt that this position was disingenuous, and was a convenient smoke screen for the 'political' basis of donor funding decisions.

Validity of data

The accuracy and interpretation of information was called into question, with particular reference to crop assessments in Malawi where predictions varied widely from one week to another. For some, this undermined the strength of the argument that a crisis was looming. For others, irrespective of the disagreement between figures or methods used (e.g. maize versus maize equivalents), there was enough evidence to suggest a significant shortfall and a worsening trend. It was agreed that greater standardisation of assessment approaches was needed.

Conclusions

Gaining an insight into the rationale behind aid responses and strategies in Southern Africa was considered a valuable outcome of the meeting, and was deemed essential to understanding diverse agency activities. Discussions also gave an insight into the detailed conceptual frameworks and analysis that underpin agency positions, communications and activities in complex emergency situations.

Irrespective of varying agency perspectives, and persisting difficulties in ascertaining the level of "crisis" risk of different countries, it was felt that the situation in Southern Africa was serious and likely to deteriorate. All of those present agreed that a similar type meeting, to share agency operational experiences and strategies, would be valuable and should be timed for early 2003.

¹ Country reviews were based on agencies experiences and activities at the time of the meeting (5th November 2002). These may not necessarily reflect the situation current at time of publication.

² Source of figures: USAID, October 4th, 2002. Anticipated population size affected and food aid needs are based on SADC (Southern African Development Community) FANR (Food, Agriculture and Natural Resources) assessments released on September 16, 2002.

³ Estimated figures have since been revised to 1.9 million by WFP (Dec, 2002)

⁴ Surveys in western (MSF-H) and southern Zambia (MSF-H, World Vision) have shown low levels of malnutrition, ranging between 3.3-4.3% global acute malnutrition and 0.7-1.2% severe acute malnutrition. The surveys covered various periods between May and July, 2002.

⁵ Oxfam GB nutrition surveys of Southern and Western Provinces. Prevalence of global acute malnutrition <6%, prevalence of severe acute malnutrition 1-2% (July, 2002)

⁶ UNICEF nutrition survey found an average 6.4% prevalence of acute malnutrition, but in some areas this was as high as 18.2% (May, 2002). In July 2002, surveys by SC UK in the Zambezi valley area found an acute malnutrition prevalence of 5.1%.

⁷ SADC/FANR Vulnerability Assessment Committee (VAC) Report (August, 2002)

⁸ Oxfam GB surveys: Mulanje: 1.7% GAM, 0.5% SAM and Phalombe: 0.85% GAM, 0.3% GAM (September, 2002)

⁹ Family Quartering Areas now officially referred to as gathering areas (Dec, 2002)

Ethiopia: another 1984 famine?

By Saul Guerrero



Saul Guerrero has a background in Social Anthropology. He is currently completing a Masters in Humanitarian Assistance at University College Dublin, while undertaking an internship with the ENN.

This article is based on a review of recent literature as well as a number of interviews with humanitarian agency staff that have had long-term experience and knowledge of Ethiopia. The basic question that the ENN has tried to address in this piece is 'are we about to see another "1984" in Ethiopia as various appeals have anticipated or have lessons been learnt which make this unlikely?'

For almost a year, the government of Ethiopia and a number of international organisations have been warning of widespread famine in the country, should the international community not bring in sufficient food aid to remedy the food-deficits left by the crop failures of 2002. The result of erratic (short) and meher (long) rains was a projected food deficit of over 1.4 million MT for the first quarter of 2003, with the number of people requiring immediate food assistance estimated at 11.3 million, or approximately twenty percent of the total population. Crop-failure estimates vary between regions, however the nationwide average is 15-20%. The impact of such failures is even more significant in a country that is only barely self sufficient in the best of years. Nutritional surveys have demonstrated a serious situation in some areas, with 15% and 11% GAM (Global Acute Malnutrition) reported in eastern Oromiya and eastern Tigray respectively.¹

The scale of the situation has led many international agencies to compare the current situation with the historic famine that affected Ethiopia in 1984-85. At the heart of this comparison lie two main indicators. First, the estimates of people in need of food assistance - a figure that stood at approximately 8 million people in 1984 has risen to 11.3 million in 2003. Secondly, the per capita income in Ethiopia has significantly declined from US\$190 in 1981 to US\$108 in 2001, thus markedly reducing the purchasing power of the population at large. While such statistics may not be sufficient for an accurate comparison, the media attention that the present situation, is enjoying demonstrates the impact of such comparisons, and the paramount need to prevent a repetition of the traumatic 1980s experience. A legacy of the horrors of 1984 may be that few have

questioned the real scale of the present situation while even fewer have attempted independent analysis/estimates that may lead to lower estimates of food-deficits in the country than those in the Ethiopian and UN appeals, and expose the uncertain basis for the continual comparison with the events of 1984.

There are, however, certain comparisons with 1984 that can confidently be made. These relate to the underlying causes of the food crisis. Anne Callanan (who has extensive Ethiopia experience with the WFP and Concern) argued that climate-dependent agriculture, state-controlled land tenure, poor infrastructure and high population density have contributed immensely to both events, and more importantly, to the creation of a marginal and highly vulnerable agricultural system in Ethiopia. Both events - the 1984 famine and the current food crisis - are also mainly the result of cumulative bad-harvests due to drought. "The cycles of drought" say Callanan, "are coming closer and closer together; we can count 1974 when there was obviously two, three drought years before that because famine is never a result of just one drought year. Then there was '84, which was again the end point of a five-year drought cycle [...] the year 2000 was another extremely bad year and people are just not recovering". The effects of such droughts have been similar on all occasions; coping strategies are reduced, as cattle, personal possessions and just about any marketable goods are sold or traded to satisfy short-term needs. "Save the Children" explains Callanan, "have done a lot of Household Food Economy Assessments (HFEA) in one particular area and they are documenting the gradual impoverishment of the population...HFEAs divide people into wealth groups, and they are actually seeing shifts in people down through the wealth groups going from middle-income to poor and to very-poor".

While the succession of crop-failures prior to 2003, with all its effects on coping mechanisms, may be comparable to the 1984 experience, much has changed in the way the government of Ethiopia, and perhaps more importantly, the international

community are responding to drought and its impact on the country. These changes - whether preventive or in response to food-crisis - may prove vital in the current situation.

Dan Maxwell (CARE International) had this to say on the subject; "the dimensions of the shock that triggered the current crisis may well be comparable, but that is no reason why the humanitarian crisis needs to be comparable. The shock, and the decline in domestic production - with all the knock-on effects this has for food access at the producer household level as well as in terms of the market - may well be proportionately as big as what happened in 1984. But the entire emergency response has been geared to preventing the shock from translating into a humanitarian disaster". Maxwell identified a number of mechanisms which have been introduced post-1984 and have been designed to identify and respond to recurrent 'shocks'. Among some of the most successful are the Early Warning Systems (EWS) found working throughout Ethiopia, e.g. the USAID funded Famine Early Warning System (FEWS), which monitors a range of indicators of food security including satellite imagery on crop and vegetation production. Similarly, the World Food Programme 'Vulnerability Assessment Mapping Unit' and the Ethiopian Disaster Prevention and Preparedness Commission (DPPC) monitor the food-security status of regions throughout the country.

The EWS have proven effective in identifying





problems and in highlighting them sufficiently in advance. Yet their signals do not guarantee a response. “The Early Warning Systems” says Callanan, “were definitely sending out the alert in 1999 and nobody was reacting at the time and continued to send out alerts in 2000 by which time there was widespread suffering notably in Somali region. This time they are sending out the alert again...”

Another significant difference introduced in post-1984 Ethiopia has been the creation of the Emergency Food Security Reserve (EFSR) which is capable of storing over 400,000 MT of food. For many, including Maxwell, the EFSR has proved to be working “better this time around [than in 1999-2000]” and thus could prove vital in addressing the identified food-deficits for 2003. Yet, critics such as John Seaman (Save the Children, UK) have argued that the reserve has been repeatedly utilised and manipulated for political purposes. Certainly the reserve has experienced a rapid decline in its physical stocks from over 350,000 MT in early 2002 to an estimated 134,801 MT for March 2003. This decline has jeopardised the stock which, if it does not receive standing payments may cross the operational threshold of 100,000 MT when the delivery of further loans becomes impossible.

Significant changes have taken place over the past two decades on a wider political level which augur a

different outcome to 1984. The present Ethiopian government appears more ready to acknowledge and act upon the crop-failures. This attitude is very different from that of the Mengitsu government during the 1980s. For Maxwell, this is noteworthy; “[Unlike the 1980s] the government in Ethiopia is not trying to sweep it all under the rug [...] and there isn’t a war complicating relations with the donor community or absorbing a lot of internal attention”. Callanan has also noted the impact of domestic policies on donor’s commitment. “The early 1980s”, says Callanan, “was the time of the Cold War and Mengitsu was heavily supported by the Soviet Union and of course the Soviet Union does not donate food...and actually to get food at the time from Western donors was a big political battle”. This political reluctance to support Ethiopia no longer holds with a contextual change that, according to Seaman, makes the famine of 1984 and the current situation almost incomparable.

All the positive developments since the 1984 famine do not seem to have appeased the international community’s fear of history repeating itself. The comparison between the current food crisis and the traumatic events of the 1984-85 famine continues to be utilised by the UN, Ethiopian Government and a wide variety of NGOs’ appeals. Yet, if the humanitarian sector responds to all the warning signals in time there appears to be little risk of another 1984. The fact that the comparison has been

extensively used as an advocacy tool is perhaps understandable. After all, the 1984 experience was a benchmark in international humanitarianism, both in terms of its traumatic effects on the attentive world as well as the resulting commitment to prevent such tragedies occurring again. For many, including Callanan, the comparison has neither been used inappropriately nor prematurely, considering the results of harvest assessments and the lag time between donor pledges and the actual physical distribution of food to Ethiopia. Yet, the use of such comparisons inevitably raises the question should the situation never reach the end point it did in 1984, what will happen if, and when, in the future if and when we do witness another serious food shortage in Ethiopia? Will the donors be compelled to act? Or will what may be seen in hindsight as a form of ‘crying wolf’ this time round, cost the Ethiopians precious time and assistance in the future?

I would like to express my sincerest gratitude to Anne Callanan, Dan Maxwell (CARE) and John Seaman (Save the Children UK) for their time, assistance and wisdom shared during our interviews.

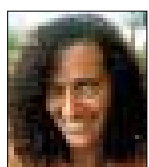
¹ Figures taken from the “Emergency Assistance Requirements & Implementation Options for 2003; A Joint Government-UN Appeal”, December 7th, 2002.



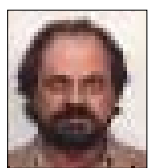
Burundi Ngozi province. Survey to assess economic security in a village
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Household Economy Approach in Burundi

By Sonya LeJeune and Julius Holt



Sonya Le Jeune is currently a programme manager with SC UK in Liberia, working on a food security and livelihoods programme. Previously she has worked with SC UK in Burundi, where she was seconded to the WFP.



Julius Holt is a full-time partner in the Food Economy Group consultancy, with an academic background in anthropology and human nutrition. He first observed drought and hunger as a VSO relief assistant in Botswana in 1966, and became more involved with famine relief for SC-UK in Ethiopia in 1973. Since then, he has specialised in food security assessment and programme planning, with particular interest in the Horn of Africa and the Sahel.

This article outlines key elements of the Save the Children UK Household Economy Approach and Food Economy Analytical Framework, and describes WFP's successful adaptation of the methodology in Burundi. The field experiences described are based on a WFP report drafted in September 1999.¹

Since 1993, the World Food Programme (WFP) has provided food support in Burundi, with activities focused on the distribution of emergency food rations to displaced people, vulnerable group feeding and food for work projects. Since May 1995, Save the Children UK (SC UK) has seconded food security advisors to WFP-Burundi. The main role of these advisors has been to help WFP try out and adopt the Household Food Economy Assessment approach (HFEA),² as a means of helping target beneficiaries within the displaced population.

Making Sense of IDP Sites

Significantly, the displaced population have accounted for about two-thirds of the WFP's food aid in Burundi. In 1999, there were roughly 750,000 internally displaced people (IDPs) in approximately 300 sites, with numbers ranging from fifty to several thousand people (almost all of rural origin) in each site. Some had fled their homes spontaneously in the face of perceived danger and had sought official protection in sites, whilst many more had been officially moved from their homes and 'regrouped' in sites for security reasons. At any given moment, while some IDPs would be newcomers, most would have been present for one or several years.

Access to land has been the single most important determinant of economic status. However cash savings, realisable assets, remittances, capacity to undertake casual employment and the offer of employment are also key determinants of economic security. The majority of people in the IDP sites were near enough to their own land to allow them convenient access for cultivation and, in some cases, those displaced could borrow nearby land. For others, however, distance or insecurity has prevented land access.

