Food shortages in Malawi
Outpatient therapeutic feeding in Darfur
Possible konzo in Afghanistan
Nutrition in conflict: review of advances
Failure to learn lessons from past experience is a recurring theme in this issue of Field Exchange. Alain Moyre, the long-serving headquarters nutritionist from ICRC, laments the continued practice of implementing emergency supplementary feeding programmes in the absence of adequate general rations. Alain describes his recent experience in Burundi where agencies rushed headlong into implementing emergency SFPs when what was really needed was a good basic ration for the affected population. One reason offered by Alain to explain what happened in Burundi was the over-specialisation of agencies such that no one was responsible for taking an overview of the situation and co-ordinating ALL necessary food security activities. Predictably, the nutritional status of the children at the feeding centres did not improve (and in many cases started to decline sharply). This was simply because there was insufficient food at home. Either the take away supplementary ration was shared by the whole family or those entitled to a meal at the centre (on-site feeding) did not receive enough food at home. The rate of re-admission also increased sharply, the centres became over-crowded and the food supply could not keep pace with the influx. Frustration amongst feeding centre staff was high and the ‘beneficiaries’ became quite desperate.

MSF Holland’s experience in Maslakh camp for drought and conflict affected IDPs in Western Afghanistan during 2001/2 is also described in this issue. Saskia van der Kam highlights the failure to set up an adequate food distribution system in the camp resulting in exclusion of some from the system. The extent to which this was a cause of the apparent deterioration in nutritional status for those residing in the camp for long periods is unclear as an analysis of the health and care environments was not included. Food was however being poured into the camp for far larger numbers than actually existed. Arguably, the politicised nature of the camp should have given a clear lead a lot earlier for establishing a distribution system which could not be abused by more powerful groups, i.e. food distribution to household heads. Once again it appears that lessons from the past may have been drawn on earlier. It is only eight years ago that international humanitarian agencies witnessed the appalling effects of inequitable food distribution systems in the Rwandan refugee camps in Zaire. In this instance, the highly politicised nature of the camps meant that certain groups, including female headed households, received very little food while others received up to 10,000 kcal/s per person per day. It was only after changing the food distribution, so that rations were allocated to household heads rather than representatives of groups of households, that nutritional status started to stabilise and improve. On the positive side for Maslakh a recent survey has shown minimal malnutrition. Whether this is due to the change in distribution policies i.e. bread is made in bakeries and distributed daily, or due to the massive outflow of refugees back to their areas of origin, is unclear.

In the research section we carry the findings of a study carried out by a WHO intern to determine the awareness and progress in the field on detecting and/or preventing micro-nutrient deficiency outbreaks in emergencies. The study found that agencies lack capacity to diagnose mild and moderate states of deficiency disease. Also, very few agencies actually monitor the food basket amongst refugees and IDPs with particular reference to risk of micro-nutrient deficiencies. Yet the need for assessment and monitoring of the nutritional content of food baskets has been acknowledged and widely proclaimed in international fora from as far back as the 1980s when large-scale outbreaks of scurvy and pellagra affected refugee populations in Somalia, Malawi and Zimbabwe.

The address at the symposium on Nutrition in times of conflict and crisis, at the 29th ACC/SCN session given by Austen Davis, General Director of MSF Holland, in Berlin earlier this year, may offer some explanation for our seeming inability to learn lessons and translate these into more effective programming. Austen asserts that the humanitarian imperative is all too frequently tainted by political agendas. However, this can only be part of the explanation. Agencies seem to be devoting more resources to documenting experiences so that lessons can be learnt - indeed Field Exchange was set up specifically for that purpose. Yet there appear to be other impediments to translating lessons gleaned from hard experience into practice.

In the recent emergency in Afghanistan, the high turn-over of agency expatriate staff, lack of effective on-site learning environments, mistrust amongst NGOs, UN agencies and donors and the proliferation of new players have certainly not made for an ideal learning environment. There have also been additional impediments to implementing best practice e.g. the harsh physical environment, the political manipulation of humanitarian space and the unstinting efforts to manipulate the system by powerful groups and needy people. But such explanations are impressionistic and not backed up by evidence. Surprisingly, the more systematic exploration of why the ‘humanitarian community’ seems to be such a slow learner and what can be done in the short-term to rapidly strengthen field level learning. It may well be time to try out some new ideas like the ‘on-site learning office’ being proposed in certain quarters. It is certainly time that editorials such as this became redundant.
Françoise Grunewald presented a paper on lessons learnt from recent disaster responses in Central America at a conference in Paris in March 2002. The paper sets out to analyse the work of humanitarian actors and the impact of their actions in Central America. In order to do this the author examines country context, the impact of different disasters, the nature of programmes implemented, the consequent short, medium and long-term effects, and lessons learnt.

**Context**

Central America is extremely diverse in terms of agro-ecology, history, agricultural policies and human resources. The variation in agrarian economies between the three countries affected by recent disasters (El Salvador, Nicaragua and Honduras) has important implications in terms of vulnerability and ability to withstand shocks. Central America has suffered years of damage due to internal conflict. Natural disasters are common in the region but preparedness and mitigation capacity have not been strongly developed. Economies are geared towards export, e.g. coffee production, rendering farmers vulnerable to fluctuations in the international market, as occurred recently following the development of Vietnamese coffee exports.

**Different Impacts of Disasters**

Hurricane Mitch had several types of physical effect. Torrential and long lasting rainfall following the hurricane led to overflowing of rivers in the lower regions, mud slippage and land slides in the mountainous regions and tidal waves in the medium altitude areas. These physical events had the following impacts on the region:

- Destruction of inhabited areas including housing (some urban sites like Tegucigalpa and Posoltega and agricultural settlements were completely devastated).
- Destruction of productive areas including physical infrastructure and economic activities.
- Deforestation and recurrent forest fires in certain mountainous regions leading to significant physical vulnerability of ecosystems.
- Destruction of communication infrastructure, limiting economic activities for months after the event.

Although the impact of the two earthquakes in San Salvador was essentially different to that of Hurricane Mitch, there were a number of common features:

- Agricultural production was barely affected in the short-term since the hurricanes occurred outside of the agricultural seasons. However, in certain regions there may have been a negative impact on the productivity of trees due to weakening effects on roots.
- Marked destruction of urban and peri-urban living and commercial buildings.
- Marked impact on the coffee economy in certain regions.

**Aid Programmes**

Aid programmes were geared towards food and economic security measures. These included general rations, food for work, and very occasionally, seeds and tools distributions. Measures were also taken to safeguard assets and relaunch a limited number of micro-finance projects. There was a flood of activities targeted at rural areas but economic support for urban and peri-urban areas was relatively rare and seemed to be a blind-spot for agencies. Furthermore, compared to the African context, there seem to have been very little seeds and tool distributions. Also, delays in implementing programmes sometimes meant that programmes planned following one disaster were only implemented in time for a subsequent disaster to happen. After both Hurricane Mitch and the earthquakes in San Salvador, there were numerous initiatives to resettle people in camps-often far from areas of origin. These ascensionamentos were very crowded with little space for privacy and had many associated economic and social problems.

**Impact of assistance**

While it is clear that all these responses had visible positive effects in the short-term, medium term impacts were not always considered as much as they might have been.

For example:

- Food aid can have secondary negative effects, e.g. dependence of the population and disincentive to work.
- Programmes involving participation of the community that did not take into account the agricultural seasonal calendar may have had an adverse impact on food production.
- In some cases, rehabilitation programmes involving population re-settlement deprived people of access to their land or normal places of employment. This led to loss of income and food insecurity resulting in further displacement back towards their place of origin or, in some cases, abroad.

**Lessons learnt**

i) Considered analysis of disaster affected populations and appropriate responses still remains weak and more probing impact evaluation is required.

ii) It is critical to take into account seasonal agricultural patterns and economic activities for acute emergency and reconstruction activities as soon as a significant level of participation is required from those affected by the disaster.

iii) Choosing the location of new settlements must take into account food insecurity and economic impacts of such population movements.

iv) Micro-finance schemes had been implemented in a number of locations prior to the disasters. These schemes provided excellent entry points into solidarity networks and could have been utilised as a means of channelling cash-flow and aid to the beneficiaries. At best, they were ignored; at worst, they were undermined by initiatives which encouraged dependency thereby weakening the credit and saving ethic that had been nurtured.

v) It is vital to re-establish the communication and transport sector as soon as possible following a disaster.

vi) In the post-disaster period, longer term technical solutions to food insecurity were over-emphasised whilst political initiatives were usually ignored despite their critical relevance. For example, on the steep slopes of the Pacific coast, farmer induced erosion will not be improved through technical measures but by improving access of people to land in the grassland plains. As long as the latter are used for intensive livestock rearing, recommendations about terraced cultivation on the slopes makes little sense. Ultimately what is needed is a mini-agricultural revolution which depends as much on political will as agricultural know-how.

*"Torrential and long lasting rainfall led to overflowing of rivers in the lower regions"*
Livestock and livelihoods in emergencies
Lessons learned during the 1999 – 2000 emergency response in Kenya

Summary of report*

The largest ever livestock intervention programme in Kenya took place in 2000/1, targeting drought affected pastoral areas of the country. At the time of this review, thirteen agencies were involved in a total of 21 projects that had been implemented, or were in the process of being completed, throughout ten districts of Kenya. Between June 2000 and January 2001, donors provided close to $4 million for the drought-related livestock intervention programme.

The programme supported a variety of interventions including:

- destocking, which involved the purchase, including payment in kind, and slaughter of 36,307 sheep/goats, 194 camels and 5,955 cattle in 9 districts. This generated an estimated 667 tons of fresh meat (or the equivalent in dry meat) which was then distributed to a large number of beneficiary families including school children, patients and orphans;
- the provision of livestock feed to 8,000 sheep;
- the provision of a transport subsidy to allow transfer of 21,940 sheep from Mandera and 1,175 cattle and 3,584 sheep from Turkana, to Nairobi;
- the restocking of some 400 families with 30 sheep each;
- the vaccination and medical treatment of hundreds of thousands of animals;
- enabling some 100,000 head of cattle to access grazing pasture across the border in Uganda during the height of the drought.

A review of the programme revealed a variety of experiences and successes in different districts. Overall, destocking proved the most successful intervention throughout all the districts. This was attributed to strong community interest and involvement in the operation.

The livestock feed programme was successful in Marsabit owing to previous experience in handling readily available feed concentrates. However, in Garissa, the livestock feed programme did not achieve its objectives due to lack of local knowledge necessary to successfully implement the programme. In Turkana district, the supplementary livestock feed operation never took off because the programme relied on one supplier who failed to deliver the imported animal feeds.

The transport subsidy component was effectively implemented in Mandera because of the long experience of traders in undertaking this activity during non-drought years. In addition, the experience and local knowledge of the implementing agency ensured effective and thorough planning of the intervention together with the traders. In Turkana, although the internal transport subsidy within the district was a failure because of cheating by the traders, its external programme of moving livestock out of the district was effectively implemented.

The animal health component was successfully implemented in Samburu, Marsabit and Moyale. This was largely due to the involvement of local communities, the Kenyan government veterinary department and the community-based animal health workers in both planning and implementation.

The peace and border harmonisation intervention in Turkana enabled pastoralists to utilise resources across international borders as a result of an on-going initiative that was stepped-up during the drought. More specifically, the programme found that:

- pastoralists are willing to sell their stocks in times of hardships (and possibly in normal times given the opportunity).
- Compared to dry meat, fresh meat is cheaper and simpler to produce, faster to distribute, entails minimum wastage, provides greater bulk satiety and above all, is preferred by pastoralists.
- With proper planning, fresh meat can be distributed at regular intervals as happens with relief food, thereby establishing the possibility of replacing plant protein (beans and chickpeas) in the relief food ration with animal protein at a much reduced cost.
- The purchase of relief meat supports the local economy and livelihoods directly, represents a form of local economic investment, and benefits outweigh costs.
- Assuming donor flexibility, funds allocated for destocking could be turned around and used for restocking, should improvements in the weather conditions reverse the needs of the population. Transport subsidies can be instrumental in the off-take of large numbers of stock from drought-stricken areas to terminal markets. However, tight control mechanisms are essential to avoid abuse of the system.
- The provision of feed concentrates as supplementary feed during drought is a more economically feasible option than restocking or buying an animal in the market when the drought is over.
- The provision of veterinary drugs, such as de-wormers, prolongs the life of an animal for a period of 1-2 months even when pasture and water conditions remain the same. Other types of drugs also reduce the outbreak of diseases in times of stress.
- Movement and migration, including cross-border utilisation of resources, is key to the survival of pastoralists. The intervention has enabled the migration of the Turkana during the peak of the drought into Uganda (as a result of the OAU-IBAR peace initiatives) and of pastoralists from the North and North-east Kenya into Ethiopia (arranged through traditional system).

The factors that led to the failure of some of the intervention programmes included poor planning, lack of clear ideas and local knowledge, institutional...
Giving voice to silent emergencies

Summary of editorial

Recent issue of Humanitarian Exchange focuses on ‘Silent Emergencies’. According to the editorial, many emergencies do not attract significant amounts of publicity or political attention. They are ‘silent’ since they receive little media interest and are marginalised in donor funding decisions. It is argued that aid is apportioned in highly imbalanced and partial ways. UN consolidated appeals (CAPs) reflect this. In 1999, the response to the CAP for former Yugoslavia was $207 per capita compared to only $16 for Sierra Leone and $8 for DRC. While these commitments partly reflect the relative costs of doing business in Africa and Europe, they also reflect the level of political commitment and interest.

A cycle emerges where scant media attention leads to limited donor interest, poor aid commitments and ultimately low estimates of funding that may be available. This in turn reduces the level of proposed programming for the next round of funding. Even further down the scale are those long running emergencies that do not merit a CAP at all, such as the separatist war in western Sahara, the ethnic conflict in Nagorno-Karabakh and the insurgency in Southern Philippines.

Furthermore, aid budgets are dwindling. During the 1990s, foreign aid budgets stagnated despite an increase in the number of active wars. For example, OECD humanitarian aid decreased from 0.03% to 0.022%. These patterns are undoubtedly linked to the level of outside political interest and media attention.

Ten countries/areas receiving most humanitarian assistance (US$m)¹:

<table>
<thead>
<tr>
<th>Country</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRY (Serbia and Montenegro)</td>
<td>237.24</td>
</tr>
<tr>
<td>Europe (unallocated)</td>
<td>177.64</td>
</tr>
<tr>
<td>Ex-Yugoslavia (unspecified)</td>
<td>141.79</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>102.39</td>
</tr>
<tr>
<td>Mozambique</td>
<td>94.59</td>
</tr>
<tr>
<td>East Timor</td>
<td>91.59</td>
</tr>
<tr>
<td>Iraq</td>
<td>75.77</td>
</tr>
<tr>
<td>Sudan</td>
<td>51.91</td>
</tr>
<tr>
<td>Angola</td>
<td>48.27</td>
</tr>
<tr>
<td>Dubai</td>
<td>43.08</td>
</tr>
</tbody>
</table>

Ten countries/areas with most people in need of assistance²:

<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Korea</td>
<td>8,004,042</td>
</tr>
<tr>
<td>Somalia</td>
<td>4,000,000</td>
</tr>
<tr>
<td>South East Ethiopia</td>
<td>3,500,000</td>
</tr>
<tr>
<td>Sudan</td>
<td>2,367,200</td>
</tr>
<tr>
<td>Angola</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>1,300,000</td>
</tr>
<tr>
<td>Burundi</td>
<td>800,000</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>760,000</td>
</tr>
<tr>
<td>Uganda</td>
<td>585,000</td>
</tr>
</tbody>
</table>

The editorial asserts that political interest and media attention depends on how important countries are to donor agencies. Working outside of the livestock sub-sector working group and resulted in a lack of consensus on practice among NGOs/donors/government. For example, VSF-Switzerland applied a 20% cost recovery rate for veterinary drugs in Mandela, Wajir and Garissa; COOPI charged a payment of one goat for each 25 head of cattle or 50 shrots treated/vaccinated in Moyale and Samburu, while CARE introduced a 50% cost recovery rate scheme in Garissa.

In general, the NGOs that were most successful in their activities displayed a number of key characteristics. NGOs that were involved in fewer types of interventions (one or two) proved better focussed, while those with whose head offices were located in operational areas displayed the benefits of making decisions at field level. Smaller NGOs had a shorter chain of command and NGOs with intimate local knowledge, and did, make best use of local traditions and practices.

Shabunda: the ‘forgotten Kosovo’

Summary of article

An example of the ‘Silent Emergencies’ phenomenon is the situation in Shabunda, Democratic Republic of Congo (DRC). The DRC is in the grip of nine individual conflicts. More than 2.5 million people have died, an estimated limited to figures available from areas where NGOs are based. Isolated and cut-off regions are forgotten. Currently only one international NGO is active in Shabunda, a particularly isolated region of DRC. Located in the extreme east of the country, it is 3,500 km from the capital. Conflict is widespread with many living in perpetual fear and insecurity. Thousands have taken refuge in jungle areas or towns like Bukavu, while others have been forced to join armed bands.

Throughout Shabunda, traditional subsistence agriculture is at a standstill, livestock rearing has been decimated and fisheries have been destroyed. People are living off tubers and manioc, and marasmus and kwashiorkor are endemic. Although Shabunda is extremely rich in mineral resources, their exploitation is monopolised by the Great Lakes Mining Company, an operation set up by one of the areas rebel groups.

