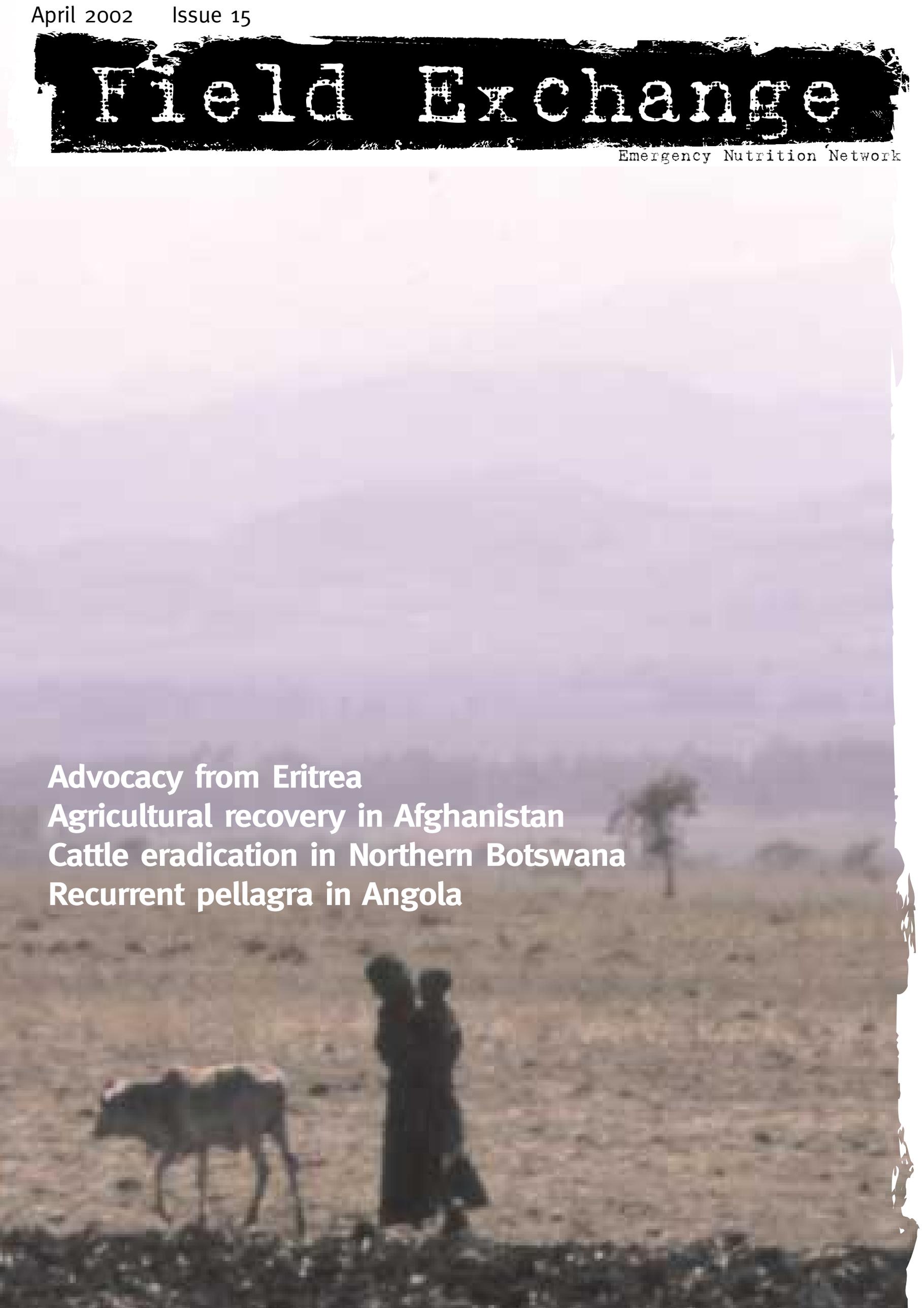


Field Exchange

Emergency Nutrition Network

A photograph of a dry, open landscape, likely a savanna or steppe. The ground is brown and dusty. In the foreground, a person wearing a long, dark, traditional robe stands with their back to the camera, looking towards the horizon. To the left of the person, a dark-colored animal, possibly a cow or a horse, is partially visible. The background shows a few scattered trees and a hazy, distant horizon under a clear sky.

Advocacy from Eritrea
Agricultural recovery in Afghanistan
Cattle eradication in Northern Botswana
Recurrent pellagra in Angola

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Two of the field articles in this issue of Field Exchange address to varying degrees the subject of advocacy. The dictionary definition of the word is 'recommendation' or 'active support of an idea'. In the humanitarian aid sector the term tends to have a specific connotation, i.e. advocacy takes place on behalf of some disadvantaged group or in order to right some wrong. What is often overlooked by 'advocating agencies' is that the key to successful advocacy is 'process'. At field level there is frequently a fine line between successful advocacy and jeopardising working relations with those agencies being lobbied. In a sector where programme efficacy is highly dependent upon good relations and co-ordination between agencies and individuals, the process of advocacy is all important. Countless evaluations have highlighted that good inter-personal relations and process of advocacy adopted by agency staff is critical to the success of agency co-ordination. Conversely, where advocacy has been over-zealous and insensitive, agency relations and co-ordination have often broken down with significant adverse impact on programme efficacy.

The field article by Dr Jean Gladwin concerns the process of establishing an 'Emergency Nutrition Coordination Unit' within the Disaster Prevention and Preparedness Commission (DPPC) of the Ethiopian government. Jean describes the importance of identifying the key decision-makers in government who would potentially use information from this unit, and then consulting with them on key objectives and modus operandi of the unit. In Jean's view, this kind of stakeholder analysis and consultation was critical in obtaining the support necessary for establishing a workable unit.

The article by Hassan Taifour from SC UK is about successful advocacy with WFP in Eritrea. It details the type of anthropometric and food consumption data that SC UK were able to present to WFP in order to convince them that a full ration (rather than a 60% ration) was necessary for returnee IDPs. Hassan highlights the advocacy lessons learnt. "This experience has demonstrated that the provision of timely, reliable, and accurate field data can be used to

advocate for programme change. In this instance an effective and trusting working relationship was established with WFP. A key element of effective advocacy is the field presence of experienced and dedicated staff who can make, and support clear recommendations".

On a completely different subject, we have an article by Saskia van der Kam from MSF Holland on the difficulty of introducing F75 into an adult therapeutic feeding programme in Wau, southern Sudan at the height of the 1998 famine. Saskia questions the extent to which the use of F75 is able to reduce mortality in severely malnourished adults in this type of situation. She describes a range of strategies for therapeutic feeding in difficult circumstances and calls for these strategies be evaluated as a matter of urgency. This subject is receiving a lot of interest as of late (see letters and news section). The postscript to the article by Michael Golden and Yvonne Grellety highlights the beneficial properties of F75 for severely malnourished children.

One other piece to highlight in this issue is the review of pellagra outbreaks in Kuito, Angola by Professor Mike Golden. This review, conducted last year during a visit to the area, highlighted a number of worrying as well as interesting features of the pellagra problem. Particularly worrying was the fact that the outbreak was the third in the previous three years and appeared to be affecting at least 10% of IDPs. Furthermore, 'limited' diagnostic capacity of health staff noted by Golden may have meant that the problem was more widespread than thought, i.e. existed in other areas of the country. A point of interest to nutritionists and others dealing with this type of outbreak was that those affected were often not wasted (the prevalence of wasting in the population was low - 3% in March 1999). Golden explains how pellagra is a type 1 nutrient deficiency that is not associated with wasting. This finding may well mirror those documented in a recent issue of Field Exchange (issue 13) where an outbreak of scurvy in north Afghanistan was associated with low levels of wasting among the population.

Enjoy!



“The combined effect of drought and cattle eradication in Ngami East resulted in a two to threefold increase in total malnutrition rate”

The impact of cattle eradication in Northern Botswana

Summary of published paper*

Poor crop yields and livestock mortality during drought often results in higher rates of malnutrition. There have been many nutritional surveys that have purported to show the dual impact of crop and livestock losses. There have been far fewer studies demonstrating a nutritional impact of livestock loss alone. A recent study in Botswana shows such an impact.

An outbreak of contagious bovine pleuropneumonia (CBPP) in the northern part of Botswana in 1996 was contained through eradication of all heads of cattle in Ngamiland district (Ngami East and West) in the period April 1996 to February 1997. The main livelihood in Ngamiland is cattle farming and Ngami East is the area most dependent on cattle. The outbreak and eradication programme posed a serious threat to those who depended on the livestock sector for sustenance. While subsistence arable agriculture is also practised throughout the district, activities are heavily constrained by poor soils and drought. Coincidentally, the district and the country as a whole had been declared drought stricken in both June 1997 and June 1998. This was reflected in national nutritional surveillance data. While the average malnutrition rate based on monitoring of weight for age of under fives attending MCH clinics remained stable at about 13.5% in 1995 and 1996, by 1997 it had increased to 18.4%.

The aim of the study was to assess the impact of the cattle eradication alone on the nutritional status of children under five years. Using existing data routinely collected by the Botswana National Nutrition Surveillance system (NNSS), quarterly malnutrition rates for Ngami East were compared with national figures for the period of January 1995 to March 1998. The NNSS was introduced in 1978 at all primary health care facilities in the country. At district level the NNSS data informs drought relief decision-making. At national level the data are used by government bodies for policy, planning and programming purposes. The NNSS also reports

findings to the National Early Warning Technical Committee.

Until 1996, malnutrition rates for Ngami East had been the lowest in the country for many years. Total malnutrition rates in this region were less than half the national figures. The drought in Botswana in 1997 and 1998 contributed to a moderate malnutrition increase (35%, relative risk 1.048) in the country as a whole. However the combined effect of drought and cattle eradication in Ngami East resulted in a two to threefold increase in total malnutrition rate over the same period (185% increase, relative risk 2.299).

The outbreak of CBPP triggered a number of significant changes in the pattern of life in the district. For example, many people migrated from cattle posts to either lands or villages increasing dependence on subsistence arable farming. In addition, the majority of households who opted for compensation for the loss of their cattle used the cash for routine household expenditure to meet their immediate needs. Reduced animal stocks may account for the continued increased levels of malnutrition observed in 1998.

The prevalence of malnutrition rose in Ngami East several months before the national rate increased, which may reflect a particular impact of the cattle eradication programme on nutritional status. The attributable risk for cattle eradication impact on malnutrition was 4.6% for Botswana and 54.4% for Ngami East.

Failure to return to cattle farming as the main livelihood in Ngami East is likely to perpetuate the negative impact of the CBPP outbreak on nutritional status.

*Boonstra, E, Lindbaek, M, Fidzani, B and Bruusgaard, D (2001); Cattle eradication and malnutrition in under fives: a natural experiment in Botswana. Public Health Nutrition 4 (4) pp 877-882

Malnutrition and psychotherapy

MSF experience in the Palestinian territories

Summary of published paper*

In 1996 MSF set up a mental health programme in the Palestinian territories concentrating on the southern part of the West Bank. The work was carried out in conjunction with Terre Des Hommes (TDH) who were running a medical programme including weight monitoring of children combined with nutritional advice to carers.

Malnutrition in the Palestinian territories was mostly attributable to lack of food, costly and poorly executed infant feeding practices using formula milk and problems in the mother-child relationship. After three months of observation MSF set up a programme of psychological support for mothers and children as certain mothers were finding it very difficult to re-nourish and care for their malnourished children. The premise of this programme was that mothers were depressed due to collective phenomena, e.g. early marriage, repeated pregnancies, the social environment being disrupted by the conflict and that women were isolated and had little by way of support networks.

The MSF intervention was initially based on individual interviews at nutritional centres with a female psychologist, followed up by home visits. In January 1998 MSF began to conduct research by focussing more on the nature of the bond between a mother and her malnourished children and on methods of re-establishing this bond. The hypothesis was that the malnutrition seen was partly due to modes of interactive behaviour which were characteristic of attachment disorder within the mother-child dyad (pair).

Mother-baby dyads for the research were selected on the basis of the following conditions: moderate or severe malnutrition, a dysfunctional mother-child relationship and children aged one month to two years. The dyads were observed over a period of one year and received psychological counselling while the children continued to have growth monitored.

It was observed that care and attention for malnourished children during feeding was not given the same priority as 'well-nourished' children, e.g. the child was not fed on demand and feeding times were irregular. The behaviour patterns observed were also sub-optimal in terms of holding, visual and tactile interaction. For example, in holding the child would be resting against its mother's stomach but not held in her arms. Very often the mother made no attempt to wrap her arms around the baby or to support its head and neck. Also, there were no reciprocal visual exchanges between mother and child - which may have been because the mother completely enveloped the child in the carrier blanket or her Islamic chador. Similarly, mother made very little use of language to communicate with the child. The vocal interaction was mainly tongue clicking and whistling noises intended to stop the baby crying or keep time with the mothers rocking movements. Tactile interaction through skin to skin was also extremely limited. There were many other behaviour patterns which were not observed in 'healthy' mother-baby dyads.

The main findings of the study were that:

- Failure to hold the baby during feeding appears to be a significant mode of behaviour amongst mothers in the study. This possibly reflects the way the mother herself is unsupported by her own family circle and cultural group.
- The mother's physical and psychological defences were weakened by the political, social, economic and family environment. Her suffering is then expressed by symptoms of depression leading to inadequate maternal care and attention.
- Through its food disorders, e.g. anorexia, the baby reflects not only the mother's problems but also

those of her whole family and Palestinian society.

The authors also claim that through this study MSF have learned the importance of evaluating:

- i) the quality of holding, as well as the three other levels of interaction (behavioural, affective and imaginative) in mother child dyads and,
- ii) the context, in order to understand vulnerability factors at the root of the maternal problem, e.g. conflict, trauma and acculturation

The authors assert that these observations have allowed MSF to refine techniques of therapeutic care for malnourished children and to work towards restoring the maternal function and the attachment bond in situations such as those found in the Palestinian territories.

* Fernandez, S, Lachal, C and Moro, M (2001): Malnutrition and Psychotherapy, the MSF Experience in the Palestinian Territories. MSF Medical News, volume 11, No 2, August 2001, pp 77-80

Cornell-Radimer hunger scale measures household food security in Java

Summary of published paper*

Field Exchange 6 reported on the use of the Radimer-Cornell hunger scale to measure prevalence of hunger in the Russian Federation. One of the conclusions of the Russian study was that the scale may be useful in providing early warning that dietary quality and diversity in a population are worsening before frank malnutrition (as measured by anthropometry) becomes prevalent. Classifying individuals on the basis of household and individual hunger is a simple and straightforward way of identifying those households that would benefit from different kinds of intervention.

A more recent study in Java is the first time the tool has been used in an emergency setting. In 1997/8 Indonesia was struck by severe economic crisis exacerbated by El-Niño induced droughts and significant political change. By May 1998 food prices had increased by 74% compared to the year before and there were concerns about the overall supply of rice. Data on food security at household level remained scant and largely anecdotal. Speculation about food supply, and widespread concern about a subsequent increase in prevalence of malnutrition,

were based almost entirely on price and supply indicators.

The survey was carried out in June-August 1998 involving 1423 mothers with children under five years of age. Qualitative and quantitative data contributed to understanding food insecurity. The questions asked, responses and method of classifying household food security can be seen in figures 1 and 2. The data showed substantial household food insecurity with 94.2% of households found to be uncertain or insecure about their food situation in the previous year. Overall, 11% of respondents reported losing weight in the previous year because of lack of food. Food security in Java was undoubtedly compromised by the economic crisis. This study has demonstrated how the tool provides a useful measure for rapidly assessing food insecurity in an emergency. Further research to validate the approach in various settings is warranted.