The challenge for WFP was to devise an assessment process which would inform them whether or not food aid was needed in a given site, and if so, why, for how long and whether specific groups within the site were at particular risk. Two outstanding problems had to be faced from the start. First, the sheer number of sites to be assessed limited the time that could be devoted to any one site and secondly, there was an almost complete lack of documentation regarding the sites and their immediate hinterland.

A hesitant beginning

When the first food security advisor was seconded to WFP in May 1995, the

SC UK Household Economy Approach (HEA)²

The main objective of the Household Economy Approach (HEA) is to identify the impact of a shock on the ability of households to acquire food and non-food goods. The first stage in a food economy analysis is the development of a baseline profile, which involves:

- defining the food economy/ household zones in the area of analysis
- socio-economic differentiation, defining wealth or 'access' groups within each food economy zone
- interviews to establish sources of food and income, and expenditure, for households in each wealth group.

The second stage involves collecting hazard information, such as changes in rainfall, crop production, pasture condition or market prices. Outcome analysis involves incorporating the hazard information into the baseline profile.

Both primary and secondary information is compiled, most of which is collected at a community level. Primary data are generated through PRA/RRA,³ focus group interviews, key informant interviews, ranking (including pair-wise) and proportional piling. Interviews are conducted with representatives of particular wealth groups which are self-defined by the community. The interview then refers to a 'typical' household in that group. Interview locations are usually chosen to include as much variation as possible. Interviews are highly structured and a typical interview takes about two hours. Secondary data are used to define the food economy zones.

Analysis aims to estimate the likely effect of a shock on the ability of households within a population to:

- acquire sufficient food
- maintain its non-food consumption, e.g. education, health, fuel, soap and other goods.

Food, cash income, and expenditure are converted into 'food equivalent' units. For the baseline profile, sources of food and income must add up to an average of 2100 kcals/person/day (the designated minimum food requirement for survival). The approach also assumes that there are minimum non-food requirements that need to be satisfied through income and production.

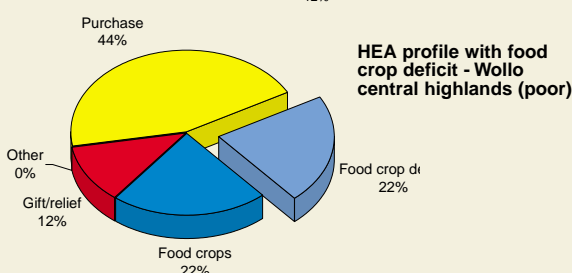
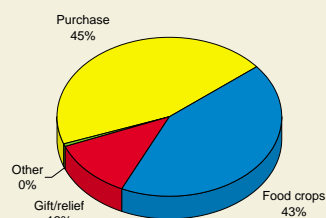
There are two steps involved in estimating whether the household faces a food deficit. The first requires calculating the likely household deficit resulting from the problem, while the second estimates the household's ability to overcome this deficit.

For example, if a household usually generates 50% of its income from food crops, a 50% fall in food crops will lead to an overall 25% fall in household income. An analysis of the ability of a household to overcome the deficit will include:

- consumption of food stocks
- expanding income from wild foods
- receiving gifts
- generating additional income through labour, sale of livestock, and borrowing from kin.

In determining the food gap and consequent requirement for food aid support, certain types of coping strategy will not be accounted for, e.g. sale of key assets, environmentally damaging activities, and illegal activities.

HEA profile - Wollo central highlands (poor)



HFEA methodology had only recently been formalised by SC UK and its first major application (with WFP food monitors in south Sudan) was at an early stage. Although the seconded food security advisor was aware of the technique, she had no direct experience of the field procedures. Whilst proving a useful learning experience for all involved, it did delay the WFP's particular application of the approach until the arrival of a second more experienced advisor in October 1997.

Throughout 1995, a strong commitment developed within WFP to use the methodology and a process of documentation and training began in the latter part of the year. An initial workshop was held in November 1995 to introduce the food economy framework to eleven WFP field staff. The participants then carried out assessments in a variety of settings, including amongst IDP and refugee populations. Findings from these assessments were presented during a second workshop in December 1995 where participants considered the advantages and disadvantages of the method and refined procedures accordingly. A third workshop was held in July 1996 to introduce HFEA to new field staff and assessments then continued as a periodic duty of programmes and field officers.

In early 1997, WFP established two permanent evaluation teams (three people each), who were assigned responsibility for all site assessments using HFEA. One team was based in Bujumbura, the second in Ngozi. A third team was planned in 1997 but for various administrative reasons, was not created until March 1999, again based in Bujumbura. The arrival of the new food security advisor in October 1997 marked the beginning of a second more technically secure phase in the application of HFEA to the context of IDP sites.

Donor requirement

A donor requirement attached to food aid supplied by the US was that WFP should not give food to populations it had not seen. Therefore a visit had to be made to any population identified as potentially needy. This contributed to a high workload, since it was not possible to group similar sites together for planning purposes. Also, where a population was inaccessible due to insecurity or distance from a useable road, the teams had to arrange for people to come to an accessible point, such as a nutrition centre. This congregation limited the possibility of forming representative groups and also increased expectations of a food distribution, potentially biasing answers more than usual.

The time factor

The large number of sites to be visited prevented teams spending more than one day at each site for a given exercise. Day length would be further reduced by security considerations (security clearance would only be given at 9am). In Bujumbura, signatures for forms needed to be obtained which often delayed matters up until 10am. During calm periods, vehicles had to be back by 4.30pm but when there was a 'tense' situation, this would be brought forward to 3.30pm. Given that it took an average of 1.5 hours to travel between office and site, a day in the field did not allow much time for interviews. As a result, teams generally forfeited their lunch break.

Fieldwork was a continuous activity. To avoid unthinking routine, each team could only undertake two field visits per week, with the other days devoted to complete write-up of results. During a four month period (one agricultural season), this amounted to approx. 100 site visits (not allowing for staff holidays,

illness, training, being grounded for insecurity, etc.). Generally, there were more than one hundred sites identified as being potentially in need of assistance during an agricultural season. Clearly, there was a lot of pressure on teams to get enough information from just one limited day of questioning.

Population movements

HFEA depends on the target population having been present long enough to establish some identifiable pattern of life - perhaps a month or more. This was the case for most people in most sites. However, in some localities there was much movement, depending on security conditions and large numbers of recent arrivals (perhaps just coming out of hiding). New arrivals in a poor state of health automatically received full rations for several months, however the overall recommendations for the site were based on interviews with long-term residents.

First phase of HEFA (Early 1996 - October 1997)

From May 1997, the WFP carried out site evaluations on a systematic basis. Personnel identified provinces most in need and programmed a series of visits to cover all the accessible sites. In order to get through the work, teams were sometimes obliged to do two evaluations in a single day. Once the supervisor had passed all site reports and recommendations had been accepted, a summary table of distributions was prepared and agreed with the governor of the province. Distribution planning then followed, which could be several weeks after a site visit. However, for obviously urgent cases a distribution was carried out before all the site visits were completed. Sometimes food aid coincided with harvest time, or it was not given during the most food insecure months (timing of distribution was not planned to fit in with the agricultural calendar). There were occasional unscheduled visits in response to urgent requests.

The initial food assessments were based on semi-structured interviews, with questions aimed at the population as a whole rather than trying to characterise typical families. There was no wealth group breakdown. The evaluators collected information on current food and income sources and how they differed from normal (a year from before the crisis - usually 1992 when people were not displaced). The relative importance of the different food and income sources was estimated from proportions stated by informants without proportional piling, or other verification or backup calculations. Pie charts were drawn to compare current food and income sources to before the crisis. The evaluators estimated actual consumption by asking about kilos of food consumed (converted into kcalories). Based on these findings a

Application of HEA

Although qualitative descriptions contained in baseline profiles may identify the need for a range of responses, the assessment is mainly focused on determining or rationalising food aid needs. However other potential applications can include vulnerability analysis, modelling the impact of interventions, e.g. food aid, and estimating the effect of economic policy at the household level. Indeed the approach is increasingly being used to strengthen analysis of livelihood patterns through the baseline profiles, and to identify the nature of vulnerability of different Food Economy Groups (FEG) and wealth groups.

recommendation was made for a number of monthly rations or (if no urgent need was seen) for a Food for Work (FFW) project.

Second phase of HFEA (October 1997 onwards)

The new food security advisor who arrived in October 1997 had been trained in HFEA and was seconded to WFP specifically to provide technical support to the evaluation teams. It soon became clear that there were basic comprehension problems for the teams, largely due to their incomplete initial training and lack of technical support. It was therefore decided to allow teams participate in a real HFEA exercise in a rural area, so that they could see how the various items of information are supposed to link up, to practice hypothesis testing, to understand the calculations and to appreciate the use of secondary sources. The opportunity was taken in January 1998 to conduct a full HFEA in Gitega, to coincide with a nutrition survey.

The fact that the exercise bore little relation to their usual assessment procedures served to confuse the team initially, e.g. two weeks spent in the field instead of a few hours, analysis on the basis of wealth groups, the time period being a year rather than a few months. But the teams slowly grasped the approach and the following six months were devoted to monitoring, correcting and reinforcing the teams work. During this period, a visit from a technical consultant from SC UK helped to focus the timing of evaluations and recommendations so they fitted more appropriately into the seasonal calendar.

By September 1999, WFP were prioritising site visits based on perception of greatest need, rather than systematic coverage. During harvest time there were few assessments of sites with access to land, as farmers would be busy in fields and were also unable to make accurate assessments of crop quantities. This period was therefore used by teams to arrange provincial level meetings with key informants to identify geographical areas where people had not been able to cultivate properly and where there was likely to be a need for food aid in the coming months. A calendar of evaluations was prepared and visits planned to fit in with the agricultural calendar. This process had to be flexible enough to accommodate unscheduled urgent requests.

The core framework of the HFEA was applied and adapted to the specific context in Burundi during the second phase. The chief differences from normal HFEA practice are outlined in table 1.

Conclusions

i) The adaptations made to the HFEA approach have not been fundamental and the basic field procedures, e.g. focus group interviews, have proven workable. As sites had more or less homogeneous populations, it was possible to identify typical households that represented the greatest proportion of each site.

ii) The first phase of the introduction of HFEA in 1995 improved upon the previous rapid evaluations, since it added a new element of food-and-income logic to the exercise. But it was not until the second phase from late 1997, with a fuller and more rigorous application of HFEA, that greater insights were gained into the economy of sites and the economic differentiation of groups so that better reasoned estimates of need were obtained.

iii) The specific constraints of the context did limit scope and depth of analysis, e.g. lack of secondary data to gain better knowledge of the physical and economic areas surrounding the sites. The sites were rather lonely places for evaluation teams and there was little extraneous information to back up what they found out.

iv) Time constraints and the large number of sites to deal with limited the depth of information obtained. Teams had just enough time to get a 'convincing story' but more information, e.g. to help target within sites, would have required more time at each site.

Recommendations

First, there were some concerns about maintaining data quality. During the second phase in particular, the teams gained a strong technical background and sound work patterns developed. However, it was felt that sustaining this effort might be difficult. HFEA depends on each team member being intellectually 'alive', but repetition week in week out may encourage field workers 'to go onto automatic'. There is, therefore, a need to break routine. The authors suggest that the lengthy HFEA procedures used in revisits to sites might be curtailed (at least for the first two visits after the first full HFEA). Extended enquiry would only be necessary if some key factor had changed dramatically. Thus, two proximate sites could be visited in a day. The 'spare' time could then be devoted to outstanding questions which never get answered, for example improved understanding of access to land and its constraints, the casual employment market and the time taken for new arrivals to gain an economic foothold.

Secondly, in order for HFEA to be used to estimate the proportion of a site population requiring food aid, enquiry would need to be extended into an in-depth analysis of wealth groups. This would require more field work time.

The HFEA has proved an adaptable methodology to the IDP site situation in Burundi. It is hoped that this experience will have relevance for others, beyond the Burundian situation.

For further information, contact Sonya LeJeune, SC UK-Liberia, email: dambudzo@mail.com, or Julius Holt, The Food Economy Group, Longview, Browns Spring, Potten End, Berkhamsted, Herts HP4 2SQ, UK. Tel: +44 (0)1442 875 709 or email: feg.uk@foodeconomy.com

¹ Le Jeune S and Holt J (1999): Making sense of IDP sites. A review of the use of household food economy analysis to target food aid for internally displaced people in Burundi. World Food Programme, Bujumbura, September 1999
² The Household Economy Approach. A resource manual for practitioners. Save the Children, 2000
³ PRA/RRA: Participatory Rural Appraisal/ Rapid Rural Appraisal
⁴ Since this report was written, the term Household Food Economy Analysis (HFEA) has been changed to Household Economy Analysis (HEA) within Save the Children, to reflect the fact that food is only part of the household economy.
⁵ At the time of the 1999 WFP Report, HFEA calculations were based on a 1900 kcal survival ration. This has since been revised to a 2100 kcal minimum daily ration.