Rates of morbidity and mortality have increased rapidly over the past few years with four out of five children dying before the age of five. There is only limited access to primary health care with each health centre serving a population of some 35,000 people. Illnesses that had been eradicated, such as smallpox and chicken pox, have reappeared. Widespread rape of young women and children is so high that HIV infection is rampant. There are approximately fifty dispensaries for 1.5 million people and only 5% of children have access to education.

The article questions why Shabunda has been forgotten and suggests the following reasons;

i) those in power in the territory wish the emergency to remain unknown because this allows them to continue to exploit the territories mineral wealth in secret
ii) insecurity has made relief work very difficult
iii) donors do not consider the region to be of direct strategic interest or threat, so that the scale and complexity of the crisis do not warrant the expenditure that would be needed to make a difference.

² Bilateral allocation only (data refers to 2008) Source: DAC
³ Data refers to 1999 Source: OCHA Consolidated appeal
Use of case definitions and awareness of micronutrient deficiencies

Summary of Unpublished Study*

Micronutrient deficiencies have been reported in emergencies in populations who are dependent upon food aid, particularly refugees and IDPs. A review was recently carried out by a WHO intern to determine the awareness and progress in the field in detecting and/or preventing these outbreaks. Questionnaires were sent out to approximately 80 contacts, including academics, NGOs, aid agencies and individuals to gather information about activities and knowledge in the field. The results were analysed as follows.

Use of Case Definitions

Few agencies had defined case definitions. Agencies who had been in direct contact with and worked in areas with severe micronutrient deficiencies had developed case definitions on presentation of symptoms, but only for severe cases. No specific case definitions or risk assessment methods were specified to identify mild cases (symptoms are rarely obvious in mild and moderate cases anyway). Several organisations demonstrated an awareness of the classic symptoms of severe cases. MSF during their surveillance strategy, identified risk factors which would indicate the potential for micronutrient deficiencies. As expected, no agencies had the facilities to determine micronutrient deficiencies biochemically. Furthermore, many of the agencies contacted did not have any guidelines for assessing or recognising micronutrient deficiency disorders. Generally, there appeared to be a lack of awareness of micronutrient deficiencies, probably because many of the organisations had no direct experience of dealing with them.

Problems of Assessment

A major problem in detecting micronutrient deficiencies in the field is the occurrence of deficiencies in people of normal weight or those whose food rations are sufficient in quantity e.g. Nepal. An assessment in 2001 in Angola found that out of the 209 patients that were diagnosed with pellagra, none were wasted or oedematous, many were obese, and all were within the normal age height range.

Another problem with assessment is the variation in presentation and incidence between men, women and children. Much of the feedback and reports from the field suggest that micronutrient deficiency disorders are prevalent mainly in women of child bearing age and adolescent boys. This may be due to variations in symptom presentation. Variations in presentation of symptoms between adults and children also pose a problem for assessment through case definitions and none of the agencies recognised the potential for differences in symptoms or an awareness of the need to assess a ‘new vulnerable group’.

Previous outbreaks of scurvy in refugee camps in Somalia and Sudan showed that the prevalence of scurvy was high in those who had been in the camp longest, adults, females and those over 45 years of age - very different from the traditionally ‘vulnerable groups’ with respect to general nutritional deficiencies. Other authors have highlighted the prevalence of micronutrient deficiencies among young women and adolescents. During the pellagra outbreak in Mozambican refugees in Malawi, there was a significant variation in the attributable risk for gender. Women were found to be at 7.8 times higher AR than males. Children under 5 also appeared to have a lower attributable risk than the general population. No agencies have separate specific case definitions or assessment methods for adults and children and nutritional assessments generally focus upon the general nutritional status of children under 5 (anthropometric assessment).

Training

Several field workers reported that training in assessing risk and awareness of micronutrient deficiencies was insufficient in NGOs and that experienced nurses, doctors and nutritionists missed the clinical signs of these deficiencies in the field, due to the expectation of ‘text book’ pictures. Field workers also stated that in retrospect they had seen cases in the field but were unaware at the time due to lack of training, resulting in deficiencies not being treated.

Monitoring of Food Baskets and Surveillance

Rations containing insufficient micronutrients are consistently a major factor in the development of micronutrient deficiencies. It is vital that, due to the difficulty in diagnosing mild micronutrient deficiencies that other methods of assessment are used to determine risk before severe cases present. The need for assessment and monitoring of the nutritional content of food baskets was acknowledged to be critical for early warning of potential micronutrient problems as far back as the outbreaks in 1980s in Somalia and Sudan. However, the development of health information systems within refugee camps, to systematically assess ration content at a household level is often not embarked upon. Assessment of risk factors, e.g. insufficient food rations, lack of fresh vegetables and fruit, insufficient ration to enable exchange of food stuffs, high prevalence of protein-energy malnutrition, length of time dependent upon food aid, should suggest the potential for micronutrient deficiencies. Several NGOs in the study undertake food basket monitoring and household food security assessments but with no specific analysis of the potential for micronutrient deficiencies. There was also criticism from some individuals in the study, that prevention of micronutrient deficiencies was not a priority amongst some aid agencies and NGOs, specifically relating to fortification of food, and that co-ordination and interest was limited. The fact that the major incidences of scurvy, pellagra and beriberi have recently occurred in populations solely dependent upon food aid suggests that problems still remain in determining and/or supplying food sufficient in micronutrients to maintain the nutritional status of the population.

Conclusion

Due to the fact that clinical signs are often difficult to determine before severe cases are present, ration content and household food security should be monitored on a regular basis. There needs to be an assessment strategy developed between agencies to ensure that assessment can be easily carried out to determine risk, but can also be easily interpreted by the WFP and others to provide appropriate response. The development of universal assessment and surveillance methods would help in ensuring that all NGOs and others involved know what to look for. However, every crisis is different and presents varying arrays of difficulties. Improved communication between relief agencies and NGOs is vital to ensure that co-ordination in detection and surveillance of nutritional status of populations takes place.

Training of personnel in detecting cases and using information from food security/household assessments, may be an effective strategy to ensure early detection of risk. However, further research is required. Increased awareness of the risk associated with ‘traditionally less vulnerable populations’ is also required.

* Unpublished study by Helen Mitchell, WHO intern, Sept.-Dec. 2001. For more information contact: Zita Weise Prinzo, WHD HCR, Geneva (weiseprinzo@who.int)
Suspected toxic ingestion outbreak in central Afghanistan

By Gerald Martone, International Rescue Committee (IRC)

Humanitarian assistance operations in Afghanistan are only just beginning to reach beyond major towns and cities. There remain, however, many inaccessible and isolated rural communities. This is particularly true in the remote and mountainous areas of central Afghanistan.

In the highland areas of Afghanistan where the northern, eastern, and western regions intersect, impassable snowdrifts and freezing temperatures limit access to a fairly restricted time of year. The terrain is inhospitable with dangerously deep crevasses, insurmountable rocky slopes and steep ravines. No motor vehicles are capable of reaching many of these places. The only way to penetrate these mountains is by an arduous journey for several days, usually on horseback, donkeys, or by foot.

Due to a shorter growing season in the higher altitudes, agricultural livelihoods above the tree line are particularly vulnerable to even minor climatic changes. The recent drought has resulted in depletion of household assets, complete loss of agricultural self-reliance, and significant food scarcity. Hundreds of thousands of internally displaced Afghans have migrated from their ancestral homes in these rural communities towards larger towns and cities in the hope of receiving some external assistance.

While conducting field assessments and food surveys in remote areas, International Rescue Committee (IRC) staff member, engineer Hamidullah Hamidi, visited the remote village of Abdulgan and its neighbouring sub-villages in Zari District on December 2 and 3, 2001. Hamidi reported agonising food shortages and ‘starvation’ of villagers as a result of the drought.

In response, the IRC Northern Afghanistan program organised a caravan of 400 donkeys to try to move relief assistance up the mountain to Abdulgan. From January 5-21, 2002, IRC transported and distributed over 3,000 metric tons of wheat. During the arduous journey up and down the mountain footpaths, four men and one donkey died from hypothermia and exposure.

It was during the return mission that the field staff reported an unusually high prevalence of illness and death due to conditions that the villagers were unfamiliar with. IRC staff reported that food was so scarce that villagers were foraging for wild plants, grass, and roots that were not normally part of their diet.

On recalling the toxic nutritional state, ‘Konzo’, seen occasionally in sub-Saharan Africa during drought or extended dry seasons, we felt it was critical to arrange a return investigation to the region. The plan was to conduct follow-up interviews of villagers and explore the status of their coping strategies, and determine if toxic ingestions of wild foods were, in fact, occurring.

The etiology of Konzo is presumed to be the consumption of improperly prepared cassava root (Manihot Esculenta), particularly the bitter variety. This toxic state occurs in communities that consume cassava root that has not been boiled and washed sufficiently. The hasty preparation of cassava root is sometimes seen during acute food shortages and drought. Some observers have regarded Konzo as an early famine warning sign or even as a crude proxy of pre-famine conditions.

Investigation

From February 15–18, 2002, the IRC Northern Afghanistan Program conducted a follow-up field assessment to Bini Gaw sub-village, Babah Ali village of Abdulgan, District of Zari, Balk Province, departing from Mazar-I-Sharif.

Abdulgan is among some of the most remote communities in Afghanistan. It is located about 150 miles south of the city of Mazar-I-Sharif in the Mushkel-Hal Mountains. The altitude of Abdulgan is approximately 2,800 meters above sea level. There are no roads, no electricity, and no indigenous water sources beyond the capture of surface run-off from rain in underground stone cisterns.

Abdulgan is divided into four main villages; Baya, Fulad, Babah Ali, and Dawlat Muhamad. The total population at the time of this assessment was 1,407 families with approximately five persons per family. The people of this central region are ethnic Hazara, hence they refer to the area as Hazarajat.

The rapid assessment was conducted through key informant interviews, focus group discussion, and a brief household survey. The primary informant was Atahullah Kashifi, Chief of Abdulgan, now living in Bini Gaw sub-village. The interviews were conducted in Dari and translated into English by the field mission staff.

MUAC (Mid-Upper Arm Circumference) measurements were obtained on eight children under 5 years old. Two children were identified with moderate malnutrition (110-124mm circumference) and no cases of severe malnutrition (less than 110mm) were noted. Villagers anecdotally describe the main causes of illness and death as acute respiratory illness, measles, and diarrhoea. The nearest health facility is in Zari town. This very basic health unit is a six and a half hour walk from Abdulgan on a treacherous and icy mountain trail.

As an indication of the level of food insecurity that had developed, almost all villagers had to sell some of their personal possessions, roof timbers from their houses, and draught animals to cope with the loss of their livelihood. Many villagers explained that they had eaten their seeds and were unable to plant for the next season when they hoped the rains would finally come. There is no agricultural irrigation and the steep mountain fields are entirely rain-fed.

Villagers recounted the occasional consumption of wild plants and atypical roots as a coping strategy to expand their dwindling food reserves. One particular food that was described was a starchy white tuber referred to as ‘tartran.’

Tartran is the root of a wild plant. It vaguely resembles parsnips in appearance. People report that tartran grows in the higher altitudes on mountain slopes. In fact no samples were available in villages at lower altitudes that were surveyed in Faryab Province, although people reported climbing the
mountains in search of the root during past food shortages. The grassy part of the plant is traditionally used as animal fodder for the winter. The leaves are sun-dried and stored and then fed to domesticated animals when they are no longer able to graze as a result of snow cover.

Several dried root samples were obtained and brought back from a villager’s food stores in the hope that an analysis might be conducted at a later date. A sample of round bread containing wild grass (used to expand the grain content) was also given to the team to take back for examination.

In the focus group discussion, people reported that tartran was last consumed 30 years ago during the severe drought of 1972 when people discovered that you could eat this root. To prepare the root, it is first peeled and then the starchy interior is boiled at least three times, each time discarding the water. According to all accounts, tartran tastes very, very bitter. Some people offered that the taste is so disagreeable that it is almost inedible, especially if it has not been triple-boiled.

Times of extreme nutritional distress seem to promote short cuts in the processing of the root. One woman described how over the last several months she would not wait for the thorough preparation of tartran and would on occasion prematurely serve the root after only one boiling. The scarcity of firewood in these areas contributes to the rushed and insufficiently prepared tuber.

Very few Afghans outside of remote and isolated areas have ever known of this root or its name. The guides that accompanied us on the mission had never heard of it. One sixty-year old man from Aque Kupruk town recognised the root and confirmed that it was something that was rarely eaten except in times of food scarcity, such as the drought of 1972. On later investigation, a former rural resident from as far away as the highlands of Badakhshan Province confirmed his knowledge of the use of tartran root during the previous and current drought. He referred to it as “tartre.”

One mother in Babah Ali village described the sudden death of her three-year old child. The child had eaten tartran only two days before. The mother reported that the child “could not walk” after eating tartran. The mother also reported abdominal distention and coughing.

This winter in Bandicheep sub-village, a mother reported that her unattended 4-year old boy pulled a tartran root out of the pot before the boiling was complete and ate it. The mother reported that her child developed abdominal distention, gastritis, and “white water coming from his mouth.” He died one day later.

In the sub-village of Bini Gaw (population 65 families) several people reported that nine months ago, five children were foraging together in the mountains for food. They recounted that these children came back to Bini Gaw and were acting “mad.” The children were described as aggressive and repeatedly running away from the home without direction or destination. Approximately five days later, the children were reportedly returned to normal. The villagers believed that this behaviour was the result of a mythical spirit. Some villagers suspect, however, that the children had eaten tartran, among other wild plants, that they may have discovered. This description was later verified by Chief Kashifi.

A Toxic State?

When the symptoms of paraparesis or sudden difficulty with walking were described, several villagers responded that there had been “many cases” in Abdulgan. The descriptions consistently fit the abrupt onset and rapid deterioration typically ascribed to the Konzo syndrome.

During the time of this assessment, however, we were unable to observe any active cases of this suspected toxicity. Since we were unable to observe an active case, the team could not test for lower limb hyperreflexia, observe spastic abnormality of gait while walking, nor could we check for impaired eye movements and/or blurred vision. It would also have been useful to obtain a urine sample from an active case for later analysis for the presence of thiocyanate.

The symptoms of Konzo have been attributed to dietary cyanide exposure. If the tuber is prepared without sufficient maceration/grinding, drying, fermentation, soaking, and/or cooking, the toxin will not be liberated from the plant’s cells and converted to hydrogen cyanide, which then evaporates and renders the food safe to eat. Typically cassava root should soak in water for at least 3 nights. The soaking time must be extended much longer if the water is cold.

Further complicating the toxicity of dietary cyanide is a diet low in protein. Without adequate protein intake there is insufficient dietary sulfur amino acids. These sulfur substrates are the major metabolic detoxification pathway for cyanide, converting it to thiocyanate.

The word Konzo means “tired legs” in the indigenous language of the people in Zaire where the disease was first recorded. One of the more noticeable signs of dietary cyanide poisoning is the spastic gait. Many sufferers describe weakness, trembling, and heaviness in the legs. There is a tendency to fall while walking as well as an inability to stand. Some afflicted people are even bedridden for several days. These symptoms have sometimes been confused with polio infection.

Most documented outbreaks of Konzo were confined to areas of Africa that were rural, poor, and remote. The majority of described cases occurred during dry seasons, particularly in times of drought.

Conclusion

As this analysis and survey were informal, anecdotal, and unscientific, definitive interpretation of the findings would be premature. However, considering the potential impact that this unconfirmed toxic ingestion might have on distressed rural communities, a methodical and scientifically rigorous investigation of potentially poisonous “famine foods” in Afghanistan should be conducted. An investigation by a follow-up research mission should include a qualified toxicologist as well as provision of appropriate assay methods that could more adequately investigate the existence of a toxic-nutritional syndrome.

Active cases of recent ingestions as well as old cases with persistent upper motor neuron symptoms should be examined for neurological sequelae. Fresh samples of the tartran root should be collected for later analysis for cyanide derivatives. These specimens must be prevented from drying out during transport, as evaporation of hydrogen cyanide would reduce the detectable levels of cyanide compounds during the assay. It is advisable to also collect specimens of other “famine foods” or wild plants for later analysis should there be a toxic state where tartran was in fact not the causative agent.

An additional toxic nutritional condition known as Lathyrism has been described in India and Bangladesh. The symptoms result from the excess consumption of peas of the Lathyrus family otherwise known as chickling peas. The amino acid Beta-N-oxalylamino-L-alanine in some strains of chickling peas is a known neurotoxin. This toxin affects the central nervous system and produces an untreatable slowly progressive paraparesis.

If further investigation strengthens the suspicion of a disease condition with a dietary etiology, a
Konzo: A distinct type of upper motor neuron disease

Definition
Konzo is characterised by the abrupt onset of an isolated and symmetric spastic (increased muscle tone) paraparesis (weakness of both lower limbs), which is permanent but non-progressive.

Aetiology
An association between konzo and dietary cyanide exposure (from consumption of insufficiently processed bitter cassava) has been linked with the onset of konzo in several epidemiological surveys. A combined high cyanide/low sulfur (low protein) intake has also been implicated. Despite its epidemic occurrence and familial clustering, konzo patients show no signs of infection and outbreaks tend to be restricted to remote rural areas.