* Studdert L., Frongillo E. and Valois P. (2001): Household food insecurity was prevalent in Java during Indonesia's economic crisis. Journal of Nutrition, Volume 131, pp 2685-2691

Figure 1. Outline of responses to household food security questions

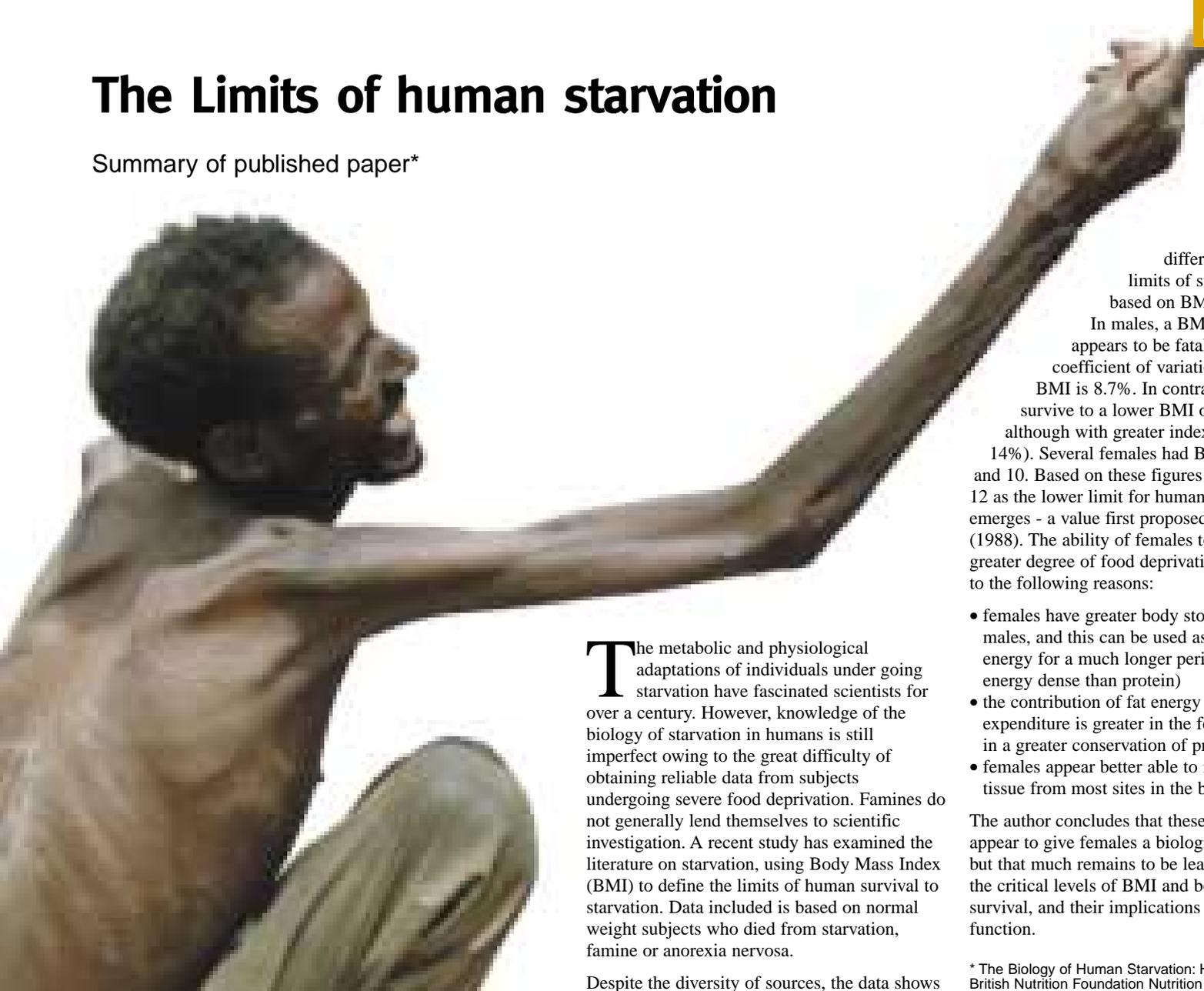
Question	Positive response
1. Do you worry that your family may run out of food before you have money to buy again?	79.2%
2. Do you worry that you may not be able to afford to buy adequate food?	76.9%
3. Do you wish you could buy more food if you had more money?	68.7%
4. Has your family ever run out of food because you do not have more money to buy food?	33.2%
5. Has your family ever eaten the same type of food for several consecutive days because you do not have enough money to buy different food?	40.7%
6. Have you ever eaten less than you want because you do not have enough money to buy food?	30.8%
7. Have your children, according to you, not had enough to eat because you do not have enough money to buy food?	24.4%
8. Do you have enough money to buy healthy and nutritious food for your children?	19.0%
9. Sometimes a person's body weight drops because of not eating enough. Has your body weight dropped in the last year because of the lack of food?	11.1%

Figure 2. Method of classification of household food security

Category	Classification based on responses to household questions (figure 1)
Food secure	No affirmative response
Uncertain about food	Affirmative response to questions 1 and/or 2 only
Insecurity for family	Affirmative response to Q 3,4 and/or 5 but not Q 6,7 or 9 and at least two affirmative responses
Insecurity for adults	Affirmative responses to Q6 but not Q 7,8 or 9 and at least three affirmative responses
Severe insecurity for children and adults	Affirmative responses to Q 7,8 and/or 9 and at least four affirmative responses

The Limits of human starvation

Summary of published paper*



The metabolic and physiological adaptations of individuals under going starvation have fascinated scientists for over a century. However, knowledge of the biology of starvation in humans is still imperfect owing to the great difficulty of obtaining reliable data from subjects undergoing severe food deprivation. Famines do not generally lend themselves to scientific investigation. A recent study has examined the literature on starvation, using Body Mass Index (BMI) to define the limits of human survival to starvation. Data included is based on normal weight subjects who died from starvation, famine or anorexia nervosa.

Despite the diversity of sources, the data shows a remarkable consistency. In particular, the

review illustrates a sex difference in the limits of survival when based on BMI classification. In males, a BMI of around 13 appears to be fatal. The coefficient of variation (CV) of the BMI is 8.7%. In contrast, females survive to a lower BMI of around 11, although with greater index variability (CV 14%). Several females had BMI's as low as 9 and 10. Based on these figures a mean BMI of 12 as the lower limit for human survival emerges - a value first proposed by James et al (1988). The ability of females to withstand a greater degree of food deprivation may be due to the following reasons:

- females have greater body stores of fat than males, and this can be used as a source of energy for a much longer period (fat is more energy dense than protein)
- the contribution of fat energy to total energy expenditure is greater in the female, resulting in a greater conservation of protein
- females appear better able to mobilise adipose tissue from most sites in the body

The author concludes that these three factors appear to give females a biological advantage but that much remains to be learned concerning the critical levels of BMI and body weight for survival, and their implications for health and function.

* The Biology of Human Starvation: Henry. CJK (2001) British Nutrition Foundation Nutrition Bulletin Vol 26, pp 205-211

Seasonal patterns of weight for age: Zimbabwe

Summary of published paper*

A study has just been completed in Zimbabwe to examine seasonal patterns of malnutrition and to investigate whether these patterns vary within the country. A better understanding of seasonal variation should aid the interpretation of cross-sectional prevalence surveys carried out at different times of the year. This understanding may be critical in emergency situations where it is not always possible or appropriate to conduct nutritional surveys at the same time of the year. (Eds.)

The analysis was based on anthropometric data collected as part of a clinic-based growth monitoring programme that forms part of the national health information system (NHIS). Weight for age data of attending children under 5 years were analysed for the period 1988 - 1995.

No evidence of seasonal variation in underweight prevalence was found in the majority of districts studied (49 out of 60). In the remaining 11 districts, there was a small but significant increase in prevalence of underweight during January to March. This coincides with the period of food scarcity before harvest and when prevalence of diarrhoea and malaria are at their peaks. It is also the period of greatest workload for mothers. However, participation in growth monitoring also varies seasonally and could account for the increase observed.

No seasonal difference was observed on comparing subsistence with commercial agricultural districts.

The authors recognise a number of limitations when interpreting the NHIS data, e.g. non-systematic errors, such as miscalibration of weighing scales; incorrect age assessment or transcription and data-entry errors can occur. More importantly, there is a

risk of systematic bias since the data are based purely on those who attend the clinics. It is possible that the observed patterns in prevalence of underweight are due to changes in the characteristics of attendees rather than seasonal variation of nutritional status of the population as a whole. It is possible for example, that underweight children are less likely to attend growth monitoring between April and June thereby accounting for the observed seasonal variability in percentage underweight in the eleven districts. Despite these limitations the authors draw the following conclusions from their data:

- Seasonal influences on the estimated prevalence of underweight appear to be small and are unlikely to substantially affect estimation of underweight trends obtained through surveys.
- Based on the authors' field experience, health services can expect to encounter slightly more cases of underweight children between January and March. Sudden increases in underweight are unlikely to occur.
- Geographically this seasonal trend in underweight is just as common in rural commercial farming areas as in the subsistence based communal lands. However no seasonal pattern was observed in the major cities.
- Food scarcity and a higher prevalence of diarrhoea, typically observed between January and March, is a greater risk factor for underweight than increased respiratory infections experienced during the drier, colder months.

* Wright, J, Vaze, P, Gundy, S, Ferro-Luzzi, A and Mucavele, P (2001): Seasonal aspects of weight for age in young children in Zimbabwe. Public Health Nutrition 4 (3), pp 757-764

Recurrent pellagra in Angola

Summary of report*



Since March 1999, successive waves of people have arrived in the town of Kuito, Angola, displaced by fighting in their native Bie province. As a result, June 1999 saw the creation of thirteen camps for internally displaced persons (IDPs) in the north, south and east of the town which have continued to expand since. Currently, the resident population of Kuito is about 80,000 and the total of IDPs approximately twice that figure. Roughly 80km to the east lies the municipality of Camacupa where a number of IDP camps are also located. Camacupa came under government control in early 2000.

For the past three years, there has been an annual epidemic of pellagra in the Kuito area of Angola. There have been three major peaks of the outbreak all occurring between June and October each year. By the end of August 1999, the first cases of pellagra were identified in the Kuito camps. In response, a study of the ongoing pellagra problem in Kuito took place between July 17th and August 1st 2001. This involved:

- an analysis of humanitarian agency reports on the outbreak
- analysis of WFP data on planned and distributed rations
- interviews with agency staff and other key informant interviews
- transect walks through camps with visits to households and clinical diagnosis of pellagra cases
- observation of clinicians admitting new pellagra patients
- ward rounds in therapeutic feeding centres (TFCs)
- market visits to assess food availability.

Main findings

Transect walks through four camps in Kuito and three camps in Camacupa involved clinical assessment of whether there were cases of pellagra in 300 and 200 households respectively. This led to an estimated prevalence of approximately 10% pellagra in the IDP camps around Kuito and 30% in Camacupa. Since January 2000 there have been a greater number of the resident population affected.

During the transect walks it became apparent that health professionals were not good at recognising the symptoms of pellagra. This may be partly explained by the fact that most teaching/text-book photographs are based on cases presenting with 'classical' symptoms whereas in the field most cases do not present with textbook lesions. This is a major drawback of teaching material used. The authors caution that this may have the worrying implication that pellagra exists in other areas of Angola but may be unrecognised. However it is likely that the epicentre of this epidemic is Bie province for a number of reasons. In Bie land is devoted largely to maize (niacin-deficient) cultivation and there are no groundnuts (niacin-rich) in the diet. Furthermore, in recent years there has been a reduced consumption of animal products, also a good source of niacin.

There do not appear to be substantial numbers of people with niacin deficient diarrhoea or nervous system complaints without skin lesions in Kuito. However, the signs are more advanced in Camacupa where diarrhoea seems to be a feature.

The pellagra patients are normal weight or overweight. This is because the nutrients involved (pyridoxine, riboflavin and niacin) give rise to a type 1 deficiency which is not associated with loss of body weight (wasting) rather than a type 11 deficiency which is characterised by stunting and wasting. The fact that pellagra is apparently mainly occurring in female and adolescent residents of normal body weight indicates that those who are not eligible to receive any WFP rations may be those most at risk. The general ration is targeted to IDPs while the vulnerable group feeding is targeted to

patients in TFCs or those with pellagra and their families.

The population is clearly in nutritional crisis with a continued high mortality rate for over three years. Although nutritional deficiencies underlie this excess mortality they are not reflected in the rate of wasting. Crude mortality rates in March 2001 were 1.4/10,000/day and had risen to 4.0/10,000/day by July 2001. Surveys conducted between March 1999 and June 2001 found global rates of malnutrition ranging from 3-16% in the camps in Kuito (with four out of the seven surveys recording rates of less than 10%) and 3-8% in towns. Type 1 nutrient deficiency as the dominant type of micronutrient deficiency does not directly give rise to wasting; it does however cause severe illness including both pellagra and kwashiorkor, immuno-incompetence and death. The survey data show both an excess of severe malnutrition and more particularly mortality rates that are far higher than would be anticipated given the overall rate of wasting. For example, in March 1999, overall rates of malnutrition were 3% while rates of severe malnutrition were 1.3%.

There have not been outbreaks of malaria, cholera, shigellosis or other major infectious disease epidemics to account for the high mortality rate. These findings should alert the responsible agencies to the probability of widespread type 1 nutrient deficiency and lead specifically to programmes aimed at improving the quality of the diet rather than simply supplying sufficient energy and protein.

A major proportion of the population is entirely dependent upon humanitarian aid. Almost 60% of the population receives humanitarian aid and over two fifths of all food eaten in the area is flown in by WFP. Without this sustained effort the population would starve. It is noticeable that the widespread pellagra outbreak reached a peak two to three months after gaps in the WFP pipeline led to the food actually distributed having a niacin content lower than that known to cause overt clinical pellagra in otherwise healthy experimental subjects. During these periods there were marked reductions in the delivery of CSB and beans.

Recommendations from the study included:

- That the WFP food basket for both general distribution and vulnerable group feeding be revised to improve the provision of micronutrient rich foods with emphasis on niacin, pyridoxine and riboflavin (CSB and/or groundnuts).
- In the meantime that the currently agreed food basket be fully supplied and about 35% of cargo capacity space used for non-maize food items
- That there be a market intervention in Kuito and elsewhere in Bie to bring niacin rich food for sale, at cost or at a subsidised price, to the non-general ration receiving population.
- That the mills in Lobito, the port of entry for shipments of maize, be upgraded and fortification equipment purchased and installed.
- That all the maize imported into Kuito be milled in Lobito and fortified with a micronutrient mix, that includes niacin, riboflavin, pyridoxine, iron zinc, vitamin C and antioxidants such as a vitamin E, before it is flown in and distributed.
- That an extra 60,000 hectares of land be brought into cultivation in the Kuito area in the long term.
- That the land provision to families should wherever possible be increased from the present 0.5 hectares to close to 3 hectares.
- That the seeds distributed for crop production on this land are diversified and the technical help of a nutritionist is sought by the agricultural agencies.

Report of a visit to investigate recurrent epidemics of Pellagra in Kuito Angola. July 17th - 1st Aug 2001. Prof. Michael Golden. Email contact: mgolden@eircom.net

From emergency food aid to sustainable food security: 10 years of agricultural recovery in Afghanistan

By François Grunewald



François Grunewald is an agricultural engineer specialising in the rural economy. He has worked in the field of crisis and post crisis operations since 1979 with NGOs, ICRC and UN agencies. His more recent postings have

taken him to Cambodia, Tchetchenia, Somalia, Sudan, Rwanda, Angola, Mozambique, Former-Yugoslavia and North Korea. He currently chairs the URD Group (an inter-agency research body) and is Associate Professor at Paris XII university in charge of a masters degree on humanitarian affairs.



Agricultural evaluation in central Asia

Afghanistan is a country of breathtaking beauty inhabited by poets and warriors. Over the past 10 years I have been lucky enough to regularly work in the food security and agricultural recovery sector of Afghanistan.

The current agricultural and food security situation in Afghanistan is deeply rooted in the years of war which have stricken the country over the last two decades. While civil war has continued to rage around Kabul, many other areas have gone through periods of calm since 1989. This had enabled Afghan farmers to recover at least partially. However, the international embargo after the Taliban take-over considerably limited opportunities for further improvement. In addition the drought that has since affected various Afghan provinces, has reduced the area cultivated, the yield, and consequently the availability of seeds. This is expected to have an impact on both the 2002 spring planting season and the subsequent autumnal harvest. It has also resulted in large scale de-stocking of livestock and devastating effects on perennial crops, which play a critical role in food security during winter. Both losses represent an important de-capitalisation which must be energetically tackled.

The events of September 11th marked a new era for the country. Within a few weeks the situation in Afghanistan changed dramatically. Mazar-I-Sharif fell into the hands of the Northern Alliance, followed by Herat and Kabul a day later. As military events rapidly unfolded the mood changed within NGOs and UN agencies. Instead of preparing for a protracted refugee operation, many moved back to the offices they had evacuated in the immediate aftermath of the 11th of September 2001. Following a decade of indifference, if not disdain, the international community flooded Afghanistan with a flurry of missions and initiatives. Observers could not help but be aware of intense inter-agency competition for funding and limelight. This posed a risk to years of patiently accumulated knowledge and experience as new 'actors' jostled for 'humanitarian space' without the experience or knowledge to mount effective or appropriate interventions. Many of these new agencies could so easily fall into a number of traps in the months ahead. The article below highlights where some of the dangers lie and what this implies for planning and intervention.

The Crisis of the Uprooted people in Afghanistan

The years of war against the Soviet invasion drove around 6 million refugees from Afghanistan to Iran (2.3 Million) and Pakistan (3.6 Million). While a small part of the Afghan population is nomadic (mainly the Kushi tribes which have been estimated

at 300.000 to 500.000), most of the other tribes are closely linked to their home territory. Here, water rights and land rights are deeply ingrained in people's consciousness. People only abandon traditional territory under dramatic circumstances. These years of exile have profoundly affected the social fabric of the country and brought about dissension between the "Peshawar Shura" (the co-ordinators of the Afghanistan Resistance in Pakistan) and the Commanders of the Interior.