Sketch of a typical day in the field

Before arrival at the site there is a quick visit to the communal administration to get permission to proceed, for both protocol and security reasons. On site the first interview is with the site leaders. This is a discussion about the general situation such as agricultural conditions, details of recent population movements, the security situation. The teams ask the leaders to describe the main criteria characterising differences of wealth, and, by proportional piling, to estimate what percentage of the site population falls into each one. Based on this, the teams identify the focus groups they wish to interview, e.g. men and women from the 'active poor'. There is usually time for each investigator to conduct 2 group interviews before it is time to leave, allowing for only six interviews in total on site (assuming all three team members are present). However, sometimes an interview will have to end before information makes full sense - the cost of time pressure. If possible, time is set aside for some feedback between evaluators on site, in order to check points and ensure coherence of information.

Back in the office, the team undertakes the analysis based on a consensus of the data collected. The analysis allows the team to:

- a) calculate monthly income earned from different sources
- b) calculate cost of the basic food basket using average price information collected during visit
- c) calculate cost of monthly essential non-food purchases
- d) calculate what percentage of the food basket can be afforded after meeting other needs
- e) convert kilos of food from different sources into calories
- f) calculate the contribution of each food source as a percentage of family needs
- g) verify that they can afford to purchase the balance of basic food which they need to meet an average minimum of 1900 kcals⁵ per person per day.

The information is represented as a hand drawn pie chart to accompany the report. The team usually manages to finalise the reports within 2-3 days of the visit. Once checked the report is used by WFP to plan food distributions.

Table 1 Adaptations made to usual characteristics of Household Food Economy Analysis (HFEA)

Item	Usual characteristic	Adaptation
Food economy zone	A defined population in a geographic area, the majority of whom obtain their food and income through a similar combination of means.	A single site of any size, e.g. administrative area.
'Normal' period	A former year or season which was neither particularly good nor bad.	The past few months, or since the last harvest, or some other logical time point.
Key informants	Give overall information about the food economy zone itself.	Identify geographical region where there may be a problem, or identify specific sites, with reasons for choice. Give permission for the site visits.
Wealth groups	Three or more groups identified on criteria and in proportions, as a result of discussions with key informants.	In addition, identify an outstanding group with problems. For example, those with no access to land because they come from insecure collines or people who have recently arrived.
Secondary data sources	Census, agricultural survey, price records, etc	The teams collect what they can from key informants and group discussions. Limitations include nutrition surveys conducted only occasionally and which might only include site population, minimal official agricultural information due to lack of resources and personnel, and market price data which is not routinely collected in the rural areas.
Scenario	Predict the impact of a given event (e.g. prospective harvest failure) on people's ability to meet needs over a season or year	No 'event' but rather prediction of how families will meet their needs during the immediate future. For those without land, predict for the next 6 months and for those with land, predict up to the next harvest.

Learning from nutrition interventions in Eritrea, Ethiopia and Kenya

Summary of evaluations¹

SC UK survey team in Eritrea
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SC UK recently evaluated a number of emergency nutrition responses undertaken in Eritrea (Gash Barka and Northern Red Sea), Ethiopia (Legambo and Fik) and Kenya (Wajir) during 2000-2001. Reviewed programme interventions included targeted and blanket supplementary feeding, and therapeutic feeding.

Whilst the content of the main recommendations from the evaluations are not ground breaking, they do reiterate the fundamentals of good programming, and the importance of respecting these principles in the difficult circumstances in which emergencies often present. In two of the contexts considered (Wajir and Fik), the affected pastoral populations presented specific programme challenges, while three of the contexts were affected by insecurity (Wajir, Fik and Eritrea). Moreover, since the emergencies coincided in terms of timing and region affected, considerable pressure was placed on SC UK's capacity to recruit additional staff and provide necessary programme support.

The following brief highlights of the key lessons learned may prove useful to other agencies operating in similar contexts.

Preparation and decision-making

From the outset, investment must be made in establishing management systems, such as finance, logistics and administration. Failure to do this reduces the effectiveness of technical staff whose energies are diverted to administrative issues, and risks compromising both programme effectiveness and accountability to donors.

Integration of therapeutic feeding centres (TFCs) into existing health structures such as hospitals, increases efficiency, is more economical and builds upon the skill levels of Ministry of Health (MOH) staff.

Where a programme is predominantly nutrition focused, health outcomes can sometimes be poorly defined. The health component of the nutrition work must be clearly specified with measurable objectives. Particular attention should be given to ensure that reasonable vaccination coverage is achieved in order to prevent further nutritional deterioration. Mass health education, as well as individual advice and treatment, can also be built into a nutrition programme.

In pastoral areas, fixed feeding centres in central locations may not be effective. In such settings, it may prove difficult to conduct cluster sample surveys or to alert people in advance when distributions are to occur. Also, people are not necessarily able to remain in one place for a long period of time. For these reasons, alternatives need to be explored, such as community based therapeutic feeding. More resources and attention are needed to monitor and supervise feeding programmes in such an environment.

Difficulties in recruiting experienced international staff need to be addressed. This could be achieved through developing an apprenticeship scheme for on-job training under the guidance of a mentor. Also,



guidance on rapid, but fair and transparent, recruitment processes for national staff in an emergency is particularly important when opening new operational bases. This helps to reduce future staff management problems and ensure recruitment of the best available staff from the outset. Staff with local knowledge can be critical in managing activities such as staff recruitment, and in dealing with local matters, e.g. clan issues and security.

Nature of interventions

Criteria for withdrawal from a country or area must be identified from the outset of operations, and the programme reviewed against these on a regular basis. These criteria, and the strategy for withdrawal, may need to be revised but will provide a benchmark against which the programme can be reviewed.

Realistic timeframes for interventions should be established from the beginning. This makes for greater continuity of staff and allows for more effective planning. In particular, clear and consistent messages can be given to partners and local authorities about programme objectives, criteria for withdrawal and expected length of stay.

High turnover of international staff, particularly project managers, places programmes under considerable strain and can lead to:

- lack of continuity and consistency in management
- inevitable gaps between international staff assignments, which lead to unsatisfactory interim arrangements for project management
- poor relations and rapport with project partners
- recruitment demands on programme management.

Wherever possible, the preparation and implementation of national guidelines for nutrition in emergencies should be promoted, thus investing in intervention sustainability. Guidelines need to be updated regularly.

Issues to consider regarding supplementary

feeding programmes (SFP's) include:

- Staff numbers must be based on the number of beneficiaries and the geographical coverage of the programme. The location of a SFP needs to take into account accessibility for the population and beneficiary numbers, which in turn will affect coverage and defaulting rates.
- Purpose built structures are resource intensive and limit the opportunities for capacity building among MOH staff. Existing health facilities can be used to assist health aspects of the programme, but travel implications for beneficiaries and additional demands on health centre staff may reduce the quality of the programme.
- Careful consideration should be given before opening a SFP in areas without an adequate general food ration (GFR). However, the reality is that SFPs will be set up even where there are no resources for a GFR, or the GFR is inadequate. In these instances, the supplementary ration should take into account the likelihood of the ration being shared.
- Blended foods must be fortified to ensure adequate supplies of micronutrients.
- Targeting pregnant women during the last six months of pregnancy may prove problematical, as determining gestational age is time consuming and may not be practical.
- In general, a comprehensive SFP should be up and running prior to a TFC being established. Supplementary feeding reaches many more children and vulnerable groups and should help prevent children from becoming severely malnourished.

Nutrition surveys can be used to establish the effectiveness of interventions and provide the stimulus for programme improvement. However, surveys can be costly and time consuming exercises, and may be particularly difficult to carry out in pastoral communities. Nutrition surveys should only be implemented where results will directly inform decisions about the type and scale of response. Furthermore, surveys should be standardised to allow comparison over time and between regions, and should gather relevant

information on food security and health. Where possible, quicker and cheaper ways of making decisions should be explored. For example, SC UK is currently exploring the possibility of using lot quality assurance sampling².

Ensuring community involvement in establishing feeding programmes helps in planning issues, such as:

- Appropriate siting of centres.
- Understanding and support of feeding programme objectives, including acceptance of targeting criteria. For example, the rationale for admission according to anthropometric criteria, irrespective of socio-economic status, may be difficult for communities to understand without proper explanation.
- Participation of mothers/ carers throughout the length of stay in a feeding programme.
- Reduction in defaulter rates by carers understanding how the feeding programme works, better siting of centres, and advice on population movements.
- Providing volunteer outreach workers who can screen children for referral to the centre.
- Alerting the team to security risks and changes.

Working with the government

In an acute emergency, it may be necessary to take a more directive role to ensure life saving responses. A commitment to work through the MOH needs to be tempered by a realistic understanding of local ministry capacity. For example, giving full responsibility for the medical components of a TFC to a weak and disorganised MOH will compromise programme quality. Thus, when planning a TFC the following steps should be taken:

- A comprehensive assessment of the MOH's capacity to help, e.g. to receive sick children referred from a SFP, to provide lab facilities for TFC and available nursing and clinical support for the TFC.
- Where MOH skills are lacking, capacity building must be resourced, taking into account staff turnover (which is often high). In the interim, the programme should employ additional medical staff.
- Ensure regular joint management meetings of the TFC with the MOH.
- Ensure that there is clarity regarding any incentive payments for hospital staff.

Monitoring

The impact of feeding programmes on settlement, displacement and migration in pastoral areas should be monitored, and adapted in response to any negative influences. Findings should also be weighed against the programme withdrawal criteria, which in turn should be periodically reviewed and revised as necessary. Regular project review meetings enable the project to adjust to changing situations and context. Clear guidelines are required on how to use monitoring information to manage the performance of feeding programmes.

Contextual analysis of the wider political, health, and food security context is the key to responsive programming. Without this, programmes will stagnate or fail to respond to changing conditions.

The contribution of Elizabeth Stevens, Policy Officer at Save the Children UK, in compiling this summary is gratefully acknowledged.

For further information, contact Anna Taylor - Nutrition Advisor, Save the Children UK, 17 Grove Lane, Camberwell, London SE5 8RD, UK. Email: a.taylor@scfuk.org.uk

¹ Review of Save the Children UK's Emergency Nutrition Programmes in Ethiopia, Kenya and Eritrea, 2000 by Dianne Stevens, August 2001 (then consultant to SC UK, currently SC UK Programme Director in Angola), and South Wollo targeted nutritional support programme, Legambo Woreda: Lessons Identified, October 2000-May 2001 by Kiross Tefera, November 2002 (Emergency Nutrition Officer, SC UK Ethiopia programme)

² Lot quality assurance sampling (LQAS) is a methodology that originated in the manufacturing industry and has been applied to health contexts, such as immunisation coverage. Sub-populations are divided into 'lots' and the sample size is the number of units that are selected from each lot. Before sampling, a decision must be made on the number of 'defective' items, e.g. children not immunised, that will deem a 'lot' unacceptable, which in turn will influence sample size. Since the response for each sample is binary, i.e. acceptable or non-acceptable, smaller samples are required compared to other survey methods. By combining information from different 'lots', the LQAS method offers a less conventional means of stratified sampling. (WHO/V&B/0126(2001))

Nutrition causal analysis: planning and credible advocacy

By Paul Rees-Thomas



Based primarily in Eastern Europe and the Horn of Africa, Paul Rees-Thomas worked for five years with Action Contre Le Faim (ACF), latterly in the food security department at the Paris headquarters. Since then, he has worked for Medecins sans Frontieres (MSF) in Kenya.

The contributions of MSF Spain and Manuel Duce in preparing this article are gratefully acknowledged.

This article outlines some of the key components of nutrition casual analysis, and describes how this assessment method was successfully used to provide a multi-sectoral overview of factors affecting nutritional status within an urban community in Kenya.

Since 1993, various sections of MSF have been engaged in the region of Mandera, north-eastern Kenya, which has played host for up to 60,000 Somali refugees displaced from the civil war raging in their own country. The district of Mandera has been described as suffering from 'chronic poverty compounded by successive environmental pressures.'¹

In July 1996, MSF-Spain responded to the needs of a primarily local population affected by drought, by establishing therapeutic and supplementary feeding centres, and general food distributions. With few exceptions, nutritional surveillance since then has demonstrated how the 'usual' rate of malnutrition within Mandera district has consistently remained between 20 and 30% Global Acute Malnutrition (GAM)² (see graph 1).