Clinical manifestations
The onset of konzo is sudden, in 90% of cases less than 1 day. The initial symptoms, often triggered by a long walk or hard work, include trembling or cramping in the legs, heaviness or weakness of the legs, and a tendency to fall. The severity of konzo varies between individuals but ranges from hyperreflexia in the lower limbs to a severely disabled, bedridden patient. Associated signs include weakness of the trunk and arms, impaired eye movements, dysarthria (disordered articulation) and possibly visual impairment. Examination including co-ordination, sensory function as well as urinary, bowel and sexual functions are all normal. While typically the condition remains stable, some patients may suffer a sudden and permanent worsening of the spastic paraparesis (second onset).

Treatment
There is no known cure for konzo. Immediate treatment with high doses of multivitamins (especially B vitamins) has been suggested, to avoid possible increased neurodamage due to concurrent vitamin B deficiency. A good and varied diet with adequate protein is essential. Physical rehabilitation has proven successful in achieving independent locomotion.

Prevention
Konzo is not a major public health problem in populations as a whole, but is in affected communities. There is a risk of konzo epidemics where agro-ecological problems turn bitter cassava into the major source of calories and where food and/or fuel shortage may lead to short-cuts in cassava preparation. Konzo can likely be prevented by applying effective processing of the cassava root.

Adapted from WHO WEEKLY EPIDEMIOLOGICAL RECORD, No. 30, 26 July 1996 (Based on a report from the Department of Nutrition, Uppsala University, Sweden).

References
Cliff et al, Konzo associated with War in Mozambique: Tropical Medicine and International Health, Volume 2, Number 11, pages 1068-1074
Cassava Cyanide Diseases Network (CCDN). Towards the elimination of Konzo, TAN and other cassava cyanide disease.

For further information contact:
Gerald Martone, R.N., M.S., Director of Emergency Response International Rescue Committee 122 East 42nd Street, New York, NY 10168, email: gerald@theIRC.org


Since the launching of the first edition of the Sphere handbook (2000), over 25,000 volumes have been sold and the handbook has been translated into 15 languages (eight spontaneously). Handbook feedback forms, the text of the first edition and additional information can be found at www.sphereproject.org. A revised edition of the handbook will be published in late 2003. In Spring 2003, a draft of the revised text will be available on the website.

Sphere handbook review process
The revision’s purposes are: to strengthen the link between the Humanitarian Charter and the Minimum Standards; to update the qualitative and quantitative indicators and guidance notes as needed; to address cross-cuttings issues such as children, women, the elderly, disabled, HIV-AIDS, and the environment; to enhance linkages between sectors; to iron out inconsistencies, faults and important omissions from the first edition; and to change the format and text. In addition, as per an earlier commitment by the Sphere Management Committee, Minimum Standards relating to Food Security will be developed as part of this process. This will build on the work already done in this area, including the Inter-Agency Workshop in 2001 on Minimum Standards for Food Security in Disaster Response, organised by Oxfam GB. The nutrition, food security and food aid focal points will be working closely together to ensure their respective standards are well integrated.

Six Focal Points and the Sphere project office will undertake this work over the year. Each Focal Point will work in their own particular way based on their sector-specific needs. All Focal Points are committed to a broad-based consultative process with feedback and input from field-based users and with an emphasis on consultation with the agencies that are regularly using the handbook in disaster response. Comments are encouraged from national and international NGOs, UN agencies, donor governments, governments where disaster response frequently takes place and academic institutions. Individuals from NGO and UN HQs as well as those from academic institutions will participate as reviewers to the revision.

To make sure that you and your agency’s experience, insights and technical expertise inform the Sphere handbook revision, please either fill out a handbook feedback form (due September 30, 2002) and submit it to the project office or contact the relevant Focal Point.

Who to contact
The six Focal Points listed below come from NGO agencies that have generously donated staff resources. In addition to their regular work with their respective agencies, these staff are responsible for managing the revision process. Please contact the Focal Points listed below with any names, contacts, suggestions, recommendations or comments!

Water and Sanitation: Andy Bastable, Oxfam GB (abastable@oxfam.uk.org)
Nutrition: Anna Taylor, Save the Children UK (ataylor@archivchf.org.uk)
Food Aid: John Solomon, CARE USA (jsolomon@care.org)
Shelter & Site: Graham Saunders, Catholic Relief Services (graham.saunders@crcshh.ba)
Health Services: Rick Brennan, International Rescue Committee (brennan@theirc.org)
Food Security: Helen Young, Tufts University (Helen.young@tufts.edu) This position is exceptional in that it is contracted.

The Sphere Project, PO Box 372,1211 Geneva 19, Switzerland. sphere@ifrc.org
**African wild harvest project**

By Rory McBurney

The ‘African Wild Harvest’ project is a collaboration between the Royal Botanic Garden Kew and the UK Medical Research Council’s Resource Centre for Human Nutrition Research (HNR), Cambridge. The project began in February 2002. Its purpose is to link Nutritional and Botanical data on African wild food plants and fungi, highlighting future research needs.

**Why Wild Foods?**

During times of severe food shortages, populations have come to depend on wild foods for survival. In the long term, where local populations are heavily reliant on external food aid, there is a rapid loss of the ability and desire to utilise wild foods that may have been routinely added to diets in previous generations. In addition population displacement and environmental degradation often associated with famine and food shortages have resulted in species loss from certain areas. ‘African Wild Harvest’ builds upon a pilot project on Sub-Saharan famine food legumes, which resulted in a manual entitled ‘Dryland Legumes in Africa: Food for Thought’ (Huxham et al. 1998). This drew together information on 35 lesser-known legumes including line drawings, distribution, preparation methods, and nutrient contents. The first output from ‘African Wild Harvest’ will be a compilation of the nutrient content of wild foods of North East Africa, focusing on Ethiopia. It is hoped that this output will be of immediate use to field workers calculating the contribution that wild foods make to the household food basket. In the future the project hopes to investigate the interactions between humans, wild foods, and the environment.

**External Partners**

The UK Medical Research Council’s Resource Centre for Human Nutrition Research (HNR) has particular expertise in both data quality assessment, and compilation of food composition tables and databases. In particular, a number of HNR studies are designed to investigate how poor rural populations adapt to low nutrient intakes and how to define the limitations of these responses. At present ‘African Wild Harvest’ is also in discussions with international Relief agencies operational in the field of human nutrition and food security. It is hoped that through working directly with them, the project can contribute both botanical skill and nutritional information in order to understand the contribution that wild foods make to the food basket of populations under acute and chronic nutritional stress.

**The Long Term Goal**

Together with its partners, ‘African Wild Harvest’ hopes to create a resource with a user-friendly interface that has information on:

- Nutrient content of wild plants and fungi
- Additional types of information, such as toxicology
- Botanical and cultivation information and uses
- Related cultural and social aspects (such as preparation methods)

This information should in turn be useful to local staff and international organisations alike, contributing to the long-term management and availability of wild plants as sources of nutrients.

**Survey of Economic Plants for Arid and Semi-Arid Lands (SEPASAL)**

African Wild Harvest is part of SEPASAL, which is a major database on useful ‘wild’ and semi-domesticated plants of tropical and subtropical drylands. It began in 1981 with funding from OXFAM. The database contains information on more than 6200 useful dryland species, excluding major crops, but including information on many wild food plants. It is widely used by aid and development organisations, government departments and non-governmental organisations to help support sustainable use programmes in drylands. Data include: scientific name; plant family; vernacular and trade names; geographical distribution; ecology; uses of plants; properties and chemical analyses, and references. SEPASAL offers an advisory service that can be accessed on the Internet by the following link: http://www.rbgkew.org.uk/ceb/sepasal/. If you don’t have access to the Internet, you can still write to us. The information SEPASAL provides is free for NGO’s involved in development work.

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**New course**

**Evaluation of Health Programmes in Complex Emergencies**

The London School of Hygiene & Tropical Medicine will be running a course on ‘Evaluation of Health Programmes in Complex Emergencies’. The next course is scheduled to take place on 16-20 September 2002. The course will offer instruction in practical evaluation tools as well as exploring some of the unresolved challenges of humanitarian assistance evaluation. It will also examine alternative approaches to evaluation and learning in the context of health programmes and invite participants to share and debate their experience.

Field experience in humanitarian work is required. Applications are welcomed from health professionals who want to upgrade their evaluation skills. The course may also be relevant for others with experience in humanitarian work and an interest in evaluation in the context of complex emergencies. The number of participants will be limited to facilitate group work. Competence in English is required.

The course content will include evaluation criteria, accountability and international standards for health, the Sphere project and other recent quality enhancement initiatives.

Applicants should obtain the application form and return it as soon as possible to: Registry, London School of Hygiene & Tropical Medicine, 50 Bedford Square, London WC1B 3DP Telephone: +44 (0)20 7999 4648, Fax: +44 (0)20 7232 0638, e-mail: short_courses@lshtm.ac.uk, Internet http://www.lshtm.ac.uk

Those requiring further information about the course should contact the Course Co-ordinator, Dr Egbert Sondorp Telephone: +44 (0)20 7612 7883 e-mail: egbert.sondorp@lshtm.ac.uk
The right to nutrition

Summary of unpublished paper

The initial premise of the paper is that there is a common misunderstanding that most human rights law does not apply during conflict situations because it may be derogated (meaning that states may temporarily suspend certain obligations under International Human Rights Law). But human rights law is not so often derogable in conflicts as many assume. In fact the International Covenant on Economic, Social and Cultural Rights (CESCR) and the Convention of the Rights of the Child (CRC) are not derogable at all. “Furthermore, based on the list of non-derogable rights contained in article 4, para 2 of the International Covenant on Civil and Political Rights, the authors assert that the second treaty is in no way permitted to suspend or reduce many of their legal obligations to ensure the adequate nutritional status of their citizens during times of emergency conflict. In addition, states have legal obligations for foreign nationals seeking refuge in their territory including facilitating access to adequate food and protection necessary for maintenance of adequate nutritional status.”

Various forms of protection are also available to civilian populations in civil or non-international armed conflict. For example, the starvation of civilians as a method of combat is prohibited. There is also strong evidence that some of the provisions in the Additional Protocol to the Geneva Convention of 1949 apply even to States that have not signed them because they have become part of the body of customary international humanitarian law. This means that in the case of (non-international) internal conflict, the protocol applies to non-state warring parties such as liberation movements and rebel groups.

The authors of the paper argue that, given that most humanitarian crises today are also crises of human rights, the obligations of humanitarian agencies to address protection as a fundamental and integral aspect of humanitarian action has to be more systematically addressed. Humanitarian workers increasingly recognise the need to root their work within an ethical framework. There is no one list of humanitarian principles but they are widely seen to include: the humanitarian imperative, neutrality, impartiality, independence, transparency, accountability, do no harm, protect from future vulnerabilities and respect local custom and culture. Various attempts have been made to codify and enforce these principles, e.g. IFCRC/NGO code of conduct, OLS ground rules, etc.

Human rights represent relationships between a subject with valid claims (claim holder) and objects with correlative duties and obligations (duty-bearers). International human rights law primarily deals with the obligations of the state. In a human rights approach to programming (HRAP), identification of all key duty bearers in relation to specific human rights, including right to adequate food and nutrition, is required.

Three case studies were used in the presentation to demonstrate ethical dilemmas and resolutions adopted in recent crises.

Situation: In Sudan, malnutrition rates in Bahr el Ghazal (BEG) did not decline after food aid started to pour in during 1998. This was largely recognised to be due to a re-collection and re-distribution of food by local political leaders (chiefs, traders, military, commanders, SPLM and SRRA). This situation persisted so it was difficult for OLS to maintain that its operation in BEG was neutral, impartial or transparent and it was very difficult to be accountable to anyone, e.g. beneficiaries or donors.

Ethical dilemma: WFP considered two options; to suspend the delivery of food to BEG or to suspend non-life saving capacity building support to SRRA. The first option would have meant violating humanitarian principles and the second risked the SPLM/SRRA retaliating by expelling OLS from its areas, denying access and preventing OLS from seeking to meet the humanitarian imperative.

Resolution: Option one was rejected primarily as it was considered preferable to accept some partial subjugation of other humanitarian principles to maintain supremacy of the humanitarian imperative and option 2 was rejected for fear of losing access.

Situation: In Afghanistan a conflict developed over the use of military assets for the delivery of humanitarian supplies. Many military forces, particularly coalition forces – offered support for obvious political reasons, e.g. there were concerns that UN agencies did not have adequate resources to meet all necessary humanitarian needs. The dilemma therefore was between the humanitarian imperative and the neutrality and impartiality of humanitarian assistance.

Resolution: it was agreed that:
- there was a difference between using planes belonging to those governments actively engaged in the conflict
- there was a difference between using planes inside the country and those outside it
- a balance had to be struck between neutrality and the need to deliver life-saving assistance whenever needed.

Situation: in Burundi in 1998 the Government adopted a policy of forced relocation or regroupment of civilians to restricted camps. Despite international protests the government proceeded with its policy and called on the UN and NGOs to provide food, health care and other humanitarian services to the camps.

Ethical dilemma: There was a conflict between the humanitarian imperative and assisting and legitimising the government in an illegal action that violated the rights of many of its citizens.

Resolution: UN system and NGOs applied maximum pressure on government to change its policies while at the same time providing a minimum amount of humanitarian assistance to maintain an adequate nutritional status. All agencies agreed not to provide any form of assistance that could help sustain the camps on a long-term basis, e.g. trucking water rather than digging bore holes even though this was more expensive.

The main conclusions and recommendations of the paper were as follows:
- Much of international human rights law is applicable in armed conflict situations and should be used.
- Human rights law is not so often derogable in conflicts as many assume. For example, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child are not derogable at all.
- There is a need and a possibility to extend HRL to include duty bearers other than the state parties. This would mean that duty bearers should be identified at all levels of society with specific accountabilities.

Some of the areas identified by the authors for further analysis and action were:
- Achieving consensus on the definition of protection competences.
- Improved and more systematic training in human rights and international humanitarian law and their application for humanitarian workers including nutritionists.
- Improved analysis of claims and duties in relation to the right to nutrition in conflict situations.
- More systematic management of ethical dilemmas. Ideally an agreement among agencies should be reached on how to respond, in a phased manner, to a crisis that increasingly compromises the humanitarian imperative.


For further information contact accscn@who.int
A Review of the advances and challenges in nutrition in conflicts and crises over the last 20 years

By Frances Mason and Anna Taylor
Abbreviated version of unpublished paper

Introduction
The main purpose of this paper is to assess the principal advances made over the past years in nutrition in conflicts and crises and to propose direction for further advances in the field. The term 'advances' refers to developments in technical knowledge and nutrition policy and practice. The Project Cycle Management is used as a framework for presenting these advances and the challenges that remain. It is hoped that this will contribute to the development of a plan of action for the international community that will accelerate the pace of advances in the field of emergency nutrition: advances that will lead to significant improvements in relieving the suffering, death and degradation of disaster-affected communities. The first step in this process would be a plan of action developed through the collaboration of bilateral agencies, UN Agencies, and NGOs through the UN ACC/Sub-Committee on Nutrition.

Background
This paper is not able to provide significant detail on how the advances described took place, but it is essential to emphasise the important role that interagency collaboration has played in furthering the sharing of technical knowledge and improving the policies and practice of nutrition in conflicts and crises. Table 1 describes the key developments in interagency collaboration and policy development. Many of these were initiated by interagency meetings held since 1988. These meetings provided a forum for improved coordination, mutual understanding and enhanced analysis of the constraints within the humanitarian system. A central focus of the interagency work was the move towards Public Nutrition indicating a shift from the individual to the population level and from a narrow set of technical interventions to a wide range of strategies, policies and programmes to combat malnutrition (Harinarayan 1999). The interagency group has also provided a catalyst for a number of initiatives that have enhanced policy formulation and practice guidelines.

Analysis and assessments, advances
As the paradigm of public nutrition began to be established in the early 1990s, UNICEF developed a conceptual framework for understanding the causes of malnutrition. The framework was later adopted by a wider group at the International Conference on nutrition in 1992 (Shoham 1999) and has been instrumental in ensuring an understanding of malnutrition that goes beyond inadequate intake to include the range of food security, care and health factors that contribute to malnutrition. Analysing these processes in specific contexts has created opportunity for intelligent nutrition programmes which address real rather than assumed causes.

While the assessment of malnutrition in children under five years and the estimation of prevalence has become routine work for many emergency nutritionists, there remain substantial gaps in understanding how to measure acute malnutrition in other age groups, namely infants (<6 months), adolescents, adults and the elderly. This is due to the inadequacies of reference population data and inter-ethnic variation. In the last few years the limits of our understanding of how to measure these groups have become more widely discussed and the research agenda has become clearer.

Analysis and assessments, challenges
Despite consensus on appropriate anthropometric survey methodologies, there remain frequent examples of poorly conducted surveys or assessments which serve to misinform rather than inform decision making (Collins 2001). Common mistakes include fundamental errors on sample selection, unclear and
aid went to emergency activities, the highest proportion for 23 years. While the proportion of food aid allocated to emergencies has increased, the overall quantity has varied substantially through the 1990s due to intermittent appearance of global surpluses. There have been enormous advances at donor level (bilateral and multi-lateral) with regard to provision of food aid and other resources for food and nutritional emergencies. Many of these advances have grown out of identification of the political, institutional and bureaucratic constraints which affect donors in extremely specific ways. The implications of the potential negative effects of food aid have also begun to permeate donor thinking in recent years. The ODI Humanitarian Policy Group and NutritionWorks (Jaspars 2000a) reviewed the principles and practice for food distribution in conflict and made the following key recommendations:

- Programme situation analyses should include risks to lives and livelihoods, war strategies and war economy and political contracts to determine the risk of diversion of food aid.
- Agreement with authorities and co-ordination between agencies should be based on an analysis of accountability of local authorities.
- Appropriate distribution methods should be identified considering whether beneficiary representatives or local institutions can be relied on to distribute to the most vulnerable and if not whether registration is possible for direct distribution.