The end of the war and the withdrawal of the Soviet troops resulted in the launch of Operation Salam with more than 2.4 million refugees being repatriated from Pakistan and 0.9 million from Iran. In large parts of the devastated country, agricultural rehabilitation and support to the much needed social services were the focus of many NGO and UN programmes, for both returnees and the local population. But power sharing between the Resistance from Pakistan, the Resistance from the Interior and the Usbek groups who until late in the war were allies of the pro-soviet Kabul Regime, was difficult. Inter ethnic tension heightened between the Pachtoun tribes, the mainly Farsi speaking Tajiks, the Hazara (Shi'ite), and the Usbek. For the first time ever Kabul was heavily shelled. With the civil war reaching new levels, repatriation came to a halt while internal displacements skyrocketed. Kabul became the scene of a great deal of internal movement, e.g. population transfer from one side of Kabul to another depending on the level of intensity of the fighting. Many areas outside the Kabul plain remained nevertheless quiet and enjoyed various types of rehabilitation and development projects.

With the rise of the Taliban movement, the net balance of displacement reversed, with more refugees appearing in Pakistan, Iran and even Tajikistan, than returnees coming back to Afghanistan. War north of Kabul as well as in the lower Hindukush resulted in the displacement of between 600,000 and 1,500,000 people. Meanwhile a flow of refugees from Mazar-I-Sharif and Hazarajan continued to cross the Iran border.

However, until September 11th, large parts of the country remained calm. This enabled the UNHCR to assist the voluntary repatriation of thousands of Afghan refugees and permitted many others to go back home on their own. The remaining refugee caseload stayed away worried by both the security situation and the economic situation inside Afghanistan. After September 11th and ensuing events many of these people are now returning home. However, drought induced displacements continue in the most affected areas with hundreds of thousands of new IDPs adding to the suffering in the country, such as in the western foothills of Hindu Kush.



Linking agricultural recovery and mine awareness

The irrigation systems in Afghanistan comprise:

- Traditional diversion canals on river courses, the latter being fed mainly by melting water in distant mountains.
- Modern irrigation schemes based on large scale diversion canals and primary distribution canals. Initiated in the early sixties, these systems have been constrained by difficulties related to water distribution, infrastructure maintenance and soil management. Erosion of canals, decreasing motivation of farmers confronted with weak secondary and tertiary distribution networks and soil degradation have been frequent problems.
- Karezes are water collection systems through underground canals in the alluvial substratum. These ancient systems require much maintenance which was often lacking during the anti-soviet war. A lot of rehabilitation took place during the period of relative peace which has prevailed since then.
- Simple wells and bore-holes: The multiplication of these bore-holes in certain areas in the South appears to have led to an accelerated depletion of the underground water reserves.
- Outside this irrigated sector exists a complex rain-fed agricultural sector, based on cereal, legumes and perennial crop production.

Fighting food insecurity in a complex environment

Afghan agricultural systems are extremely diverse. They range from arid pastoral systems and localised food production areas where irrigation is vital, to sub-mountainous systems where rain-fed cereal and legume production neighbour fruit tree production and altitude adapted animal rearing. The topology also affects agricultural practices, e.g. large valleys where agriculture is only constrained by the availability of water, narrow riverine zones where the slopes limit the arable land, immense quasi flat arid steppes, etc. No one technical package will serve all agricultural systems. It is therefore important to understand the resilience and vulnerability associated with different agro-ecosystems.

An important element of this diversity is access to irrigation, which is mainly a product of topology.

The rain-fed cereal production sector in Afghanistan has received very little attention in the past. There has been minimal research into this sector so that there is little understanding of the agricultural systems in this harsh and hazardous environment.

Farm sizes and land tenure systems are equally diverse. The hilly areas of Afghanistan are dominated by small landowners. These represent an important group of very small and land-less farmers who complement their production capacity through sharecropping arrangements that can take many different forms.

- In the larger plains surrounding the Hindu Kush ranges in the North (Mazar-I-Sharif), West (Herat), South (Helmand, Kandahar), or East (Nangahar along the Kabul and Kama rivers), the proportion of larger farms increases. Here, the proportion of sharecropping also grows significantly. By and large, it results in a transfer of wealth from poor farmers to landowners. However in the absence of any credit system it also represents the only way poor farmers can access means of production.

- In the narrower valley and middle hills, the number of large land owners diminishes slightly but sharecropping, land renting and mortgaging remain important mechanisms for poor farmers to access land.

The social aspects of the Afghan systems of production are very seldom mentioned in NGO and UN reports related to food security and food crisis. This is a significant omission as the “semi-feudal” nature of agrarian society functions on the basis of inequitable distribution of wealth between those who control access to land and water and those who have to pay (in kind, by labour or in cash). This is a crucial element to consider in planning agricultural interventions. The different actors, e.g. sharecroppers, Khan (big landlord with local political power), Malek (village headman), and Mirab and Wakils (water managers) exist in a delicate equilibrium. Engaging and influencing this precarious equilibrium is risky. The first large-scale attempt to introduce some equality into these systems (The Taraki Agrarian Reform), targeted the unequal production relationships. This led to the 1978 rural insurgency and resulted ultimately in the Soviet invasion.

Urban versus rural

Rural areas produce, urban centres consume. The key to this relationship is the purchasing power of the urban population, which is currently very heterogeneous. Urban poverty is currently widely spread and many Afghan urban centres shelter huge numbers of rural displaced who have little, if any, access to job opportunities.

The overall approach to food security

In my view the key strategy for Afghanistan should now be based on one over-arching objective: establishing sustainable livelihoods in an uncertain, hazardous and diversified environment where food insecurity has been the norm over the last two to three decades. This will only be achieved through multi-sectoral intervention.

The issue of F75

Dear Editor,

MSF would like to thank Schofield et al for their constructive criticism in the letter section of the previous edition of Field Exchange. We believe that academic and scientific debate is indispensable to increasing the efficiency and professionalism of medical interventions. MSF agrees with the suggestion that severely malnourished individuals should receive night feeds and, wherever possible, we ensure that children are kept in feeding centres on a twenty-four hour basis. MSF also agrees that iron should not be administered to patients during the first two weeks of treatment.

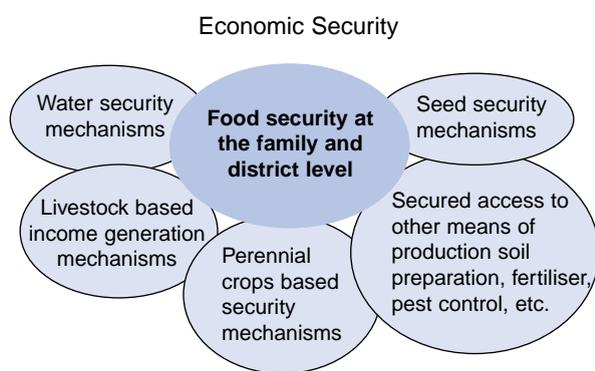
We would like to respond to the commentary made about MSF's protocols for administering F100 during Phase I of nutritional treatment and for antibiotic treatment. Subsequent to thirty years of experience in the field, MSF believes that medical and nutritional protocols cannot be interpreted in black and white terms. Because every field situation is unique and has its own operational constraints, field knowledge and experience are crucial to determining the hands-on decisions that save lives.

F75 and F100 are therapeutic milks designed for the treatment of severe malnutrition. In the previous issue it was alleged that MSF's use of F100 during Phase I for the treatment of severe malnutrition diverges from the "best practice" and, consequently causes unnecessary deaths. MSF believes that there is only circumstantial evidence to prove the superiority of F75 over F100 during Phase I treatment, and that there is no clear relationship between F75 and mortality rates.

MSF agrees that F75 has several theoretical advantages over F100. F75 has a lower energy content and osmolarity than F100; it is high in carbohydrates and has little fat and protein. As a consequence, F75 causes reduced metabolic stress on kidneys, the vascular system and liver. This being said, MSF feels that it is too simplistic to assume that the use of F75 makes a difference between life and death under field conditions. Mortality in Therapeutic Feeding Centres is always caused by a multitude of factors (e.g. poor patient management, low capacity of staff, slow decision-making, limitations imposed by insecurity and in the cases of Angola and Wau mentioned in the letter, being a referral centre for other feeding programmes).

Throughout its experience in nutritional interventions, MSF has found that ultimately there is no clear correlation between F75 and low mortality rates. We have worked in several emergency contexts where the use of F100 has contributed to low mortality rates, even in situations with high incidences of kwashiorkor and marasmus (Burundi 2001, Congo Brazzaville 2000); conversely, we have also seen situations where our use of F75 did not affect mortality rates (South Sudan 1998 - see page 11). During a mission in Ethiopia 2000, MSF witnessed low mortality rates among patients receiving F100, and high rates among those receiving F75. This comparison, made possible by different organisations working amongst the same population, calls into questions the superiority of F75.

MSF believes that the use of one type of therapeutic milk is more efficient during nutritional emergencies, because it simplifies health care management on all levels. It eliminates the possibility of confusion (e.g. mistaking one milk for the other during preparation, prescription and handout). F75 complicates nutritional interventions since it requires additional storage facilities, planning and ordering procedures, and complicates emergency preparedness (e.g. product expiration). Although scientific study helps inform 'best practice', ultimately field staff must determine the most feasible practice by weighing the benefits of a more simple protocol against benefits of a more complicated one. In the case of F75 the theoretical advantage is clear, but the extent of its



For a pro-poor strategy: Limitations of current approach

The current approach for promoting food security in Afghanistan being employed by many agencies is predominantly one that focuses on the "most promising areas". The assumption has been that the international community would get "better value for money" by investing in these zones, where irrigation is available and intensification of the production systems are possible. This view can be challenged on both practical and ethical grounds:

- better yields in the already most favoured areas will have little impact in the pastoral highlands or in the rain-fed belt, where food insecurity is endemic.
- the semi-feudal nature of the social agricultural system in Afghanistan does not pre-dispose to redistribution of wealth. Supporting the most promising areas is not therefore an equitable approach.
- the push for increased productivity and the means of achieving this may be contrary to the primary objectives of farmers (i.e. minimising risks and strengthening resilience).

These observations support a strategy that includes the poorer areas of the country.

Responding to the Emergency

An appreciation of the complexities and the challenges of Afghanistan is critical in formulating a response to the current emergency. Based on the

outlined experiences and observations, recommendations for activities and response time frame are summarised in the table.

Better knowledge for enhanced planning and monitoring

The international community is currently confronted with a food security information problem in Afghanistan. Information is sketchy, with comprehensive reports available in some operational areas and a total absence of information in others. There is a wealth of data available for certain sectors such as nutrition, e.g. nutrition surveys, but little in depth knowledge on livelihood systems, especially among the agencies new to Afghanistan. To inform adequately the planning, monitoring and evaluation of the humanitarian response to the food and agricultural crisis in Afghanistan and in the interests of transparency and accountability, it is essential that "a nation-wide coordinated" food security information system is established. This should become an essential part of the international community's effort towards co-ordination and accountability and pave the way for a national system of food security information that can later be transferred to the government.

For further information contact François Grunewald at: fgrunewald@urd.org

Level	Actions	Timeframe
First level of urgency	Respond to the prevailing "seed insecurity"	For the coming spring planting season
	Reinforce the soil preparation capacity by bringing in tractor spare parts	For spring 2002
	Address risks threatening livestock survival in certain parts of the country as a result of the drought	As soon as possible
Second level of urgency	Save as much of the locally produced planting material in order to ensure the highest possible level of seed availability. Protect the endangered bio-diversity and the availability of local seeds	For the 2002 Autumn cropping season
	Strengthen the existing Seed Multiplication Programme of the PEACE project	For 2002 onwards
	Facilitate the return of refugees and IDPs through the distribution of basic agro-kits. Support of mini-projects for receiving communities in order to enhance their capacity to absorb returnees. Co-ordination with UNHCR is essential	Spring 2002
	Create a mechanism of credit for fodder procurement in order to avoid further selling of animals by livestock owners	Winter-spring 2002
	Create jobs in the cities and towns, to encourage economic activity and create a demand for local production	Spring 2002 onwards

impact is not clear at all. There is a need for research in emergency contexts.

Malnutrition and infection often occur simultaneously. MSF provides systematic antibiotic treatment to all children during emergency situations for greater efficiency and coverage. MSF prefers an individual approach to antibiotic administration for adults (i.e. one that includes individual clinical examination, diagnosis and treatment). Adults are able to better articulate their physical complaints; therefore, antibiotic treatment can be adopted accordingly.

Retrospective investigations and evaluations have enabled field workers to analyse lessons learnt, and identify new ideas and future directions.

MSF appreciates constructive criticism and scientific debate, and looks forward to hearing operational conclusions.

Saskia van der Kam: MSF Holland

Aranka Anema: MSF Holland

Sophie Baquet: MSF Belgium

Marc Gastellu: MSF France

Dear Editor,

Congratulations for a fantastic journal which always has plenty in it to read. But that's not what we are writing about today. In your last issue you had a delightful gallery of pictures entitled "People in Aid". It cannot be allowed to pass without comment.

It struck me as profoundly depressing that all the people pictured at the Nairobi meeting were from the North. The only Africans were hidden in the background and unrecognised. Now this may have been representative of that particular gathering but it is not representative of 'People in Aid'. Aren't we in the aid community trying hard to break away from the myth of 'good people from the rich countries helping poor people from poor countries'?

Khemraj Upadhyaya, Luis Morago and Roger Yates (ActionAid Emergencies Unit)

Dear Khemraj, Luis, Roger

Thanks for the email and comment on our pictures in the People in Aid section. We fully appreciate your concerns about representation of people in aid. We are certainly aware of the increasing consideration given by many agencies to the importance of getting imagery right and the dangers of 'Eurocentricity' in representation. However we would also like to point out that, up until now, this has been the 'less serious' section of Field Exchange and is not intended to be representative of all people in aid. The People in Aid section has developed from ENN team members travelling with a camera. We also encourage agencies and field personnel to send pictures in to us for this section and have published all pictures we have received (so there is no selection bias).

Eds.

Dear Editor,

We refer to the Article by Vanessa Tilstone "Older people, Nutrition and emergencies in Ethiopia" (issue number 14, November 2001). We agree that the welfare of the elderly in emergencies has received much less attention than is necessary. The result is a dearth of field expertise upon which to draw and almost no data upon which to base judgements. There clearly needs to be a lot of research in this area. HelpAge is to be congratulated for initiating both research and debate on how to recognise and appropriately help the vulnerable elderly in emergency situations.

The cut-off points for definition of severe and moderate malnutrition in childhood are based upon over 50 years of data analysis (from the initial paper by Gomez published in the 1950's). The mass of data from around the world, for this age group, clearly shows relationships between the definitions of the grades of malnutrition and the risk of death. Severe malnutrition means that the child has a high risk of death from malnutrition. No relationships have been established for the elderly in terms of risk of death or even other adverse outcomes. This is an area where data is desperately needed to inform the debate so that meaningful opinions can be reached.

The use of the term "severe malnutrition" itself carries the connotation of the person being at high risk of death and should only be used when this is the case. This should not be an arbitrary decision, or even one based upon fulfilling some sort of quota of patients needed to justify a programme at field level, but upon the real risk and needs of this section of the population.

In the absence of a body of outcome data, there is no basis for the choice of any particular cut-off point, which will either divert the limited resources available in an emergency away from, or to, the elderly. Steve Collins comes closest to this with his analysis of outcome in relatively small numbers of adults (not the elderly) of particular ethnic groups. Collin's cut-off points are rejected by HelpAge; the basis for this rejection is unclear. Nevertheless, it is probable that very small numbers of elderly would be selected by Collins' criterion.

HelpAge therefore chose a criterion said to be based upon a personal communication from myself (Yvonne Grellety). In this I have been totally misrepresented. I have no data upon which to base such a judgement. I have therefore never advocated any cut-off point for either BMI or MUAC for definition of malnutrition in the elderly. We did not use the quoted cut-off point for selection of either adults or the elderly in Rwanda. Incidentally, I was with UNICEF in Ethiopia and not ACF. My main concern is to avoid confusion at field level and consequently ask the readership of Field Exchange to ignore all quotations ascribed to myself in this article.

Nevertheless, we agree that in the absence of meaningful data some reasonable cut-off point should be chosen pragmatically, on an experimental basis, for inclusion of the elderly in programs. The onus is then for the agency to determine the outcome of the elderly, both those included and particularly those excluded by that criterion, in order to build up a body of knowledge and experience with which to refine the criteria and definitions whilst not ignoring the humanitarian needs of this section of the community. Any particular cut-off point cannot be justified post hoc by quoting an incorrect personal communication that the readers cannot verify.

In case study 1, given the demography of Ethiopia, we are astonished that the ratio of age groups admitted was 1 pregnant/lactating mothers, 4.5 children and 14 elderly. Were resources in that programme really being distributed according to need? This case study seems to show how the selection of an inappropriate criterion for "malnutrition" in one age group can lead to real problems with resource allocation at field level.

Yvonne Grellety, Michael Golden

Dear Editor,

I received a copy of the letter from Yvonne Grellety and am grateful that she has re-emphasised the need to do more research to define and measure malnutrition among older people.

I apologise sincerely for misquoting her in any way. What was written was based on my understanding of the recommendations she gave to HelpAge when she very kindly advised us on our programmes in Ethiopia while working for UNICEF there. As stated in the article, we were not happy with the MUAC cut off points suggested by Steve Collins nor HelpAge cut-offs, based on our nutrition survey results using the MUAC, and therefore we used those suggested by Yvonne on an experimental basis, based on what we understood was ACFs practical experience in Rwanda.

