East Timor: Money for Work
Kenya Refugee Programme evaluation
Remittances in Somaliland
Nutritional Screening in Ethiopia:
Involving the community
Dear Readers

Two topical themes emerge in this edition of Field Exchange. The first is food security interventions which do not involve free hand-outs of food aid; the second is how to respond appropriately to situations which are connected with nutritional food security assessments. An article by Mike Parker about a cash for work programme in East Timor shows how a non-food aid response to a food security crisis can be extremely effective. There are few documented experiences or studies of cash interventions in emergencies although a number of donors seem to be getting more interested in this type of response. Consequently, Oxfam UK are undertaking research into cash interventions in emergencies based on a set of case studies. The study will examine issues like cost-effectiveness, the effect on gender relations, and cost effectiveness (see research section page 3).

Humanitarian agencies have grappled with some of the more intractable operational problems that arise in emergency food aid programmes for many years, e.g. targeting and interruptions in the food aid pipeline (see SC (UK) article on Wajir in this edition). More recently however a number of agencies have begun to consider whether in some circumstances cash based interventions might be more appropriate. Market interventions, whereby prices of key food commodities are moderated by propping up the market, are also relatively unexplored as an emergency response to food crisis. Conceivably, market support might be a more cost-effective method of targeting the most vulnerable than handing out free food aid. In general few NGOs have experience of, or guidelines on emergency food security strategies which do not involve free food donations, e.g. cash for work programmes, livestock off-take or market support programmes. There are even a lack of operationally useful guidelines for Food for Work Programmes in spite of the fact that there have been many experiences of implementing FFW during emergencies. Guidelines would have come in very useful in Kenya during 1999 when a number of multi-agency assessment teams recommended widespread food for work programmes in response to the drought affecting large parts of the country. The recommendations were made without any assessment of the institutional capacity to set up and manage FFW programmes or of the number of beneficiaries that could realistically be served. In the event only a handful of small-scale FFW initiatives could be implemented.

During the drought which affected central Tanzania at the end of the 1990s, an INGO in conjunction with government attempted to implement a market support programme. This intervention was recommended as a means of getting around problems of targeting food aid in a large widely dispersed rural community. The intervention failed as the tonnages of maize released onto the market did not have the desired impact in reducing prices. With hindsight the analysis leading to the recommendation for this intervention was probably flawed as it did not take into account parameters like size of market and overall effective demand. These, and other experiences point to the growing need for research leading to the development and dissemination of basic principles and guidelines for selecting and establishing these ‘lesser-tried’ types of emergency food security intervention.

Although not necessarily their main focus this edition of Field Exchange also carries a number of articles which highlight some of the difficulties and issues connected with the assessment phase of responding to food emergencies. An article by Kate Sadler of Concern shows how anthropometric surveys in Wolayita, southern Ethiopia effectively identified the need for general ration and selective feeding programmes as well as demonstrating the impact of these interventions so that decisions about phase out could be made. In contrast, Ken Baileys article about a food crisis in Amhara region of north west Ethiopia suggests that the resources devoted to anthropometric surveys to determine intervention impact might be better used elsewhere. He reasons that once an intervention had begun it would make more sense to set up a community based nutritional surveillance system. This would help tackle longer-term nutritional problems connected with feeding and health practices in the country rather than try to re-engineer the market. His suggestions for establishing this type of surveillance were supported by the INGO in question.

An article by Robin Wheeler from WFP Kenya describes how one of the driving forces for improving food security coordination in Kenya was the lack of standardisation in assessment approach adopted by agencies and, in some instances, poor adherence to standard survey protocols resulting in poor quality data.

The article by SC (UK) about a micronutrient deficiency disease outbreak in Wajir district of Kenya explains how there was confusion about case definitions for the multiple micro-nutrient deficiency diseases which were being documented experiences or studies of cash interventions in emergencies although a number of donors seem to be getting more interested in this type of response. Consequently, Oxfam UK are undertaking research into cash interventions in emergencies based on a set of case studies. The study will examine issues like cost-effectiveness, the effect on gender relations, and cost effectiveness (see research section page 3).

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Addressing the nutritional needs of older people in emergency situations: ideas for action

Summary of Review

Help Age International (HAI) has produced a preliminary review of the nutritional needs of older people in emergency situations. This is part of an ongoing commitment by HAI to develop assessment tools, methodologies and approaches in all aspects of nutrition interventions for older persons in emergencies. The review is based on the premise that older people are a sub-group of the population whose needs must be addressed more systematically in emergency contexts.

The document was prepared by Annalies Borrel, a consultant with Vald International (UK) after a thorough review of recent scientific literature and emergency nutrition guidelines, consultation with NGOs and use of practical case studies. The document addresses issues of nutritional requirements of older people and examines these in light of current emergency food and nutrition interventions. It also provides a preliminary framework for the design of emergency nutrition interventions for the purpose of piloting and review. It is hoped that the document will be further developed based on additional case-studies and further lessons learnt from programme experience. In view of the comprehensive nature of this review only some of the findings can be represented in this summary.

Key Findings

General Principles

While older people are commonly accepted as being a vulnerable or potentially vulnerable group in emergency situations, at present humanitarian interventions often ignore older people’s specific needs, using systems that discriminate against and on occasion, undermine their capacity to support themselves.

Context and individual-specific risk factors will determine the nutritional status of older people. In emergency situations, the changes that impact directly on older people’s nutritional vulnerability includes disruption or loss of social structures, family separations, stressful events, the need to adopt coping strategies and increased public health risks.