There remain substantial shortfalls in the adequacy of response to early warning information resulting in early warning systems that have not been as useful in preventing emergencies as had been hoped. While the increased use of anthropometric data in planning emergency response can be regarded as progress, prevalence of malnutrition is usually apparent relatively late in a crisis and yet is a measure that is increasingly being used to trigger decisions. This untransparent presentation of data and failure to include assessment of oedema. These errors reflect poor human resource capacity and the failure of those agencies responsible to utilise technical expertise in nutrition. The importance of clear case definitions for micronutrient deficiencies, adequate sample size, and, where possible, biochemical confirmation during micronutrient deficiency assessments has been widely recognised. However, challenges for implementation and the lack of validated field-friendly sample collection and analysis technology exist still.

<table>
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The emphasis placed by Amartya Sen’s work (Sen 1981) on accessibility of food as well as availability transformed analytical thinking. To improve the effectiveness of programmes aimed at preventing malnutrition

Mid 1980s: Growth and development of early warning systems sometimes alongside nutritional surveillance (eg FEWS, FIVIMS, FEWSNET). To provide macro level data on food availability to identify countries facing acute food insecurity

Early 1990s: Food Security and Livelihoods Analyses: improved methodologies, analyses & coordination. To improve analytical base for programming and move from an understanding of food availability to food access.

Mid 1990s: Anthropometry: an increasingly widespread use; use of standard indices including z scores; increased research (although still very limited) into the role of anthropometry in adolescents, adults and the elderly. To ensure greater standardisation of use of indices and cut-offs. To provide an influential factor for resource allocation.

Table 1: Interagency Collaboration

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Table 2: Analysis and assessment

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<td>To provide a practical framework for accountability by connecting the principles of humanitarianism to standards of service delivery and an operational tool or reference to help structure the planning and management of emergency programmes.</td>
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Food aid, advances

Since 1989, the proportion of global food aid allocated to emergencies has increased from one eighth to one third in 1999 when it equalled 4.7 million MT (IASC 2000). In 2000, 86% of WFP food

untransparent presentation of data and failure to include assessment of oedema. These errors reflect poor human resource capacity and the failure of those agencies responsible to utilise technical expertise in nutrition.

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marginalising and institutional constraints which affect donors in extremely specific ways. The implications of the potential negative effects of food aid have also begun to permeate donor thinking in recent years. The ODI Humanitarian Policy Group and NutritionWorks (Jaspars 2000a) reviewed the principles and practice for food distribution in conflict and made the following key recommendations:

• Programme situation analyses should include risks to lives and livelihoods, war strategies and war economy and political contracts to determine the risk of diversion of food aid.
• Agreement with authorities and co-ordination between agencies should be based on an analysis of accountability of local authorities.
• Appropriate distribution methods should be identified considering whether beneficiary representatives or local institutions can be relied on to distribute to the most vulnerable and if not whether registration is possible for direct distribution.

There remain substantial shortfalls in the adequacy of response to early warning information resulting in early warning systems that have not been as useful in preventing emergencies as had been hoped. While the increased use of anthropometric data in planning emergency response can be regarded as progress, prevalence of malnutrition is usually apparent relatively late in a crisis and yet is a measure that is increasingly being used to trigger decisions. This untransparent presentation of data and failure to include assessment of oedema. These errors reflect poor human resource capacity and the failure of those agencies responsible to utilise technical expertise in nutrition. The importance of clear case definitions for micronutrient deficiencies, adequate sample size, and, where possible, biochemical confirmation during micronutrient deficiency assessments has been widely recognised. However, challenges for implementation and the lack of validated field-friendly sample collection and analysis technology exist still.

Mid 1980s: Memoranda of Understanding (MoUs) and Letters of Agreement between UN organisations, intergovernmental and NGOs and national entities. To facilitate co-operative action and to ensure accountability via a vis respective responsibilities to beneficiary populations

1990s: ACC/SCN Working Group on Nutrition in Emergencies linking to Interagency Group. To share information; assist in the harmonising and alignment of agency actions & identify critical issues for SCN participating bodies

1993: ACC/SCN RNIS Refugee Nutrition Information System To provide information and analysis on the nutritional status of refugee and displaced populations to key decision makers

Mid-Late 1990s: The Interagency Group meetings: Impacts of this include: shift of emphasis to public nutrition and standardisation of procedures and protocol To share experiences and knowledge, and to move away from the concept of owning knowledge. Opportunities to contribute to the improvements in standardisation of procedures and protocols

1996: Emergency Nutrition Network (ENN) set up Field Exchange (primary output of ENN). To provide a networking mechanism for those working in the humanitarian food and nutrition sector and to institutionalise agency programme experience.

1996: Infant Feeding Intergroup Groups developed and referred To formulate a coherent, appropriate and widely acceptable policy and strategy statement for humanitarian agencies and to identify practical tools to assist agencies in the implementation of policy

1997: NGONUT To allow a prompt forum for sharing experiences and questions amongst a global group of nutritionists.

1998: The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response (Sphere 2000) To provide a practical framework for accountability by connecting the principles of humanitarianism to standards of service delivery and an operational tool or reference to help structure the planning and management of emergency programmes.

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<th>OBJECTIVES OF ADVANCES</th>
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To ensure greater standardisation of use of indices and cut-offs. To provide an influential factor for resource allocation.
The politicisation of food aid in emergency food aid resourcing.

In recent years, in the emergency food aid sector there are innumerable mismatches between the number of severely malnourished children in affected countries and to increase national capacity building to manage severe malnutrition.

Livelihood support, challenges

Despite the significant lack of official policies or guidelines on livelihood support approaches, donors and humanitarian agencies are increasingly exploring different modes of food security support in emergencies. However, there is little guidance on appropriateness of types of livelihood intervention in relation to stage, type and scope of an emergency and implementing agency resources and capacity.

Furthermore, as donor funding opportunities and mechanisms diversify and change and in the absence of clear donor policies on livelihood support, bureaucratic difficulties can multiply making it harder for NGOs to access resources quickly and efficiently.

A remaining challenge to effective livelihood programming in conflict-related emergencies is the political factors underpinning these imbalances are working in the humanitarian aid sector. The geopolitical factors underpinning these imbalances are often overlooked.

Livelihood support

Recent years have seen considerable advances and consolidation of existing knowledge in relation to the treatment of severely malnourished children (see Table 3). Despite improved understanding of the pathophysiology and treatment of the severely malnourished child, the median case fatality rate of children in hospitals in non-emergency settings has remained unchanged over the last 50 years and is on average 20 – 30%, with highest levels of 50-60% (Marchand 2000). However, analysis of children in a number of therapeutic feeding centres in Africa, during emergencies, shows a case fatality rate of 9.6% (Grellety 2000).

Efforts have begun to support sustainable forms of treatment of severe malnutrition in emergency-affected countries. A study comparing centres treating cases of severe malnutrition in Liberia showed that the chief factor determining the rates of mortality was the adequacy of the management and training skills of the senior staff (Marchand 2000). This example demonstrates the importance of longer-term efforts to build capacity at the national level in countries that are frequently affected by disasters.

In addition to technical advances, progress has been made in giving recognition to the importance of care and stimulation for children during rehabilitation from severe malnutrition, to promote recovery. In past emergencies these programme components were often overlooked.

Selective Feeding Programmes, advances

Selective Feeding Programmes, challenges

While significant technical advances have been made in the management of severe malnutrition, challenges remain regarding how and when to intervene. There is a particular need to improve the integration of interventions within the Health Ministry of the countries concerned and to increase national capacity building to manage severe malnutrition.

Much consideration is being given to the role of ‘at-home’ treatment of the severely malnourished. The challenge for improving the outcome and appropriateness of home based treatment remains how to ensure that mortality rates for all children remain low while designing programmes that are appropriate to the operational, environmental and socio-economic context. Studies show that detailed analysis of data collected prospectively in real-life service settings can lead to major improvements in the management of severe malnutrition. The Prudhon Index can be used to assess expected mortality.

• Risks of abuse at each stage of the distribution process should be identified and strategies developed to minimise them.

Food aid, challenges

In spite of the many advances in recent years in the emergency food aid sector there are innumerable challenges to be overcome. Once again a few examples will have to suffice here.

Food aid resourcing.

The politicisation of food aid in emergencies is at times scandalous. The mismatches in food aid allocation between emergency affected populations is a profound embarrassment to those working in the humanitarian aid sector. The geopolitical factors underpinning these imbalances are often overlooked.

Livelihood support, advances

Over recent years there have been notable attempts to further the experience and understanding of humanitarian agencies in the effectiveness and appropriateness of interventions aimed at supporting livelihoods without the use of food aid. Examples of these are seen in table 3.

Livelihood support, challenges

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giving room for greater focus on ways to reduce mortality.

There are also several key technical challenges to existing treatment protocols for malnutrition. The emphasis on patient care, especially during acute phases of HIV/AIDS provides a significant challenge to those treating severe malnutrition. Understanding of how such patients can be cared for in feeding programmes and within the community remains limited in emergency contexts. Finally, despite several best practices guides (Shoham 1994), there is very limited understanding of the efficiency and efficacy of supplementary feeding programmes.

Monitoring and evaluation, advances

In the early 1990s the UNICEF ‘Triple A’ Cycle (Assessment, Analysis, Action) was conceived within the developmental setting of Iringa in Tanzania. Like the conceptual framework, this cycle has been influential in the emergency sector too. Alongside these developments, the use of the Logical Frameworks in which monitoring indicators and sources of verification must be specified has gradually been taken up by donors, and in turn agencies, to the point where the presentation of logical frameworks is now mandatory for e very major emergency. These initiatives reflect the growing importance that agencies are placing on monitoring and evaluation. Donors are now increasing the availability of resources for these activities. This appears to come hand in hand with the advanced awareness of the need for accountability of our work in humanitarian contexts.

The Sphere project has also created a valuable impetus to monitor the context in which interventions are made, conduct evaluation and institutionalise learning.

Monitoring and evaluation, challenges

There is a significant dearth of thematic evaluations. For example there has been no comprehensive ‘review’ evaluation of emergency supplementary feeding programmes.

Impact indicators (usually primarily quantitative) are prioritised in monitoring and evaluations, often at the expense of process indicators (Toole 1999). Too great an emphasis is placed on anthropometric and mortality indicators as a means of monitoring and evaluation. There is little agreement on appropriate indicators for early warning, recognising that deterioration in nutritional status is usually a late indicator of a crisis.

In many contexts where agencies have previously worked for many years under relatively stable conditions, at the onset of an emergency, there is frequently a substantial lack of base-line data available. The gathering of baseline information in emergency prone communities is an essential component of emergency preparedness.

One of the regular findings of independent evaluations, e.g. CDC, bilateral government evaluations, and material submitted to Field Exchange, is that there are still enormous difficulties with local ownership and the implementation of the Global Hunger Principle (Toole 1999). There may be many reasons for this, such as absence of guidelines at project level, poor training of field staff and lack of technical support by headquarters staff.

Conclusions and recommendations

This paper has attempted to highlight the work of NGOs, donors and the UN as complementary parts of the humanitarian system over the last 20 years. The paper shows that those active in the emergencies sector recognise the importance not only of technical solutions, but of social, economic and political determinants of both the problem in the first place, and also the role of social processes in implementing effective interventions.

Some generic recommendations can be made which will contribute to the development of a plan of action for NGOs, donors and the UN Agencies through the Sub-Committee on Nutrition:

- An NGO-sponsored website should be established to enhance accurate media reporting on food and nutrition in humanitarian situations, drawing the whistler on major injustices in resource allocations. Extension of the international cooperation and collaboration between international agencies to more regionalised initiatives involving local institutions and local nutritionists should be prioritised. This could be addressed through the existing Capacity Building Thematic group in the SCN Nutrition in Emergencies Working Group.
- The links between the donor and the practitioner need to be strengthened. Past experiences of failures and successes need to be shared. This requires the essential development of much stronger relationships between public nutritionists, donors and key decision-makers. The ACC/SCN could consider providing a forum for a working group to facilitate this interaction.
- Policies must be translated into practice: All agencies need to ensure a routine incorporation of training modules into their human resource development systems and also to set up effective monitoring and evaluation of the impact of this.

Other recommendations that must be prioritised by all agencies include:

- Readjustment on the part of all major food aid players and institutions, in order to ensure that humanitarian needs are met adequately. This includes WFP, bilateral agencies, particularly the two largest bilateral food aid donors, the US and the EU, as well as international NGOs who deliver food aid. These agencies should engage in a paradigm shift from food response to nutritional response allowing for the reform of food aid to be consistent with a nutritional imperative.
- Food aid resources should be part of a more flexible system of response. In such a system emergency food aid would be procured and supplied from the most efficient and timely source for purposes of meeting the assessed quantitative and qualitative nutritional need. Similarly, resources for non-food inputs for health, livelihood or other inputs required to protect, maintain and rehabilitate people from nutritional assaults.
- Monitoring and evaluation needs to consider issues of accountability and a willingness to document mistakes. The Sphere project should be seen as a vehicle through which to achieve this. Agencies should work together to produce and reach consensus on interim indicators to monitor before anthropometrically irreversible deterioration.
- This should be emphasised in both the ENN and RNIS forums. Monitoring and evaluation systems must be expanded beyond inputs and outputs (UNACC/SCN 2000) - e.g. must include unusual threats to livelihoods, an understanding of the changes in the external environment, social, cultural, environmental and fiscal impact of programmes.

In 2001 there were 79 emergencies classified by the US Government (OFDA 2002). Affected populations in very recent years are still showing extremely alarming rates of malnutrition – up to 70% global acute malnutrition in 1998 in southern Sudan (Maxwell 2000) and micronutrient deficiency outbreaks still occur. While there have undoubtedly been advances the humanitarian situation in the twenty first century leaves no room for complacency.

Bibliography


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ADVANCES MADE

1993: Methodological guidelines for evaluations were created (eg Overseas Development Institute).


1997: Indicators defined for Monitoring and Evaluation to see that standards are being reached (eg Sphere minimum Standards).

1999: The Sphere Project was made possible through the support provided to the Food and Nutrition Technical Assistance (FANTA) Project by the Office of Programming and Management in the Bureau for Democracy, Conflict and Humanitarian Assistance (DCHA) and the Office of Food and Nutrition of the Bureau for Global Programs Field Support and Research at the U.S. Agency for International Development, under terms of Cooperative Agreement No. HRSA-A-00-98-00406-0 awarded to the Academy for Educational Development (AED). The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

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OBJECTIVES

To improve standardisation of methods.

To improve objectivity of the undertaking and analyses of the evaluation.

To improve institutional learning and ensure interagency sharing.

To ensure that monitoring and evaluation have the adequate resources and time provisioned.

To standardise indicators to allow for comprehensive comparisons.


Launch of DfID’s new strategy paper on eliminating hunger

Summary of Publication

The Department for International Development in the UK (DfID) recently launched a strategy paper (May 2002) ‘Eliminating Hunger; Strategy for Achieving the Millennium Development Goal on Hunger.’ The Millennium Development Goal referred to in the title of the paper is to halve extreme poverty and hunger by 2015. The paper highlights the main areas which the UK sees as important to international efforts to tackle hunger, as well as areas in which DfID will place its own resources.

The main points to emerge from the paper are as follows:

• Poverty reduction is essential to eliminating hunger.
• There is relative optimism about the capacity of the world to produce enough food to keep up with population growth – but only if we pursue appropriate policies, maintain adequate investment in research and work to ensure environmental sustainability.
• Globalisation and trade liberalisation brings both benefits and risks for poor people and for hunger reduction.
• Appropriate government policies in a range of sectors allied with overall good governance are critical for creating an environment in which people can obtain enough food.
• Food security is an overriding priority for poor people who lack assets and depend for their survival on a wide range of resources for both consumption and sale.
• Nutritional status is determined by the amount and quality of food consumed and by health status. These factors are in turn influenced by household food security, intra-household food distribution, care practices, environmental factors and health services, Communicable diseases, and HIV/AIDS in particular, have adverse effects on both nutritional status and food security.
• Conflict, drought and other disasters are playing a major part in slowing global and national progress towards the Millennium Development Goal. Food aid has been an important way of responding to crises, but the flow of aid has often had more to do with food surpluses in OECD countries than with actual needs. Food aid has had only limited success in alleviating food insecurity and malnutrition and it can also depress local prices and local production.

If the Millennium Development Goal is to be achieved the following actions and improvements will be necessary:

• trade reforms that improve the food security of poor people;
• investment in agriculture more precisely targeted at reducing poverty and hunger;
• multi-sectoral interventions to tackle malnutrition both in emergencies and stable situations;
• better systems to cope with the impact of conflict and natural disaster;
• more effective ways of using and monitoring food aid;
• more effective ways of dealing with risk to poor people;
• more effective ways of measuring progress towards the Millennium Development Goal on Hunger.

Ongoing and new areas of work by DfID which it is hoped will lead to better responses to drought, conflict and emergencies are as follows.