The MSF-Spain programme continued through 1997 due to persistent drought, and into the main part of 1998 due to floods and heavy rain brought on by 'El Niño'. Although the programme was scaled down and eventually closed in 1998 (GAM around 20%), a survey in May 1999 found that the prevalence of GAM had risen to a new high of 39.2%, with 6.9% severe malnutrition. In response, selective feeding programmes were re-opened by MSF and

continued until May 2001, when a cluster survey demonstrated that GAM rates had again fallen to 20%.

In March 2002, a MSF nutrition survey, conducted in the urban area of Mandera Central, showed a significant decline in the nutritional situation³. Similarly, an Oxfam-Quebec survey found high levels of malnutrition in the eastern flank of the district⁴. In light of these results and a subsequent influx of Somali refugees in mid April 2002 (recent surveys had shown high rates of malnutrition),⁵ MSF re-introduced both therapeutic and supplementary feeding programmes.

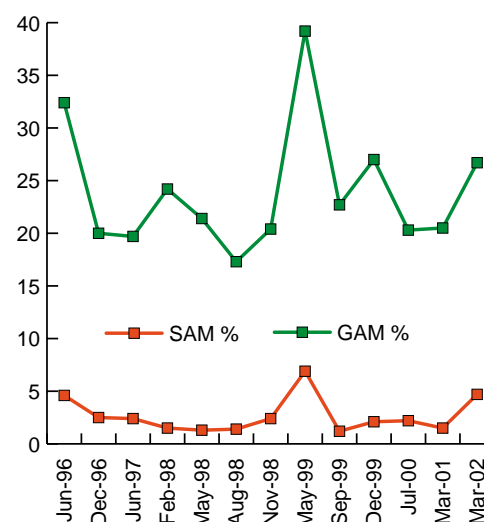
Mandera district currently endures significant environmental degradation, worsening pasture coverage and declining quality of livestock, as well as an increasing number of urban pastoral destitute. This group is composed predominantly of pastoralists who have lost their entire herd and is characterised by the households' almost complete dependence upon 'casual labour' in the urban vicinity. As a result, the level of outright poverty within the division of Mandera Central continues to increase. The increasingly competitive manual labour market has heightened the levels of vulnerability for much of this urban destitute group.

In this context of successive extended dry seasons in an area of widespread chronic poverty, many actors have found it increasingly difficult to justify emergency responses (involving selective feeding) following acute shocks, e.g. drought or flood. Many of these issues were more recently highlighted and discussed during a multi-sectoral assessment conducted in the last quarter of 2001. The findings of the assessment, which was overseen by the District Steering Group (DSG) and conducted by several organisations, formed the basis of the District Strategic Development Plan for Mandera District. A causal analysis has previously been conducted in Mandera District⁶. However, it was considered important to conduct such an assessment specifically for Mandera Central, in order to gain the population's perspective of the current causes of malnutrition within this urban setting and to generate a baseline advocacy document.

Basis of casual analysis

A causal analysis investigates and presents a 'multi-sectoral' overview of the contributing factors affecting nutritional status within a given community. Causal analysis first aims to establish the relative importance, or the perceived weight of contribution, of the underlying 'spheres' or factors that influence nutritional

Graph 1 Nutritional surveillance by MSF Spain in Mandera Central (1996-2002)



status (see diagrams 1 and 2). Secondly, and perhaps more importantly, it investigates the relationships between these factors.

While individual sector reports provide vital information and recommendations, causal analysis provides a greater insight through cross-sectoral mapping and by illustrating how the inter-connected nature of these factors contributes to malnutrition. Having established the 'relative importance', the type of relationships, and hence the associated factors, a more integrated approach to project planning and implementation is feasible.

Causal analysis framework

The causal analysis methodology used was qualitative and participatory, involving a number of rapid assessment techniques and based upon the 'framework of causal analysis for malnutrition' (see diagram 1). The first vital step of this analysis was to identify the most recent and important 'secondary' documentation relating to the area (e.g. reports of previous assessments and analysis in Mandera). Ideally, these reports would form the background to the subsequent investigation, and provide baseline information with which to confirm, elaborate or even adapt assessment findings.

The participatory data collection and analysis entailed two activities, *household investigations* followed by *workshops*. Household investigations were carried out using semi-directive interviews rather than set questionnaires. This method allowed those being interviewed to identify and prioritise the issues that they themselves felt were the most pressing problems currently being faced in the community. The technique relied on posing open questions, with direction only given when detail and elaboration were required on issues that had already been highlighted. Households were purposively selected to represent the two previously identified livelihood economies in the district, i.e. 'pastoral'



Goats being watered in Mandera, Kenya. June 2002 © PAUL REES-THOMAS

Diagram 2: Perceived Relative Importance on Underlying Causes

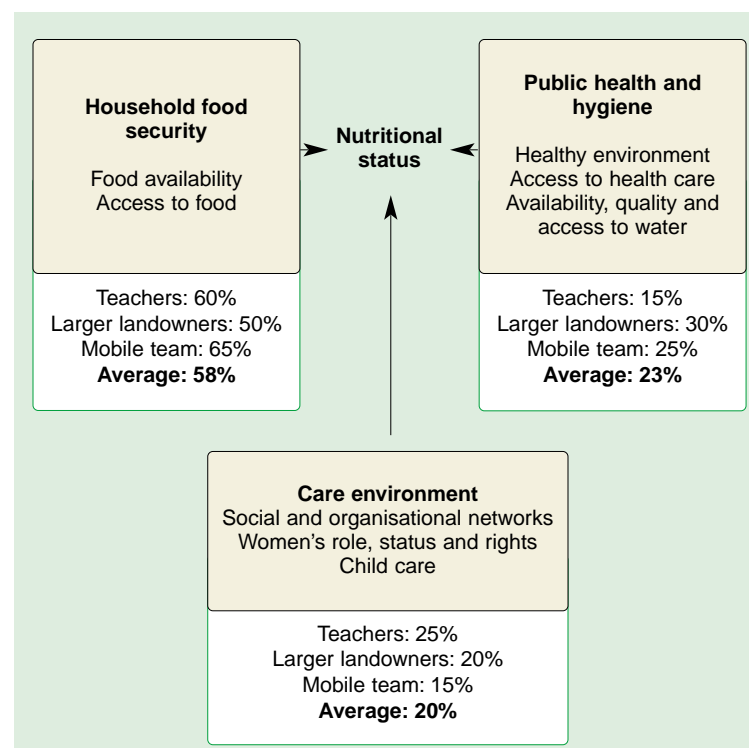


Diagram 1: Framework for casual analysis of malnutrition

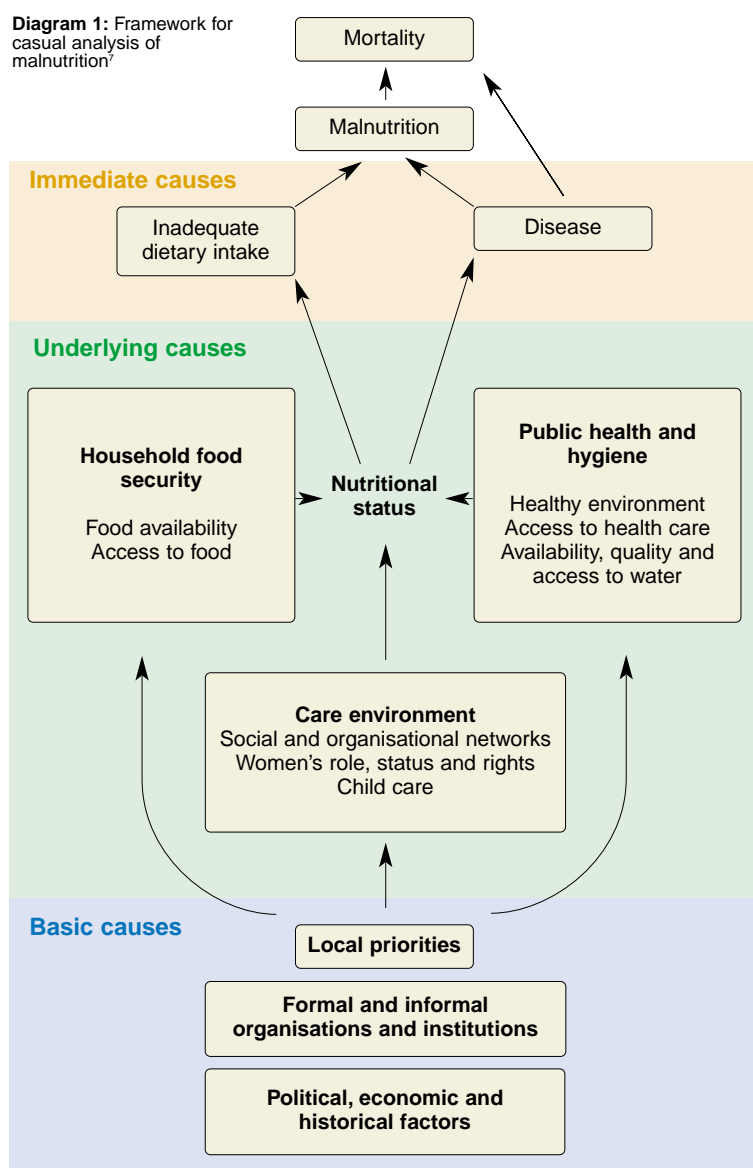
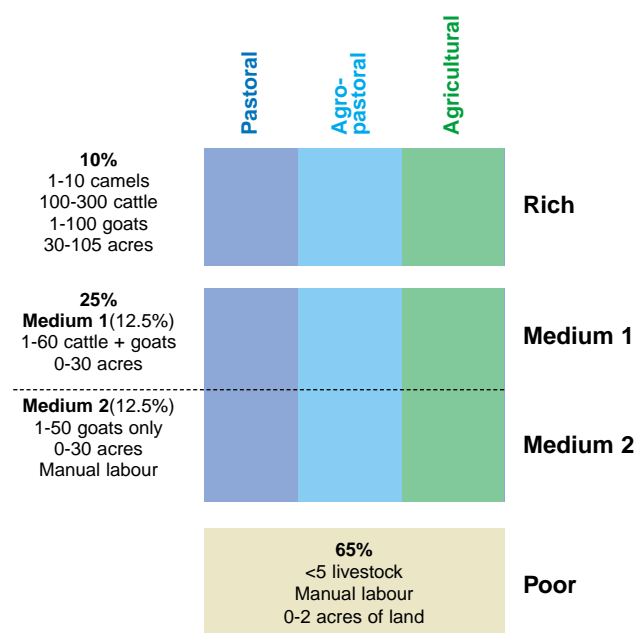


Diagram 3 MSF Wealth Classification, Mandera Central (version 2).



and 'riverine' households who practice agriculture. Geographical variations, as well as poorer and wealthier households, were also taken into account. Any further distinction or categorisation of wealth was deferred to the workshops. Essentially, households visits continued until the information collected became repetitive, and nothing significantly new was being established or expressed.

The workshops were typically comprised of five or six individuals drawn from various 'groups', such as mothers, teachers, traders, pastoralists and farmers, as well as the MSF mobile team. The overall purpose of the workshop was to cross-reference and, where possible, elaborate further upon the identified causes. The workshops also attempted for the first time, as far as possible, to quantify the findings to date.

Relative importance of causal spheres

During the workshops, participants were initially asked to assign a percentage to their 'perceived relative importance' of the spheres representing underlying causes of malnutrition in the 'causal framework' (see diagram 1). Only three 'groups' were content to quantify importance of the spheres in terms of percentage. Another three groups were only prepared to 'rank' the underlying causes. However, taken together, the results provided our first key finding - confirmation that household food security was the most significant factor contributing to malnutrition.

Other tools, such as mapping, timelines and agricultural calendars, further helped discussion about the type of relationships between the spheres and how they had changed (primarily over the previous three months). Household information was not presented to the workshops but was referred to, to encourage elaboration and clarification.

It also proved possible to include previous workshop results in order to facilitate and provoke discussion. The results of the 'wealth classification' exercise (diagram 3), that provided a socio-economic categorisation of both poverty and wealth through the communities' eyes, were presented within the final report.

Process of wealth classification

The wealth classification exercise, outlined in diagram 3, provided our second and vital finding. This was related to the continuously increasing urban destitute caseload in Mandera Central. The various workshops almost unanimously agreed that fifty to sixty five percent of the urban population was presently made-up of this 'urban destitute' group. Amongst these, vulnerability was linked to the insecurity and irregularity of low-paid work that forced households to purchase food daily at higher retail prices.