There are numerous challenges that need to be overcome before the needs of older people can be addressed more effectively. These include; a recognition that older people are a heterogeneous group of people whose capacities and needs vary greatly between individuals and between situations and the positive contributions that older people have within communities, including during emergency situations.

The United Nations principles for Older Persons (resolution 46/91), which was adopted by the General Assembly in 1991, addresses issues of independence, participation, care, self-fulfilment and dignity. While these principles provide a useful overall framework for action, the report defines more specific principles that can be applied to the design of nutrition interventions for older people in emergency situations.

Nutrient requirements

The report discusses the nutrient requirements for older people in relation to younger adults. While energy requirements for older people, in general decrease, the need for micronutrients does not. There are many factors causing an increase in requirements for micronutrients and in some cases, micronutrient deficiencies among older people. These include; a general decrease in energy intake, a reduction in intake of nutrient dense foods, a lower secretion of intrinsic factor, a high incidence of chronic disease and gastrointestinal bleeding. However, much of the research findings, largely based on studies on older people, in industrialised countries, remain equivocal.

In summary, it is recommended that older people consume:

Addressing the Nutritional Needs of Older People in Emergency Situations. This preliminary report was prepared by Annalies Borrel (with support from Vald International) for HelpAge Africa Regional Development Centre (ARDC).
The framework for programme design of selective feeding programmes for older people is based on six elements.

Community and nutritional assessment
- The nutritional vulnerability of older people will be determined largely by the absence or break-down of community social support structures; these social risk factors are best defined by the communities themselves through local community-led initiatives.
- The acceptability and effectiveness of the programme will be enhanced if the community’s older members, are involved in its design and have an understanding of its objectives.
- Where qualitative information shows that older people are likely to be more vulnerable than other population groups, an assessment of the nutritional status of older persons will be included as part of a broader assessment.

Out-reach activities
- Many of the most vulnerable older people who are often not visible and unable to present themselves, such as those who are too weak and/or have no family, will need to be accessed through community health workers.
- Older people require information on their entitlements and it cannot be assumed that they have access to general information systems.

Nutritional rehabilitation: selective feeding
- Based on anthropometric and clinical criteria, older people have access to therapeutic or supplementary feeding.
- Nutrition rehabilitation is based on well-established nutrition and medical protocols, similar to those for adults and children.
- Discharge is based on subjective criteria and the capacity of the family/community to continue to provide support.
- Those older people who are chronically ill and/or who are not responding to nutritional treatment are referred to a community-support programme.

Individual case-assessment
- During the period of rehabilitation, an identified ‘care’ or family member is involved in the rehabilitation process.
- Specific nutritional-support tasks that are required to prevent a deterioration in nutritional status in the household following discharge, are identified.

Community-support programme
- Community-based worker provides support to the ‘carer’ and/or family to ensure support tasks are being carried out and older people have access to basic daily needs in the community.
- The nutritional status of older people is monitored.
- Support to the carer or family is provided in terms of training, emotional support, feedback and motivation.
- The capacity of older people to re-integrate into the community is monitored.

Longer-term case
- Once social support structures have been rebuilt, food security has improved or an appropriate ‘safety-net’ is in place, older people must have information on, and access to longer-term support structures.

Foods that are nutrient-dense in vitamins and minerals.
- Vegetables and fruits that are deeply coloured, for provision of folate and antioxidant nutrients.
- Dairy products e.g. milk, for the provision of adequate amounts of calcium and vitamin D.
- Adequate amounts of nutrient-rich foods such as; fish, dried beans, eggs and nuts. Variety in these foods is important but selection will be based on factors such as: availability, cost, chewability, individual preference and ease of preparation.
- Foods that are high in dietary fibre, such as fruit and vegetables.
- Relatively higher volumes of fluid, since thirst sensation is decreased in older people.

Emergency general ration
In theory, the recommended per capita general ration does meet the nutritional requirements of older people in terms of energy, fat and protein. Energy requirements for older people generally decrease in comparison with younger adults. However, the minimum per capita energy requirement of (2,100kcal), when provided in the form of food-aid commodities such as maize, beans and oil, is inadequate in terms of meeting the micronutrient needs of older people.

There are also physical, social, and programme design factors which increase the risk of older people suffering from inadequate food intakes in emergency situations. These include:
- An inadequate assessment of needs at the outset: the involvement of older people in decision-making processes concerning food aid needs and programme design is frequently lacking.
- Poor physical access to the ration: distances to food collection points in centralised distribution systems are often too great, there are inappropriate queueing systems and the elderly may be left out of the information loop about the general ration distribution.

Constraints in food processing and preparation:
- Whole grains cereals and beans are difficult to prepare needing longer cooking time and involving the collection of water and fuel.

Limited opportunities for accessing food through complementary coping strategies: rarely does the general ration alone fulfil the nutritional needs of emergency-affected populations. Additional food is usually accessed through mechanisms such as informal trade and labour, fishing, labour activities in exchange for food, etc. Older people often do not experience the same opportunities for these complementary activities as those of younger adults.

A number of recommendations for actions to address these inadequacies are outlined in the report. These include:
- Involve older people as key-informants during assessments and collect information on the nutritional status of older people.
- Provide no less than 30g of blended food per person per day as part of the general ration.
- If quantities of blended food are limited, children under five years old and older people should be prioritised over other population groups.
- Ensure physical access to the general ration by establishing mechanisms to inform older people of their entitlements to food rations as well as the intended distribution schedule.
- Decentralise distribution sites and prioritise older people at distribution points.
- Older people must have sufficient support or means to access sufficient fuel and water for cooking.