A copy of the paper can be obtained from: DfID, 1 Palace St London, SW1E 5HE. Website: www.dfid.gov.uk. Public Enquiry point: 0845 3004110

When is a system not a system?

Challenges to improved humanitarian action in food crises

Summary of symposium presentation

The basic perspectives on food security analysis, famine theory, nutritional assessment and food and nutrition intervention have been established for some time. There is also general consensus that effective reaction to nutrition crises depends on a multi-disciplinary approach: strategically and practically coordinating aid and nutrition intervention in which DfID will place its own resources.

There have been some considerable advances in the technical and logistic capacity of the various aid agencies to deliver timely and effective responses to nutritional crises around the globe. However, despite these advances there has been little substantive progress in our shared capacity effectively to assist, protect, support and care for the needs of the majority of people in need. We still have terrible hunger, we still have chronic pipeline problems, and major shortages in food basket quantities and qualities. We have major inequities in the distribution of foodstuffs and services, with resources concentrated in certain politically sensitive areas – and other populations abandoned. We have inarticulate migration, shelter, livelihood, nutrition, and other agenda political or religious (independence) and is non-partisan in the social struggle in which it is operational (neutral) – then it has the greatest chance of being allowed.

What this argument proposes is that humanitarian action is grounded in a set of principles designed to promote maximum access to people in crisis and the prioritisation of a particular set of objectives relating to alleviation of acute human need and the preservation of dignity. If this argument is accepted, then it is logical that humanitarian action becomes a small and limited ideology – grounded in an ethic of self-restraint and not the normal utopian and progressive ideologies that inspire us. Humanitarian action does not aim to provoke social change – it aims to assist and protect victims and inspire discipline and restraint in the use of force for social change (this does not mean it is unimportant or unpowerful). Humanitarian action is practical and politically realistic. It must be action oriented; it must be non-coercive; it must be provided solely for the benefit of those we seek to assist. Humanitarian action is targeted to humans and not society and therefore humanitarian actors must take responsibility for the delivery of their assistance all the way down to the beneficiary. The basic conditions that humanitarian actors require are that the freedom to assess needs; the freedom to deliver assistance and the freedom to monitor the outcome. If these conditions are denied, humanitarian action is likely to be compromised and sow the seeds of its own destruction.

The ‘community’ of donors, UN agencies, NGOs often try to find solutions based on an assumption we are all part of a ‘humanitarian system’. But different political and bureaucratic interests, different ideological perspectives, the technical compartmentalisation of aid delivery, and a focus on service delivery and cost-effectiveness ignore important ethical and political considerations.

Austen Davis, the General Director of MSF Holland made a presentation on ‘Challenges to Improved Humanitarian Action in Food Crises’ at the symposium on Nutrition in the Context of Crisis and Conflict’ at the 29th ACC/SCN session in Berlin. Highlights of the address follow.

Food and health interventions. In short, the much-vaulted humanitarian ‘system’ that has emerged has developed enormously in its capacity to talk and to meet and to have papers written on important subjects such as protection. But it does not seem to be able to significantly reformulate itself to be able to implement lessons learned. Why is this?

There is one paradigm that says the ‘system’ is non-coercive; it must be provided solely for the freedom to monitor the outcome. If these conditions are denied, humanitarian action is likely to be compromised and sow the seeds of its own destruction.

The ‘community’ of donors, UN agencies, NGOs often try to find solutions based on an assumption we are all part of a ‘humanitarian system’. But different political and bureaucratic interests, different ideological perspectives, the technical compartmentalisation of aid delivery, and a focus on service delivery and cost-effectiveness ignore important ethical and political considerations.

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Austen advanced a number of ways forward to respond to this critique. Key amongst these are the following:

i) The current system is not a system, or at least not one driven by humanitarian concerns. It is important to have a greater sense of realism about what the major momentum in humanitarian and political intervention entails, so as to recognise opportunities and threats for the development and promotion of effective humanitarian action.

ii) States will always try and manipulate humanitarian assistance for their own ends. The funding patterns of donor governments should reflect their humanitarian responsibilities. Humanitarian funding should be given to mandated bodies in a manner to promote effective impartial action in support of humanity. Funds should not be provided to mandated agencies (such as ICRC and the UNHCR) on a project basis, as this promotes concentration of funds in certain crisis situations and undermines the impartiality of the specialist agencies.

iii) States should enact law to define and control the use of humanitarian budgets; to enforce separation between the use of humanitarian funds and the pursuit of political interests; and to define their humanitarian responsibilities.

iv) Clear categories of intervention in crises should be developed, with concordant principles and clarity of objectives to guide intervention. Not all assistance provided in emergency situations needs necessarily to be humanitarian, but the objectives and mode of operation needs to be clearly defined so that decisions to act are held democratically accountable; so interventions aim to achieve their true objectives; so the correct institutional capacities are developed to maximise intended goals; and so that humanitarian action is not degraded by incoherence and degradation of its principles through association.

v) There needs to be much better reporting on emergency actions, achievements and quality indicators. Information must be able to be aggregated so there is increased transparency about what is being done, for what reason and what are the trends.

vi) UN agencies must be given a mandate and the resources to act in such a way as to enhance cooperation and fulfilment of the mandate. If they fail they should be held technically accountable, whilst states should be held politically accountable. There should be an independent review capacity, to map out the UN mandate, to what degree the UN agencies fill their mandates, and if the sum of UN agency actions fulfils the total mandate.

vii) As humanitarian workers/activists we must always be acutely aware of the critical balance between an agency’s real drive to meet the needs of people and the bureaucratic imperatives of the organisation. It is important for us all to struggle to insist on the value of our work through the agencies we work for, and to counter the bureaucratic imperative.

Without a commitment to humanitarian principles; the immediate needs of people; and the human development needs of non-coerce populations; and alignment of the objectives of the humanitarian aid community – ‘systems’ perspectives will not serve to enhance our capacity.

Synthesis of Key points from the SCN Symposium ‘Nutrition in the context of crisis and conflict’

As reported in the last Field Exchange, the ACC/SCN Sub Committee on Nutrition 29th Session hosted an symposium on ‘Nutrition in the context of crisis and conflict’. Key points and recommendations to emerge from this symposium were as follows:

1. A significant advance in emergency nutrition has been the increased recognition of the social, economic and political determinants of malnutrition in emergencies and the role of these determinants in programme success. Food and nutrition interventions in conflicts require careful analysis of the potential risks associated with implementation. Programmes should seek to maximise good and minimise harm.

2. The humanitarian imperative drives a needs based response. The humanitarian imperative in emergencies is frustrated, and in some instances, undermined, by the politicisation of humanitarian assistance including food aid allocations.

3. Upholding the dignity of disaster affected communities is highlighted in Human Rights legislation. The presentation on human rights did not go as far as outlining the practical application of human rights programming in emergencies. The Sphere project is an example of the practical application of human rights in emergency assistance.

4. The momentum created to explore programming to prevent malnutrition through livelihoods support and health intervention needs to be invested in. Flexibility should be applied to the use of resources for emergency response to allow programming which is determined by local need. More flexibility should also be applied in food aid programming, such as to allow local purchase where appropriate. There is also a need to devote greater resources to non-food items as part of humanitarian assistance, in order to effectively address the multiple casual factors responsible for malnutrition in emergencies.

5. The specialisation of agency mandates risks creating gaps in intervention capacity.

6. There is a lack of agency presence in low-profile areas. These low-profile emergencies are under-resourced and the multiple casual factors responsible for malnutrition. However, this is not always reflected in the policies guiding the allocation of resources, and operational practice, of the international community and national governments.

Furthermore, although the current conceptual framework promotes multisectoral interventions, many agencies find it difficult to cover all sectors and there is an increasing tendency towards agency specialisation. Although specialisation can improve effectiveness of humanitarian intervention, it can also create gaps in intervention capacity and often means that some of the emergency needs of a population are missed. This problem could be resolved through more clearly defined MOUs between agencies.

We, the SCN, recommend the following actions:

1. There is a need for greater resources to be put towards the implementation of longer term more sustainable programmes that promote a one-day symposium on ‘Nutrition in the context of crisis and conflict’. Key points and recommendations to emerge from this symposium were as follows:

2. The Working Group on Human Rights engages with the Working Group on Emergencies regarding sharing insights between the groups on the multiple determinants of malnutrition, and the role of these determinants in programme success. Food and nutrition interventions in conflicts require careful analysis of the potential risks associated with implementation. Programmes should seek to maximise good and minimise harm.

3. The Working Group on Emergencies links further with the Working Group on Capacity Building to determine what forms of capacity building might be appropriate in situations of emergency.


5. The attached statement is put forward for endorsement by the Secretary General.
Maslakh camp located approximately 20 km from Herat in Western Afghanistan. A period of drought and conflict in the region led to large numbers of IDPs moving into the camp in late 2000. MSF Holland began working in the camp in 2000, implementing a supplementary feeding program for children under five and pregnant and lactating women. Medical screening (including measles vaccination and MUAC measurements) was also carried out by MSF at a reception site with medical cases being referred to MDM clinics for treatment. An MSF Therapeutic Feeding Centre (TFC) was subsequently opened in July 2001 and a second one in December 2001. MSF were also working in the paediatric ward of the regional hospital in Herat, which involved treatment of the severely malnourished cases.

During this period of MSF activity in the camp, it was unclear how many IDPs actually lived there. Estimates ranged from 160,000 to 300,000 people. Up until September 11th, the Taliban had a base nearby and were effectively in control of the camp. They were very reluctant to allow information gathering in the camp. Surveys were therefore not allowed nor was it possible to ask too many questions at the reception site screening.

From what information was available, it appeared that the majority of the IDPs had left their places of origin (mainly Badghis, Ghor and Faryab provinces) due to hunger and drought, while a smaller proportion had fled due to fighting, insecurity, discrimination and violence or fear of violence. In the absence of accurate population figures, WFP provided rations for 300,000 people up until the re-registration exercise by IOM (International Organisation for Migration) in February 2002. The ration comprised 50 kg of wheat per month per family (equivalent to 800 kcal per person per day for a family of six).

Post-September 11th
Following events of September 11th, MSF expatriate staff were evacuated. Local staff however continued to work in the camp and expatriate staff returned towards mid-November. At this time there were large movements in and around the camp. Prior to September 11th the IDPs mainly comprised of Pashtun, but after September 11th there were increasing numbers of new arrivals of Uzbek and Tajik origin.

With the American bombardment close to the camp, IDPs panicked and fled the camp to safer locations. With increasing pressure on the Taliban, more and more of them mingled with the IDPs in the camp – often concealing weapons. The situation in the camp was unsafe and tensions were ever present. Pashtun men and women were arrested at random and taken into jail in Herat city where their relatives needed to pay money to get them released. Ration cards were sometimes taken from Pashtun people with the offer to return them in exchange for information about the Taliban. Groups of armed men entered the camp in the evening to commit robbery and intimidation.

Throughout this time MSF continued the medical screening at the reception site. In November 2001 approximately 10% of children screened were malnourished (MUAC ≤ 12.5 cm). MSF Holland had opened a second TFC shortly after the return of expatriate staff in November. However, the default rates in the TFCs were extremely high (approximately 30-40%) with the peak in October probably coinciding with an increasing population movement (Pashtun leaving and Tajik and Uzbek entering the camp) as well as increasing tension and insecurity in the camp. Interviews with mothers at the TFCs highlighted a number of pertinent factors.

Reasons for high default rate at the TFC
Mothers had been in the camp for several months before their children became malnourished (3-7 months). The high default rate from the TFC was due to:
- Reluctance to leave their habitation for fear of theft of treasured possessions. Women were also reluctant to be out in late afternoon when it is starting to get dark.
- Reluctance to attend the TFC for fear of missing a re-registration or a food distribution.
- “My husband looks after my other child when I am not there and he takes him along when he goes looking for firewood. My home is empty during the whole day... I am afraid that if somebody passes by for a survey we will not be registered and therefore not receive any distributions. That’s why I decided to come to the TFC every other day instead of every day” (Abida comes from Badghis and is mother of 2 young children).
- Reluctance to leave other children behind. “Now that my mother is gone it is a problem for me to come here every day. My father works and I need to take care of my other brothers and sisters as well. I hope this one will get better soon so I can stay home” Amina is 13 years old and comes from Chakhchak (Ghor). She has been living in Maslakh for 8 months now and comes to the TFC with her baby sister. She has 4 brothers and sisters and her mother had just died after Ramadan.
- Husbands would not allow wives to leave for more than one day. Many men do not want their wives to talk to other men or for men to look at their wives. There were reports of violence against women by their husbands because of their attendance at the TFC.
- Mothers/careers were not seeing immediate improvements in health and nutrition of children.
- Some of the defaulters mentioned the fact that it was winter and they did not want to leave their shelter in the morning due to the cold.

Nutrition survey findings
Because of the high defaulter rate at the TFC and the fact that most children attending the TFC had been in the camp for several months, MSF were concerned that the prevalence of malnutrition in the camp was higher than the one detected at the reception centre. This prompted MSF to conduct a nutritional survey. At the end of January 2002 MSF conducted a MUAC survey with a representative sample of 1,869 children
in the camp. This found a global malnutrition rate of 26.4% (MUAC <12.5) and a prevalence of 6.6% severe malnutrition (MUAC<11.0 cm). A MUAC survey was conducted rather than a weight for height survey mainly to allow a rapid survey. The camp was unsafe and it was incredibly cold. The survey only took one day.

**Inappropriate food distribution system and registration difficulties**

MSF concluded that the high rates of malnutrition in the camp were mainly due to an inappropriate food distribution system, difficulties with the registration system (which was imposed by the Taliban) and insecurity in the camp.

Some of those interviewed in MSF programmes indicated that new arrivals were waiting for one to three weeks before being registered at all in the camp, while widows and orphans without male representatives may not be registered. In addition, some Afghan men had two wives and thus two families. They would often bring their first wife and family to the camp and then once settled in, return home for the second one. When they subsequently tried to register their second family, they may be accused of cheating as their name was already on the registration list. When new arrivals at the camp were waiting to be registered they would not have proper shelter or food supplies. Others were moving into the camp without being registered.

“We left 3 days ago and arrived here the day before yesterday. We lost two children during the journey because they were sick, hungry and cold. When we got here we had many problems at the registration. Originally we were 20 families but they only registered 16 of us. Four women are widows and as they have no male head of family to represent them, they could not be registered. When we get something we will share our distributions with them. For the moment we are all hungry and cold and we sleep out in the open air. We don’t have any relatives to help us. Two of my children are very hungry and sick. I think they will probably die” (mother at registration site).

The situation around the registration site was at times disorganised and on occasions quite hostile. The level of fraud and intimidation by those trying to repeat register under different names was such that in mid-December the site had to close for security reasons following a shooting incident. (It remained open as a distribution point for non-food items.) IDP registration was moved to 4 outlying sites on roads leading into Herat, in order to only register genuine cases.

Families were registered in groups (up to 40 families) with one representative (block leader) nominated to receive the registration list and be responsible for all the families. This individual was therefore responsible for the distribution. There were however some problems with this method, e.g. families did not know each other well, making the system subject to disputes.

The new authorities were actively searching for Taliban in the camp and used the food distribution as “poor registration and food distribution systems and insecurity in the camp”. Although these could have been contributing factors, more analysis would have been needed before arriving at a definitive conclusion. Furthermore, there is no mention in the article of other potential underlying causes, such as morbidity and inadequate water and sanitation provision. The April UNICEF survey found an under-five mortality rate of 6/10,000 per day. High levels of pneumonia and diarrhoea morbidity as a result of poor hygienic and shelter conditions in the camp were significant contributing factors. Although there were 3 months between the MSFH and UNICEF surveys and a number of important changes had occurred including many people leaving the camp to return to areas of origin as well as a change in the distribution system, the influence of the health environment on the deterioriation in nutritional status of under fives was not examined in the MSF survey.

It was extremely difficult to organise a re-registration in the camp as everyone was worried about the insecurity. Some agencies did not want to participate in such an exercise because of the high level of insecurity.

The constraints and obstacles to assessments and interventions in this environment cannot be overstimated. There were reports from the distribution agency about abuses of the system including numerous accounts of attempts to cheat the system and physical threats and beatings of staff when false distribution cards were withdrawn. The UNICEF survey team had to abandon the last few households to be surveyed as “an angry mob consisting of 200-300 people (males and children) surrounded the team and threw stones after them but the team managed to escape”. Obstacles to appropriate assessment and investigation were even greater under Taliban rules.
Dear Field Exchange,

First my gratefulness goes to Professor Michael Golden and Yvonne Grellety for their detailed and scientific article based on the research outcome of about 8500 children comparing the observed to expected mortality rate done in different therapeutic feeding institutions (Field Exchange, issue 15, April 15, pp. 12-13). Second I would like to thank MSF for sharing their field experience on therapeutic milks (F-75 and F-100) with comments on using F-75 (Bid. pp. 9-11).

My comment is on the MSF article, Van der Kam et al about their list of justification not to use F-75 always. I have listed their justifications below and tried to forward my opinion.

1. “MSF has found ultimately there is no clear correlation between F-75 and low mortality rate.”

Using F-75 only is not a guarantee to achieve low mortality rates unless you improve all your procedures. Let’s say, if the appropriate re-hydration practice and correct use of ORS, RESOMAL, and IV fluids are not in place, you can’t expect low mortality rate. In conclusion, whenever we accept a new approach we have to review the other procedures as well. Also it would be useful if MSF could present data on observed and expected mortality in the centres they refer to, using the Proudhon index. This allows valid comparison of death rates at various stages of treatment and between centres.