The fact that the number of older people registered in case study 1 was higher than the other groups may have a number of causes, including: the prioritisation of certain members of the family for food, the fact that supplementary feeding programmes for children had been carried out since 1999, and probably most significantly because older people may have been more actively recruited in the programme.

These issues need to be further explored and the understanding shared and I hope that this will be done, along with more comprehensive international and longitudinal studies of elderly malnutrition in order to help a group of people so often overlooked in emergency situations.

Vanessa Tilstone

A pragmatic approach to treating severe malnutrition in emergencies: Is F75 always beneficial?

By Saskia van der Kam



Saskia is the headquarters nutritionist in MSF Holland.

This article describes MSF's experience of implementing a therapeutic feeding programme for adults in Wau, southern Sudan in 1998. Current MSF guidelines advocate a pragmatic approach to the treatment of malnutrition and, depending on the circumstances, advise the use of a single formula regimen in order to simplify protocols (see letters section, page 9 and excerpt from current MSF guidelines below). Readers should note that this is contrary to WHO guidelines highlighted in the box below. MSF challenges current thinking on the use of only one standard strategy to treat severe malnutrition (e.g. 2 milks, 3 phases, 24 hour inpatient care) and calls for further research. (Eds.)

Mortality in an Adult Therapeutic Feeding Centre in Wau

Wau, an enclave in South Sudan controlled by the government in North Sudan, had about 80,000 inhabitants in the spring of 1998. During the famine of that year, 72,000 displaced Dinkas entered the town between May and September 1998. The peak of the influx was in July with 1000 per day arriving. The displaced were in a deplorable state. Rough estimates of the mortality rates in town were 15-20/10,000/day (August 1998).

A survey of resident and displaced children under five found global and severe malnutrition rates of 43.3% and 18.6% respectively. In the internally displaced population (IDP) alone, the global and severe malnutrition rates were 71% and 41% respectively (UNICEF, August 1998). Amongst 329 adults (18-49 years) screened on first arrival, 56% of males and 45% of females had a BMI below 16 kg/m² (ICRC, southern reception point, August 1998).

By July, some NGOs (CARE, SCF, ICRC) had begun operating supplementary feeding programmes and were distributing soups or porridge. Other NGOs were only able to start feeding interventions in September (ACF, Goal).

In July, MSF established a Therapeutic Feeding programme for children in the hospital. Later, MSF took over the adult ward in the hospital and began a feeding programme for adults. Both programs were closed in the third week of December since mortality and malnutrition rates in Wau had declined and other NGOs had established additional feeding programmes. By November the overall global and severe malnutrition rates in Wau had declined to 9.6% and 2.4% respectively.

The mortality rate (measured as % of exits) in the TFC for children was 5% in August and 1.7% in September despite admission criteria of < 60%

weight for height. The mortality rates subsequently increased to 11% in October and 12% in November, eventually returning to 4.2% in December. This increase in mortality can mainly be explained by the fact that despite the increasing number of other NGO feeding programmes treating a greater number of children elsewhere, the most severe and sick cases remained within the MSF programme.

The results on the adult ward were disappointing. Although the mortality rate declined from nearly 100% at the time of MSF take over of the ward, the rate stabilised at 25% and improved no further.

Several reasons for the high mortality rate were identified:

- Lack of care in the ward: adults had no caretaker and there was limited staff capacity to provide the needed care, i.e. feeding, washing, helping the many who could not walk to the latrines.
- Only the most severely malnourished were admitted. The admission criteria were restricted to BMI < 12 kg/m² or the very weak, i.e. not able to walk. Most patients were too weak to sit straight and patients were often brought in unconscious.
- Late referral: Other feeding programs and outreach teams only referred very sick (and often collapsed) patients to the adult TFC
- Patients often had multiple severe medical complications, e.g. malaria, diarrhoea, TB, respiratory tract infections and possibly HIV infection
- Protocols for feeding severely malnourished adults were not developed yet so that the diet was not appropriately adapted from the start
- Unrestricted use of RESOMAL increased the risk of heart failure
- On feeling slightly better (usually after 2-3 days) patients often would not accept a diet exclusively of milk: they tried to get into the second phase as quickly as possible to get porridge and were often fed by family members with a home-prepared meal
- Organisational difficulties

The organisational difficulties were:

- Supply constraints of F100 and F75 (due to importation restrictions, transportation difficulties and reliance on other agencies)
- Limited expatriate staff capacity (due to visa restrictions)
- Limited national staff capacity/commitment (due to low educational and language levels, mistrust of staff belonging to tribes opposed to the Dinka)
- Poor communication (no email, no radio, and limited ability to provide technical support)
- Poor co-ordination between UN and NGOs (absence of referral systems and lack of joint statements)
- Overwhelming scale of emergency resulting in a low expatriate staff : patient ratio

The feeding regime initially used was High Energy Milk (HEM) made from DSM, oil and sugar. In September this was replaced by F100, and F75 was introduced in October. This staggered introduction was necessary due to shipment delays to the field. An interim recommendation to decrease the osmolality of the HEM by dilution was only received by the field at a relatively late stage (beginning September). At this time staff decided to 'wait' for shipment of F100 and F75 so that they would only have to introduce one change to the feeding protocol. With hind-sight this was probably not a good decision since F75 did not subsequently arrive until October. However, the introduction of F75 was not met by the anticipated reduction in the mortality rate (see graphs).

The following is an excerpt from current MSF guidelines on choosing a therapeutic milk.

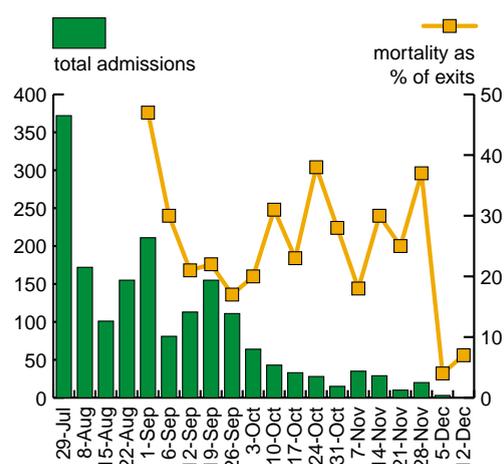
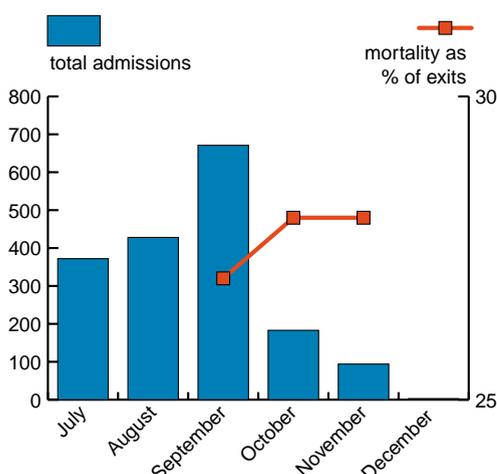
- F100 milk is recommended in emergency situations (preference)
- When F100 milk is not (yet) available or affordable, high energy milk (HEM) can be prepared.

The use of F75 or F100 diluted can be considered when:

- TFC is well organised
- There are a high number of kwashiorkor admissions
- Many adults fail to improve
- Mortality rate in a TFC is high

Current WHO guidelines recommend the use of both F75 and F100 in the management of severe malnutrition. F75 is used in the initial phase of feeding and F100 in the rehabilitation phase, after appetite has returned. The initial phase using F75 may last from 2-7 days, the duration being determined by the child's appetite and general condition.

Management of severe malnutrition: A manual for Physicians and other senior health workers. WHO, Geneva, 1999



In the event of a similar scenario in the future, MSF will use F75 where available (see excerpt from MSF guidelines) and will take steps to dilute HEM milk as necessary. However, despite the theoretical basis supporting F75, this programme experienced no reduction in mortality following the introduction of F75. This case study serves to highlight uncertainty over the extent to which use of F75 is able to reduce mortality in severely malnourished adults in this type of situation.

Range of strategies

This case study illustrates how in emergencies, constraints such as population access, insecurity, poor supply lines, limited staff capacity, poor communications and overwhelming scale, limit the possibility of implementing the best programme in terms of technical practice. Field staff had to adopt pragmatic compromises in the face of numerous constraints. In general, complex protocols or complications in emergency circumstances may need to be avoided in order to achieve efficient and effective programme implementation. Currently there is a range of strategies for treating severe malnutrition that are under discussion. These vary from optimal 'scientific' practice in controlled environments to highly adapted protocols as a pragmatic response to practical constraints. Treatment of severe malnutrition has been organised as follows:

- 24 hour care in 3 phases using 2 types of milk (F100 and F75)
- 24 hour care in 2 phases using 1 type of milk (F100)
- Day-care only in 2 phases (with provision of a nutritious snack for use at night)
- Phase one treatment in a specialist centre and phase two at home (in the community)
- Provision of weekly supplementation (SFP)
- Entirely at home (community treatment)

The alternatives to 24 hour care in specialised therapeutic feeding centres aim primarily to improve coverage of the feeding programmes and thus overall programme efficacy. These strategies rely on newly developed products that are suitable for consumption at home (cookie, bar or paste).

However we urgently need to evaluate these relatively new strategies and protocols in terms of impact (coverage, case fatality, efficiency), advantages and limitations. Only then will we be able to give guidance to field staff on which type of strategy is best suited to an emergency situation with a specific set of constraints and morbidity/malnutrition patterns. For those of us faced with decisions about programme design in emergencies, it will come as a relief to be able to make more informed choices out of a range of options for treating severe malnutrition.

For further information contact Saskia van der Kam at: saskia_vd_kam@amsterdam.msf.org

Post Script: F75 helps to avoid sodium

Michael Golden, Yvonne Grellety

It is quite wrong to consider the advantage of F75 as "theoretical". However, a decreased mortality will not be seen if other aspects of faulty management dominate mortality. It is important that readers of Field Exchange understand the reasons and the underlying physiological changes that occur in conjunction with malnutrition, because they have much wider implications for management than simply whether or not to use F75. It is now clear that if fluid and electrolytes (including those contained in the diet) are not managed correctly there will be a high mortality.

The metabolism of sodium and the function of the kidney and heart are very abnormal in all malnourished patients. They are very sensitive to excess of sodium intake from any source. It is the total intake that matters. The diet only forms part of this sodium load and any benefit from using a low sodium diet is immediately removed when excess sodium comes from other sources (resomal, infusion, ORS, transfusion).

The rate at which sodium and other electrolytes are filtered in the kidneys is only about half normal in a malnourished child. If given an infusion of sodium the malnourished child retains most of the sodium in the body. If given ReSomal the amount of fluid that the well nourished child with diarrhoea can excrete in 20 minutes takes 10 hours in the malnourished child! The well nourished child with diarrhoea can excrete the excess rapidly with no danger of fluid overload. In contrast the malnourished child with changes in kidney function will retain more and more until the patient either gets peripheral oedema, acute pulmonary oedema or heart failure. The situation is even more critical in children with kwashiorkor.

How much sodium is too much? Data from Uganda showed that 17% of children developed heart failure when the total sodium intake was above 3 mmol sodium/ kg/d. Few children went into heart failure when the intake was less than 1 mmol/kg/d of sodium. Resomal has about 45 mmol sodium per litre. F100 has 19 mmol sodium/ litre (1000kcal). F75 has 6 mmol/ litre (8 mmol/ 1000kcal). Thus, an unacceptable number will get heart failure if more than 70 ml/kg of resomal, 160 ml/kg of F100 or 500 ml/kg of F75 is given (these are the amounts that give 3 mmol/kg sodium) in excess of losses. With Resomal and F100 these quantities are easily and regularly exceeded.

The situation is even more finely balanced during early recovery. Inside the marasmic child's cells the average sodium concentration is about 70 mmol/ litre cell water whereas the normal child has 35 mmol/ litre cell water. Thus, during early recovery 35 mmol sodium /litre of cells has to come out of the cells into the circulation and be excreted. If this happens before the child's kidneys recover the patient may go into heart failure. The sodium coming out of the cells will either be deposited in the interstitial space giving "refeeding oedema" or be excreted by the kidney or remain in the plasma. For a typical malnourished child weighing 10 kg, if the sodium is retained in the circulation the plasma volume will increase by 16% per day and the haematocrit will fall by about 3% per day. Even

larger falls in haematocrit are frequently seen in practice. Even without any additional sodium intake there is the potential for a major increase in plasma volume simply from reversal of the electrolyte imbalance. If large amounts of F100 are given during recovery this further increases the risks of an expanded circulation.

These phenomena have been known for a very long time. Researchers working in therapeutic feeding centres in Jamaica strictly limited sodium intake in malnourished children. The mortality was about one fifth of that expected and for one period of 18 months there were no deaths. In Tubmanbourg, Liberia where no infusions were used and glucose-water was used instead of sodium containing fluids, there were only 16 deaths from 900 patients which again was much less than expected. There have been similar findings in Burundi, Bangladesh and Somalia.

A large number of children have already died to give the data and insights used to design F75 and the other aspects of modern protocols. The same applies to adults - in experiments in Minnesota during the war 4 of 13 patients who had their central venous pressure measured were found to be in incipient heart failure during refeeding and one patient (no 47) went into overt heart failure.

Recently we have analysed the outcome of about 8500 children comparing the observed to expected mortality rate. It is clear from this analysis that those centres where children have a high initial weight gain (reflecting fluid retention) have an excessive mortality and that most excess deaths are preceded by at least one days weight gain. It is also clear that where there is no appropriate control of other aspects of fluid and electrolyte management or too rapid progression through the phases, then no advantage can be shown to come from the use of F75. Indeed, because the rate of recovery and the cellular electrolyte changes are much slower with HEM than with F100, there can be a lower mortality with HEM, than with F100 itself if the F100 is not used with understanding. These diets are strong drugs and as with all drugs should only be used by those with appropriate training.

There are several common ways in which patients get fluid overload, heart failure and die. First, they are given excess fluid at admission because of confusion over the signs of dehydration and malnutrition (oedematous children by definition are already "overhydrated" although they may have low circulating volume). Second, the child is started on F100 and the amount given increased too quickly. He then gets an osmotic diarrhoea which is then treated with Resomal, instead of simply changing the diet to remove the intestinal osmolar load. Third, the child is noted to have a fall in haemoglobin during treatment and this is "treated" with a transfusion. The haemoglobin ALWAYS drops as the sodium comes out of both the cells and the interstitial spaces and increases the plasma volume without increasing the red-cell volume - indeed the extent of fall of the haemoglobin can be used as a measure of the degree of expansion of the plasma volume and the additional stress the heart is under. A large fall in haemoglobin is a real danger sign for heart failure and must not

be treated with a transfusion that further expands the circulation at this critical time. Indeed, many of these children are diagnosed as dying from “anaemia”.

How does this translate into practical procedures at the field level?

1. Oedematous patients should not be given infusions or resomal unless they are unconscious from hypovolaemia, and then the amounts should be very small. Resomal should, in general not be used in oedematous children.
2. Patients should be weighed daily, after admission if they have not lost weight, even if they have diarrhoea, they should not be treated for dehydration, for weight change is by far the best measure of net fluid balance.
3. Diarrhoea, during treatment, should be treated with a change of diet - amount and/or quality (back to F75).
4. The liver edge should be marked on admission with an indelible pen. If the liver size increases by more than 2 cm then the patient’s circulation is increasing and there is incipient heart failure. Those who have an increased respiratory rate with a steady or increased weight have heart failure (pneumonia gives rise to weight loss).
5. If anaemia is to be treated by transfusion this must be within 48h of admission and no food or fluid should be given that day. The very maximum that should be given is 10 ml whole blood per kilo over at least three hours with close surveillance. After this time Hb can be used as a measure of heart failure (and if very severe anaemia has to be treated this should only be done with a small exchange transfusion - just as in a neonate).
6. Intravenous fluids should not be given. Administration of quinine or antibiotics should not be by infusion of a sodium containing solution. When the child’s haemoglobin drops and he dies the wrong diagnosis will be made.
7. All complications in phase two should be first managed by putting the child back to phase 1.
8. The introduction of a transition phase between phase one and two has decreased the mortality from overfeeding in the initial phases of treatment.
9. F75 should be used along with the other ways in which the total sodium intake is restricted.

The physiology is clear with respect to sodium homeostasis (control). However, the use of F75 will not solve many of the problems seen in a centre run by inappropriately trained or supervised staff, where the benefits gained from F75 are overshadowed by the detrimental effects of other forms of faulty management. On the other hand giving F75 is exceptionally simple to implement and will do no harm. It is certainly much easier and less likely to mishap than many other procedures that are seen to be “essential” skills in many TFCs, such as diagnosing and treating malaria, putting up a drip, cross-matching and giving blood, or even maintaining a cold chain to give a vaccine.

For further information contact Michael Golden at mikegolden@eircom.net or Yvonne Grellety at ygrellety@wandoo.fr.