Selective Feeding Programmes
Malnourished older people should be given equal access to nutritional rehabilitation centres as those of other demographic groups. In many cases however, older people will not necessarily respond to nutritional treatment, especially those who are suffering from underlying chronic illness. In this context, the design of nutritional rehabilitation and support programmes should enable older people who are at nutritional risk to be given the opportunity to remain within their communities with the support of community-based assistance. This strategy will aim to strengthen existing support structures, allow older people some dignity and independence as well as create opportunities for older people to re-establish themselves in their traditional roles within communities. In this context, the Community-based Support Programme (CSP) within the overall framework of selective feeding programmes for older people is most important and should be a priority. This programme focuses on identifying specific risk factors on an individual basis and strengthening family and community support mechanisms.

Elements of overall programme framework
There is no need to create separate selective feeding programmes for older people but rather, expand and...
During 2000 community based targeting of emergency food aid was introduced into Kenya. WFP were instrumental in promoting and implementing the community-based system (CBTD). (see article “Development of Kenya Food Security Coordination System (KFSCS) by Robin Wheeler for a full description of CBTD systems). Previous systems of emergency food aid targeting in Kenya were acknowledged by most to be grossly inefficient as more or less everyone received a food aid ration. As a result ration receipts were extremely small (as little as 1 kg per person per month of maize) and therefore of limited use to genuinely food insecure families. During September 2000 WFP undertook an assessment of the CBTD at three sites in Marsabit district. There were 70 distribution centres in the district with 80% of the population targeted for food aid. A large component of the WFP assessment was geared towards determining the extent to which WFP policy commitments regarding women were being fulfilled as part of this programme. The findings of the assessment provide useful insights into gender related aspects of this increasingly employed mode of targeting emergency food aid. The project document for the WFP emergency programme in the region - EMOP 6203.01 commits itself to addressing gender related inequalities by: • Ensuring that all community-level relief committees have at least 50 percent women and where possible a female chairperson • Including a gender awareness component in the training on CBTD • Building awareness in gender sensitive facilitation skills • Registering and distributing food directly to women • Recruiting both female and male food monitors. The WFP assessment was carried out using PRA techniques including key informant interviews and focus group discussions. The following questions were asked in the assessment: • How many men and women are on the relief committee • What is the role of the relief committee • What roles do the men and women play - are they different or the same • Who calls meetings • Who sets the agenda • What is the group’s perception of the CBTD system • What is their perception of the role of women in the CBTD system - what are the particular problems that women face in taking an active, participatory role Key findings of the gender related aspects of the assessment were as follows: 1. At the beginning of the EMOP men were resistant to women taking a leadership role on the Relief Committee although they accepted the participation of women because it was policy. 2. As the EMOP has proceeded they have gradually seen that women’s participation has brought a sense of transparency and accountability to the distribution process. 3. The women stated that they were nervous at the beginning but they are now more confident and appreciate the support that they have got from the men on the Relief Committee. 4. Women identified illiteracy and patriarchal culture as challenges to their level of participation. 5. They stated that most of the chairpersons and secretaries are male. 6. The men complained about the time the women members of the RC spend on distribution when they also have domestic work to undertake. The women did not see this as a problem and said that they usually arrange for other members of the household to support them. 7. The men complained about the lack of remuneration for relief committees. The women said that they were used to voluntary work. 8. Overall, relief committees members interviewed stated that their status in the village had improved and they were confident that the targeting process is fair and the most vulnerable are being reached. Recommendations given by the community included: 1. More leadership and gender training for the Relief Committees. 2. The lead NGO should keep monitoring the number of women on the Relief Committees. 3. More advocacy for the community and other development agencies on the role of Relief Committees especially concerning the participation of women.

Assessment of community based targeting from a gender perspective

Summary of Report*

* Gender Assessment of Selected Relief Committees in Marsabit District-A field mission report by Hendrica Okondo and Kate Newton. WFP Kenya - September 2000.

* Amongst these policies are commitments to: i) Target relief food distributions to households, ensuring that women control the family entitlement in 80 percent of WFP funded and sub-contracted operations, ii) Take measures to ensure women’s equal access to and full participation in power structures and decision making.

* Kenya EMOP 6203.01: Assistance to Drought-Affected People in Rift Valley, North Eastern and Coast Provinces of Kenya.
Remittances and their economic impact in post-war Somaliland

Published paper

An enduring difficulty of assessing needs amongst certain emergency affected populations has been uncertainty about whether the affected population are sent income from relations abroad or living in other parts of the country (remittances), and if so, how much. It is extremely difficult to quantify or monitor remittances as sources, and channels are diverse with cash flows often taking place in the ‘black’ economy.

A recent study in Somaliland has thrown some light on this subject. The study examined the role of remittances provided by a large global diaspora of migrant workers and refugees in post-war Somaliland. Field work was conducted in 1998/9 and examined trends in the size, source, and means of remittance transfer as well as the use of remittances, their role in livelihoods and in the country’s economic recovery. Sample households were randomly selected from a list of recipients obtained from telephone and money transfer companies. A semi-structured questionnaire was used. Data was also obtained through detailed interviews with leading money transfer agencies on the amount of money that goes through these channels and details of individual transfers.

Estimating remittances in Somaliland is problematic for a number of reasons. First, remittances are transferred in a number of forms and through different channels. They can be cash in kind, e.g. cars, furniture, jewellery, clothing or electronic goods and they can also be channelled through trusted merchants or hand carried by migrants when they visit home. Secondly, there is no data available on the global numbers of migrants and refugees from Somaliland. Third, Hawaalado (money transfer companies) who are responsible for a significant part of transfers, sometimes deliberately under-report the size of the flows for fear of government interference in the form of taxes or new regulations.