The three key data sources (key informants, households and workshops) helped to triangulate information, thereby solidifying priorities, identifying trends and establishing connections between different sectoral needs and expenditures. For example, these three data sources helped build a considerable understanding of expenditure on medication and health services. It was found that the price of medication for 75ml of cough syrup (250 shillings) or multi-vitamins (300 shillings) equated to 10 to 15 days of the adult food basket. There was strong evidence pointing to a reduced availability of basic medication within government structures, forcing those in need to approach and spend available cash in private pharmacies.

Wherever possible, the exercise endeavoured to include the food equivalents of basic expenditures, as well as the food equivalents of casual wage labour. This illustrated potential food gaps from irregular casual labour for a range of smaller or larger households. The analysis also determined that more and more individuals were being forced into daily casual labour, allowing less time to be spent supervising younger children. Also, seasonal water

price changes had forced vulnerable and remote households to draw water from the river, a source shared with livestock.

Advocacy role

Undertaken correctly, qualitative and participatory assessments have been increasingly accepted in decision-making fora. Improved credibility has given advocates greater confidence in approaching various bodies, fuelled by a higher chance of being given time to present findings.

The strength of this type of assessment lies in complementing, *not* replacing, existing forms or channels of advocacy. It can provide additional information and 'capital' for debate and discussion, as well as reinforcing more technical/ quantitative survey findings and improving their credibility. In this sense, causal analysis assists in ensuring a more profound discussion with regard to targeting and programme priorities.

Clearly, there is a time limit as to how long any particular causal analysis study remains credible and 'active' for advocacy purposes. At the same time, a causal analysis may provide the first step towards the inclusion of additional and more regular data collection and analysis within national Early Warning Systems (EWS).

One of the main aims of conducting the causal analysis in Mandera was to provide a basis of understanding to use for advocacy purposes. Subsequently, MSF-Spain intends to become more involved in the EWS, primarily in the areas of health and nutrition, and investigate further which civil society actors could act as partners in these activities.

Under-pinning the entire advocacy potential generated from the causal analysis, is the primary aim of assisting the local communities and civil society, wherever and whenever possible, to advocate for themselves. From the outset, participatory methodologies aim to include the community and civil society actors in the entire process, to ensure that their opinions are heard and correctly noted. These voices are central to the decision making process involved in combating the issues and problems facing their community. Subsequently, whatever lobbying activities are undertaken, efforts should be made to allow these local partners to benefit and become actively involved in lobbying networks, which are often only open to larger (and frequently international) organisations.

By developing a picture of the multiple challenges facing a given community, causal analysis can assist organisations and the communities with whom they work, to identify and articulate why certain conditions are not improving or, in fact, are deteriorating. Emergency orientated organisations can sometimes find themselves dealing with protracted emergencies or addressing acute shocks within an area experiencing chronic poverty. Causal analysis provides important information and opinions to assist these organisations to either plan or advocate for appropriate medium term, higher impact interventions aimed at reducing vulnerability.

For further information, contact Paul Rees-Thomas at email: rees-thomas@tinyworld.co.uk

¹ Alistair Blair, Health Assessment of Mandera District, MSF-Spain, 2001

² Global acute and severe acute malnutrition rates measured using weight-for-height z scores

³ MSF-Spain nutrition survey, Mandera Central: 26.7% GAM, 4.7% SAM (March 2002).

⁴ Oxfam-Quebec nutrition survey, Eastern Mandera: 33.3% GAM, 5.3% SAM (March 2002).

⁵ FSAU Nutrition Up-date December 2001. FSAU led survey in Belet Hawa, Gedo Region, Somalia. Conducted with UNICEF, Care and Gedo Health Consortium. The results found a prevalence of 37.2% Global Acute Malnutrition (Dec 2001).

⁶ Causal Analysis for Mandera District, by Abigail Montani, Action Against Hunger.

⁷ Adapted from an Action Against Hunger version of the UNICEF original framework.

Christian Aid

Jeremy Shoham interviews Phil Crane and Sarah King

Name	Christian Aid
Address	35 Lower Marsh London SE1 7RT, UK
Telephone	+44 (0)207 620 4444
Fax	+44 (0)207 620 0719
Email	info@christian-aid.org
Internet	www.christian-aid.org
Year formed	1945/6
Director	Dr Daleep Mukarji
HQ staff	approx. 300
Overseas staff	approx. 16 expats/100 local
Annual budget	approx. 55 million UK pounds

Phil Crane and Sarah King from Christian Aid (CA) were interviewed in their London Headquarters near Waterloo station.¹ Phil works in the Eastern and Central Africa team. His early work experience included a job as an accountant in the city, followed by two years with a Pakistani non-governmental organisation (NGO) where he kept the accounts and did some teaching. He then returned home to the UK, to the more tranquil setting of a church book (and coffee) shop, before joining CA in 1990 as an accountant. After covering for two maternity leaves he took up his present full-time post. Sarah, who works as an emergency capacity building officer in the emergency unit, joined CA towards the end of 2001. She has previously worked as a nutritionist for CARE and UNICEF in Kenya and brings nutritional expertise to the organisation.

CA was created at the end of World War II by UK and Irish churches, in response to the devastation in Europe and the urgent need for reconstruction. Phil remembers seeing an audit from 1946, which showed CA sending bicycles to Belgium and biscuits to Hungary. Later, the wave of decolonisation and independence in the 1960s led to a greater awareness about developing country problems, so that CA changed its focus to emerging states in the 'third world'. It now works in 56 countries around the world.

Phil explained that there are a number of key internal policies which underpin the way CA works. CA is not an operational agency - it works through partners. The belief behind this is that 'local people are closer to the poor and will therefore have a better sense of what the problems of poverty are and how best to solve them'. CA has recently established a network of field offices. This process began following the Rwandan crisis in 1994, when a number of partners were placed under tremendous pressure during the civil war and CA felt a need to be present to provide extra support and capacity. However, these relatively new field offices are not implementation offices but rather they are, support partners. They also make it easier to access decentralised funding sources, as well as monitor projects more closely. Phil maintained that the value of field offices was proven during 1998 in south Sudan. Here, the Nairobi office was able to support information flows and logistics, and ensure a more rapid response overall, than would otherwise have been possible. There are now 16 field offices with the greatest concentration in Africa.

Typically CA works with between 10 and 20 partners



Sudanese cattle farmer
© ADRIAN ARBIB/CHRISTIAN AID

in a country, of which, on average, approximately half are church based agencies. Essentially CA is open to working with 'whoever is doing the best anti-poverty work'. "It is important to build up long term relationships with partners" says Phil. Partners approach CA with a proposal which then undergoes a rigorous appraisal procedure, including examining the track record of the agency. Often CA's partner is the national Council of Churches' relief and development arm. In other instances, CA may work through individual churches at diocese level. Phil reflected on how CA still occasionally gets approached for support to buy hymn books or rebuild churches, but was quick to point out that this was not something CA does.

Much CA funding comes from the church sector, but also from the public at large. For example, the second week of May each year - 'Christian Aid Week' - is given over to fund-raising at a local level when volunteers are each 'allocated a street'. This event, which basically consists of distributing and then collecting red envelopes ("hopefully filled"), usually raises about 12 million UK pounds a year, which amounts to 20-25% of CA funds. The CA board has restricted governmental monies to 30% of the organisation's funding. The remainder comes from individuals, churches and non-church agencies. The fact that the majority of funding comes from a wide variety of sources provides consistency of income, and prevents CA from being over-dependent on annual grants from government donors.

According to Phil, "the CA partnership approach does not make fund raising easier with agencies like DfID and EU, compared to say Oxfam or SC UK, as CA is the middle man and essentially putting someone else's proposal forward". However, good project appraisal mechanisms and the recent introduction of field offices is helping the process of fund-raising from institutional donors.

Advocacy seems to be a growing component of CA activity. Perhaps 15-20% of income now goes towards advocacy. CA is especially involved in global advocacy messages, e.g. Jubilee 2000 advocacy work was about debt. "CA can mobilise churches to get people out onto the street, while working through partners gives CA a legitimate mandate to say things", according to Phil. The 'Trade for Life Campaign' is now the main advocacy issue for the next few years, e.g. World Trade Organisation legislation, import tariffs and quotas, and access to western markets.

Historically, CA have always resisted an

emergency/development split in its work so that the 'desks' are organised along geographic lines. Phil, therefore, deals with relief, development and advocacy programmes within the east and central African region. There is, however, an Emergency Unit (created in 1995) which operates as a technical support mechanism for geographical teams and partners at the onset of emergencies. The unit currently employs seven full-time staff with experience in logistics, shelter, nutrition and disaster mitigation, as well as general project management. There are also two trained SPHERE trainers in the unit.

Like many other agencies, CAs involvement with emergencies really started with the Ethiopian famines in the 70s and 80s. Involvement in general ration programmes is common, although CA may take the view that it can be more effective in advocating for the international community to stump up the necessary food aid pledges. CA also supports partners in implementing supplementary feeding programmes and, on rare occasions, will support partner therapeutic feeding programmes. According to Sarah, another common type of programme has been 'seed protection rations' where the intention is to provide food as part of an agricultural support programme, to prevent households consuming valuable seeds before the next agricultural season. There have also been a number of general ration programmes where families, acting as hosts for internally displaced people (IDPs), have been targeted, e.g. in Kosovo/ Albania and more recently, in the Democratic Republic of Congo.

CA generally plan for longer-term interventions once involved in an emergency. For example, they have been supporting four clinics for IDPs in shanty towns around Khartoum for a number of years, with partners working under the Sudan Council of Churches. In Wau in 1998, CA started working with IDPs through relief programmes, gradually moving into provision of permanent housing, agricultural and fishery support, building clinics and schools. Phil described this as "post relief rehabilitation". In Central America, meanwhile, CA supports organisations dealing with the psychological and psycho-social effects of disaster - a crucial aspect of recovery that is all too often overlooked. Capacity building and disaster preparedness are other big components of their work. The Emergency Unit has developed a strategy for working with programme managers and partners to strengthen their disaster preparedness activities, encourage them to incorporate risk reduction measures into ongoing

development work, and encourage adherence to international guidelines. CA is a signatory to the Red Cross/ NGO Code of Conduct and encourages adherence to SPHERE standards among all partners working in humanitarian response.

Phil highlighted two big challenges that CA faces. First, the temptation to take over and become operational - which is especially strong in emergencies, and where partners are weak. Second, CA has to be careful not to set up over-demanding programmes (over-scale) with partners that appear capable, only to find out later that they have taken on more than they can handle. Phil gave an example of a seed multiplication and ox plough training programme where this happened. The programme proved too large and complex for local partners to sustain. This problem is compounded by the fact that emergencies can generate a lot of money, which creates a momentum for spending.

Sarah identified co-ordination with other agencies as an issue, in that sometimes a local/ international NGO split occurs in the field, with the former feeling excluded from international co-ordination mechanisms. One of the roles of CA, especially in emergencies, is to help local agencies integrate into national co-ordination mechanisms. CA is a member of the Action by Churches Together (ACT) network, and all its activities are co-ordinated with other ACT members, as well as with the Disasters Emergency Committee, other agencies, governments and United Nations bodies, as appropriate.

Sarah also identified a difficulty CA sometimes faces when partner agencies may be located in remote areas of the country, making communication and support difficult. She cited the example of a partner agency working in Gaza province in Mozambique, which is 650 km from Maputo. However, "this can also be a strength as the local agency is working in an area where there are no international agencies".

I asked Phil what he thought were the main strengths of CA. His response was clear and to the point.

"CA works with the poor through local partners and therefore has the advantage of being a channel for the authentic voices of the poor. It is the poor themselves who have most knowledge about poverty and the best solutions. Being a channel for the voice of the poor also gives us a legitimate and perhaps unique mandate for advocacy".

¹ The ENN would like to state that the views expressed in this article are those of the interviewees and do not necessarily represent those of Christian Aid.

Evolution of a Crisis: a Save the Children UK perspective

By Mark Wright



Malawi
© SC UK



Mark Wright was the Save the Children Programme Officer for Southern Africa from November 2000 to November 2002.

This article details Save the Children UK's (SC UK) perception of the build up to the Southern Africa crisis and charts key moments in the response of the international humanitarian community.¹ Largely using Malawi and Zimbabwe as case studies, it looks at the roles of the different actors and appraises how successfully they fulfilled their responsibilities in responding to the situation. The work of SC UK during this crisis, particularly in the realm of advocacy, is highlighted.

The contributions of Daniel Collison, Deborah Crowe, Gary Sawdon and Anna Taylor, Save the Children UK, in compiling this article is gratefully acknowledged.