Authors wanted

The ENN will be producing a series of special supplements over the next two years. The first of these supplements is on ‘targeting of emergency food aid’ and has already been commissioned. It is hoped that the supplement will be available by July 2002. The ENN would like to invite readers of Field Exchange to consider submitting proposals for other Special Supplements. Authors will receive editorial support from ENN staff. A panel of experts will be established to provide technical support to the authors and to review the penultimate draft of the supplement. The ENN is currently inviting potential authors to submit proposals for special supplements.

Proposals should be no longer than 500 words and adhere as much as possible to the criteria below.

Aim

ENN supplements aim to review selected subjects comprehensively and point towards best practice for field workers.

Objectives

The objectives of the supplements should broadly be to:

- update thinking and knowledge on a particular subject
- recommend best practice (drawing distinctions between current practice/guidelines, if applicable)
- identify gaps in knowledge, areas for future research, and what needs to happen in order to improve practice further

Subject Matter

Special Supplements should be on subjects:

- related to operational aspects of emergency nutrition and food security interventions
- on which there have been recent experiences/research/developments which have not been comprehensively reviewed or incorporated into guidelines

Style

Supplements should have a more practical than theoretical focus and use case studies to underpin theoretical or conceptual points.

Suggested Structure of Special Supplement (chapters):

- Nature of problem, issue, or theme and why topical/important. This chapter would justify why the subject warranted a ‘special supplement’, provide a context for the subject and establish basic principles and definitions.
- Current thinking or practice as represented in guidelines and reviews (if applicable)
- Recent case-studies and experiences and lessons learnt/recent research findings
- Drawing out principles, concepts and revised methodologies based on previous chapter
- Recommendations for best practice (possibly using different scenarios),
- The future, e.g. gaps in knowledge, needs for research, institutional implications, etc.

Controlling Humanitarian Aid Cowboys in Afghanistan

A senior health advisor for the Swedish committee for Afghanistan has published a letter in the Lancet complaining about the number of agencies now ‘scrapping’ for involvement in Afghanistan. North Afghanistan is apparently awash with NGOs, a mixture of established NGOs who have been there for years scaling up their operations, ones that have worked there previously and complete newcomers. The surrounding countries contain more agencies waiting to move in.

The NGOs are apparently fighting for a slice of free land to work on to avoid duplication of aid. Therefore information is shared cautiously, so others do not move in first. Once established, NGOs have to ignore other actors nearby. Every organisation has to find a justification for being there to which a competent and professional neighbour is a threat. NGOs therefore play up their own importance and downplay that of competitors to qualify for private fund raising from home.

The result of such ‘land grabbing’ is that, despite attempts by other international bodies to co-ordinate aid, these attempts generally fail to direct the aid to where needs are highest. Controls need to be addressed and the author suggests the following:

- i) International health bodies need to be controlled by another international body that specialises in co-ordination and information sharing.
- ii) Timely information and agendas need to be given to NGOs in advance of attending meetings.
- iii) Binding procedures need to be formulated for new NGOs arriving to work in complex emergencies. Disregard for these procedures needs to be sanctioned, e.g. exclusion of funding through all major international donors.
- iv) International controlling bodies must be empowered to exact common practice for NGOs working in their areas, such as agreement on salary scales for local staff.
- v) Priority for funding should be given to established quality NGOs in country to enable them to scale up their operations, instead of diversifying to stakeholders who still need to establish themselves.

Fritsche. G (2001): Controlling humanitarian aid cowboys in Afghanistan. The Lancet, vol 358, December 8th 2001

To TFC or to CBTF

Summary of published letter*

The last issue of Field Exchange carried a summary of a published article by Steve Collins on community based therapeutic feeding (CBTF). The Lancet subsequently published two letters in response to the original article and Collins' response to one of these letters. Below is a summary of these exchanges.

In one of the letters (Navarro-Colorado, et al) it was argued that therapeutic feeding has played a major role over the past 20 years in saving children's lives and that recognition of severe malnutrition as a medical emergency has contributed to a reduction in mortality from 20% to 5%. The authors however acknowledge that TFCs, especially in open situations, can have harmful effects on the food economy of patients' families, encourage population concentration and create dependence. They nevertheless caution that before designing the features of, and criteria for, CBTF in emergencies, we need broader debate, including more research and scientifically supervised experiences in the field. The identification of children who can qualify for at home treatment is the key issue. For example, the numbers of children too young for home treatment (cannot eat ready-to-use therapeutic foods) and who have complications or associated disease may be high and need to be treated in specialised centres. Also, a proper follow up system would be needed to supervise quality of recovery, educate mothers and help to relieve them from the burden imposed by treatment of the child. A final cautionary comment of the authors is that the 'Hearth' model (mother to mother education) proposed by Collins assumes that the main cause of malnutrition is lack of education and that this might not apply in an emergency situation.

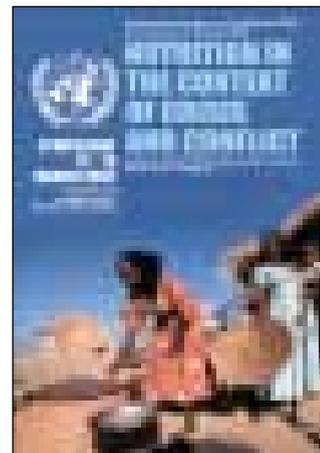
Collins' response to this letter was that there seemed to be agreement with many of the points raised in his article but that he fundamentally disagreed with the authors suggestions on 'how to introduce community based strategies, i.e. that these should evolve out of existing TFC programmes' Collins believes that the approach should be tailored to field circumstances and that one cannot know what the most appropriate intervention is in advance. Circumstances and constraints vary. For example, where TFCs are already functioning it may make sense to develop community based strategies from them. Where the emergency intervention is starting from scratch it might make more sense to develop community strategies and smaller in-patient stabilisation centres simultaneously. In some situations TFCs cannot be established so that community-based programmes will need to be 'attempted' on their own.

Collins insists that viewing CBTF as a 'bolt-on' addition to existing therapeutic feeding centres is unlikely to stimulate the profound changes in staff recruitment, training and institutional guidelines that are needed.

A final letter (Van Dame, W and Boelaert, M) in the same issue of the Lancet is more supportive of Collins' advocacy for CBTF. Like Collins, the authors are also concerned about the low coverage and effects of classic TFCs. They cite analysis of the results of a refugee assistance programme in Forest Region of Guinea where coverage of TFCs was only 3.4%. One of the main reasons for the low coverage was that mothers judged the cost of living for several weeks in a TFC with their malnourished child as too high. Furthermore, despite the limited coverage running the TFC was very labour intensive and consumed a large proportion of programme resources. The authors therefore welcomed Collins' proposal stating that care at home might help strengthen family ties, rather than further weaken them.

*Correspondence section in the Lancet (2002), vol 359, January 19th, pp 259-261

SCN Symposium: 'Nutrition in the context of crisis and conflict'



The ACC/Sub Committee on Nutrition (The UN System's Forum for Nutrition) 29th Session hosted a one day symposium on 'Nutrition in the Context of Crisis and Conflict' in Berlin, on the 12th of March 2002. The symposium was attended by representatives from a wide array of agencies including NGOs, the UN, governments, and research institutions (see page 26 for pictures of some of the participants).

Highlights of the symposium were a presentation made by Austin Davis (Director General of MSF Holland) who talked passionately about the undermining of humanitarian food aid by political agendas. Anna Taylor (SC UK) and Frances Mason (AAH) presented a paper on achievements in the emergency food and nutrition sector over the past 20 years. This was followed by a paper written by Helen Young, Yacob Aklilu and George Were on the role of livelihood support measures in reducing vulnerability and risk in complex emergencies. The paper was informed by three case studies (Kenya, Ethiopia, and southern Sudan).

In the afternoon there were presentations by Urban Jonsson (Working Group on Nutrition, Ethics and Human Rights) on 'The Right to Nutrition in Conflict Situations' and by Catherine Bertini (WFP) on 'Reaching Women: the Key to Better Nutrition in Humanitarian Crises'

This was followed by brief presentations by:

Susanne Jaspars on 'humanitarian principles and capacity building in emergency food distribution'

Manuel da Silva on 'Doing the right thing when minimum standards cannot be met'

Wolfgang Heinrich on 'Collaborative learning from experience- the local capacities for peace project'

Alain Mourey on 'how transferable are humanitarian funds from live-saving initiatives to programmes that support livelihoods'.

These presenters then participated in a panel discussion with questions from the floor.

The symposium ended with a presentation by Soha Moussa (Tufts University) on 'school feeding in crisis and conflict'.

As always the SCN symposium and session proved informative and interesting but also provided an excellent forum for networking and exchange. The various working groups shared work completed through the year and set the agenda for the coming year.

The next issue of Field Exchange will contain a number of summaries of key presentations and papers.

Mental health in Afghanistan

Summary of published letter

Following the events of September 11th all international aid workers of both local and INGO's were evacuated from Afghanistan. As a result, the task of bringing food aid into Afghanistan fell to Afghan aid workers. During the course of this work Afghan workers faced many dangers and attacks, resulting in enormous emotional stress. In a recent letter to the Lancet there were reports of Afghan workers talking about trauma and the difficulty of doing their work due to flashbacks, intrusive thoughts, non-directed anger, depression and fear of the future. Many of the men had been beaten, imprisoned or tortured and found it difficult to keep anger and other emotions out of their family life. Female staff had also been harassed and beaten. Debriefing, as a process of helping aid or disaster relief workers cope with the emotional stress of their work, is standard procedure in the western world. However, an informal survey of NGOs working with refugees in Pakistan and in Afghanistan showed that only a few agencies were addressing staff mental health needs.

The author of the letter works for an NGO called 'Cooperation for Humanitarian assistance' (CHA) which has initiated a mental

health programme for its staff working in Afghanistan. The programme initially started with a workshop in March 2001. Follow up was provided by an American Counsellor who assisted staff and trained a mental health team. The counselling method taught, called 'focusing' is closely linked to Sufi tradition and can be easily linked to Islamic models. It was chosen because it allows deep work on psychological issues to be done without breaching ethical dilemmas of trust and disclosure. Since the programme was initiated staff in CHA have reported that levels of tension and anger at work have decreased. 'Focusing' has also helped staff cope and feel hopeful for the future despite the worry and uncertainty of their situation. The programme has proved particularly relevant given the Afghan experiences in the aftermath of September 11th.

The author of the letter stresses that aid agencies must address the mental health needs of their staff in situations like Afghanistan where mental health problems may develop.

Omidian.P (2001) Aid Workers in Afghanistan: Health Consequences. The Lancet, vol 358, November 3rd, pp 1545.

Food aid for sex scandal in West Africa

A disturbing report compiled by leading aid agencies alleges aid workers from more than 40 agencies in west Africa have been involved in extensive sexual exploitation of refugee children, offering food rations in return for favours. Children specifically interviewed by the UNHCR and Save the Children UK in refugee camps in Liberia, Guinea and Sierra Leone accuse not just aid workers of sexual abuse, but claim they have also been exploited by UN peacekeepers and community leaders. In testimonies taken mainly from girls under 18, more than 40 agencies were named. Many of the girls said they believed they had to provide sexual favours in order to get rations; they did not know it was actually their right to receive food aid. Many also spoke of negotiating sex for shelter, education and medicine. The problem is deemed worst in places where there are well established aid programmes and is particularly pronounced in refugee camps in Guinea and Liberia.

UNHCR and Save the Children UK said they had made details from the report available because of the disturbing nature of the allegations, the apparent scope of the problem and the need for immediate and coordinated remedial measures by a wide range of agencies.

The report states: "Most of the alleged exploiters were male national staff who traded humanitarian commodities and services for sex with girls under 18". But the two agencies said the assessment team could not verify the allegations. Measures will now be introduced by Save the Children UK and UNHCR to combat child abuse in the region. Security will be increased and more female staff will be employed in the camps.

Adapted from an article published in the Guardian newspaper, Gillan A. and Moszynski P. 27th February 2002. "Aid Workers in food for child sex scandal"

Seminar in Oslo: Present and future nutritional relief and rehabilitation in Afghanistan

Norway took over as chair for the Afghanistan Support Group (ASG) of donors from January 1, 2002. As a preparation for this task, a one-day seminar addressing the current situation and future of human relief and rehabilitation for and with the Afghan population was held in Oslo on December 19, 2001. The seminar was organised by the International Project on the Right to Food in Development at the University of Oslo, the Norwegian Red Cross and the Royal Ministry of Foreign Affairs, with support of the HQ Defense Command Norway/Medical Branch, Disaster Preparedness Office.

This seminar, which was opened by State Secretary for the Norwegian Minister of Foreign Affairs, Mr. Vidar Helgesen focused on the nutritional aspects of food aid and supplementary feeding in the ongoing relief operations in Afghanistan. On the agenda were several practical issues related to nutrition, humanitarian aid and reconstruction in Afghanistan. Discussions focused not only on Afghanistan, but also on challenges for nutrition relief applicable in any emergency/post-emergency situation. Some of the ideas and recommendations emerging from this seminar (which will be conveyed to the new ASG chair) were:

- governmental administration and civil society organisations need to strengthen their insight on the nutritional aspects of emergency relief and its relation to reconstruction and development;
- the Afghan people must play the decisive role in the rebuilding and development of their country;
- ensure that lessons learned regarding options to promote nutritional health of the Afghan civil population, will benefit emergency situations elsewhere - present and future.

Other important issues were the establishment of democratic institutions and the consolidation and protection of human rights and, in particular, the rights of women in Afghanistan.

Ending famine in the 21st century

A conference called "Ending Famine in the 21st Century" was held at IDS from 27th February to 1st March and was attended by famine experts, academics and policy-makers from Europe, North America, Africa and Asia. The conference was part of a broader project whose overall purpose is to synthesise theoretical debates and empirical experiences into a new famine prevention policy agenda for the 21st century. A number of short papers were presented covering theoretical issues as well as case studies of recent famines and averted famines. The papers can be found on the website <http://www.ids.ac.uk/ids/pvty/Famine/famupdate.html>. A follow-up workshop for regional practitioners will be held in Nairobi in late April or early May co-sponsored by CARE East Africa and FEWS NET. The main outputs of the famine project will be an edited book and an accessible handbook for the use of donors and NGO practitioners.

New manual on fortified blended foods



The World Food Programme (WFP) has recently produced a 55 page booklet entitled 'Fortified Blended Foods: Facts and Practical Uses.' Fortified blended foods provide essential micronutrients as well as protein and energy to many populations served by WFP. The booklet includes information and recipes with the goal of improving the utilisation and acceptability of fortified blended foods, facilitating the introduction of fortified blended foods among new beneficiaries, and providing beneficiaries with possibilities for increasing variation in their diets. The booklet was prepared in response to the marked increase in the use of fortified blended foods in countries throughout the world as a way of sharing experience among WFP staff, counterparts, and beneficiaries. The booklet is available in English, French, and Spanish. Requests for copies may be addressed to: diana.populin@wfp.org.

Sphere Health and Nutrition Training Modules

The Sphere Project is developing and expanding still further. Health and Nutrition modules have been developed to give in depth technical training for humanitarian staff specialising in these fields. The training module aims to equip health and nutrition personnel with knowledge and skills necessary to implement Sphere minimum standards in health and nutrition.

The process has developed through interagency collaboration. A number of agencies¹, raised the necessary funding for the development of the training module. Peter Salama, Muireann Brennan (CDC), Annalies Borrell (Tufts), Fiona Watson (Nutrition Works) and Annie Lloyd drafted the modules. The modules will be available on the Sphere website (www.sphereproject.org) when completed.

They will contain an executive summary, background documents, facilitators guide, visual aids, session plan and evaluation strategies.

An introduction to Sphere can be carried out on the first day. The nutrition and health modules are both two days long and can be given separately. The modules were successfully piloted in Dublin among the agencies involved in their development. The training is also being piloted in Nairobi in March. One of the most important aspects of the training is that it also equips trainees to become trainers.

For more information contact Anna Taylor (SCUK): a.taylor@scfuk.org.uk

¹ SCUK, OXFAM, CAFOD, CONCERN, GOAL, Trocaire, AAH, Tearfund

Institutional development in Ethiopia: supporting an improved emergency response

By Jean Gladwin

Planned institutional development can be fraught with difficulties and diverted by internal and external political agendas. Therefore, it was with excitement and trepidation that I accepted the challenge of contributing to the development of the Emergency Nutrition Coordination Unit (ENCU) within the Disaster Prevention and Preparedness Commission (DPPC). This government department, as its name implies, coordinates the prevention, preparedness and response to emergencies in Ethiopia.

Throughout the last century the people of Ethiopia have experienced many food crises as wars, natural disasters, political instability and poor infrastructure have taken their toll. Most recently, in 2000 a drought crisis affected over 10 million people, resulting in widespread deterioration in nutritional status, primarily amongst women and children (DPPC 2000).

The Early Warning Department (EWD) at the DPPC had, for several years, sought to improve the government and its partners' response to nutritional emergencies in Ethiopia. A Nutrition Unit had existed within the EWD, but had limited resources and a different mandate. With this in mind, a detailed funding proposal (DPPC 2000) was developed with WFP and UNICEF support and, through the January 2000 government appeal, the DPPC successfully won donor support to establish the ENCU at federal and regional level. This unit had a broader mandate and consequently greater resources than the original nutrition unit. In November of that year I was recruited to begin the set up of the ENCU.