Remittances originate mainly from migrant labour in the Gulf and more recently an exodus of refugees to the West. The growth of telecommunications in Somaliland and of remittance agencies has greatly facilitated the transfer of money. The study found that the value of remittances is estimated at some US$ 500 million annually - around four times the value of livestock exports. In fact the livestock export ban by Saudi Arabia in 1998 in response to the Rift Valley fever outbreak in Kenya and southern Somalia was predicted to lead to a collapse in international trade and market exchange. It was feared that the shortage of hard currency needed to finance imports would spell disaster for the country. The ban lasted 14 months and the number of animals exported from Somaliland fell sharply from 2.9 million in 1997 to just over 1 million in 1998. However, this failed to affect the volume of imports mainly because remittances financed the entire import bill.

The study found that the average annual remittance received by households was $4,170 and that there were approximately 120,000 recipient households throughout the country - roughly one third of the population. These estimates of remittances are consistent with other studies and transfers to countries such as Eritrea and Sudan with similar migrant populations. However, it is important to note that the distribution of annual transfers is highly skewed due to large sums of money received by a relatively small proportion of households.

It appears that remittances are heavily concentrated in urban centres. While the majority of households in Hargeisa rely on remittances for their livelihoods, less than 5 percent of rural households receive money transfers from abroad. It is particularly less important in pastoral households. For agro-pastoralists internal remittances from migrant workers in urban areas are more important than international ones. Because of recent changes in the demographic structure of migrants, an increasing proportion of those receiving this kind of income are women.

The effect of remittances on households has been considerable in providing secure livelihoods. The study found that in urban areas many people had a high standard of living due to remittances. However, there is evidence to show that remittances have increased income inequality. Migrant workers and refugees generally come from better-off families who could afford the relatively high investment costs involved in sending someone abroad. The going rate for an employment visa and ticket to the Gulf is about $3000 while a ticket and travel documents to Europe or North America cost roughly $5000. Therefore it is mainly those families who can afford to invest in migration that receive remittances.

One of the conclusions of the study was that these large capital flows have contributed to rapid economic recovery in post-war Somaliland and the development of a dynamic private sector.

I

n July last year the ACC/Sub-committee on nutrition published two reports on the assessment of nutritional status in emergencies. One report deals with adults and the other with adolescents.1

Adults
Report describes simple techniques suitable for the assessment of the nutritional status of adults aged 20-60 years in emergency-affected populations. The report makes preliminary recommendations stressing that there is no consensus on a definitive method to assess adult undernutrition and that more research is required.

Main findings

Surveys and population level assessments of chronic undernutrition

The BMI may be used to estimate the prevalence of chronic undernutrition in a population survey using the classification system below:

<table>
<thead>
<tr>
<th>Classification of chronic underweight categories (Kg/m²)</th>
<th>BMI</th>
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<tbody>
<tr>
<td>Normal</td>
<td>≥ 18.5</td>
</tr>
<tr>
<td>Grade 1</td>
<td>17.0-18.4</td>
</tr>
<tr>
<td>Grade 2</td>
<td>16.0-16.9</td>
</tr>
<tr>
<td>Grade 3</td>
<td>≤ 15.9</td>
</tr>
</tbody>
</table>

In order to account for changes in body shape the Cormic Index (sitting height/standing height) must be taken into account and standardised for, when comparing the BMI of different populations.

MUAC may also be used to assess the prevalence of chronic undernutrition at the population level.

Screening severely undernourished adults

BMI is inappropriate for this purpose as it is affected by oedema and body shape and difficult to measure in any particular situation. MUAC in combination with clinical signs should therefore be used to screen adult entrance into feeding centres using the following classifications.

For admission to therapeutic feeding centres

i) MUAC < 160 mm irrespective of clinical signs

ii) MUAC 161-185 mm plus one of the following:

- bilateral pitting oedema
- inability to stand
- apparent dehydration

iii) Famine oedema (i.e. oedema demonstrable up to the knee) alone as assessed by a clinician to exclude other causes.

Additional social factors can be included in the model. The relative weighting of these must be determined locally; for example whether you need one, two or three additional social factors to tip the balance in favour of therapeutic rather than supplementary care.

For admission to supplementary feeding centres

MUAC 161-185 mm and no relevant clinical signs or few relevant social criteria

These suggested standards should only be used as a starting point and adapted according to the situation specific context.

Adolescents

The current WHO recommendations to compare the BMI of individual adolescents with a reference population made up of adolescents in the US using the 5th centile of this reference as a cut off point to define undernutrition may not be appropriate. Surveys using these recommendations have found unrealistically high levels of adolescent undernutrition.

There are several difficulties with anthropometry in adolescents; for example:

- body proportions, including indices using weight and height measurements change with age, making it necessary to compare an individual to adolescents in a reference population who are of the same age. As a result, age must be collected on persons screened for admission to feeding programmes or measured as survey subjects. Adolescents in many emergency affected populations do not accurately know their ages
- body proportions change with sexual development. The age at which sexual development occurs differs in different populations and complicates the comparison of subjects from one population to adolescents in a reference population

Possible solutions

These problems affect all anthropometric indices. The following adjustments may allow better estimates:

- better methods of assessing the age of attainment of key pubertal landmarks may allow adjustment for difference in maturational age between survey and reference populations.
- Cormic Index may to some extent be used to adjust for ethnic differences in body proportions - however this technique has not been studied in adolescents.
- a new international reference consisting of adolescents from 6 countries and a new method of determining cut-off points may alleviate some of the biases from using a reference population for a single country.

Preliminary recommendations

i) Until better methods can be developed and validated, screening for severe undernutrition in order to determine the need for therapeutic feeding should use clinical criteria.

ii) In surveys, some correction for different ages of sexual maturation should be carried out if the age of sexual maturation differs substantially between the survey and reference population.