2. “MSF believes that the use of one type of therapeutic milk is more efficient during nutritional emergencies.”

In my opinion, we can’t compare the cost of human life with the efficiency of a project (manpower, money, time...). MSF agreed the theoretical advantage of F-75 and recommend using when there is high number of kwashiorkor, many adults fail to improve, and mortality rate in a TFC is high. If the advantaged of F-75 is agreed in principle, why do wait until there is high mortality. We should respect the value of human being instead of calculating the simplicity or efficiency of using F-75 unless there is scientific evidence.

3. “It eliminates the possibility of confusion (e.g. mistaking one milk for the other during preparation, prescription, and handouts)”. This is usually resulted due to poor training for the staff. If the staffs are properly trained, there will not be a question of confusion.

To make it simple, we can use the following methods:

- Using different buckets – e.g. red bucket for F-75.
- Admitting in separate building/places – we can keep phase one in separate building if there are enough places, if there is only one room, we can classify based on bed number or mat number etc...
- Giving F-75 and F-100 There should be eight meals given in Phase 1 (meals should be given every three hours). For example, the timetable for F-75 is 6am, 9am, 12am, 3pm, 6pm, 9pm, 12pm and 3am. The schedule for F-100 depends on the number of meals per 24 hours. Where five or six meals are given in a 24 period, to avoid overlapping with F-75, we can schedule meal times before or after F-75. For example, start F-100 one and a half hours after F-75. The timetable for F-100 would then be 7.30am, 11.30am, 3.30pm, 7.30pm, 11.30pm and 3.00am.
- 4. “It requires additional storage facilities, planning and ordering procedures, and complicates emergency preparedness in storage units.”

From December 2000 to May 2001, I was working in Save the Children UK’s TFUG in Wollo. We used both F75 and F100. There was no problem in storing both therapeutics milks. There was no special recommendation to store F-75. For both products, the expiry duration was the same. So you can use one of the two that you prefer.

MSF should consider the implications of their policies for other agencies. Their new recommendations are not consistent with WHO. Their protocols are widely adopted by other agencies – many with less experience than them as an agency. In an effort to promote better practice and support coordination and interagency consistency on standards, couldn’t they reconsider their recommendations?

Dear Kiross Terefa,

One of the biggest challenges MSF fosters is that the quality of care should be optimal as possible, taking into account the latest insights and best practices. However, in emergency situations one must often compromise between the best practices and feasible interventions.

One of the biggest dilemmas of the best practices is: do we wait with an intervention until all preconditions are available (F100, F75, sufficient expant and national staff available and trained, government agreement, cars arrived, structures in place, funding secured, etc.) or do we start an intervention with the means we have? For instance in Wau 1998 (Field Exchange 15, April 2002) we certainly considered using F75 in our intervention; F75 was ordered but the delivery in Wau took several months. The high mortality in this particular intervention in Wau (South Sudan) was mentioned by Schofield et al. (Field Exchange 14, November 2001) as evidence of the necessity of F75. However, we did not see any change when we finally used it, despite the fact that other operational aspects (access, staffing, logistics, etc.) had improved since the start of the intervention. Nevertheless MSF believes the F75 is a very appropriate food in the first phase and certainly MSF recommends the use of it, in order to optimise quality standards. However, we want to be flexible and adapt the therapeutic regimes according to emergency context and available resources, in order to intervene promptly, and to avoid inertia.

Saskia Van der Kam (MDF Holland)

Dear Editor,

Save the Children UK would like to follow up the short article in issue 15 of Field Exchange, “Food aid for sex scandal in West Africa”. The report to which this article refers raises very serious issues for humanitarian aid agencies, and SC UK is trying to incorporate the lessons learned from this episode into its practice and advocacy. SC UK would like to share with readers its assessment and permiting or overlooking the sexual exploitation of young girls and to punish those who refused to be exploited.

1. Refugee and IDP families receive a ration that is insufficient to meet their calorific requirements. Alternative livelihood options are extremely limited and permitting or overlooking the sexual exploitation of young girls in exchange for material benefits has become widespread because the alternative is severe hunger.

2. Refugee and IDP communities are poorly informed about the services to which they are entitled and how they can be accessed. For example, who (what age / sex / household type) should be registered to receive food. An adolescent girl reported that she was told she could not register alone and so got married in order to receive food. As a consequence of the war and widespread sexual exploitation, household composition and type has been affected and has resulted in ‘girl’ mothers, separated children etc. The food needs of these groups do not appear to have been adequately addressed by the food distribution system.

3. International agencies staff use the powerful position which they hold within the refugee communities to sexually exploit young girls and to punish those who refuse to be exploited.

4. Communities most affected by sexual exploitation are those without a political voice. They have no functioning mechanism for ensuring that their experiences are heard and addressed. This has implications for food aid programming as well as for other areas of intervention.”

There are a number of practical steps and advocacy messages that humanitarian agencies can take in order to address the child protection problems listed above.

1. Protracted refugee emergencies are those probably most subject to erosion of the ration received due to both donor disinterest and an (often unsubstantiated) assumption that the longer a community is displaced the more likely they are to have established livelihood alternatives. Agencies should ensure that decisions to reduce rations are based on sound information and a thorough analysis of how communities access food and whether they are employing high risk coping strategies (such as sexual exploitation).

2. It is of course true (prasad to: 1) investigate household type and composition to ensure that the registration system does not discriminate against certain household types 2) to regularly inform communities about the services available to them. In reality these issues are often overlooked and distribution systems are not adapted to local circumstances. While this may be understandable in the first phase of an emergency, it is inexcusable in a protracted refugee situation.

3. The report points to the need for a separate reporting mechanism for communities to reach responsible senior agency officials to report breaches in agency child protection policy in commodity distribution.

4. Staff recruited for food distribution should be trained in child protection issues and managers hired should be known to the agency (either as long term employees or recommended from another agency with adequate child protection checks). Managers should have in place transparent monitoring mechanisms for commodities for distribution and should be supported (in terms of time and management back-up) to conduct ad hoc investigations into the behaviour of distribution staff. This may involve talking to communities, cross checking distribution records etc.

The West Africa report does not mention feeding programmes, but these also have the potential for child abuse and exploitation, which should not be ignored. When a mother and sick child are admitted into a therapeutic feeding centre for 24 hour care, children who are left at home may be vulnerable to abuse and exploitation. Alternatively, if an adult carer is not admitted into the feeding centre with the child, there is a risk that the child might become separated from its family. Abuse by staff, particularly at night, of children and mothers who have been admitted into feeding centres is also a possibility. Abuse of children may also occur where the food distribution mechanism relies on giving food to families only when children are malnourished rather than providing a general ration; this may encourage withholding food or medical treatment from children to ensure that they meet entry criteria for the programme.

SC UK hopes that the revised edition of the Sphere handbook will address these issues of child protection within humanitarian responses. It would be useful to hear from other agencies how they intend to, or already do, build child protection measures into their food aid programmes.

Anna Taylor
Nutrition Advisor (Save the Children UK)
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Malawi food shortage:
how did it happen and could it have been prevented?

By Sarah King

Malawi, like much of the rest of Southern Africa, is experiencing the threat of imminent famine. On 27th February 2002, a state of emergency was declared by the president, but in reality the situation had already been deteriorating for many months before.

In early 2001, flooding affected over 335,000 people in southern, central and northern Malawi. This destroyed crops, homes and possessions, and displaced thousands of people. The harvest in April 2001 resulted in an overall shortfall of 200,000 MT of maize, with wide geographical variations in production level.

The international and donor community had advised the Malawi government to reduce agricultural subsidies, in order to stimulate competition and the private market. This resulted in privatisation of the state run marketing board (ADMARC) which normally buys maize from farmers and provides them with agricultural inputs. Privatisation resulted in closure of many of the more remote ADMARC outlets and loss of this vital support. Donors, including the International Monetary Fund (IMF), also recommended that Malawi cut its maize reserves from 167,000 MT to between 30 and 60 MT, just enough for a month or two’s buffer in times of emergency. Much of the stock had been in reserve for several years and required rotating. The National Food Reserves Agency (NFRA) actually went further than this recommendation and sold off the entire strategic grain reserves during 2001. They then failed to replenish them adequately or in time to counteract the shortfall in production.

In October 2001, price fixing on maize was suspended. Overnight the price of maize rose by 340%, from 5MK/kg to 17MK/kg, in many parts of the country. By the end of December, 59% of households countrywide had exhausted their food stocks. By February, this had risen to over 70%, according to district assessment teams. Surveys by SCF-UK showed a sharp decline in nutritional status over the same period (see table).

Table 1: Results of Anthropometric Surveys - SCF-UK

<table>
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<tr>
<th></th>
<th>Mchinji</th>
<th>Salima</th>
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<tbody>
<tr>
<td></td>
<td>Dec 01</td>
<td>Mar 02</td>
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<tr>
<td>Global Acute Malnutrition*</td>
<td>11.8%</td>
<td>12.5%</td>
</tr>
<tr>
<td>(weight/Height &lt;-2 Z scores +/- or oedema)</td>
<td>(7.2-16.4%)</td>
<td>(9.04-16.04%)</td>
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<tr>
<td>Severe acute malnutrition</td>
<td>3.8%</td>
<td>3.6%</td>
</tr>
<tr>
<td>(weight/Height &lt;-3 Z scores +/- or oedema)</td>
<td>(1.9-5.7)</td>
<td>(2.27 – 5.02%)</td>
</tr>
<tr>
<td>CMR** / 10,000 / day</td>
<td>-</td>
<td>0.21</td>
</tr>
<tr>
<td>USMR** / 10,000 / day</td>
<td>0.75</td>
<td>-</td>
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</tbody>
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* Compare this to 5.5% found in the Malawi Demographic and Health Survey 2000.
** Crude and Under-5 mortality rates
Malawians usually experience a hungry season between January/February and March/April, so they have developed many systems of dealing with food shortages. This year (2002), however, the hungry season had started the previous November, and by now the “copied” strategies were starting to fail. Individuals and communities are exhausted: food stocks, selling livestock, and other assets, are running low; harvesting green maize prematurely, eating maize bran normally fed to animals, eating wild and raw foods and turning to theft which is punished by severe beatings, amputations and worse. In this country of small food farms and little employment, the physically able are spending more time searching for food than working to prepare their fields for the next crop, and rural-urban migration is increasing. HIV/AIDS and TB are widespread, there is a lack of available drugs, health services, and people who try to manage the effects of AIDS with good diet, are losing their fight.

Compounding the food shortages further, cholera outbreaks began in September 2001, and have claimed over 1,000 lives countrywide. It is estimated that 10% of GDP is now spent on funerals. In rural areas, where 80% is above the age of 60, the high price of rice, maize and other alternatives remains. This is why it is important that they are able to design their own programmes, rather than being contracted to implement another NGO’s externally devised programmes. However, they usually do not have significant funding reserves to call upon when disaster strikes, which can undermine these advantages. Some partners, such as Churches Action for Relief and Development (CARD), (based in Blantyre), are large organisations with personnel experienced in disaster relief. Others are smaller, with a more generalised, development-focused mandate, who are requested by their communities to ‘do something’ in times of emergency. This means that there is a great deal of commitment and motivation from the staff, but technical and human resource capacity may need to be strengthened to meet the specialised needs of emergency response. The organisation’s employees and/or their families are often directly, personally affected by the disaster. Rapid staff turnover is a common problem, especially when large international agencies arrive offering high salaries.

Although they are extremely well-placed to respond, distance from main towns and limited human resources can mean that smaller NGOs are not always able to attend coordination meetings, and therefore miss out on vital information and collaboration opportunities. Indeed local NGOs are very often not even invited to national level coordination meetings, possibly because they tend not to mix in the largely expatriate circles where a lot of the informal information sharing and coordination takes place. In Malawi in the early stages of the international response to the crisis, there was no functioning formal, national-level coordination mechanism at all.

Multi-faceted response

Malawi presented a particular problem for Christian Aid’s partner NGOs who despite limited capacity, wanted to act to save lives and livelihoods in the early stages of the crisis. Securing donor funding (eg DFID) was difficult because of stipulated conditions, such as avoiding local purchases of maize. This presented a real dilemma: maize was unavailable in country at reasonable prices, and what was available may have been the ‘missing’ NFRA grain from 2001. Yet to import maize was costly, time consuming, the delays could have resulted in more deaths, and our partners did not have the capacity to do it.

Christian Aid recognised early on the highly complex nature of the situation. The malnutrition and mortality is the result of many factors, all of which are reflected in the UNICEF conceptual framework of malnutrition: inadequate diet, disease, food insecurity, lack of health services, poor health environment, social factors, and fundamental political, economic and structural factors (mentioned above).

It is not possible for any one organisation to address all these issues. Christian Aid has been working with various partners addressing different aspects of the crisis, strengthening programme design, ensuring SPHERE standards are applied where possible, and assisting in coordination between international, donor and local organisations. Those partners with particular strengths have been supported to address certain issues, and links with other agencies have been facilitated to address different needs (See Box). A Regional Emergency Manager will be posted shortly to oversee the emergency programmes in Malawi, Zimbabwe and Zambia.

Food for thought?

Malawi is a country that does not usually get much international publicity. At the time Malawi’s crisis was unfolding, the world’s attention was focused almost exclusively on Afghanistan. The warning bells sounded by Malawian NGOs were not heard until it was too late. It could not have been a more serious problem, and it was almost too late to do anything other than ‘firefight’. Yet still donors seem reluctant to respond. The impact on Malawi will be considerable, and it will take years to recover from a situation whose severity could have been mitigated by paying more attention sooner rather than later. How many other countries have personnel to Central Asia or another “Disaster of the Moment”, leaving them unprepared for disaster situations? How many more innocent citizens must pay the ultimate price for their government’s actions?

Acknowledgments

The article was made possible by Christian Aid and its local partners, especially CARD (Churches Action for Relief and Development), in Blantyre, Malawi. For further information, contact Sarah King at: sandie@christianaid.org or Mary Corvill at: mcovill@hango.zw

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11 Malawi Economic Justice Network – Collins Magalasi, telephone conversation with Jane Drapkin, Christian Aid, 21 May 2002

Food security in the medium term: Aims and activities

To integrate immediate food needs with health provision:
• CARD have distributed maize and likuni phala (a popular, locally made, fortified corn/soya porridge) to 29,000 families in two districts. Since they do not run health programmes, CARD linked up with SCF-UK in Salima, and strengthened existing links with the MoH in Nsanje to ensure treatment and referral systems for patients.
• Livingstonia Synod are running feeding centres for 4,500 under-lives in the north of the country, and providing general ration and agricultural support to the families of the affected children. They know from experience that intra-household food allocation means children in that region often do not receive the food meant for them if it is given as take-home rations.

To mitigate against the effects of HIV/AIDS:
• The Likulezi Trust is supporting 825 families affected by HIV/AIDS in Phalombe district, southern Malawi, with food aid and home-based care. It also supports the families of the volunteers who provide this care.

To address household food insecurity:
• Christian Aid is assisting five local organisations to prepare a joint seeds and agricultural input programme for approximately 100,000 families in 16 districts. Funding will be sought from donors who prefer dealing with a few large proposals than many small ones. This will promote crop diversification (cassava, potatoes, groundnuts, vegetables) to reduce dependency on maize, provide extensive training and include fertiliser to improve yields, in time for the next harvest.

To take fundamental issues into consideration:
• Christian Aid is supporting the Malawi Economic Justice Network and a local advocacy network, the CDCC, which works on civic education, essential in a country still recovering from a brutal 30-year dictatorship.
Field Exchange interviewed Maura O’Donahue in London, where she is the health and nutrition advisor for CAFOD’s Emergency Support Section (ESS) in the Headquarter offices in London. Maura is a doctor and Medical Missionary of Mary. She started her overseas work in Africa specialising in public and community health. Her involvement with CAFOD began during the 1984 Ethiopian famine when CAFOD supported famine relief work in which she was involved. She then worked in Addis Ababa for the Ethiopian Catholic Secretariat between 1984 and 1987. She subsequently set up an HIV/AIDS desk within CAFOD which became the lead agency for this type of work for CARITAS International. After nine years and a short period in New York she moved back into emergency work taking up the health and nutrition advisor post in 2000.

Maura explained how CAFOD was formed in the 1960s when the Catholic Women’s League responded to a hurricane in the Caribbean. After this the Bishop’s conference for England and Wales created CAFOD as the national CARITAS for the UK and Wales. CAFOD’s mandate dictates that it works in both relief and development and works through implementing partners. Although most IPs are church based, CAFOD does occasionally work through non-catholic or non-faith based partners. For example, Islamic Relief have recently been an important partner in Ingushettia. CAFOD receives its funding through voluntary income raised through parishes, schools and religious communities, and through institutional donors like DiD and ECHO.

The emergency support section was only set up in the last 5 years. The section has a Strategic Framework with a set of goals, objectives and indicators for monitoring achievements. There is also an emergency handbook which sets out principles, procedures and guidelines for emergency responses. For example, there is a set of questions that have been designed to determine at what level CAFOD should respond when considering an emergency. If CAFOD is considering a corporate response then the curiously named ‘Bubbling Emergency Group’ is convened to reach decisions and take forward the response. ESS support to partners can take a variety of forms such as making joint assessments in the initial stages of an emergency, providing specific technical inputs, working together to set standards and develop indicators with which to monitor and review the impact of the work and undertaking capacity building particularly in protracted emergencies.