The DPPC envisaged that the creation of the unit would initially go through three phases, each being roughly one year in length. In the first year the ENCU would be established at federal level and in regional offices whose needs were considered greatest. In the second phase regional units would be developed with extra support being given to the most severely affected zones. Further strengthening of the federal level ENCU and existing regional units would also take place. The third Phase would include further regional and zonal expansion and strengthening of existing units.

The need to develop objectives

The new unit was a highly ambitious plan and as a newcomer I considered it an important challenge to develop detailed objectives and activities for the ENCU.

The DPPC is supported by many partners. These include other government departments (e.g. Health, Agriculture, Water) at both regional and federal level. The main UN agencies involved are WFP, UNICEF, UNHCR, OCHA and UNEUE. In addition many local and international non-government organisations provide services, technical advice, funds and other resources. Finally, donors from many countries fund relief efforts in Ethiopia, and in some cases provide technical assistance.

At the time of my arrival there was a degree of distrust and misunderstanding amongst some of these stakeholders, which appeared to be affecting the on-going relief effort. Some improvements in these relationships therefore needed to be realised if the ENCU was to become an efficient unit. In addition major funders felt they had not fully discussed and agreed the objectives and activities of the ENCU and that greater transparency regarding objectives and activities was needed.



Dr Jean Gladwin is an independent consultant and researcher. She was seconded from the World Food Programme as a technical adviser to the Ethiopian government department responsible for co-ordinating emergency response, prevention and preparedness.

There was also a complex funding arrangement and even though funds and resources had been informally pledged, in addition to those from the DPPC itself, none had been officially committed for various reasons. This left the DPPC unable to plan ahead even in the short term. Major donor stakeholders wanted to influence the objectives and priorities of the ENCU, and although they were not fully satisfied with the objectives given in the funding document they had informally agreed to give funding and leave the discussion of those objectives and priorities until the ENCU was established.

Finally, the lack of technical input when drafting the original project proposal had limited the vision of the unit and not taken the organisational context sufficiently into consideration.

Developing the objectives in consultation with stakeholders

With these issues in mind I began to develop the objectives and detail the associated activities. At this stage there was no attempt to prioritise the activities given their complexity and the need to first develop a greater understanding of the situation.

Various documents were reviewed including those from government, UN, donors and non-government organisations. These included policy documents, funding proposals, field reports and assessments. Consultation with individuals proved most time consuming with discussions held on a one-to-one basis, both in small and large groups.

As the discussions progressed it became possible to develop the ideas and the detail with groups of people who had many different perspectives. This eventually resulted in a version of the objectives and activities, which was acceptable to the government and the major stakeholders.

Drawing upon personal experiences of working at district and regional level during the recent food crisis in Somali Region in Ethiopia, in feeding centres and previous experience in other countries, greatly facilitated this task.

The objectives of the ENCU

The over-arching objective of the ENCU was to 'Facilitate the use of good quality nutrition and nutrition-related information to enable the rational use of food aid and other resources in emergency-affected areas'. This was translated into several sub-objectives including:

- Initiate the ENCU within the DPPC with an emphasis on sustainability and flexibility;
- Establish and build the ENCU at regional and zonal levels in stages;
- Build the technical capacity of staff at federal, regional and zonal levels to collect, review and use nutrition and nutrition-related information in their evidenced-based practice;

- Contribute to the improvement of nutrition surveys/surveillance, in drought affected areas of the country;
- Contribute to the improvement of nutrition interventions in drought affected areas of the country;
- Assist in the identification of geographic areas and vulnerable groups in need of nutrition and nutrition-related interventions;
- Contribute to the co-ordination of nutrition and nutrition-related responses of various organisations in drought affected areas;
- Provide nutrition and nutrition-related information to needs assessment for general food assistance and other resources;
- Strengthen and add technical justification for emergency food aid targeting;
- Facilitate targeting and monitoring of appropriate supplementary food assistance to selected groups;
- Assess the effectiveness of relief operations in meeting the nutritional needs of the affected population;
- Develop management and strategic planning capability within the DPPC Early Warning Department.

There were many activities associated with these sub-objectives. These included:

- focusing on assessing the organisational set-up, available capacity and constraints to the establishment of the unit at national level
- analysing the organisational structure to discover if there are impediments to the use of nutrition and nutrition-related information to inform decisions concerning allocation of food and other resources
- facilitating organisational change in order to utilise nutrition and nutrition-related information to inform management decisions
- developing a nutrition information management system at national and sub-national levels that focuses on collection, analysis, and dissemination of nutrition and food data and other information. This, in turn, will have a direct influence on decentralised management decisions concerning the targeting and monitoring of supplementary food assistance
- developing links with other national/sub-national information systems and an ENCU management information system to assist in the targeting of food assistance including general food rations

Lessons learnt

Need to understand the decision-making structures

An original aim of the ENCU was to 'trigger nutritional interventions'. However, I felt that this was an unrealistic aim as at best the unit would only be able to provide information to other people to help them take such actions.

Input from all stakeholders

Given the wide range of stakeholders interested in the activities of the ENCU it was important to consider views of all interested parties.

Adaptability of methods and tools

I had expected to be able to use the Soft Systems Methodology, as originally developed by Checkland (1981) to develop an in-depth understanding when problems are not well defined. However, as the level of transparency and willingness to reach consensus

through discussion was not what I had envisaged I used a different approach. Instead of bringing most stakeholders together I often discussed their needs in separate situations.

Time frame

Although it took several weeks to develop the new objectives and associated activities this was a relatively short time for this process. There are a number of reasons for this shorter time-frame. First, since the DPPC was the main instigator of the ENCU, i.e. it was not a donor-imposed unit, there was an immediate willingness to progress. The technical advisor had a background in information management and organisational change and resources were pledged from the outset. Finally there was a commitment from UN organisations, local and international NGOs and stakeholders to participate in the discussion process.

Importance of highlighting essential policy and frameworks

There are several basic policy approaches and theoretical frameworks that have to be considered in this type of process. For example, the EWD and its funding partners did not appear to recommend a broad based approach to malnutrition. I therefore placed emphasis on an integrated approach that took into consideration many factors (food security situation, quality and quantity of water, sanitation, health services, care and feeding practices, knowledge, attitude and practice of preventative health issues) when developing the unit. This approach was, in turn, reflected in the objectives and activities of the unit. In addition, it was important to decide whether nutrition status was perceived as an early or late indicator of food crisis, as this would affect interpretation of data and recommendations for support.

Need to consider an informational approach to management

As I had expertise in information management, this allowed ENCU to facilitate nutrition and nutrition-related information gathering and to consequently become a management tool for the DPPC, DPPB and other managers taking management decisions regarding resources. This informational approach to management may become a new approach, that is distinct from centralised or 'convenience' decision-making. Moving to this management style is not an easy transition to make and recent research (Gladwin 1999) indicates that organisations often have to undertake specific changes in order to do this. The ENCU objectives and activities needed to reflect this, since it was important to identify and support the necessary changes, e.g. identification of impediments to decision-making and development of additional management and other skills.

Danger of inappropriate indicators driving data collection and processing

There was much discussion on how the ENCU data and information could be used by non-service providers. For example, there was a demand from international donors to use the data to evaluate their own contributions to the emergency. Some donors wanted to be able to use outcome indicators, that is levels of malnutrition and mortality, to suggest that their contribution (food aid) had had a positive benefit to those in need. However, such indicators are unlikely to be useful for that purpose due to the multi-causal nature of malnutrition. Therefore it would be more useful to use process indicators, for example, those which show where food went to and if these communities had been identified as in need in an earlier assessment. External pressures should not dictate the data collection and processing that routinely occurs within the government system.

Conclusion

This case study and the lessons learnt point to the following recommendations when developing or changing a department which aims to provide information support to decision-makers:

- understand the organisational structure and where the decision-makers are, as the objectives need to be appropriate to the level of decision-making;



Ploughing irrigated field in Kalu Worreda

- focus on the need for organisational analysis and change;
- have someone with an information management background who understands the need for organisational change as well as a nutritionist to develop a unit such as the ENCU as this will save time;
- assess the organisational ability to use information as this could be inhibited by a lack of training, management expertise and inappropriate management procedures and tools;
- identify who the stakeholders are at an early stage and realise that there will be more than one stakeholder in each organisation;
- be aware of a variety of methods to achieve your goal and be willing to adapt;
- ensure the most powerful stakeholders are 'on board' in order to make progress;
- take into consideration fundamental policy approaches and frameworks at a very early stage;
- take a long term view;
- educate donors in the complexity of factors affecting malnutrition and resist pressure to use levels of malnutrition and mortality as the indicators of programme success when it is not warranted.

Although the stakeholders have accepted the objectives and associated activities of the ENCU in Ethiopia, it does not necessarily mean these will be adhered to. It will be important to assess needs at different organisational levels and not use a top-down approach when developing sub-national units and support. A participatory approach is most likely to work, even though this will take longer.

Finally, the ENCU produces a regular Progress Report on its activities, and will soon have other information outputs including updates of nutrition assessments on various parts of the country. Anyone interested in receiving these should contact the ENCU Information Manager Amir Siraj by email at Amir.Siraj@wfp.org

For more information contact Jean Gladwin at: jgladwin_99@yahoo.com

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Dashti Qala town, Afghanistan

Under the burqua



By Ariane Curdy

“FINISHED FILES ARE THE RESULT OF YEARS OF SCIENTIFIC STUDY COMBINED WITH THE EXPERIENCE OF YEARS”.

Read this sentence again, and quickly count the number of F's in it. How many did you count?

Perception is selective. At any one time there are too many stimuli in the environment for us to observe. Therefore, we screen out most of what we see and allow only selected information, which is often culturally determined, into our conscious mind. In the sentence above, most non-native English speakers see all six F's - whereas many native English speakers only see three F's: they do not see the F's in the word 'of' because 'of' is not an important word in understanding the sentence's meaning. We selectively see those words that are important according to our cultural conditioning (in this case, our linguistic conditioning).¹

Afghanistan is sometimes referred to as the 'crossroad of Central Asia'. In terms of culture it is one of the richest countries I have ever encountered. There are eight 'official' ethnic groups living in Afghanistan speaking more than 30 different idioms. There are also extremes of geographic diversity including lowlands, deserts with sand dunes and majestic mountains.

However, after the liberation of Kabul in early December 2001, it felt like the collective perception of the western media, and consequently the western world, was selectively focused on the burqas that the women of Kabul were wearing. Needless to say the focus was tinged with culturally influenced negative connotations. How many unveiled women would we see walking "liberated and free" in the streets today? For some of the English-speaking women I have worked with in Afghanistan over the past decade, the burqa was indeed, perceived 'as a prison'. But for many others I have talked to, it was experienced as a source of freedom: "Inside, you feel free. A burqa stops others from seeing you, not you from watching them. You don't have impertinent eyes coming in when you want to be left alone..." These were statements I could relate to. I recall a short summer vacation I had spent all by myself in a capital city of Southern Europe: I would probably have enjoyed my stay and the sightseeing much more, if I had found a way of not being watched in the way that I was. I also remember a scene in Kabul City in 1988 (long before Taliban rule): I was sitting with a colleague in a car, waiting for pedestrians to cross the road in front of us. One woman, under her blue burqa kept on turning and looking at the car in a playful way. I watched her for a while, and finally asked my

colleague how he felt about it. He laughed, smiled, and admitted to feeling somehow flattered - although a little bit unsure of whom could possibly be under the burqa. "Under the burqa, you can watch - but you are not seen".

I don't mean to promote the burqa! I merely wish to underline the different perceptions one can have on the place and use of this item of clothing depending on one's cultural and social background. Burqas have been worn by Afghan women for ages. As an Afghan friend of mine, who has lived in Afghanistan until recently, told me: "Complete veiling reflects a tradition of our very conservative society. I hope that the western world would advocate a free choice for Afghan women to wear it, or not, depending on how they personally feel about it".

It seems to me that very often, we have our own 'mental burqa' on - looking at a new environment or culture through the 'grid' of our own cultural values and assumptions. We can therefore easily miss realities and are prone to misinterpreting.

In a way one can consider that the burqa fits into a wider cultural tendency to protect and care for women in Afghanistan. I have many experiences of Afghanistan's legendary hospitality. As a guest, I would be welcomed, honoured and protected. More than once did I find myself with a group of Afghans surrounding me tightly, or even covering me, in order to protect me - be it from shootings, or from a tent pole falling on me during a meeting. Hospitality often goes hand in hand with 'divine' food, in Afghanistan. I remember the delight of a beautiful winter's day, sitting in a small house in a Pashun village, and eating local cheese, tandoor-warm nan and dried fruits. I also remember a majestic meal, with the traditional sheep-head as a special delicacy at the house of a Tajik rugs seller who was probably earning far more than any expatriate in town. But then there was also this Hazara widow, almost living in hiding, who insisted on sharing her only piece of bread (which happened to be hard as a rock) with me. With the exception of the period of Russian occupation I was never rejected or refused access to any household, and the hours I spent sipping tea in this country (black tea with sugar in rich households, green tea without sugar in poor households) are among my richest Afghan memories.

So - if you want to explore Afghanistan's culture fully you may just need to take off your own burqa, and look beyond those of others.

¹ Nancy J. Adler, International Dimension of Organisational Behaviour, Third Edition, South Western College Publishing, 1997



Checking ration cards before food a distribution

A fragile situation in Sudan

review of the 2001 nutritional situation

By Mutinta Nseluke-Hambayi



Mutinta Nseluke-Hambayi is a nutritionist who has been working as a Nutrition Emergency Officer for the past 3 years, supporting all WFP emergency and protracted related nutrition interventions in Sudan. Prior to 1999, she worked with the FAO Food Health and nutrition information system in Zambia. This article is a reflection of the complexity of nutrition programmes in humanitarian work.

The views expressed in this article are the authors' and do not represent those of the organisation.

WFP interventions in Sudan are guided by nutritional surveillance data provided by UNICEF and NGOs specialising in the health and nutrition sector. Based on such data a trend analysis showed a sharp rise in overall malnutrition rates in the second half of 2001. Prevalence figures rose from 10-15% for most locations in 1999, to 15-30% country-wide especially in the drought affected areas (figure 1). In conflict-prone non-drought affected areas, malnutrition levels have fluctuated depending on the level of food aid receipts, the degree of security and seasonal effects (figure 2).

It appears that the nutritional gains achieved between 1999 to mid 2000 have been reversed by the interplay of heightened conflicts and raging drought that affected some parts of Sudan. This has resulted in widespread food insecurity, diseases and exhausted coping mechanisms. Deterioration has been especially pronounced in areas where insecurity has interrupted planned food aid deliveries. Some insecure areas such as those along the railway line of the Aweils, in Upper Nile, Eastern Equatorial, and Unity/Leech state now experience malnutrition rates between 25-30%, throughout the year.

In the Red Sea State where the drought has affected the entire state, there has been an annual deterioration since 1998. Inadequate provision of basic services such as health, water and poor sanitation throughout the Red Sea State remain an underlying complex of factors that prevent nutritional improvement.

These recent trends in nutrition also reflect national level factors which have had an impact on economic well-being including:

- the effects of the Structural Adjustment Programme
- reduced access to and provision of health services due to introduction of cost sharing schemes

Return to baseline levels of malnutrition will call for both higher levels of food aid distribution and relative stability to allow households to re-engage in livelihoods.

Typical situations are presented as scenarios 1-4.

Scenario 1

Unity State (an example of areas where continuous conflict and displacement hinders effective food aid programmes, e.g. Upper Nile, Jonglei)

Unity state

Unity State, an area prone to high levels of insecurity, has consistently shown very high rates of malnutrition (ACF 2001) since 1999. This situation has persisted throughout 2001. Overall global and severe malnutrition was reported for Bentiu at 30.7% and 4.1%; Rubkona 26.0% and 5.8%; Pariang 28.7% and 3.7%; Komagon 16.7% and 1.2%; and Tor 17.3% and 2.0% (ACF Feb 2001). Under five Mortality Rates ranged from 1.7/10000 to 4.1/10000 per day in Bentiu and Rubkona respectively. Children under three years comprise the majority of those severely malnourished. Limited information is available in non Government of Sudan (GoS) held areas of Unity (known as Western Upper Nile) although there are indications that the situation is serious and similar to Bentiu.