For pre-pubertal adolescents, weight for height could be used as the anthropometric index and compared to revised weight for height tables currently in use.

For post-pubertal adolescents, BMI could be used as the anthropometric index and compared to a new international reference population.

Appropriate cut-off points could be used to identify malnourished individuals.

iii) Regardless of which index is used, cut-off points are age-specific; as a result age should be collected as accurately as possible on all adolescents measured during screening or survey activities.

iv) The reference population of American adolescents, currently recommended by WHO for use with BMI should not be used.

v) Adolescents should not undergo nutritional assessment in isolation. A large discrepancy between the estimated level of undernutrition in adolescents and other population subgroups should stimulate investigation of the validity of the methods and results of the adolescent assessment.

vi) In order to assess the methods and comparability of surveys, all survey reports should describe in detail the anthropometric index used, how measurements were taken, which reference population was used, how individuals were compared to this reference, and the cut-off points used to define various degrees of undernutrition.

1 Adults: Assessment of nutritional status in emergency-affected populations; July 2000. Collins, S. and Myatt, M.
3 Reports available from ACC/Sub-Committee on Nutrition, 25, Avenue Appia, 1211 Geneva 27, Switzerland. Email: accscn@who.ch or online at http://acc.unsystem.org/scn/Publications/RNIS/
A s part of a “Food aid Policy and Strategy Project” Oxfam GB is undertaking research into the use of cash as an alternative to food aid. Whilst Oxfam GB has increasingly engaged in cash programming, e.g. in Asia and Africa, it has been difficult to judge the effectiveness and impact of these programmes. Other organisations have undertaken cash interventions, however, as with Oxfam GB, these have not been widely reviewed or disseminated.

As part of the research Oxfam GB is interested in collecting information from organisations on cash based interventions including cash for work programmes, free cash distributions and voucher distribution. Existing literature suggests certain key areas which the research will address.

Research Issues

Context
Contextual analysis will determine when and how it is appropriate to implement this type of programme. Three different disaster scenarios will be used to inform the research. These are slow onset natural disasters, such as drought, quick onset mass destruction such as cyclones or earthquakes and conflict. Using these scenarios an analysis of ‘appropriate contexts’ for implementing cash interventions will be developed.

Economic Impact

There are a number of ways in which cash interventions could have an economic effect.

- There may be an inflationary impact on prices as a result of improved purchasing power. However, the consequences of this inflationary effect are not known.
- Cash provision may act as a disincentive for economic activity. Economic activities that could be under threat include agricultural production and trade.
- Increases in prices can stimulate the trade of food from food surplus areas into food deficit areas. This has been one of the key strategies adopted by the government of India in famine prevention. More information is required to determine the extent to which this occurs and the benefits.

Gender

The use of cash as a relief measure could have a major impact on gender relations. Critics of the approach have suggested that women will have limited control over cash resources in contrast to food aid.

Cost-effectiveness

Cost effectiveness is also an important factor to consider when designing programmes. It has been estimated that as a result of using cash, rather than food, in an employment generation programme in Wolayita, Ethiopia, programme costs were approximately 50% of those which would have been expended had food been used instead. In 1999 a cash for work scheme in Wajir district of Kenya (see Field Exchange 10), was judged to be the most cost-effective recovery intervention compared to other measures taken in response to a severe drought followed by floods.

Although often an acceptable intervention amongst communities, organisations often find it difficult to secure funding from donor agencies. The acceptability of this approach among donors has varied. The research hopes to shed light on why some donors are more willing to fund cash interventions.

To aid this research Oxfam are collecting information on cash interventions. Field Exchange readers can help by sharing experiences of such programmes. If you have any information on any of the following please send it to the contact below.

Information sought on cash interventions includes:
1. Direct personal experience
2. Organisational perspectives and policies
3. Research carried out to date
4. Any form of documentation
5. Other contacts that might provide relevant information

Any information regarding cash interventions is welcome and should be sent to Hisham Khogali (e-mail hkhogali@oxfam.org.uk). Alternatively contact him at OXFAM, 274 Banbury Road, Oxford OX2 7DZ. Tel: +44 1865 312 776
Conflict: a cause and effect of hunger

Summary of draft review

The International Food Policy Research Institute (IFPRI) is currently working on a review of what is known about the linkages between hunger. Some of the key findings of the review are outlined in this summary.

At the end of 2000, violent conflict and its aftermath had left nearly 24 million people in 28 developing and transition countries and territories food insecure and in need of humanitarian assistance. In addition, some 35 million war-affected refugees and internally displaced persons showed high rates of malnutrition.

Armed conflict leads to the destruction of crops, livestock, land, and water, and disrupts infrastructure, markets, and the human resources required for food production, distribution, and safe consumption. Combatants frequently use hunger as a weapon: they use siege to cut off food supplies and productive capacities, starve opposing populations into submission, and hijack food aid intended for civilians.

The trigger condition for violent conflict may be natural, such as a prolonged drought or economical, such as the change in price of the principal food (rice in Indonesia) or cash crop (coffee in Rwanda).

Econometric studies provide additional empirical evidence of a link between food insecurity and violent conflict. These find a strong relationship between such indicators of deprivation as low per capita income, economic stagnation and decline, high income inequality, and slow growth in food production per capita on the one hand and violent civil strife on the other.

However, more research is needed to learn about the dynamics in which alleged environmental or food scarcities have not contributed to violence.