The ESS are involved in a range of emergency sectors including food and nutrition activities. CAFOD does not purchase or shift food. They supply funds to local partners to purchase food and depend on partners to identify the best type of response in a food emergency. CAFOD supports a range of food and nutrition activities including general rations, supplementary feeding, food for work and cash for work, seeds and tools programmes and agricultural rehabilitation. CAFOD also devotes a lot of resources to providing technical support for their partners who may have steep learning curves to go through. As Maura explained ‘in some situations CAFOD have to provide a lot of training’. At the same time Maura was at pains to point out that working through local church-based organisations can have enormous benefits. ‘Local church structures have pretty good outreach into a community and can find out what is going on at grass-roots level’. ‘People also have a lot of confidence in their local parish, for example, In Tigray CAFOD have been supporting local church organisations in responding to recurrent drought for many years.’ More recently local churches have been questioning why things appear not to improve. This has led to activities like reducing soil erosion through terracing, reclaiming gullies and promoting horticulture. Maura believes that without the infrastructure of the church and local trust in it, this type of longer-term activity would not have been possible.

The grass-roots nature of faith-based organisations can also improve access to information for advocacy purposes. Maura gave an example from the Somali region of Ethiopia where it was relatively easy to get information on the fact that the general rations being received were far less than the amounts that humanitarian agencies were claiming. In support of the idea that church based agencies offer comparative advantages, Maura cited a recent experience in Marsabit, Kenya where UNICEF have been capacity building with local church organisations and increasingly using them as implementing partners in situations of drought. As part justification for the UNICEF programme the Nairobi based representative recently stated that ‘when others leave church-based groups will still be there’.

I asked Maura what were the things that she came across in the course of her work that currently worried her the most. She had a number of concerns, for example:

- ‘Emergency supplementary feeding programmes often ended up supplementing nothing’ (because general ration programmes were not being adequately implemented).
- Creating dependence by routinely implementing emergency feeding programmes in drought vulnerable areas without supporting longer-term preventive programmes.
- ‘NGOs only manage to get resources for intervention when there is evidence of acute malnutrition when what is needed is a preventive response’ (CAFOD recently supported an ‘early’ intervention in Binga and Bulawayo in Zimbabwe which was a form of livelihood support programme).
- The micronutrient content of general rations is not given enough consideration (she cited IDP camps in Ingushettia as an example where anaemia was rife).
- Lack of availability of measles vaccines (she cited this example in Iraq).
- Lack of time for proper lesson learning in CAFOD supported programmes.
- Lack of provision of non-food aid items for refugees and IDPs.

I also asked Maura what were the high and low points that stood out for her in a long and distinguished career. High points for her were when local partners took a longer-term approach to problems, e.g. local partners addressing chronic problems in Tigray. Low points included those all too frequent situations when the general ration failed to reach the 2100 kcal benchmark and people’s nutritional status started to deteriorate. Maura also referred again to the IDP camps in Ingushettia where tents that had an eight month shelf-life were still being used after four years and were being patched up by any means available; and sanitation in the camps had reached the appalling state of there being only one toilet per 120 people. Maura finished our interview with the statement that she would like to see more imaginative food and nutrition interventions. I asked for examples. She in turn asked me if I had heard of the Moringa tree. I had to confess that I hadn’t, at which point I thought I noticed the slightest of disappointments. Maura went on to explain that the tree, which is indigenous to many parts of central and east Africa, Asia and central and Latin America, has many nutritional benefits. It has more calcium and protein than milk, it has a high percentage of oil, more potassium than bananas and more vitamin A than carrots. It also has certain medicinal properties and although as yet scientifically unproven may have a water purification potential. It’s leaves, flowers and pods are all edible and (according to Maura) if powdered leaf is added to porridge malnourished children have shown greater weight gains than with special foods used in selective feeding programmes. Some CAFOD partners have already started growing the trees in nurseries although the potential of this tree is virtually unknown amongst INGOs.

In parting Maura warned me that she was going back into the field in a couple of days and so would not be able to check the draft of this agency profile. With country responsibilities that include, Ethiopia, Tigray, Zimbabwe, Kenya, Ingushettia, Chechnya, India and the Philippines, I realised that I was lucky to have grabbed an hour with such a busy person and someone whose unstinting commitment, drive and work-load were a shining example for many of us.
Over the last twenty years, humanitarian organisations have accumulated a wealth of technical expertise in nutrition to guide emergency interventions. Causation models have been fine-tuned to predict the scope and severity of nutritional crises. Early warning systems and nutritional surveillance tools impart information about market fluctuations, food availability and insecurity. Anthropometric indices (e.g. Z-scores, Weight for Height) provide data about individual and population nutritional status, indicate the severity and prevalence of malnutrition, and detect vulnerable groups. Furthermore, mapping systems estimate changes in food access, means of livelihood and coping mechanisms.

In spite of these developments however, humanitarian aid organisations are often still unable to assess accurately the extent and severity of looming and/or actual nutritional crises, or determine appropriate and optimal intervention strategies. MSF recently conducted an evaluation workshop to address challenges it faced during a nutritional intervention in West Darfur (2001).1 Questions remained about how and why MSF’s nutritional assessments failed to predict accurately West Darfur’s nutritional situation, and consequently failed to steer effective and appropriate programme responses.

Unpredictability in the Context of West Darfur

West Darfur has a population of 1.6 million people, 90% of whom live in isolated rural areas. The region is affected by sporadic tribal conflict and poor rainfall, resulting in sudden market fluctuations, livelihood changes and displacement. The national health system is non-functional (e.g. primary health care is limited and inaccessible; drug supply and vaccination coverage are low; medical staff numbers are inadequate). The combination of geographic isolation, erratic precipitation, existing socio-political instability and an ineffective health system render inhabitants particularly vulnerable to medical and nutritional problems. Seasonal food shortages (or ‘hunger gaps’) in the region combined with drought create a time bomb in the waiting.

Whilst West Darfur chronically teeter-totters between sustainable food security and food crisis, inhabitants employ diverse coping mechanisms to survive. They engage in alternative systems of trade, adopt different means of livelihood and modify their staple diet (e.g. from sorghum and meat to wild berries, nuts, seeds, etc.). It has been argued that premature humanitarian intervention can interfere with local coping capacity, and create a culture of dependency. The alternative to this, however, is to delay humanitarian aid, and risk causing increased mortality and morbidity. Humanitarian organisations are thus faced with the operational dilemma of determining when exactly they should intervene.

Assessment Tools Gone Awry

Central to determining an appropriate time for intervention is the accurate prediction of a population’s nutritional needs. Market and livelihood assessment indicators provide key information about whether and when a ‘hunger gap’ is developing into food crisis. However, as MSF experienced, these nutrition information systems cannot capture the complexity and unpredictability of nutritional situations.

In December 2000, the FAO and SC-UK reported alarming food shortages in Western Sudan. Market and livelihood indicators pointed towards an imminent nutritional crisis in North Darfur:2

1. The harvest in 2000 was reported to be worse than in previous years, due to insufficient rainfall, pests and insecurity.
Market prices for sorghum and salt grains (e.g. millet) were at a record high (prices had doubled and in some instances tripled, compared to previous years).

The price of livestock (sheep and goat) had plummeted.

Daily wage rates were decreasing.

Residents were selling assets, pursuing alternative income generating activities, migrating for labour and changing their sustenance habits (i.e. in meal type and frequency).1

MSF-H conducted its own assessment in West Darfur, confirming SC-UK’s findings. Market and livelihood indicators suggested that rates of severe malnutrition would increase dramatically within the coming few months, and that humanitarian intervention was imperative to avoid wide scale loss of life and destruction of livelihoods.

MSF-H and SC-UK decided to take a proactive approach to maintaining food security and local coping capacity. MSF-H deliberated about whether to initiate a general food distribution (GFD) to cover the entire population and a Blanket Food Programme (BFP) targeted to vulnerable groups, or to adopt an alternative approach. In the end it was decided that a GFD would be too complicated to implement effectively due to poor logistical and human resource capacity (i.e. inadequate staff, food pipeline institution, and lack of political support from the Sudanese government), and difficult access due to the rugged geographical terrain. MSF-H opted for a measles vaccination campaign, coupled with MUAC screening. These initiatives were supported by emergency preparedness measures (e.g. the delivery of foodstuffs and materials) before the rainy season. A nutritional surveillance was implemented to monitor trends in nutritional status, internal displacement and coping capacity, and produce nutritional data to lobby for a GFD.2

Indecision set in, however, when assessment findings from SC-UK and MSF-H showed discrepancies in malnutrition rates. SC-UK’s Weight-for-Height assessment in North Darfur revealed a global malnutrition rate of 23.4% among the resident population and 26.1% among the displaced. MSF-H’s MUAC assessment of the entire population and the other interventions reported global malnutrition rates ranging between 4-12%. The inconsistency in malnutrition rates between the organisations prompted MSF-H to repeat its survey in West Darfur using Weight-for-Height measurements. The second assessment confirmed preliminary MUAC results and the fact that West Darfur’s nutritional situation was not as critical as in North Darfur. Confusion stemmed from the fact that the nutritional situation in West Darfur was expected to be the same as, or even worse than, that of North Darfur. The discrepancy between MSF-H and SC-UK’s assessment findings was eventually explained by a combination of factors: variations in methodology and cut-off points (i.e. MUAC versus Weight-for-Height) and geographic differences in nutritional status (i.e. between North and West Darfur). ERRing on the side of caution, however, MSF-H continued its operation.

The general indecision about whether a food crisis was even imminent was confronted by problematic access to West Darfur. The onset of the rainy season, lack of roads and geographic dispersal of the population caused logistical constraints and dilemmas about appropriate intervention strategies.3 MSF-H vaccinated 18,000 children, and by August 2001 determined the situation was sufficiently stable to close the programme.

Lessons Learned

MSF-H’s experience in West Darfur brings to light several ideological and operational issues. In an attempt to clarify decision-making procedures for future situations, working groups at the MSF-H evaluation addressed several action points:

1) MSF-H agreed that a proactive or preventative approach to nutritional interventions is necessary in all contexts, regardless of the potential for unnecessary expenditures on financial and human resources. Once significant morbidity is reported and high mortality is imminent a reactive approach is considered ineffective, since it implies the late provision of assistance. A proactive approach addresses the causes of mortality and prevents potential for rises in morbidity and mortality.

2) MSF-H’s proactive approach should be triggered by forecasts from other sources (e.g. early warning information from reliable organisations such as WFP, FAO, SC-UK in Darfur 2001). However, since early warning information can be misleading through inter-organisational inconsistencies in assessment methodology, differences in assessment protocol need to be systematically communicated. Methodologies should be clearly defined in advance, and cut-off points should be transparent and adhered to during the assessment process.

3) Contrary to MSF-H’s predictions, West Darfur’s population proved to be resilient and innovative in the face of food shortage. Although socio-economic and anthropometric indicators provide invaluable facts about food access, availability and insecurity, they cannot identify the totality of factors that influence nutritional situations. The dependency of all organisations on quantifiable assessment data risks leaving out other crucial information. In order to act in a timely and appropriate manner, MSF-H must gather more context-specific information about coping strategies, specifically among populations experiencing chronic food insecurity. By understanding traditional coping strategies with respect to food shortages (e.g. seasonal migration patterns, trade routes, etc.) humanitarian organisations can potentially distinguish between ‘normal’ famines and ‘famines that kill’.4

4) MSF-H agreed that future decisions to intervene in West Darfur would be determined by the same methodology as the 2001 experience; namely broad-based assessment findings (including more relevant socio-cultural information) and analyses of available infrastructure and resources. Meanwhile, the decision about exactly when to intervene was refined. MSF-H has labelled the grey area between early warning information and the actual onset of a nutritional problem as the ‘window of opportunity’ for proactive intervention. Proactive interventions will be initiated immediately after the early warning stage, and triggered by the prevalence of the majority of the following indicators: global malnutrition rate over 20%, increase in displacement and morbidity, wide-scale slaughter of cattle, and degradation of geo-political security.

While a lack of response to early warning information can be disastrous, an inappropriate response to assessment indicators can take away from local coping capacities and humanitarian aid resources. The 2001 West Darfur experience enabled MSF-H to evaluate past strengths, weaknesses, opportunities and trends that can assist future decision-making and policy. MSF-H looks forward to further refining its proactive approach by gathering context-specific information about coping strategies, promoting inter-organisational communication about assessment methodology and defining its ‘window of opportunity’ for intervention.

5) Nutritional Interventions in Open Situations: Evaluating the Experience in Darfur, North-Sudan. MSF-H Workshop, Amsterdam, January 31, 2002
6) Save the Children UK, Darfur Food Information Bulletin. Feb. 19, 2001 Volume 54
7) WFP, FAO, SC-UK in Darfur 2001. However, 14,534MT was estimated to be needed in the form of free food. Save the Children intervened in May by distributing 3,000MT of food aid. WFP committed 5,000MT but delivered only 900MT and the government in West Darfur distributed over 1000MT. In July 2001 rates of malnutrition were found to be 15% and 21% (including 4% severe malnutrition) in the two food economy zones studied. These data were gathered using two-stage cluster surveys. The latter, at least, is a rate concomitant with a food and nutritional crisis.

MSF’s interpretation of events appears to be that a crisis was predicted but never occurred for a variety of reasons, including the depth of coping strategies of the affected community. However, we are not convinced that MSF’s data were of adequate quality to draw these conclusions and even if they were data drawn from one rural council should not be used to generalise about the entire province. Save the Children’s analysis of the situation in West Darfur was that it became serious but that general food distributions probably mitigated the worst effects of the crisis.

Finally, I would like to comment on the lessons learned and add a few key lessons from our own experience. Certainly, Darfur presents an extremely difficult operating environment. Save the Children’s work in Darfur has shown the importance of an in-depth understanding of the context of the emergency intervention in order to be effective and timely. This can only be achieved through consultation and communication with all key stakeholders and through careful assessments of the economic situation as well as nutritional circumstances. For SC UK a proactive approach means intervening before malnutrition rates reach high levels in order to prevent nutritional deterioration and protect livelihoods.
Outpatient therapeutic programme (OTP): an evaluation of a new SC UK venture in North Darfur, Sudan (2001)

Summary of internal evaluation1 by Anna Taylor (headquarters nutrition advisor for SC UK)

North Darfur experienced a severe drought in 1999 and 2000. This caused widespread crop failure, disruption to markets, a decrease in earning power of all families and a generalised decline in food security.

In October 2000, a SC UK and Development & Rehabilitation Committee (DRC) food economy assessment of North Darfur concluded that during 2001, between 17,192 and 26,057 MT of relief grain would be required in order to prevent loss of life and destitution. The report recommended that this food be distributed from March 2001, to prevent the start of an extended hunger gap and to ensure that food was available before the planting season in July.

From October 2000 onwards, repeated efforts by SC UK to mobilise donor support for food distribution proved unsuccessful. Nutrition surveys subsequently carried out in April 2001 revealed the following prevalence of acute malnutrition:

<table>
<thead>
<tr>
<th>% (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global1</td>
</tr>
<tr>
<td>23.4% (21.8 – 25.0)</td>
</tr>
<tr>
<td>Severe2</td>
</tr>
<tr>
<td>2.1% (1.8 – 2.6)</td>
</tr>
</tbody>
</table>

1. Z-Score < -3 or Oedema
2. Z-Score < -2 or Oedema

Following this survey, funding was successfully secured by SC UK to respond. Funds available were inadequate to do blanket supplementary feeding or further general ration distribution. Subsequently in August 2000, an outpatient therapeutic programme (OTP), using ready to use therapeutic food (RUTF), and a supplementary feeding programme (SFP) were established. Overall, 836 severely malnourished children were treated in the OTP between the period August 11- December 12 2001. In addition, the targeted SFP enrolled approximately 24,000 children and 23,000 pregnant and lactating women, in 10 rural councils of North Darfur, during the same five-month period. General ration distribution of 15,000 MT of grain was also made between May and October 2001.

It was hoped that outpatient therapeutic care would offer the following programmatic advantages:

- Avoid setting up numerous therapeutic feeding centres (TFCs) that would have been beyond the capacity of any operating agencies. The large geographical area and scattered population would have required the construction, staffing, and equipping of dozens of TFCs in order to achieve acceptable levels of coverage and equity of provision.
- Avoid having children concentrated in centres risking cross infection and being treated by medical staff with limited training and competency.
- Allow the community greater participation in the programme and reduce the costs to families often associated with participation in an inpatient programme.
- May prove cheaper than inpatient TFCs since the costs of technical staff and physical infrastructure would be reduced.

Outpatient Therapeutic Programme design and content

Children were screened in the first instance using MUAC and by checking for nutritional oedema.

- Infants aged 6-11 months with a MUAC <110mm and children aged 12-59 months with a MUAC <115mm were immediately assessed using weight for height.
- Infants aged 6-11 months with a MUAC 110-115mm and children aged 12-59 months with a MUAC 115-119mm immediately received supplementary food and were assessed one week later using weight for height.
- Inpatient treatment
  - Children with <70% weight for height or with nutritional oedema were immediately seen by the medical team comprising a medical assistant and team nurse.
  - Children who presented with
    - oedema
    - severe dehydration,
    - no appetite and visibly not eating RUTF when offered
    - temperature exceeding 39 °C
    - increased respiratory rate (> 35 if over 2 years, > 40 if 1 - 2 years or > 50 if less than 1 year) or
    - any sign of illness
  - were referred in the first instance to a hospital (four hospitals were being supported by GOAL to give therapeutic care).