The major cause of malnutrition in the state is recurrent hostilities resulting in marked population movements, limited health service provision, disease epidemics, low vaccination coverage (52%), poor

Figure 1: Malnutrition prevalence trends. Drought Regions. 1998 - 2001

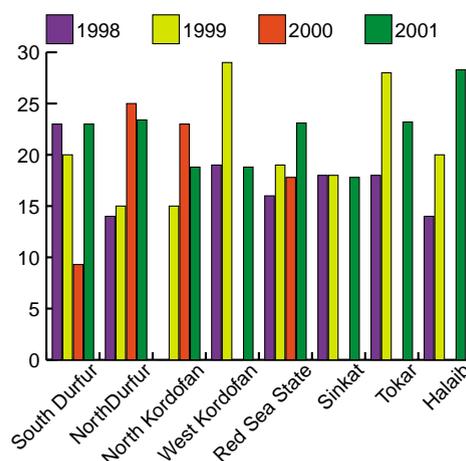
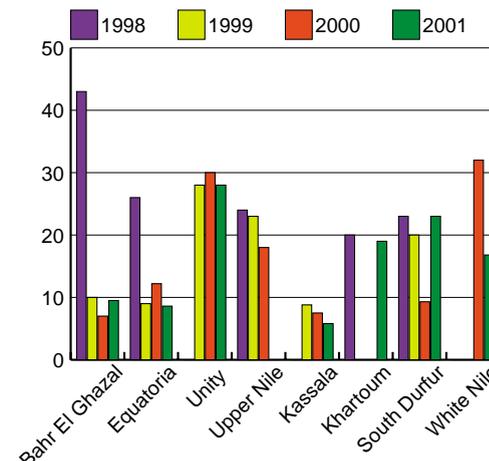
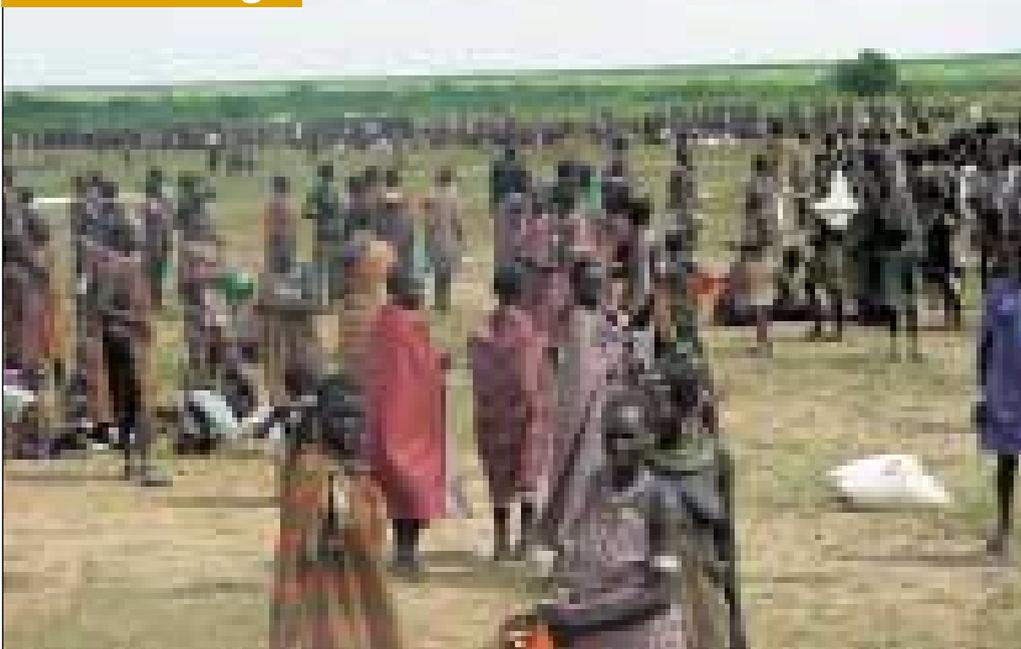


Figure 2: Malnutrition prevalence trends. Conflict prone. 1998 - 2001



¹ BMI - weight (kg)/squared height (meters). WHO Cut off points: (<9%) Low BMI - warning, (10-19%) poor, (>20%) critical situation



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Kapoeta, Food distribution in the war zone area. 98% women, men rarely seen.

health and sanitary facilities, and limited access for humanitarian agencies. WFP supports one of the largest targeted and general ration programs in Unity state through NGOs implementing partners. However, insecurity in the area is an ongoing obstacle to the effectiveness of the food assistance. For example, WFP supports 54,000 beneficiaries in Bentiu. However, during 2001, food distributions were severely disrupted from June to August, coinciding with the hunger gap. Overall, food distributions were only possible for eight months of the year and therefore only achieved 66% of planned coverage for vulnerable households.

Scenario 2

Wau IDP camps (an example of areas where food aid programmes have been effective in controlling levels of malnutrition e.g. Kassala, Juba, Wau, S. Darfur IDP camps)

Wau IDP camps

WFP, working with implementing partners, succeeded in reducing malnutrition rates sharply, in the IDPs camps in Wau. Prevalence levels fell to under 15% during 1999 and to less than 10% in 2001 (ACF Jan 2001). In Wau town global and severe malnutrition rates went as low as 8.2% and 0.7% respectively; while Bariah camp registered a low of 7.0% global. This is an all time low since the height of the famine in 1998, when global malnutrition rates of over 45% were recorded in some of the worst affected areas of northern Bahr el Ghazal. In contrast, non GoS areas of Northern Bahr El Ghazal such as the Aweils continue to show unprecedented high levels of malnutrition. The highest levels of global and severe malnutrition are reported in Twic country 29%, and 4.5%; Aweil East 19.8% and 9.6%; Gogrial 17.5% and 2.3%.

In Wau IDP camps food aid remains a major controlling factor of levels of malnutrition such that levels rise dramatically even if food aid distributions are missed for one month only. Malnutrition levels are therefore highly sensitive to the degree of insecurity and accessibility of the camps to outside humanitarian agencies. In 2001 WFP distributed over 92% of estimated food requirements for 22,000 beneficiaries in Wau.

Scenario 3

Red Sea State (an example of a chronically drought affected area, e.g. Kordofan, Darfur)

Malnutrition in the drought prone Red Sea has remained above 15% since 1998 and has been increasing annually. The highest rates of malnutrition for 2001 were reported in Halieb (28.3%), Tokar (23%) Sinkat and Rural Port Sudan at 17.8% each. This year severe malnutrition was above 5% for all provinces. The highest rates of severe malnutrition are in Halieb (8.3%), Sinkat (6.2%) Rural Port Sudan

(6%) and Tokar (5.3%). Under nutrition amongst adults, measured by Body Mass Index of less than 16 (BMI <16)¹ and a sign of chronic energy deficiency, was investigated and revealed to be high. Overall, in Red Sea State, a quarter (25.6%) of women are underweight of whom nearly one in every ten (9.7%) is severely malnourished. In Sinkat alone nearly half of women (45.6%) are underweight, followed by Halieb 37.8%, Tokar 21.6% and 16% in Rural Port Sudan (MOH /OXFAM Nutrition Survey April/Sept 2001). Currently all provinces, with the exception of Red Sea Province, are in a critical situation and one which has persisted for the past 3 years. Among the provinces, Halieb has the worst indications for both adult and child malnutrition. A recent assessment (July 2001), observed women to be very thin, anaemic and lethargic. Micro-nutrient deficiencies were also evident. For instance angular stomatitis was observed while biotot spots was common in children. There is no doubt that the nutritional situation for the population of the Red Sea State is deteriorating, especially for Halieb and Tokar states. The multiple causes include reduced dietary intake, high disease prevalence and eroded livelihoods.

A series of state-wide joint assessment missions in February and July and the annual needs assessment of November 2001 have been key determinants of a WFP response. The assessments highlighted increasing vulnerability with depletion of assets and exhaustion of survival strategies. Terminal migration of entire families to urban centres was dramatic evidence of the desperation of large numbers of people.

In response to the nutritional and food security assessment data, WFP supported 238,038 beneficiaries with full rations (through implementing partners), providing a total of 15, 500 MT of food aid from August through to December 2001.

Scenario 4

Transitional Zones (for example, Khartoum, White Nile, Malakal and S. Darfur camps)

White Nile

Transitional zones encompass camps with long term internally displaced persons (IDPs) residing in one place for 5-10 years. IDPs in transitional zones subsist mainly from the urban economy because the camps are usually located in and around urban centres. Typically, sanitation and housing is very poor leading to diarrhoeal diseases, especially during the rainy season. In all camps with recent data, malnutrition rates range between 15-19% and fluctuate seasonally. The main cause of malnutrition is repeated disease episodes.

WFP assistance for these zones focuses on collaborative initiatives with the Ministry of Health, town planning and UNICEF to improve health and sanitation, e.g. pit latrine construction and training of women in health, nutrition and hygiene. Vulnerable group feeding is also undertaken during the rainy seasons to mitigate the impact of disease. Food for work and food for training is the major modality of WFP assistance.

The Outlook

This review of recent nutritional data and trends reaffirms that causes of malnutrition are ever changing in Sudan and that one intervention policy is not a prototype solution for everywhere. The data also show where interventions are succeeding and where more needs to be done.

In the short-term the nutritional outlook remains alarmingly fragile for many areas with possible further deterioration in places like Unity State. The data show that timely food aid interventions can play a key role in improving and maintaining nutritional status. However, the data also show that this can only address part of the problem as insecurity continues to undermine livelihood systems and prevents access by humanitarian agencies while poor health, water and sanitation services contribute to an unacceptable disease burden. At the same time economic and social service policies at government level do little to improve the situation.

For further information contact Mutinta.Hambayi@wfp.org



Equatorial, WFP assisted school in war zone area, food pallets use

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Children's Aid Direct

By Jeremy Shoham

Name	Children's Aid Direct
Address	Crown House, 6-8 Crown Street, Reading RG31 2SE, UK
Telephone	0044 118 958 4000
Fax	0044 118 958 1230
Web site	www.childrensaiddirect.org.uk
Year formed	1990
Executive director	Nick Thompson
HQ Staff	49
Expats overseas	31
National staff	455
Annual budget	£6.9m



Clockwise from top left: Distributing CSB, Tajikistan supplementary feeding programme. Burundi women's group, cultivating group farm; women become engaged in the group through their children being registered in the supplementary feeding programme. Nutrition training for women with children in the supplementary feeding programme. Mixing CSB, Tajikistan supplementary feeding programme.

I recently interviewed Tim Bainbridge (Technical Support Advisor / Programme Support Manager) and Dr Ephrem Emru (Health Advisor) from Children's Aid Direct for the Field Exchange agency profile slot. Tim has worked in Children's Aid Direct for over four years while Ephrem is a relatively 'new boy' with only three months experience in the organisation. Both their jobs involve supporting the development of proposals and providing technical support for project staff.

Children's Aid Direct mission statement is to provide immediate and lasting support to children and their carers affected by conflict, poverty and disasters.

Children's Aid Direct was started by a group of highly motivated individuals who established a UK organisation Feed the Children affiliated to the US organisation of the same name. The agency's first humanitarian response was in Romania and Bulgaria where it delivered food, medical supplies and clothes to hundreds of children suffering from years of neglect and abuse in institutions. In its first year of operation it delivered over £1m worth of aid.

As the agency grew so did the scope of work the agency undertook and in 1996 the decision was taken to become fully independent and change its name to Children's Aid Direct. The focus of its work continued to be children and their communities, with a particular emphasis on addressing their longer-term needs as well as immediate needs from the outset of an intervention.

Children's Aid Direct presently works in Former Yugoslavian Republic (FYR) of Kosovo, FYR Macedonia, Albania, Liberia, Sierra Leone, Burundi, DPRK (North Korea), Tajikistan, Afghanistan and Azerbaijan.

Although Children's Aid Direct tends to get involved in countries on the back of emergency events it adopts as much of a development approach as possible, e.g. work through government ministries and community institutions. "The agency will stay in a country for as long as it can make a positive impact, which may mean long after the acute emergency is over" Tim explained. In some situations, like in Tajikistan, Children's Aid Direct is not drawn in through an emergency event, but

through its experience of working in similar situations. In other situations Children's Aid Direct may be invited into a country. This happened in the DPRK when the government actually approached Children's Aid Direct to help with child focussed programmes.

In the event of an emergency Children's Aid Direct will aim to send out a multi-sectoral team (emergency managers, health and food security specialist) to make an assessment. They will however only recommend that the agency get involved when it is apparent that a programme will "add value to the situation" Tim emphasised. For example: "Children's Aid Direct had a watching brief for Afghanistan for 2-3 years and stayed out because it was felt that under the prevailing political system it would not be possible to have a significant impact on the lives of children and their carers." Furthermore, becoming engaged in Afghanistan at the time would divert limited resources away from other programmes. However as a result of the recent changes in the political landscape of Afghanistan and the associated improvements in access Children's Aid Direct has now started a programme in the North East of the country.

The agency's main project work in the emergency nutrition sector is supplementary feeding. Children's Aid Direct does not currently implement therapeutic feeding programmes. Ephrem explained how Children's Aid Direct supplementary feeding programmes work closely with therapeutic feeding programmes implemented by other agencies, e.g. acutely malnourished children from the supplementary feeding programme are referred to therapeutic feeding centres and once discharged are referred back to the supplementary feeding programme.

Ephrem talked about some of the difficulties that Children's Aid Direct face in implementing supplementary feeding programmes. All too common problems faced by field staff are: the provision of an effective general ration is delayed, the food basket is inadequate or there are difficulties in the general ration distribution networks. This means that the Children's Aid Direct SFP ends up operating in a context of inadequate food security. The result is that children discharged from the SFP need to be re-

admitted within a short period of time. This happened in Tajikistan where the local authorities were responsible for identifying eligible households for the general ration but the system did not target families of malnourished children. Children's Aid Direct is currently trying to get round this by lobbying WFP to use the Children's Aid Direct SFP targeting criteria so that all in receipt of a SFP ration also get a WFP general ration. Inadequate general rations were also a problem in Burundi where WFP had pipeline difficulties which were beyond their control.

Another problem faced during SFP implementation is that as Children's Aid Direct do not currently implement therapeutic feeding programmes they have to refer mothers with severely malnourished children elsewhere. The issue here is that many mothers do not comply with the referral, usually because they cannot afford the time to sit in a 24 hour Therapeutic Feeding centre when they have so many other responsibilities at home. In Tajikistan where this was a problem programme staff offered nutritional advice to mothers so that at least they could provide some appropriate care for severely malnourished children. This recurrent issue is making Children's Aid Direct seriously consider developing capacity to implement community based therapeutic feeding (CBTF). Children's Aid Direct is currently consulting other agencies to collaborate in building up this capacity. Ephrem anticipates that one of the potential difficulties of CBTF may be the expense of Ready to Use Therapeutic Food (RUTF) and that it may be more appropriate to find locally produced therapeutic foods that can be used. However, Ephrem's experience in Darfur of CBTF with another agency was that it works and that mortality rates were actually lower than in traditional TFCs.

Tim explained how Children's Aid Direct has also implemented a variety of food security programmes over the past ten years. These have included provision of seeds, tools and fertilisers (Liberia, S. Leone, Tajikistan), micro-credit schemes (Azerbaijan), livestock re-stocking (Burundi and Liberia) and advocacy for land distribution to displaced women in Burundi. The Burundi programme involved organising large groups of displaced women to lobby the local administration to give them land.

Though the programme successfully enabled women to gain greater access to land, it was not possible to clearly ascertain whether this came about because of the collective bargaining power of the women or because they had the backing of an International Non-Governmental Organisation.

The re-stocking programme in Burundi was also deemed to be successful although in a number of cases the cost of providing secure housing was greater than the cost of the animals themselves.

Tim explained that like other agencies it is often difficult to get suitably qualified and experienced nutrition and food security staff but that now Children's Aid Direct mainly recruit (successfully) through the internet, e.g. ReliefWeb and DevNetJobs.

Tim sees one of the main strengths of Children's Aid Direct as being an organisation that can accommodate debate and disagreement. There is a culture that people can hold different views and yet still reach consensus. It is implicitly understood that no-one is right all the time and that experiences of staff from different country programmes can be invaluable. Tim also acknowledged that the relative youth of the agency could be a disadvantage. As Children's Aid Direct lacks the profile of the longer established agencies it may well make it harder to get funding for proposals. However, at the same time 'youth' can be an advantage in that the institution has not become 'set in its ways', with vested interests backing particular project portfolios. There is still enormous flexibility and adaptability. Children's Aid Direct is also keen to learn and has a full evaluation programme involving internal staff and external consultants. Looking at the wide array of projects that Children's Aid Direct has been involved in during its existence there can be little doubt that it is an agency unafraid to try new things and learn lessons through experience.



Exchange of seed vouchers for seed in Kiritiri, Mbeere district

CRS seed vouchers & fairs – an innovative approach to help farm communities recover from disaster

Summary of internal evaluation

CRS have recently been involved in two innovative seeds projects in northern Uganda and Kenya.

CRS/Uganda Karamojong incursion project

In early 2000, Karamojong pastoralists moved in search of pasture thereby displacing an estimated 100,000 persons in Lira and Kitgum districts in northern Uganda. In response, CRS/Uganda developed a plan to assist 12,000 families obtain seed to plant when they returned home.

Lack of access to seed, rather than a lack of local availability, was identified as a major constraint to planting. With this realisation CRS developed a novel voucher system to help families get hold of seed. Rather than purchase commercial seed and distribute it to farm families, vouchers were issued that could be redeemed for commercial seed from stockists or for traditional seed from local grain traders. This was the first time that CRS had implemented this type of voucher system.

An evaluation of the project concluded that the Karamojong Incursion Project was a success for the following reasons:

- 12,000 families accessed over 200 MTs of seed of 10 different crops and 30 different varieties
- Both farmers and traders were empowered to organise procurement, transport, marketing and purchase of seed
- Almost 50% of the participating grain traders were women
- Farmers were able to access seed varieties that are traditionally planted late.