Preventing cycles of hunger and conflict

Sustainable agriculture and rural development, with an emphasis on small farmers, should contribute to reduced risk of conflict in resource-poor areas and countries. Broad-based development offers an antidote to the hopelessness that often leads to violence and agricultural development assistance should be part of conflict-avoidance. Yet official development assistance dropped 21 percent over 1992-97, aid to Sub-Saharan Africa fell 13 percent from 70 poor countries could expand agricultural lands; by 88-200 percent in Afghanistan, 11 percent in Bosnia, 135 percent in Cambodia, and 4 percent in Mozambique.

As well as being a consequence of conflict, food insecurity can also lead to conflict. Most of the countries currently experiencing conflict are classified by FAO as “low-income food deficit” and have high proportions of food-insecure households.

Environmental scarcities and food insecurity do not inevitably lead to conflict, but may provide an additional impetus. The trigger condition for violent conflict may be natural, such as a prolonged drought or economical, such as the change in price of the principal food (rice in Indonesia) or cash crop (coffee in Rwanda).

Econometric studies provide additional empirical evidence of a link between food insecurity and violent conflict. These find a strong relationship between such indicators of deprivation as low per capita income, economic stagnation and decline, high income inequality, and slow growth in food production per capita on the one hand and violent civil strife on the other.

However, more research is needed to learn about the dynamics in which alleged environmental or food scarcities have not contributed to violence.

Preventing cycles of hunger and conflict

Sustainable agriculture and rural development, with an emphasis on small farmers, should contribute to reduced risk of conflict in resource-poor areas and countries. Broad-based development offers an antidote to the hopelessness that often leads to violence and agricultural development assistance should be part of conflict-avoidance. Yet official development assistance dropped 21 percent over 1992-97, aid to Sub-Saharan Africa fell 13 percent during 1994-97, and aid to agriculture plummeted almost 50 percent in real terms over 1986-97.

Even as the total aid pie has shrunk, emergency needs have claimed ever larger slices, due to the proliferation of crises. In 1996, emergency assistance came to 9.5 percent of all development aid, compared to 3.5 percent in 1987, and 41 percent of food aid tonnages were devoted to emergency relief, as opposed to 10 percent in the 1970s.

The way in which projects are administered can also be important. Inappropriately administered aid can exacerbate tensions, as in Rwanda, where would-be beneficiaries perceived unfairness in the distribution of agricultural-programs.

• Agricultural programs need to choose paths that foster cooperation among communities or rival groups and avoid negative competition leading to conflict.

• Programs need to be structured so that they create openings for active participation by women and men from zones of high conflict potential to participate in reporting, planning, and operations.

Conclusion

The linkages between conflict and food insecurity are more and more evident in the post-Cold War era and a topic of concern to peace and food-security advocates inside and outside of government and international agencies. Food security and development programs must include conflict prevention and mitigation components. Savings from conflict avoidance need to be calculated as “returns” to aid. Likewise, relief and post-conflict reconstruction programs need to have food security and agricultural and rural development components if they are to help break the cycle of hunger and conflict.

For further information contact: Marc J. Cohen at the International Food Policy Research Institute, 2033 K Street, N.W., Washington, DC 20006, USA or E-mail: m.j.cohen@cgiar.org

Alternatively visit their website at http://www.ifpri.org for the latest IFPRI news and to access hundreds of food policy research reports.
Involving communities in nutritional screening in Ethiopia

By Ken Bailey

Ken Bailey worked on a contractual basis for WHO Geneva from 1991 to 1997 and for a considerable part of that time had responsibility for the “nutrition in emergencies” sub-programme. Since leaving Geneva Ken has worked for Tearfund/UK in Southern Sudan, the United Mission to Nepal and another INGO in Ethiopia.

I began working as a volunteer nutritionist for an international non-governmental organisation (INGO) in July 2000. The INGO had been supporting rural development work in 3 districts (total population 518 000 in year 2000) of North-West Ethiopia (Amhara region) for 15 years. In 1999 there was near-total crop failure in both rainy seasons (belg and meher) and in the first half of 2000 the belg rains came too late for normal planting. This meant that there was almost no harvest for three successive seasons.

In response, the INGO provided a general ration (wheat, CSB and cooking oil) for approximately half the households from July to November 2000 inclusive. Targeted households were selected on the basis of wealth ranking and identified through repeated consultations between Farmers Association leaders, the district administration and the INGO.

• This response effectively averted famine.
• There was virtually no displacement of households or consumption of famine foods.

The organisation wanted to monitor the impact of the food relief on nutritional status through sample surveys repeated monthly. Because of lack of manpower it wasn’t possible to do this monthly so one survey was carried out in August (before the food distribution in late July could have had any significant impact) and a second in mid-October.

August survey findings

In the August survey two districts had a moderate rate of wasting in children <5 years (approximately 7% were below -2 z-scores WfH and WfL) while in the third district the rate of wasting was far higher at 16% (<-2z-scores). This implied that there were about 2500-3000 wasted children in each district.

Adult nutritional status was also measured. The mean BMI was low - near 20.0 kg/m² combined for men and women. But there was no correlation between nutritional status of children and adults in the same households. (This was interpreted to mean that other factors e.g. ‘young-child’ feeding practices and incidence of diarrhoeal disease played a more significant role than food availability in the prevalence of wasting in young children.)

Two months on...

In October the prevalence of wasting was more or less the same although the situation in one district improved while in another it deteriorated - apparently due to spread of dysentery. Apart from overall food shortage, poor feeding practices (identified in surveys on young-child feeding) appeared to have an important role in continued malnutrition amongst this population.