In September 2002, Southern Africa was in the throes of an acute humanitarian crisis that was having countrywide impacts in Angola, Malawi, Zambia and Zimbabwe, as well as affecting significant populations in Lesotho, Mozambique and Swaziland. Across the entire region, it was estimated that 7.5 million people (plus a further 1.9 million in Angola) required immediate food assistance, a figure anticipated to rise to 16.3 million between January and March 2003. Of those in need, at least 60% were under the age of 18 years.

Southern Africa had suffered from erratic weather over the previous two seasons such that, by the beginning of the current crisis, many poorer farmers had already exhausted their coping strategies. In addition to adverse weather conditions, with drought, erratic rains, floods and tornadoes over successive years causing falls in production, other underlying factors had drastically destabilised food security. These included political instability in Zimbabwe and a fragile peace in Angola, poor macro-economic performance in all countries in the region, inappropriate government policies, and the HIV/AIDS pandemic.

In October 2001, SC UK conducted a training session in the SC UK Household Economy Approach (HEA) methodology in Malawi. This was carried out in several Food Economy Zones that overlapped those districts (Mchinji and Salima) where SC UK is operational. The results of this exercise suggested that the population was facing a potentially significant food shortfall, well before the next harvest in March 2003 and even in Mchinji district which is traditionally a bread basket area. In response, SC UK hosted a donor meeting in Lilongwe in November 2001, not only to alert interested parties but also to try and instigate a response strategy. The warning was not accepted and many maintained that the situation was less serious than was being described. Around the same time, the FEWSnet² was predicting some increased vulnerability but felt that, whilst maize was in short supply, overall food supply was adequate once root crops were taken into consideration.

Survey support

To support the SC UK argument, nutrition surveys were carried out in December 2001, which found global acute malnutrition rates of 11.8% and 9.3% in Mchinji and Salima, respectively. In themselves, these figures did not suggest a crisis. However, in

light of the HEA data and considering the time of year (at least 3 months before harvest), they were very serious findings. Again, the response from donors was unenthusiastic. In contrast, a HEA survey in Zimbabwe in May 2001, with no supporting anthropometric data, attracted funding from the Department for International Development (DFID) for a food intervention over the period September 2001 to April 2002. This was an unusual case in that the intervention was designed specifically to support livelihoods rather than combat hunger per se. This differentiated response does show apparent inconsistencies in the DFID approach to the crisis in these two countries.

SC UK began intensive lobbying of donors and the international community to support a wide-scale intervention in Malawi. Anecdotal evidence strongly suggested that the situation was deteriorating rapidly, a situation compounded by a massive increase in maize prices of 400%. To quantify the impact on the population, SC UK conducted a follow-up nutrition survey in late February 2002. This found that global acute malnutrition rates had increased to 12.5% in Mchinji and to 19% in Salima. That such deterioration had taken place in the space of only ten weeks was indicative of the seriousness of the situation.

By February 2002 it became clear that the food shortage was a regional issue and was not just restricted to individual countries. The Food and Agricultural Organisation (FAO) issued a Special Alert warning of 4 million Africans being at risk, and highlighted Malawi, Zimbabwe and Zambia as being the most affected. However, national governments were slow to admit that the problems were serious. Malawi did not declare a State of Emergency until the 27th February 2002, while Zimbabwe delayed declaration until the 26 April 2002.

Within the UK, international non-governmental organisations (NGOs) were independently carrying out investigations into the extent of the problem within their own operational areas. SC UK called a co-ordination meeting in early April 2002, both to promote information sharing amongst active NGOs and to facilitate the development of a common position on the scale and needs of the crisis. This led to the development of a joint position paper that was presented by the British Overseas Agencies Group (BOAG) to the UK Secretary of State for International Development.

Chronology of events

Date	Key events
Oct 2001	HEA assessment identifies food shortfall in areas of Malawi where SC UK operational
Nov 2001	SC UK hosts donor meeting in Lilongwe to highlight needs
Dec 2001	Nutrition surveys in two districts support HEA findings Intensive lobbying of donors and agencies
Feb 2002	Repeat surveys show deterioration in nutritional status FAO special alert for region BOAG group position paper DFID first donor to fund intervention
Mar 2002	Regional working group formed
Apr 2002	Angolan ceasefire and access to population
Apr-May 2002	Crop and food supply assessment missions to seven countries
June 2002	Figures established for population in need and predicted food shortfall
Sept 2002	Continued shortfall in WFP funding, targeting and supply Limited information on national government provisions Onus on NGOs to establish parallel food pipelines

Abbreviations: HEA (Household Economy Approach), FAO (Food and Agriculture Organisation), BOAG (British Overseas Advisory Group), DFID (Department for International Development), WFP (World Food Programme), NGO (Non-governmental organisation)

Recognition of a crisis

The prospect of a massive food shortage was now becoming more widely accepted.

DFID agreed to fund a one-month SC UK food aid intervention in Mchinji - the first donor to respond to the food situation. The World Food Programme (WFP) and FAO were also increasingly concerned and, at the Inter-Agency Standing Committee Policy Working Group meeting in March 2002, invited SC UK to present on the regional food situation. As a result of this meeting, and at the behest of WFP, a working group was formed. Tasked with co-ordinating the Crop and Food Supply Assessment missions to the region, the group was charged with a wider remit than normal. In addition to gathering routine information on food supply, there was an explicit requirement to collect data on access to food, and vulnerability issues. The missions in each of the seven countries (Angola, Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe) took place throughout April and May 2002, and SC UK participated in both the Malawi and Zimbabwe missions. Assessment findings were reported to a multi-agency meeting on the 6-7 June 2002. Referring to three phases of activity between June 2002 and April 2003, the meeting established agreed figures for the food requirements of the region and generated indicative figures of the populations in need.

Continuing food shortfall

The situation was now described as a "crisis of enormous dimensions". It was agreed that

over 12 million people in six countries would require assistance, to make up for a total cereal shortfall of 4 million metric tonnes (MT). Of this, emergency food aid would contribute 1.2 million MT until March 2003, with national governments and the commercial sector needing to source the remainder.

Coincident with these developments was the death of Savimbi in Angola and the resultant cease-fire



Malawi, Salima district, May 2002. Large distribution to about 1,000 beneficiaries.
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agreement on 4th April 2002, allowing contact with a hitherto inaccessible resident population in Angola. Almost overnight, the number of beneficiaries requiring humanitarian aid mushroomed. OCHA figures suggested that more than 3 million people in Angola would require humanitarian assistance, of which 1.9 million people would require food aid.

Within the Southern African Development Community (SADC) as a whole, maize production stood at 16.3 million MT for the 2001/02 season. Whilst this represented only a 7% fall when compared to the average over the previous five years, it masked significant country level declines. These included Zimbabwe (71% down), Zambia (-35%), Malawi (-18%), Swaziland (-22%), and Lesotho (-21%). At best, the harvest in April / May 2002 offered only temporary respite.

As of 24 September 2002, only 36% of the required \$507 million funding had been pledged to the WFP and it was estimated that the WFP Regional Emergency Operation (EMOP) was not going to meet all the emergency food aid needs, nor target all the identified beneficiaries. Targeting 80% of the affected population (10.2 million people), the WFP could provide only 67% of the food aid cereal needs. An implicit requirement of the EMOP was that other actors, principally international NGOs, needed to develop parallel food pipelines to make up for this shortfall.

Commercial and government imports

It was recognised that the international community would only partly meet the massive food needs identified. National governments and the commercial sector would need to supply the bulk of the shortfall. To allow effective contingency planning to take place, it became all the more critical that available information should be shared openly. Up until September 2002, country-specific information had been poor - published figures did little to differentiate proposed purchases, active contracts or stocks already received. No information existed regarding distribution plans for government stocks once received. In all cases, it was felt that national governments needed to be more transparent regarding their capacity to access food and their progress in doing so. This would allow the international community to assess whether the needs of the hungry were being met. Where data did exist, it was difficult to assess the reliability of the figures, although they did prove useful in identifying relative import trends.

For example, figures presented at the September 2002 meeting in Johannesburg suggested that while Mozambique had imported 78% of its requirements, Zambia had imported only 9 per cent of its estimated need.

Compounding issues

Genetically modified organisms (GMO) became an important issue in 2002. At various times, Zambia, Zimbabwe, Malawi and Mozambique all expressed concern or refused acceptance of genetically modified (GM) maize. Most of the concerns revolved around the potential contamination of local agricultural crops, although health risks were also mooted. Zambia came out strongest by banning the import of GM maize, though this may be subsequently reviewed pending more recent data collation by Zambian scientists. Malawi announced that, from the first of October 2002, all GM maize must be milled to prevent any potential environmental contamination. However, the issue of who should incur the additional milling costs was not fully addressed. While SC UK accepts the right of governments to question GMOs in principle, it believes that this crisis required greater pragmatism. If the only choice were accepting GM crops or seeing many people starve, SC UK felt that countries in the region should soften their stance and accept GM crops -milled or unmilled - for the period of this emergency.

The effect of HIV/Aids has created a new kind of crisis. The structural decline that characterises the region is now being compounded by HIV/Aids, which has implications for targeting, household food security and recovery. This is the first time we are seeing the livelihood impact of Aids on such a vast scale.

Advocacy role

SC UK was one of the first NGOs to alert the international community to the impending food crisis in Southern Africa. Using data from HEA assessments and nutrition surveys, it was possible to lobby vigorously key agencies with a strong degree of confidence in our position. In many cases this strategy led to strained relationships with our targets (who were also, in a real sense, our potential partners), but it did successfully force the issues into the public domain and encourage debate to take place.

SC UK secured an early response from DFID for



Aid distribution in Chunga, Binga district, Zimbabwe in July 2002

© BRENDAN PADDY/SC UK

food aid funding in Zimbabwe (August 2001), but despite our attempts, could only achieve the same much later for Malawi (February 2002). Intensive lobbying had begun in Malawi in late 2001. Advocacy was conducted at national, regional and international levels, either directly or through influential agencies such as OCHA. A variety of meetings, letters to key individuals and press statements were used to exert pressure for an early food aid response in Malawi, in particular targeting the WFP, the European Union (EU) and DFID. However eliciting a timely donor response proved unsuccessful. Eventually by early 2002, the WFP and DFID were responding to the crisis, however the EU continued to prevaricate.

In Angola, SC UK has constantly lobbied the United Nations (UN) to be more effective in its humanitarian co-ordination, and for the donors to respond more generously to Angolan humanitarian appeals. Part of this lobbying work took SC UK to the UN Security Council in March 2002. Through conducting food security assessments in Malawi, Swaziland and Zimbabwe, SC UK has remained an influential voice with both the WFP and the member governments of the SADC. SC UK's regional food security adviser sits on the SADC Regional Vulnerability Assessment Committee in Harare, giving the agency a strong regional overview of food security and early warning issues.

Locally, SC UK ensures its voice is heard at all levels. For example, agency staff attend the fortnightly WFP/NGO meetings in Johannesburg. Key regional issues are continuously raised with OCHA and UNICEF. These include highlighting the plight of Zimbabwean farm workers and the need to safeguard principles of neutrality, appropriate attribution of aid and safety of humanitarian personnel.

SC UK has taken the lead within Zimbabwe in providing guidance and information on food security to the British NGO group. Meanwhile in Mozambique, a group representing the Disasters Emergency Committee (DEC) agencies has also met regularly to examine food security and co-ordination concerns. SC UK is part of an influential NGO consortium in Malawi, which works alongside the WFP and the United Nations Development Programme (UNDP), and sits on several governmental task force committees to address food policy needs. Save the Children Swaziland currently chairs the NGO Drought Consortium, which handles all negotiations between NGOs, government and the WFP. These activities and meetings are mirrored by

similar groupings and meetings held in the UK amongst the relevant agencies.

Media coverage

As an international agency, the scale of the disaster made it incumbent on Save the Children to ensure that the facts were made widely known, and that they were subsequently acted upon. A key vehicle for this communication was the media. Initially it was extremely difficult to generate media interest, since for many it was 'just another annual food crisis in Africa'. During these early stages, media coverage was sporadic and was nowhere near the level required to spur reluctant donors into prompt and decisive action. Interest from other agencies was also relatively limited, although by the beginning of 2002, Concern and the WFP were clearly doing what they could.

From the outset, SC UK had worked closely with other UK NGOs to increase the profile of the crisis - a strategy that had intermittent isolated successes. To heighten awareness, SC UK decided to capitalise on a pre-arranged trip by the Mirror newspaper to Malawi, inviting the journalist concerned for a specific briefing on the crisis. The resulting coverage was of a sensational, and occasionally quite critical, nature but it did provide the opportunity to dramatically increase the profile of the issue.