Where a child could not be taken to the hospital due to the distance, they were referred to a stabilisation centre (three stabilisation centres were set up in health centres located in areas least accessible to the hospitals).

Treatment in the stabilisation centre included:
- rehydration where necessary
- treatment with a systematic antibiotic (amoxycillin)
- routine fansidar
- folic acid and vitamin A
- measles vaccination
- and all aspects of the outpatient therapeutic care.

Children were referred from the stabilisation centre to the OTP when appetite was shown to have returned (successful eating of RUTF for more than one day). Children were transferred to the hospital if they vomited more than 50% of the feed after 6 consecutive meals, had a body temperature greater than 39°C had a high respiratory rate or failed to regain appetite after 5 days in the stabilisation centre.

Outpatient management

Children admitted into the OTP received:
- systematic antibiotic treatment (amoxycillin)
- chloroquine (according to the Ministry of Health treatment guidelines)
- folic acid and vitamin A
- measles vaccination, and
- 14 packets of RUTF per week (500 kcals per packet).

Children in the OTP were visited daily by the Community Nutrition Worker (CNW) who supervised the child as required (sachets of RUTF eaten the previous day), diarrhoeal history, thirst, and dehydration. The CNW supervised the child as required (sachets of RUTF eaten the previous day), diarrhoeal history, thirst, and dehydration. They confirmed the presence of a carer and watched the child consume RUTF. In addition, children had a full medical examination and weight for height review weekly, carried out by the team nurse or medical assistant (health professional category just below a doctor in Sudan).

The CNW was also responsible for
- Identification (alongside the medical assistant and nurse) and inpatient referral of severely undernourished children who failed to thrive in the outpatient programme (usually due to anorexia or co-morbidity)
- Hygiene promotion activities and the distribution of soap to mothers of severely undernourished children with skin diseases
- Promotion of the use of ORS through home visits
- Acting as a ‘contact point’ between the community and all aspects of the outpatient therapeutic programme.

Children were discharged from the OTP to the supplementary feeding programme when they had reached 75% weight for height for 4 consecutive weeks.

In total the programme had 100 distribution points and employed 290 field staff including medical assistants and nurses, CNWs, and Team leaders.

A note about data quality

Since this was a new type of intervention for SC UK, an especially designed monitoring system was put in place to measure programme outcomes. However, it proved to be inadequate and would have to be substantially revised for any future programme. Specific problems encountered were inconsistencies between daily and weekly reporting forms; some children’s outcomes not reported at the end of the programme due to the rush to close; and failure of the system to track children through OTP and SFP.

Outpatient Therapeutic Programme outcomes

Table 1. Key outcome indicators for quality of care for 3 months of operations in the OTP

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Average</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to supplementary</td>
<td>81.4%</td>
<td>48-100%</td>
</tr>
<tr>
<td>feeding programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defaulted</td>
<td>10.1%</td>
<td>0-36%</td>
</tr>
<tr>
<td>Died</td>
<td>2.9%</td>
<td>0-7.7%</td>
</tr>
<tr>
<td>Transferred (to TFC, hospital</td>
<td>5.6%</td>
<td>0-15.4%</td>
</tr>
<tr>
<td>or dispensary)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mortality

A mortality rate of 2.9% is very low and well within Sphere standards. However, the mortality rate is difficult to interpret since children who may have died after discharge to the SFP are not reflected in the figures. The expected number of deaths (using the Prudhon index) was compared to the observed deaths in the OTP and the discharge criteria were taken into account in this analysis. Half (51%) of expected deaths of children without oedema (n=744) were actually observed while almost all (92%) those expected occurred for children with oedema (n=62). Rates did vary according to location (see ranges in Table 1).

Other indicators

The average rate of defaulting was skewed by the high rate of defaulting in one location (El Fasher town) which had the largest number of children and where up to 34% of children defaulted from the OTP. This was mainly because the children were from pastoralist families who only stayed in the town for a few days at a ‘time. Just over one-third of children (36%) defaulted from another location (Tina), a pastoral area where only 24 children were admitted.
Discharge rates were therefore also low in these two centres. With the exception of these two locations, defaulting rates in the other nine locations remained below 14%. Readmission rates were approximately 1.0% of total admissions.

**Mean length of stay** in the OTP was estimated at 25 days for wasted children and 35 days for oedematous children. First, part of the programme period overlapped with the planting season, which influenced the rate of admissions into the programme and secondly, a miscalculation was made in setting the registration targets, which may have affected the rate of case finding.

The estimates in Table 2 are problematic for several reasons.

1. The numerator is the total number of children admitted (minus re-admissions and transfers) over the 3-month project period. Coverage should be estimated at a single point in time and could therefore be as little as a third of the estimated coverage in Table 2.

2. These figures are based on 20% of the population being under five years, whereas the Bureau of Statistics recommends this figure to be 16.6%. The data for the pastoral areas could underestimate the real coverage due to overestimation of population in these areas. Both of these factors could mean that the coverage figures are underestimated.

3. The estimates of malnutrition were based on a survey conducted in April 2001 and compared to children admitted into the programme August – December 2001. Malnutrition could have increased in the run up to the harvest in October / November or, as in West Darfur, could have declined.

**Conclusions**

The programme admitted 836 children, which is probably several times more than a therapeutic feeding programme could have achieved within a 5-month period (from funding to closure) in North Darfur.

Mortality rates were very low, probably due to a combination of not being presented with the risk of poor care and cross infection in a TFC, and because rates of oedema and complicated malnutrition were low. The reduced costs to the community through a decentralised programme have not been evaluated but the overall programme costs (approximately £260 per child) do not vary substantially per beneficiary from costs per child in a TFC. Coverage rates were not as high as hoped though they were of the order achieved in well run TFCs in areas of much higher population density. Defaulting rates were generally very low except in the pastoral areas.

The future replicability of this programme needs to be considered in the light of the fact that in North Darfur, SC UK has

- a good knowledge of both the macro-economic and micro-economic (i.e. household food economies) context of the intervention setting
- a good knowledge of the geography of the intervention setting
- ready availability of qualified staff and other resources such as offices and vehicles
- good relations with the intervention population

**Future recommendations**

The results of the evaluation from the programme in North Darfur give grounds for cautious optimism. The programme was implemented with strong technical support in the phases of design and early implementation, was thoroughly and independently evaluated and the results have been disseminated. We consider these to be essential components of any future work using RUTF or aiming to treat children with severe malnutrition outside of the TFC or hospital setting. There are also some priority areas for research and analysis in any future pilots of outpatient care:

1. More experience on the potential complementary functions of traditional TFCs, hospitals, stabilisation centres (as conceived in North Darfur) and outpatient care, appropriate protocols for each level need to be developed and models for systems of referral need to be piloted.

2. Evaluate the long term prognosis of children receiving outpatient care compared to those who are discharged from a TFC.

3. Investigate the degree of compliance with systematic antibiotic / micronutrient regimens that can be sustained in an outpatient programme.

4. Identify areas that can be piloted and best practice established.

5. Review whether there is greater opportunity for improved psychosocial stimulation during therapy through an outpatient programme than through an inpatient programme.

6. Priority should be given to the use of other suitable RUTFs, such as BP100, and to the development of more scientifically evaluated products with a view to reducing prices. Nutriset Plumy Nut is currently prohibitively expensive for routine use.

7. Monitoring frameworks for home based care need to be piloted and best practice established. Experience can be drawn from monitoring for inpatient care.

**Acknowledgments**

Many people contributed their expertise and commitment to this project and its evaluation and they deserve our thanks. The consultants who have been involved in the project cycle are Steve Collins (surveys and project design), Yvonne Grellety (evaluation) and Mark Myatt (surveys and evaluation). This report draws on project documents, survey reports and the consultants’ reports.

1. For more information please contact Anna Taylor, Nutrition Adviser, Save the Children UK. A. Taylor@scuk.org.uk

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**Table 2: Rough estimates of coverage by OTP location**

<table>
<thead>
<tr>
<th>Rural council</th>
<th>Maximum coverage of OTP (excluding TFC) %</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al sayyah</td>
<td>56</td>
<td>23-156</td>
</tr>
<tr>
<td>El tasher rural</td>
<td>39</td>
<td>21-81</td>
</tr>
<tr>
<td>El tasher town</td>
<td>24</td>
<td>12-49</td>
</tr>
<tr>
<td>Karnoi</td>
<td>53</td>
<td>21-137</td>
</tr>
<tr>
<td>Korma</td>
<td>50</td>
<td>27-104</td>
</tr>
<tr>
<td>Malha</td>
<td>25</td>
<td>10-70</td>
</tr>
<tr>
<td>Mellit</td>
<td>58</td>
<td>24-162</td>
</tr>
<tr>
<td>Rohal</td>
<td>10</td>
<td>4-27</td>
</tr>
<tr>
<td>Tawilla</td>
<td>30</td>
<td>16-62</td>
</tr>
<tr>
<td>Tina</td>
<td>20</td>
<td>8-52</td>
</tr>
<tr>
<td>Umborno</td>
<td>11</td>
<td>4-28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>15-71</strong></td>
</tr>
</tbody>
</table>

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**From top to bottom:**

Traditional house in North Darfur. Child recovering from malnutrition at home. OTP Outreach workers. Malnourished infant with infant. (SCUK 2002)
During recent field work (notably in Burundi), I came across certain worrying practices in the emergency nutrition sector. Throughout my 22 years of experience in the field of nutrition, I have tended to take a broad view of the subject. This approach does not sit comfortably with the impression I have today, in that nutrition is viewed by many as a 'narrow' discipline and this in turn leads to questionable practices in the field. As Field Exchange offers a medium to voice field level experience, I would like to share mine here, as well as my worries, in the hope of getting some feedback from other practitioners.

The concept of nutrition

Nutrition is not a well defined science. Some have argued that the issues and problems nutrition addresses 'range from the ribosome to the combined harvester' (Rivers, 1979). Others have made the case that the responsibility and challenge for nutritionists today is to actively link the biological and social sciences, and to reduce the fragmentation which exists between the two disciplines (Waterlow, 1981). These views serve to underline the broad view of nutrition that it is possible to take. However, in the world of humanitarian interventions, there seems to be an increasing tendency to conceptualise nutrition as a sector that deals only with the measurement of nutritional status and treatment of moderate and severe malnutrition. These activities appear to be increasingly divorced from wider food security analysis and general food distributions.

Specialisation in nutrition: does it make sense?

The fragmentation and distinctions are not always this clear cut, but recently in Burundi such distinctions were all too clear to see. The confinement of nutrition into very specific activities may partly stem from textbooks on nutrition dealing with crisis. The MSF guidelines, as well as the recent WHO manual on nutritional emergencies, restrict nutrition largely to nutritional assessment and treatment of malnutrition. They devote little attention to methods of assessing whether a population can feed itself properly. On a practical level, the specialisation of organisations may make sense. However, in my opinion, this phenomenon undermines a 'global understanding' of what is going on and creates coordination difficulties at field level. A global understanding is necessary because I do believe that there is a fundamental link between nutritional status and food security assessment, as well as between general food distribution and feeding programmes aimed at tackling moderate and severe malnutrition.

Nutrition: an inclusive definition

My view of nutrition is that it involves different activities in the broad field of what is, unfortunately today, called “food and nutrition” - as if these two terms were different enough to be two different entities. I have tried for many years to come up with a definition of nutrition, which encompasses all components of what I perceive nutrition to be. It was only when I started to write a book on nutrition that I really had to settle on a definition which made sense of my understanding of the subject. Obviously, the definition I eventually chose had to be broad. It is this. Nutrition, as a science, studies the exchange of matter and energy between living organisms and their environment. In practice, it deals with the following:

- the nutritional needs arising from the thermodynamic reactions which characterise life, and the necessity to accommodate these reactions in a defined structure (the body) which needs to be
have, for obscure reasons, separate chapters on nutrition and food aid and in my view, do not provide sufficient warning about the limited utility and in some cases ‘abusive’ practice of supplementary feeding in times of food crisis. This fragmentation of nutrition is not only detrimental to the profession of nutrition but also to the victims of crisis. The lack of a broad definition and understanding of nutrition determines that no one has the mandate or responsibility for examining nutritional problems as a whole. It also makes for problems of co-ordination at field level.

**Supplementary feeding programmes (SFP): recurring limitations**

**Irrational targeting?**

The distribution of complementary rations (usually in the form of wet feeding) is commonly referred to as supplementary feeding programmes (SFP). In the mid-eighties, the League of the Red Cross and Red Crescent Societies (which later became the IFRC) had some painful experiences with its food relief operation in the Sabel (IDS, 1986). The programme evaluation highlighted the pointlessness of distributing complementary rations in feeding centres in the absence of an adequate general ration. The conceptual and operational inadequacy of SFP in times of food crisis and famine has been discussed and reviewed many times (Godfrey, 1986; Briend, 1995; Curdy, 1995; Shoham, 1995).

The main difficulty with SFPs is that they are supposed to supplement the basic food ration that the family has access to, either by its own means and / or through the food that is provided by humanitarian assistance in a general food distribution. However, if the basic food ration is sufficient, there is no need to give a supplement, unless it is intended to help beneficiaries recover from moderate malnutrition. If the basic food ration is marginally insufficient, one has to question whether it is sensible to target children who have a smaller energy requirement per day than adults, especially during the lean period where the physical workload of adults can be considerable. If the basic ration is quite inadequate, is it acceptable to give a small amount of food to children, whether for home feeding or in a feeding centre? If consumed at home, it may well be shared by the whole family in amounts that are only a small proportion of overall household need. If eaten in a feeding centre, it will probably be the only meal the child is going to eat. Furthermore, in situations of grossly inadequate basic rations, where the criteria for admission into the SFP is moderate malnutrition, we may well be seeing families being deliberately starved in order for desperate households to obtain access to at least some food. All these difficulties can engender a lot of frustration amongst the beneficiary population and those who have to implement the programme.

**A reflex response?**

Despite these well-known problems, SFPs continue to flourish in times of crisis, with the apparent blessing of everybody. Why is it, that while there is a consensus amongst so many nutritionists that SFPs have to be considered carefully when used to respond to nutrition crisis, implementation of these programmes is almost a reflex action for many agencies? Certainly, SFPs are aware of many problems in terms of implementation, cheaper and better for fund-raising purposes than general food distributions. However they cannot serve any useful purpose if they are employed as a relatively cheap substitute for a basic food ration is provided, then agencies have a responsibility to understand what the root causes are and the measures necessary to tackle the causes or to mitigate their effect.

**Adequate basic ration: A prerequisite to feeding programmes**

For the past 18 years the ICRC have chosen to avoid SFPs and to focus resources and capacity on first making sure that the general food distribution is adequate. In most circumstances this will allow for recovery from moderate malnutrition. If adequate access to a basic food ration is provided, then therapeutic feeding centres are not considered for the treatment of severe malnutrition. Obviously, a key difference between the ICRC and other agencies is that the ICRC implements general food distributions and can therefore safeguard against food scarcity induced malnutrition. Other agencies may not have such control and choice. However, if agencies ‘choose’ to tackle malnutrition in a curative way then they have a responsibility to understand what the root causes are and the measures necessary to tackle the causes or to mitigate their effect.

**Adequate understanding: A prerequisite to interventions**

This type of understanding can only come through a nutrition survey, which examines the way people get access to food. Agencies also have the responsibility to advocate for appropriate measures to be taken where they are aware of inadequate or inadequate action. This means that despite the specialisation of their activities, they must have a broad conceptual understanding of nutrition, which encompasses all the steps of the feeding process and all the factors influencing those steps. Such an understanding is also more likely that establishment of SFPs would be considered more carefully. In fact very their existence in crisis could be used to point to the inadequacy of the humanitarian intervention.
People in aid

Top, left to right:
MSF, Holland Afghanistan, Dr. Asad, Dr. Assemy, Dr. Ismailzada and Ramin Shahryary.
Participants at MSF Regional Meeting, Ashgabad, Turkmenistan: Alorgran, Marcel Van Stoit, Paula Frankena, Dr. Mozaffer, Dr. Kabirullah and Dr. Assemy.

Above, left to right:
Mr. and Mrs. Bawar (doctors in the AHDS clinic Rohangi), Dr Kabirulla (MSF-H) and Dr. Rachael Hardwick (MSF-H). Dr Kabirulla and Dr. M. Saud Zahir (SW Regional Director IbnSina), MSF-H nurse Jenny Anderson playing with children in the TFG, Maslakh.

Right:
Regional MSF-H meeting Ashgabad, Turkmenistan.

Below, left to right:
MSFH Supplementary Feeding Team on the road to Kesh eH Kona, Afghanistan. Qumar and Mahgan (Nurse midwives, MSFH Kandahar BHU), highlighting the dangers of bottle feeding. Jacoub (MSF-H nurse manager) and Dr. Kabirulla reviewing monthly statistic from the Infectious disease ward, Kandahar.

To appear in Field Exchange’s ‘People in Aid’ section send photos of your agency’s relief workers in the Field to the ENN.
The Backpage

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 Melin and carrying out research with SC UK. Marie is the new addition to the Field Exchange editorial team.