As the new harvest was expected in November, and the rainfall and agricultural conditions up to then were fairly good, an improvement in the situation was expected in subsequent months. However, my view was that i) the level of wasting was likely to remain above 5% - with aggravating factors (especially diarrhoeal disease) and ii) the appropriate response should include at least health and nutrition education, focusing on the prevention of diarrhoea and improved feeding practices for young children. With current practices most children begin solid feeding after 12 months and breast-feeding is very prolonged. Meals are given to children about 3 times daily.

The conventional approach at this point in an emergency project cycle would have been to continue with sample nutrition surveys e.g. at 3-monthly intervals. However, this would not have readily paved the way for action other than another round of relief distribution when/if the prevalence of malnutrition rose above a certain point.
Surveillance versus surveys

I recommended that it would be more useful to implement a total community based nutritional screening with a nutrition education programme targeted at households with wasted children rather than repeating cross-sectional nutrition surveys. This would involve training volunteers at the level of each hamlet (gott) which consists of about 50 households. At present community health agents (CHAs) are found only at the farmers’ association level (5,000-10,000 people).

A programme was subsequently prepared to train volunteers at gott level to:

i) Measure weight and length and record it on a specially designed WfL chart - one chart for each gott with measurements repeated every 3 months.

ii) Carry out education on prevention of diarrhoea and optimal feeding practices for young children in households where a wasted child was found.

Supplementary foods could also be provided for these children if found necessary.

Involving the community

Meetings were held with all leaders of farmers’ associations to explain how child malnutrition contributed to child mortality, and how to identify malnourished children and counsel the households. The leaders of the associations would therefore effectively manage the total community screening of young children on a continuing basis. They welcomed this approach and accepted the challenge.

The volunteers at gott level were to be trained by health staff of the INGO, the CHAs and community development agents who operate in each farmers’ association.

It seemed to me that it would be much more productive to involve the communities themselves in a survey process thereby achieving full community coverage, rather than to carry on with traditional sample nutritional surveys. In this way the long-term nutritional problems would be more comprehensively tackled from within each community.

I also came to believe that sample nutrition surveys of emergency-affected populations may often yield results that are in the range where educational action and perhaps targeted supplementary feeding are appropriate responses. It would be good under these circumstances to consider one further step - as a regular “development” of the initial relief effort. This could then be implemented as a follow-up response. It would be good under these circumstances to consider one further step - as a regular “development” of the initial relief effort. This could then be implemented as a follow-up response.

IDPAS will work to facilitate communication between field level and technical experts through their website, e-mail, fax, phone or courier. Its partner organisations include the Micronutrient Initiative, PAMM, ILSI, CDC, IFPRI, MOST, SUSTAIN, UNICEF, WHO, the World Bank, HKI, John Snow, BASICS, GTZ and others, as well as electronic discussion groups such as NONGUT and the Ironlist.

IDPAS is concentrating initially on newly initiated or accelerating programs and projects as well as a few well-established efforts to prevent and control iron deficiency anaemia. Priority countries include Azerbaijan, Egypt, Ghana, Indonesia, Kazakhstan, Kosovo, Kyrgyz Republic, Lebanon, Mongolia, Nigeria, Pakistan, Tajikistan, Turkmenistan and Uzbekistan.

Based on successful initial performance, the INF will expand this IDPAS service to those working on iron nutrition related activities in all countries.

IDPAS encourages those working to improve iron nutrition and reduce the prevalence of iron deficiency anaemia to get in touch.

Queries and comments about the network or on any matter related to improving iron nutrition should be sent to Gary Gleason, IDPAS, 126 Curtis Street, Medford, MA 02155 USA. Tel: (1-617) 627-2293. Fax: (1-617) 627-3968 or E-mail: gggleason@infoundation.org.

For more information contact Ken Bailey at baileyk@ozemail.com.au

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Launching the Iron Deficiency Project Advisory Service (IDPAS)

The International Nutrition Foundation (INF), in collaboration with the United Nations University (UNU) with funding from the Micronutrient Initiative (MI) will establish the Iron Deficiency Project Advisory Service (IDPAS). Based in Tufts University School of Nutrition Science and Policy, the IDPAS aims to expand a proactive network supporting those working on the prevention and control of iron deficiency and iron deficiency anaemia in developing countries and countries in transition.

IDPAS will help individuals and projects to obtain specific information on any matter related to iron in nutrition and interventions for prevention and control of iron deficiency. Potential areas of support include:

- advocacy and policy development,
- problem assessment,
- program design,
- iron supplementation for all age groups,
- food fortification including technical issues related to enrichment mixes, costs and equipment,
- communication for dietary change,
- intervention monitoring and programme review.

The network also will help identify sources of technical expertise and funding.

IDPAS will work to facilitate

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Ready to learn?

The Ready to Learn Centre at the Academy for Educational Development (AED) has received funding to support a pilot project in Nutrition Education. This initiative is aimed at any interested agency involved in nutrition rehabilitation programmes to implement or support nutrition education in the centre. Their ‘Ready to Learn’ staff can help field personnel develop simple learning tools for better early child development. These are then shared with children and carers. Examples of how the ‘Ready to Learn’ personnel can help and train your teams are:

- in selecting and inventing appropriate stories for educational purposes
- in finding ways to build on traditional simple games
- in designing short messages or discussions about early childhood development activities
- in developing community focus group topics or plans with field staff.

The ‘Ready to Learn’ team visit the centres you are working in and help train your staff on the ground. AED require the participating agency to facilitate communications and logistics. This is a short-term initiative that may be of interest to field staff.

If you are interested in participating in this project, please contact Diane Lusk at dlusk@aed.org or Sarah Dastur at sdastur@aed.org. Alternatively write to the Academy for Educational Development, 1875 Connecticut Avenue, NW, Washington, DC 20009-1202.
Training courses and refresher workshops on Nutrition in Emergencies, how to adequately meet our training needs?