One negative aspect of the programme was that instances of coercion of voucher holders by traders were reported, highlighting the need for close supervision of the process.

Combining seed vouchers and seed fairs in Eastern Kenya

In late 2000, with the start of the short rains approaching, CRS/Kenya approached FAO to

fund a project that combined seed fairs and a voucher system as a means of helping farm families obtain preferred crops and varieties.

CRS and its partners were able to organise a total of 14 seed fairs with 275 participating grain traders (more than 75% of whom were women). Over 8000 farm families accessed seeds of their choice through voucher exchange at the seed fairs. The entire project (family targeting, voucher distribution and fair organisation) was implemented within a three week period prior to the onset of the rains. In contrast, many relief agencies that ordered seed from commercial companies did not receive supplies in time for planting. In addition, the CRS project proved greater value for money. Farmers were able to access up to 14 kgs of seed in exchange for the \$8 vouchers, which would have purchased only 4 kg of commercial maize seed.

Both in Uganda and in Kenya, the innovative approaches to seed provision proved advantageous over more conventional seed programmes, in that they:

- Supported rather than undermined local seed systems
- Enabled farm families to access seed of preferred crops and varieties and of acceptable quality
- Were cost effective
- Were simple to implement, monitor and evaluate
- Could be planned and implemented in a short period of time
- Served the needs of large numbers of farm families experiencing difficulty accessing seed

For further information contact Annemarie Reilly - email address AREilly@crs-ert.or.ke

Advocacy from Eritrea: working with WFP

By Hassan Taifour



Hassan Taifour is the Emergency Response Nutritionist for SC(UK). He graduated from the Faculty of Agriculture, University of Khartoum in 1985 and completed his nutrition Masters in LSHTM in 1991. Hassan worked for NGOs, UNICEF and the Sudanese Ministry of Health. He has worked in emergency situations in Sudan, Ethiopia and Eritrea. This article arises from experiences with Save the Children UK in Eritrea.

Save the Children UK have worked in Eritrea since 1957 and in 1992 a country office was established. Between 1992-98 SC UK were involved in a wide variety of activities focusing on primary health-care supply and support, emergency drug supply, immunisation and malaria control.

When war broke out on May 12, 2000 all routine SC UK programmes were suspended so that resources could be focused on the more acute nutritional needs of displaced women and children. The majority of IDP camps which emerged in Gash Barka and Debub regions in Eritrea were formed after the outbreak of fighting in May 2000, although a few had already sprung up between 1998-1999.

In response to the emergency, nine feeding centres were established by SC UK in six of the Gash Barka IDP camps.

Camp	Approx Population	No of Feeding Centres
Af'abet	23,000	3
Ade Keshi	36,000	2
Korokon	12,000	1
Koytobia	9,000	1
Tole Gamja	5,000	1
Sheilab (<i>Expellees from Ethiopia</i>)	8,000	1

By June 2001 the number of malnourished children had fallen to less than 30 children per feeding centre. As a result the camp feeding programmes were closed and the focus switched to nutritional surveillance of the returning population. Three anthropometric nutrition surveys were carried out between July and December 2001. In addition morbidity, nutrition surveillance (weight and height of children under 110 cm were measured on a monthly basis by the ministry of health clinic staff) and daily energy intake data¹ were collected for the same period as part of the ongoing SC UK nutritional surveillance system.

Although monthly growth monitoring data were available, these were considered unreliable because the coverage was too low to provide a representative picture for the under five population. Before the outbreak of conflict in May 2000, growth monitoring data were collected (weight for height) in conjunction with distribution of a supplementary ration in the IDP

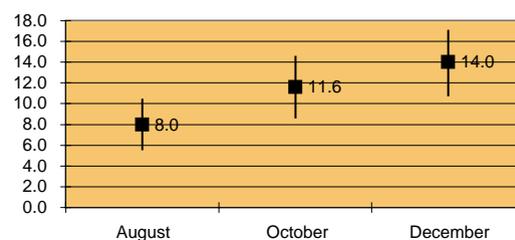
camps. After May the distribution ceased and attendance for monthly nutrition surveillance fell to less than 20%.

Major finding of nutritional surveys and nutritional surveillance

The nutrition surveys of the returning population revealed a marked deterioration in the nutritional status of children under five years. The prevalence of global acute malnutrition significantly increased from 8% in August to 14% in December. The increase appeared to be associated with inadequate caloric intake and high morbidity rates (fever (26%) and ARI (26%)).

Date	Global Malnutrition rate	Confidence Interval
August 2001	8.0%	5.5% - 10.5%
October 2001	11.6%	8.6% - 14.6%
December 2001	14.0%	10.7% - 17.1%

Global acute malnutrition returnee population 2001



Daily energy intake and morbidity data based on monthly nutritional surveillance

Community areas included in SC UK surveillance were divided into a series of sub-zones. SC UK nutrition surveillance teams visited at least three villages in each sub-zone on a monthly basis. Five families were interviewed to obtain energy consumption data for the previous two weeks. The calorific value of all food consumed (including the WFP ration) was then calculated resulting in an estimate of average caloric intake for each family. From the average of the five families a village average value was generated. Results were then extrapolated to the whole sub-zone.



Child being weighed during a nutrition survey. Gash barka region Eritrea Dec.2001

¹ While it is best practice to calculate energy intake based on a 24 hour recall, we found through field work that it was easier to find out the quantities of food that were purchased / consumed by a household over a two week period. We recognise that this will not be accurate intake data for individuals but would argue that it provides an indication of sources and access to food over the period in question.



"SC UK nutrition surveillance teams visited at least three villages in each subzone monthly"

	July	Aug.	Sept.	Oct.	Nov.
Shambuko					
Prevalence of fever	0.9%	3.5%	3.1%	14.0%	6.7%
Prevalence of ARI	3.2%	4.0%	4.7%	12.1%	7.5%
Malnutrition from Nutrition Surveillance (N.S.) Sites	8.5%	1.9%	5.3%	3.4%	0.8%
Calorie intake (Kcal/person/day)	2049	1991	1884	1451	1900
Lalai Gash					
Prevalence of fever	7.5%	14.9%	9.0%	3.2%	3.9%
Prevalence of ARI	7.7%	12.6%	5.5%	8.7%	7.0%
Malnutrition from N.S. sites	5.7%	4.3%	3.5%	6.5%	4.8%
Calorie intake (Kcal/person/day)	2004	1914	1837	1555	1654
Gonge					
Prevalence of fever	2.0%	3.1%	3.7%	8.7%	3.6%
Prevalence of ARI	3.9%	3.7%	2.8%	13.4%	5.0%
Malnutrition from N.S. sites	2.2%	1.9%	4.4%	5.2%	1.1%
Calorie intake (Kcal/person/day)	1799	1778	1698	1654	1801
The IDP camps (Ade Keshi, Korokon and Sheilab)					
Prevalence of fever	2.2%	2.5%	2.2%	4.7%	4.4%
Prevalence of ARI	1.1%	1.1%	1.3%	4.0%	5.0%
Malnutrition from N.S. sites	3.2%	3.4%	5.2%	4.0%	4.0%
Calorie intake (Kcal/person/day)	1869	1955	1984	1661	2031
Calorie intake (Kcal/person/day)					
Shambuko	2049	1991	1884	1451	1900
Lalai Gash	2004	1914	1837	1555	1654
Gonge	1799	1778	1698	1654	1801
Monthly Average	1951	1894	1806	1553	1785

The tables on the left summarise monthly nutritional surveillance data collected in the IDP camps and sub-zones by SC UK.

In all three sub-zones, caloric intake steadily fell throughout the pre-harvest period between July and October. During this time, calorific consumption never reached the recommended minimum of 2100 calories/person/day. In October (the peak of the hunger period), energy consumption declined to the lowest level, with average intake ranging between 1451 - 1654 calories per person per day. In terms of morbidity, prevalence of fever and acute respiratory infections peaked in October as the night temperatures usually drop significantly during this time and there were also 'pockets' of malaria.

Advocacy

An inadequate general food ration and high morbidity rates for fevers and ARI were considered by SC UK to be the main contributing factors to this decline in nutritional status of the returning population.

Following the October survey findings, SC UK convened a co-ordination meeting which included all NGOs operating in the nutrition and food sector, UN agencies (WFP, UNICEF, OCHA) the Ministry of Health and the Eritrean Relief and Rehabilitation Commission. The main issue raised at the meeting was the perceived inadequacy of the WFP ration. The WFP general ration had been reduced from 100% to 60% in June 2001, in anticipation of a good harvest. However most crops 'dried out' and produced very little. Increased morbidity, rather than ration size, was initially suggested by WFP as the more likely reason for the observed decline in nutritional status. However, SC UK used the nutrition surveillance data to demonstrate the inadequate average daily energy intake and advocated for a return to a full general ration

of 2100 Kcal per person/day. After a number of meetings and consultations, WFP were satisfied with the evidence from the data and agreed to increase the general ration to 100% from December 2001.

Current situation

Currently, WFP is maintaining a 100% general ration while mobile clinics are covering almost all sub-zone villages without health stations. Access to health care has now increased from 78.6% in October to 99.8% in December. It is hoped that this level of programming will help prevent a further decline in nutritional status.

Based on more recent findings in the December nutrition survey, SC UK has made a number of additional recommendations in its most recent report. These include:

- WFP/ERREC should resume the distribution of dry supplementary rations of blended food to all children under five in the area.
- An NGO with sufficient capacity should implement a targeted supplementary feeding programme for all malnourished individuals (children and women).
- Nutritional surveys should continue to be implemented at three monthly intervals to monitor the nutritional status of the under-five population and to inform any nutrition interventions. As SC UK has closed their programme in Eritrea, this should become the responsibility of the MoH with assistance from UN and other voluntary agencies.
- Full general ration distributions (2100 Kcal/person /day) should continue at least until the harvest of the following year (November/ December 2002).
- Ensure that there is good access to health care for all villagers by providing mobile clinics for villages that do not have health facilities.

- A food security monitoring system should be established. Ideally, this should be a joint initiative involving donors, UN agencies, NGOs and governmental departments (e.g. Ministry of Health and Ministry of Agriculture).

Conclusion

This experience has demonstrated that the provision of timely, reliable, and accurate field data can be used to advocate for programme change. In this instance an effective and trusting working relationship was established with WFP. A key element of effective advocacy is the field presence of experienced and dedicated staff who can make, and support clear recommendations.

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Gash Barka region, Eritrea Dec 2001

Post Script

Below are comments on the above article from Salem Elhadji and Jennifer Bitonde, WFP Eritrea

The nutrition surveys conducted by SCF-UK and MOH (Ministry of Health) in 2001, have been useful in getting an overview of the nutrition status in the surveyed sub-regions in Gash Barka region.

Based on WFP experiences in the Eritrea we would like to make the following comments about the article.

Findings

In assessing the current situation, the SC-UK article emphasizes inadequate general rations and high levels of morbidity as the main contributory factors to the decline in nutritional status of the returning population but leaves out other factors such as access to water, which are mentioned in the main nutrition survey report of December 2001.

A recent rapid assessment of the main causes of malnutrition in Asmat and Hagaz sub-regions in Anseba conducted by MOH, ERREC (Eritrean Relief and Refugee Commission) and WFP identified the following contributory factors to high levels of malnutrition.

- Lack of diversified food and the fact that the majority of caretakers are not aware of the importance of diversifying the meals.
- Health and hygiene factors and access to clean and safe water: At the household level, water was not kept safely and none of the respondents boiled water for drinking. Sanitary facilities were lacking and the majority of children defecated in the compound and/or open field, which in most cases exposed them to infections and diarrhoea.
- Social and care environment: Prolonged exclusive breast-feeding without complimentary food and poor feeding practices had links to the nutrition status of the children. Most caretakers with malnourished children did not participate in the childcare education provided at the health facilities and as a result many were unaware of the best feeding practices for their children. The

assessment also found that food was not shared equally at the household level. The male head of household received the best food (in quality and quantity) at the expense of the children. The lack of basic literacy levels among caretakers was an impediment to accessing information.

A nutrition survey conducted by COSV in Mensura, Agordat and Logo Anseba sub-regions in Gash Barka in December 2001, showed a prevalence global malnutrition of 12.8%. The report identifies morbidity and water usage as factors that need to be addressed to improve the nutrition status of the target population. COSV survey report also recommends targeted supplementary feeding programme, improvement and provision of clean and safe water and promotion of intensive growth monitoring activities at the village level.

Recommendations

The SCF nutrition report confirmed that all 590 out of 591 household surveyed received WFP general rations. The nutritional survey data that are described in the SC-UK article do not justify the need for a blanket supplementary feeding programme. Blanket supplementary feeding is recommended when global malnutrition prevalence exceeds 15% or where the general food rations are grossly inadequate, i.e. less than 1500 kcal/person/day. It is more appropriate to recommend a targeted supplementary feeding programme for malnourished children under 5 years old linked with growth monitoring promotion.

The SC UK advocacy article omits mention of a number of other factors which contribute to malnutrition in Eritrea. For instance, the SC UK nutrition survey (December 2001) reports that global and severe malnutrition are higher amongst children of 2 and 3 years because this is the time when they are introduced to weaning food and are at greater risk of infections. The report further mentions that the percentage of malnourished children within female headed households was slightly higher possibly due to

the fact that the mothers do not have enough time to look after their children as they are involved in public work to support their families. Hence there is limited health and social care. The report recommends strengthening nutrition and health knowledge of mothers and caretakers through training the MOH staff, providing sufficient water and a full general ration.

Current situation

WFP provides a full general ration (2100 kcals) to the in-camp population because this group has no other source of food/income. The 'out of camp' population (host communities) receive a 60% ration because they have access to food through farming, and other source of income. WFP has been and is still providing food to 81% of the total 'out of camp' population in the three sub-regions surveyed by SC-UK. Based on recommendations from WFP field offices, agricultural crop production data from MOA and nutrition surveys undertaken by different NGOs in Gash Barka and Anseba, WFP provided full general ration to the drought affected vulnerable groups, returnees, and host communities in December 01 and January 02.

Field Exchange would like to point out that at the end of the draft article submitted initially by Hassan Talfour there were a number of additional recommendations, two of which related to the above comments in the post-script. A number of these recommendations were edited out (with the permission of the author) in order to keep the focus of the article on food security and advocacy. The two recommendations relevant to the above post-script were:

- Provide sufficient water: at least 15 litres/person/day, (Sphere minimum standard) and distribute water containers so that every household has enough water storage equipment.
- Strengthen nutrition and health knowledge by training the MoH staff as trainers on simple practices who in turn will then train the mothers and carers of their villages. (Eds.)



Participants at the SCN symposium in Berlin, March 2002.
Top row left to right: Cheryl Jackson (USAID), Shakuntala Thilsted, Ellen Harris, Ruzu Oniango; Charlotte Dufour (ACF) and Mary Corbett (Concern).
Middle row, left to right: Austin Davies (ACF); Sonya Rabeneck (SCN), Namaga Ngongi (Outgoing chair SCN); George Were and Helen Young.
Bottom row, left to right: Alain Mourey (ICRC), Caroline Tanner (AED), Mary Lung'aho (LINKAGES), Rebecca Norton (TDH), Felicity Savage; Anna Taylor and France Mason.

UK Nutritionists meet for a NutritionWorks Christmas get-together in London's Café Goya.

Top, left to right: The back of Frances Mason's head (Nutritionist, AAH), Hisham Khogali (Food and Nutrition Advisor, Oxfam), Sean Lowrie (Training Manager, Sphere); Steve Collins.

Bottom, left to right: the band - Johnny Miller's High Energy Mix - Johnny Miller on keyboard, Jeremy Shoham on sax, Rick Finlay on drums and Pete Townsend on bass; Carmel Dolan, Susanne Jaspars and Alex De Waal (Justice Africa).

All pictures taken by Michael Wadleigh.



Participants at the sixth Food and Nutrition Training Workshop of the World Food Programme held in Rome November last year. Participants from headquarters and six country offices attended, learning basic concepts of public health nutrition related to their work in emergencies and development.
From left to right: George Aelion (programme officer, WFP Kosovo), Julie Thoulouzan (information/report officer, OHA, HQ Rome) and Helen Young explaining a daily test to the participants.



Field Exchange

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The Emergency Nutrition Network (ENN)

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

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

The main output of the ENN is a quarterly newsletter, Field Exchange, which is devoted primarily to publishing field level articles and current research and evaluation findings relevant to the emergency food and nutrition sector.

The main target audience of the Newsletter are food and nutrition workers involved in emergencies and those researching this area. The reporting and exchange of field level experiences is central to ENN activities.

The Team

Fiona O'Reilly (Field Exchange production editor) and Jeremy Shoham (Field Exchange technical editor) are both ENN directors. Jeremy and Fiona established the ENN in the Department of Community Health in Trinity College, Dublin in 1996. Earlier this year the ENN incorporated as a not-for profit company limited by guarantee.



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



Marie McGrath is a qualified paediatric dietician/nutritionist. She has an abundance of experience in emergencies, working previously with Melin and carrying out research with SC UK. Marie is the new addition to the Field Exchange editorial team.

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