On the day the Mirror newspaper published the story (21st May 2002), SC UK took the decision to use an approach that the agency had been debating about internally, and which coincidentally, had been independently used by the Mirror. The line taken by both parties compared the potential scale of the emergency in Southern Africa to the famine in Ethiopia in 1984-85. SC UK was not suggesting that the same numbers of deaths would be seen, but rather that many millions of people over a huge geographical area would be seriously affected and that, without intervention, deaths would undoubtedly occur. Although this risked conflating two wholly different events, it did dramatically illustrate the scale of the potential crisis and resulted in two days of intense follow-up coverage from television, radio and print media.

Since then, media coverage has improved but remains sporadic, with two main peaks of attention in the period since. The first was the launch of the Disasters Emergency Committee (DEC) appeal on 25th July 2002, using Save the Children spokespeople in both London and Johannesburg. The second involved coverage around the land reform process in Zimbabwe. Regarding the latter, the highly politicised

approach taken by most of the UK media frequently resulted in misleading comments about the nature and the causes of the humanitarian crisis in Zimbabwe.

Conclusions

The recent experience in southern Africa has demonstrated the following:

- i) The value of early and persistent lobbying with donors/ UN agencies, as demonstrated in the eventual international recognition and humanitarian response to the Southern Africa crisis.
- ii) The predictive power of the Household Economy Assessment models to anticipate emergency situations/ food crisis. The evidence suggests that the first warnings were accurate, that the household economy approach used in these studies was sound, and the approach should be used as a basis for future early warning and monitoring. With its focus on access to food, income and other livelihood resources, it is a valuable tool for linking poverty reduction strategies (and monitoring their impact) with disaster prevention. In view of the fact that inadequate methods of analysis, based on food availability indicators, persist in the region, it is imperative that food access be incorporated as an integral part of any analytical process.

More detailed analysis is required of the way in which newly liberalised grain markets are operating in the region. Also, to what extent was this a 'free market famine', and what steps are needed to ensure that poor harvests do not, in future, result in a similar collapse of the market system.

- iii) Communication strategies are an essential element of advocacy work. The media is a powerful means of mass communication, however humanitarian organisations do not have full control over how their information is used or a situation is portrayed. This must be considered when engaging the media and interpreting media coverage in any humanitarian crisis.

For further information, contact Anna Taylor, Nutrition Advisor, SC UK, email: a.taylor@scfuk.org.uk

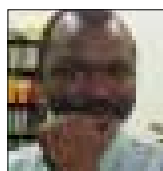
¹ Experiences drawn from two SC UK reports: Evolution of a Crisis, a Save the Children UK perspective, September 2002 and Responding to fragile livelihoods in Southern Africa, October 2002

² FEWSnet: Famine Early Warning System Network

Nutrition survey in
Binga, April 2002

Nutrition assessments in Zimbabwe: a local perspective

By George Kararach



For the past two years, George Kararach has worked as a consultant policy analyst in Zimbabwe - for the last year working with UNICEF Zimbabwe.

The support of UNICEF in preparing this article is gratefully acknowledged.

The opinions expressed in this article are solely those of the author, and not of any particular organisation. This article outlines the author's personal experience of nutrition-related assessments in Zimbabwe during the recent emergency crisis, and provides some recommendations for future assessments.

Following deterioration in the food security situation in Zimbabwe at the end of 2001, by December 2002, a number of emergency assessments had been carried out in the country. Some of these have been multi-sectoral, covering water and sanitation, health, nutrition, food security and adolescent reproductive health.

The crisis in Zimbabwe is acknowledged to be a complex emergency and is, at least in part, man-made. However, the argument by the humanitarian and international community that the crisis of governance is a major contributor to the humanitarian crisis, has met with a lot of resistance, if not outright denial, by the government of Zimbabwe. This, in turn, has contributed to what can be described as the politicisation of data¹, with the outcome of assessments contested by both donors and government, depending on who conducted the assessment. Attempts to create broad consensus around assessment findings has meant the assessment process has been slow, and in some instances painful, with technical considerations swept away in favour of pragmatic political ones.

In seeking to describe the dynamics around nutrition assessments² in Zimbabwe during this period, a broad analysis is necessary in order to interpret nutrition assessment data - especially in an environment where data are likely to be 'politicised'.

Methods of nutritional surveillance

The use of nutrition surveillance as a tool for early warning systems is fairly well understood. Many would argue that nutritional status monitoring can provide sensitive and timely information regarding 'human stress'. In particular, it crucially informs when a food crisis does become a famine, or at least begin adversely to affect nutritional status.

Nutrition surveillance has been perceived as crucial in monitoring trends in the humanitarian crisis in Zimbabwe. Findings of assessments conducted in

2002, along with the results from the demographic health survey of 1999, are summarised in table 1.

A number of different methods have been used in Zimbabwe to collect national level nutrition data.

Nutrition surveys

In May 2002, the Ministry of Health and Child Welfare, and UNICEF carried out a nutrition assessment. Using a two-stage 30x30 cluster method, 23,400 children were sampled in 28 districts of Zimbabwe and a prevalence of 6.4 % moderate malnutrition (weight-for-height <-2SD) was found. A significant limitation of this assessment was the interpretation of anthropometric data without considering other relevant factors, such as coping strategies, livelihoods and childcare practices.

Emergency food security assessments

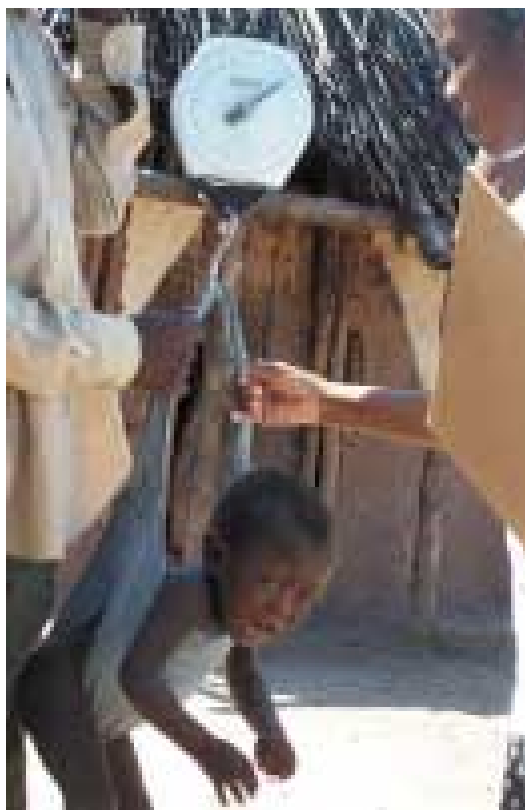
This type of assessment was carried out in August 2002, and repeated in November/ December 2002, by the Vulnerability Assessment Committee (VAC) - a conglomeration of government and humanitarian agencies. The aims of the assessment were to determine whether households were able to meet their immediate food needs (i.e. any food deficit), and to identify vulnerable households and their coping capacities.

This approach integrated analysis of the household economy, coping strategies, dietary intake, agricultural inputs, and nutritional anthropometry. Using purposive multi-stage sampling, a map of the livelihood systems in Zimbabwe was developed and used as a basis for defining household food economy groups. Food economy zones were then defined based on expert knowledge within the country - in a large part, reflecting livelihood and land-use systems. Twenty-five food economy zones were identified in Zimbabwe and households were randomly sampled from within each zone. Food economy analysis and anthropometric assessment were conducted at a household level. Fieldwork was carried out in all the

Table 1 Nutritional status in children under 5 years of age in Zimbabwe

Survey	Under five population surveyed (n)	Weight/height (<-2 sd)	Weight/age (<-2 sd)	Height/age (<-2 sd)
Demographic Health Survey, 1999	3,566	6%	13%	27%
Ministry of Health/ UNICEF, May 2002	23,400	6.4%	14.9%	29.2%
VAC, August 2002	695	7.3%	24.7%	41.3%





Measuring weight and height during the nutrition survey in Binga, April 2002

districts (57 at the time) and a total of 1,460 households were sampled. Results were scheduled for use in targeting, and to determine the relative importance of food and non-food responses.

Sentinel site surveillance

This form of nutritional surveillance took place through the national Child Supplementary Feeding Programme (CSFP), set up by the Nutrition Working Group³, as well as through community based sentinel sites operated by the Ministry of Public Service, Labour and Social Welfare. The CSFP provides data on weight-for-age through a clinic based growth monitoring system, while the community based system provides weight-for-age and height-for-age data for children under-five from randomly selected households (4,500). Owing to the humanitarian crisis, both of the systems were re-vitalised. In fact, the community based sentinel site system arose from a surveillance system that operated in Zimbabwe in the 1990s, which monitored the impact of structural adjustment policies.

While data from the CSFP sites are not nationally representative, they are perceived by many as suitable for providing information on the impact of the blanket feeding of under-fives programme, in the context of the emergency. The community-based sentinel site data provides more nationally representative data, since the sites were selected randomly across the various land-use systems throughout Zimbabwe.

Constraints

There have been a number of constraints experienced, both in implementation of assessments and utilisation of the data collected.

Politics: Only three major nutrition assessments took place in 2002 due to competing priorities amongst the various stakeholders, most notably between the government and the humanitarian community. Resisting pressure for more assessments, the government argued that the priority was getting food assistance to the communities (particularly when it wasn't being delivered) and that there was a risk of survey fatigue. The government's position was undermined by 'hearsay' amongst members of the humanitarian community, suggesting that results of the May 2002 assessment (involving the Ministry of Health and Child Welfare) were unreliable. However, no hard evidence was produced to substantiate claims that the methodology was flawed, or that there was 'tampering' during the data cleaning process.

Political dynamics also affected security during surveys. Field worker teams, conducting surveys outside the state system, attracted suspicion with threatened attacks by vigilantes in rural communities.

Lack of context for interpretation of results: Some technicians have suggested that since severe malnutrition levels could be classified as 'normal' for the area (average prevalence 1.5% severe malnutrition), nutrition interventions, especially therapeutic feeding, were not justified. However, analysis of anthropometric data in conjunction with other factors such as coping strategies, makes it apparent that *preventative* nutritional interventions are urgently required.

Preparedness is also important. Currently, therapeutic feeding is carried out within hospitals and, although there is no increase in the percentage of severely malnourished, the absolute numbers of severely

malnourished are still significant and could well rise. There is, therefore, a need to prepare for this, such as training of health workers and improvement of existing facilities.

Inter-agency co-ordination: Poor inter-agency co-ordination has impeded both the speed of survey implementation and the subsequent use of results by agencies. Since May 2002, the Nutrition Working Group (NWG) has operated as the co-ordination secretariat for nutritional surveys/ surveillance. Despite its existence, there were instances when agreements on the need for a survey were not readily secured. There were also differences between agencies over the most appropriate survey methodology. This lack of consensus affected acceptance or endorsement of results by stakeholders.

Limited government capacity: Government capacity to carry out large surveys has been gradually eroded since the mid-1990s. A 'brain-drain' of key workers out of Zimbabwe, the impact of the HIV/AIDS epidemic, and a weak economy have all been significant undermining factors. This has, in part, given impetus to the development of multi-agency assessments/ large-scale surveys, the first of which was carried out in August 2002.

Lack of geographical/area based assessments: In Zimbabwe, there have been significant population movements as a result of the land reform process. Considering this, the various assessments carried out in Zimbabwe would have benefited greatly from geographical information on population densities. A better understanding of the new resettlement areas would have complemented findings from the various assessments and strengthened service delivery to the newly resettled populations.

Recommendations for future assessments

There is a need to strengthen the assessment/ surveillance capacity in Zimbabwe, particularly in the context of emergency situations. Existing systems need to be reviewed and constraints associated with the use of the data addressed.

Furthermore, a system is required which marries the strengths of the various survey/ monitoring methodologies currently in use. Such a system should be based on multiple indicators, which allows monitoring of the key factors that influence nutritional status, as well as demonstrating nutritional trends. This inevitably requires an analysis of livelihoods and coping strategies. Critically, means must be identified to reduce the potential for political agendas to influence when surveys are implemented and how results are interpreted.

Finally, any progress will require a strengthening of government capacity to plan and implement surveys and monitoring, and an improvement in the operation of co-ordination mechanisms between humanitarian agencies.

For further information, contact George Kararach at email: gkararach@unicef.org

¹ The term 'politicisation of data' is used here to mean that data are employed to further political aims.

² The term 'nutritional assessment' is used in the broadest sense in this article, i.e. it encompasses assessments of livelihood systems and food security. Furthermore, the term assessment may be used interchangeably with surveillance, since part of the nutrition assessment data in Zimbabwe is based on on-going (routine) data collection (surveillance).

³ The Nutrition Working Group - this was made up of various agencies working on nutrition issues including government, NGOs and UN agencies, chaired by UNICEF.

Postscript

Understanding the food crisis in Zimbabwe

By Fiona Watson

Fiona has recently been in southern Africa with the Overseas Development Institute (ODI), looking at the role of needs assessments during the current crisis

The situation in Zimbabwe has spiralled into crisis as a result of complex underlying factors. First, the political environment is unstable and the government has been accused of poor governance. The Presidential election that took place in March 2002, and which returned President Mugabe to power, was described by almost all international observers as “unfree and unfair”. Gross human rights violations were documented throughout the election process and since then, politically motivated, government-endorsed violence continues against those perceived to be supporters of the opposition Movement for Democratic Change (MDC).¹ President Mugabe has stated publicly that the government intends to repress its political opponents and new laws have been passed which seriously restrict freedom of expression, association and assembly.

Secondly, the economic situation is deteriorating swiftly, with high inflation (144 per cent in October 2002 and predicted to rise to 400-500 per cent during 2003),² high unemployment (50-60 per cent) and closure of factories and businesses due to dwindling confidence in the investment environment. The donor community has withdrawn aid to the country. This, together with a severe reduction in foreign exchange earnings from sales of tobacco, gold and cotton, has led to a decline in foreign currency reserves to extremely low levels.

Thirdly, the impact of HIV/ AIDS has been devastating. Over 30 per cent of the population are affected, which has had a detrimental effect on the economy and caused increased pressure on health services. There is a lack of drugs and, in some cases, health staff in the country.

These underlying factors have had a major impact on food security. Domestic agricultural production has been reduced both by the land reform programme and adverse weather conditions. In July 2000, the “Fast Track” resettlement phase of the land reform programme was initiated. A law was passed that allowed for the compulsory acquisition and resettlement of land. To date, over 5,000 of Zimbabwe’s 6,000 commercial farmers have been issued with notice to leave and 150,000 farm labourers and their families have already been made homeless and jobless due to farm seizures. This has reduced crop production significantly. Erratic rainfall (floods followed by drought in the 2001/02 crop season) has reduced crop production further. In May 2002, it was estimated that cereal production was down by 57 per cent from the previous year’s poor harvest.³

Imports, however, have been insufficient to meet the deficit. The Grain Marketing Board, the government body with a monopoly on importing grain, is unable to import enough grain to make up the deficit. This leaves an estimated cereal shortfall of 1.5 million metric tonnes (MT) for the marketing year (April 2002 to March 2003), of which the maize shortfall (the staple food in Zimbabwe) accounts for 1.3 million MT. Private sector commercial imports are believed to be negligible. Although maize is sold at controlled prices, there is an absolute shortage of maize and prices on the black market have soared.

Thus while the crisis in Zimbabwe has been caused by a number of interacting underlying

factors, the symptomatic effect has been a growing food crisis - both in terms of absolute lack of food and lack of access to food. The latest emergency food security assessment⁴ concluded that some 6.7 million people (49 per cent of the population) would require emergency food aid up to March 2003.

Impact on nutritional status

Despite the dire food security situation in Zimbabwe, the prevalence of malnutrition has not yet risen significantly. The data shown in table 1 show a slight increase in acute malnutrition. Confidence intervals overlap, however, and it should be noted that the VAC assessment used purposive sampling and so is not comparable with the other two surveys. Furthermore, the methods used to assess anthropometric status in the VAC survey have been questioned and inaccuracies in measurement may have occurred. Thus, the data available so far do not indicate a significant increase in malnutrition.

The concern in Zimbabwe must be to address the food security crisis before a famine develops, causing untold misery and deaths. For this reason the importance of nutritional surveillance, as emphasised in the article by George Kararach, is of paramount importance.

Nutritional assessments

While national level surveys are useful in providing a ‘snap-shot’ view of malnutrition and in comparing provincial rates, their major constraint is that they are not carried out frequently enough to measure trends. Furthermore, in Zimbabwe, the government has not allowed a nationally representative nutritional survey to be conducted since May 2002, arguing that people need food and not more surveys.⁵

Sentinel site surveillance, on the other hand, has the advantage of allowing trends to be monitored. As pointed out in the article, however, the data are not representative of the total population. In Zimbabwe, sentinel surveillance of supplementary feeding programmes for children under five at community level, is due to start. This will involve the monthly weighing of children and possibly include the collection of other indicators. Currently, the lack of measuring equipment and experience in measuring height will preclude measuring acute malnutrition, but weight-for-age will be assessed.

When used in conjunction, data from surveys and sentinel site surveillance are complementary. Surveys providing an indication of the overall prevalence of malnutrition in the population and surveillance providing data on trends, should allow adverse changes to be noticed early. Clearly it is essential that nutritional data are linked with information on underlying causes, including data on coping strategies and livelihoods. The VAC assessment was unique in that it was a multi-agency attempt to link food security and nutrition data. Until now, the use of the VAC data has largely been confined to determining food aid needs, but with further analysis, the information collected could be used to inform other types of intervention.

Politics of assessments

Currently, the political climate in Zimbabwe is uncertain. Besides the ‘politicisation of data’, food is being used as a political weapon. There are many reports of families being denied the right to buy food from the government’s Grain Marketing Board warehouses because of their support of the opposition. In October 2002, both Save the Children and Oxfam were banned by the government from distributing WFP food aid as they were viewed as loyal to the opposition party.

The response

The crisis in Zimbabwe has received a certain amount of media attention and has been included in various aid agency appeals. Food aid has been viewed as a priority response. For example, over 80 per cent of the UN consolidated inter-agency appeal for July 2002 to June 2003 was for food alone, while health represented less than 10 per cent of the appeal total. Whilst food aid may serve a vital role in protecting against food insecurity and so preventing malnutrition, it cannot address the underlying causes of the food crisis. These underlying factors are likely to continue to impact negatively in the long-term. The problem of HIV/ AIDS, in particular, needs to be addressed as part of the emergency response.

As the article notes, there is a need to prepare for a potential rise in severe malnutrition by building the capacity of local hospitals in therapeutic care. In Malawi, a strong case is being made to set up community therapeutic feeding systems. In view of the state of the crumbling health facilities in Zimbabwe, this may be a way forward and perhaps needs to be considered.

Conclusions

The food crisis in Zimbabwe has complex causes, which are unlikely to be solved in the short-term. Predictions are that food security may continue to deteriorate, coping strategies will be eroded and livelihoods threatened. As yet, there has been no significant detectable decline in nutritional status. Nutritional surveillance is vital in such a scenario in order to pick up as quickly as possible any signs of deterioration.

The political environment in complex emergencies is frequently fraught. In Zimbabwe, there are particular problems concerning the collection and interpretation of data, and impartial distribution of food. Agencies working in Zimbabwe need to be alert to these problems and to work together to ensure that humanitarian principles are upheld.

Since this postscript was written, the government have allowed another national nutrition survey, conducted in February 2003 and covering all 61 districts. Using multi-stage 30x20 cluster survey methodology, these findings should be comparable to the 1000 DHS and May 2003 surveys. This time, NGOs and donors participated in the planning and supervisory filed visits. At time of print the survey was being analysed.

¹ The politics of hunger in Zimbabwe by Physicians for Human Rights, May 2002.

² Economist Intelligence Unit cited in “Zimbabwe in grip of new hunger crisis” by Andrew Meldrum, The Observer newspaper (UK), Sunday 15th December, 2002.

³ FAO/ WFP Crop and Food Supply Assessment Mission to Zimbabwe, May 2002.

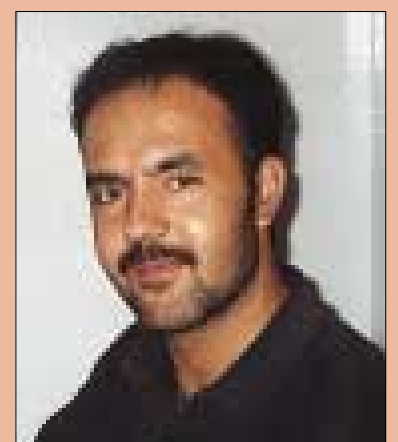
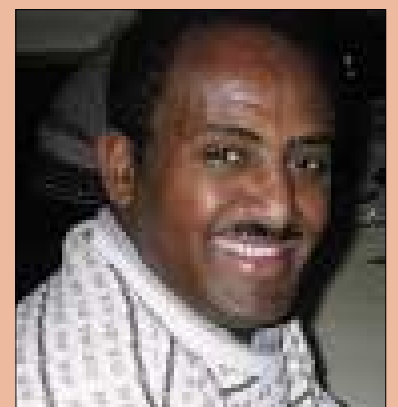
⁴ Vulnerability Assessment Committee. Emergency Food Security Assessment Report: Zimbabwe, September 2002.

⁵ Personal communication, SCF-UK Zimbabwe Office.



The Sphere Project, Training of Trainers - Course #7, January 2003 Geneva

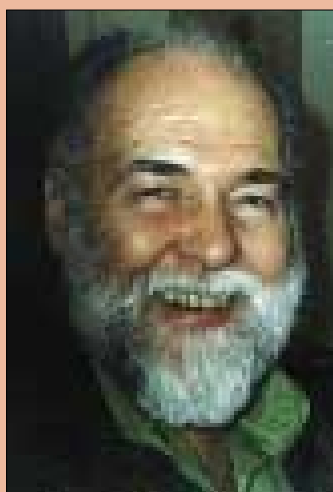
Front row, from left to right: Haitham Baltaji (Syrian Red Crescent), Elly Proudlock (Sphere Project Senior Assistant), Sean Lowrie (Co-facilitator), Juan Saenz (Co-facilitator)
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Back row, from left to right: Dereje Adugna (CARE Ethiopia), Richard Lorenz (RedR), Ron Ockwell (Independent Consultant), Sean Kennedy (IRC - DR Cong)



Upper row. Save the Children's emergency nutrition team in North Darfur, from left to right: Rowida Hassan, Kate Sadler, Abdalla Adam Eisa, Ahmed Ishag, Abdalla Adam, Jamal Abdalla Ali, Mohammed el Hafiz and Afaf Mohammed Breima | The 2 Seans (Sean Lowrie, training manager and Sean Kennedy, IRC, DRC) showing off the new Sphere t-shirts at the Sphere Training of trainers in Geneva, January 2003.

Middle row, Sphere TOT. Nan Buzzard, Sphere project manager, distributes the first Sphere t-shirt | Ayman Sadek Taqawi, CRS Egypt and Nkya Everready, LWF Tanzania | Dereje Adugna, Care Ethiopia.

Bottom row. London, February 2003, Nutrition standards review meeting, Caroline Tanner (AED), Steve Collins, Rita Bhatia (WFP), Paul Sherlock (Concern) and Alain Mourney (ICRC) looking down | Ann Callanan, same meeting, but looking up | Homayoun Naseri Wardak, Assistant head of mission, MSF France, Kabul, Afghanistan.



Sphere TOT, Geneva, January 2003. From left to right: Wendwessan Kitaw (SC UK Ethiopia) and Patricia Masanganise (CRS Zimbabwe) | Bryan Walker (Ind.) | Haitham Baltaji (Syrian Red Crescent) and Elizabeth Haywood (Salvation Army UK).

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Editorial team

Sheila Considine
Deirdre Handy
John Kevany
Marie McGrath
Fiona O'Reilly
Jeremy Shoham

Layout and website

Kornelius Elstner

Contributors for this issue

Gaëlle Fedida
Saul Guerrero
Julius Holt
George Kararach
Sonya Lejeune
Judith Lewis
Rosalyn O'Loughlin
Chandrashekar Pandey
Paul Rees-Thomas
Saskia van der Kam
Fiona Watson
Mark Wright

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Paul Rees-Thomas
Andy Seal

On the cover

Camels being watered in Mandera, Kenya. June 2002 © Paul Rees-Thomas

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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:

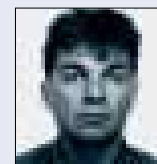
- providing a forum for the exchange of field level experiences
- strengthening humanitarian agency institutional memory
- keeping field staff up to date with current research and evaluation findings
- helping to identify subjects in the emergency food and nutrition sector which need more research

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. Jeremy and Fiona established the ENN in the Department of Community Health in Trinity College, Dublin in 1996. Earlier this year the ENN incorporated as a not-for profit company limited by guarantee.



Kornelius Elstner is responsible for Field Exchange design and layout. He is also the ENN I.T. specialist and works part time at the ENN while undertaking a degree in computer science.



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.





ENN Ltd.
The Emergency Nutrition Network

Unit 2.5, Trinity Enterprise Centre,
Pearse Street, Dublin 2, Ireland

Tel: +353 1 675 2390 / 843 5328

Fax: +353 1 675 2391

e-mail: fiona@enonline.net

www.enonline.net