NutritionWorks runs a three day course on ‘Nutrition in Emergencies’ in collaboration with International Health Exchange and Merlin. The next courses will take place in May and November 2001.

This is limited, however, in that it can only give an overview of the issues and cannot provide comprehensive practical training.

NutritionWorks is, therefore, considering expanding it’s repertoire of courses to meet the needs of both those new to the field and those with experience but who want to brush up on their skills. The following types of courses/refresher workshops are being considered:

1. An in-depth practical course on Nutrition in Emergencies for those with no or very little field experience. This course would last about 10 days (which could be in one block or for one day a week for 10 weeks). The emphasis would be on developing practical expertise (e.g. how to do an anthropometric survey/food and nutrition assessment, use of EpiNut etc.) and make extensive use of case studies and field experiences. It would basically be an expansion of NutritionWork’s existing 3 day course.

2. A one or two day refresher workshop for experienced nutritionists. This would aim to provide an update on new policy, guidelines, and research findings (e.g. the latest on infant feeding in emergencies etc.). It could possibly be structured around presentations with plenty of time for group discussion and sharing of field experience.

3. A short course on nutritional issues in food aid for non-nutritionists (e.g. agency programme staff, food logisticians) who are involved with food-related programmes but who don’t have a technical background in nutrition. The aim would be to provide an update on nutrition-related issues to non-technical staff (e.g. new forms of food aid such as blended foods, policy on distributing infant formula etc).

NutritionWorks would like to assess the demand for courses by asking the Field Exchange readership to respond to the following:

- Does your agency offer training in nutrition in emergencies? If so, what type of training and is it satisfactory?
- Do you think these kinds of courses/workshops would be useful to you or your agency?
- Would you or your agency be prepared to pay to attend such courses/workshops?
- Would other kinds of courses/workshops/training be more useful?

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USAID releases commodity reference guide

A revised Commodities Reference Guide (CRG), dated December 7, 2000, was released on USAID’s website and is available for use and comment. It can be downloaded in Portable Document Format (PDF) at: http://www.usaid.gov/hum_response/crg/. The guide is a major revision and update of the original CRG, issued in 1988.

The CRG provides information on food commodities distributed under Title II of Public Law 480 (PL. 480). This programme is administered by the United States Agency for International Development (USAID) in conjunction with the United States Department of Agriculture (USDA), and comprises emergency and development activities. Since its inception in 1954, the PL. 480 Programme and other food assistance instruments have distributed 375 million metric tons of US food commodities valued at well over $50 billion. In 1990, the Congress amended the PL. 480 legislation, re-asserting the United States’ intent to use its agricultural productivity to enhance food security in the developing world. The CRG is an information tool, providing relevant information about the food commodities used in Title II programmes. All food commodities are available to the PL. 480 Programme as long as they are not determined to be in short supply by the US Secretary of Agriculture, a determination that is made every October (per Section 401(a) of the FAIR Act, 1996) by the Secretary of Agriculture.

The CRG is designed to provide organisations with a description of available food commodities, their nutritional values and physical properties, a guide to appropriate storage and handling, and important general information regarding their safe and effective use as rations in Title II programmes. The CRG provides information on the food commodities that are in general use in the Title II programme in Part One (Title II Food Aid Commodities and Fact Sheets) and information and examples on selecting rations for different programme scenarios in Part Two (Guidelines for Selecting Food Aid Commodities).

Part Two has been developed and includes Guidelines for Selecting Food Aid with an overview chapter and the following modules:

- Maternal and Child Health Programmes
- Food for Work
- Food for Education
- Non-Emergency Humanitarian Assistance
- Emergency

USAID is interested in hearing from the readers of Field Exchange with comments on the recently released Guide.

For more information contact: Tom Marchione, Bureau for Humanitarian Response, U.S. Agency for International Development, 5300 Pennsylvania Avenue, NW, Washington, D.C. 20523
E-mail: tsmarchione@usaid.gov

ALNAP: facilitating lessons learned

The Active Learning Network for Accountability and Performance in Humanitarian Assistance (ALNAP) was established in 1997 as an international interagency forum working to improve learning and accountability across the humanitarian system. Based in the Humanitarian Policy Group at the Overseas Development Institute in London, ALNAP contains a database of evaluative reports on humanitarian programmes. The Reports Database represents a unique collection and is a valuable resource for the international humanitarian system. It provides the basis for synthesis or ‘meta’ studies on the results of evaluations in relation to particular sectors, issues or responses in particular geographical areas.

For example, at the time of the 1998 flood disaster in Bangladesh, the findings of evaluations of responses to previous flood events in the country were e-mailed to ALNAP Members and key donors. Similarly, in Dhaka - an initiative that was valued by many members. In April 1999 the initiative was repeated in relation to previous evaluations of programmes in the Balkans of potential relevance to ongoing operations in relation to Kosovo. Currently over 260 reports have been catalogued and the key sections of over 200 of these are maintained in fully searchable format on the ALNAP website at www.odi.org.uk/alnap.

ALNAP commissioned and supported activities last year included:

- Support for the preparation and publication of an edited volume ‘Doing Evaluations of Humanitarian Assistance’.
- Development of a proposal for a global study to produce a good practice handbook on ‘Consultation with and Participation by Beneficiaries and the Affected Population in the Planning, Management, Monitoring and Evaluation of Humanitarian Programmes’.
- Development of the ‘Learning Office’ concept through a field study in Orissa and complementary desk studies of Kosovo and East Timor.
- A study mapping ‘accountability’ in relation to the international humanitarian system.

ALNAP’s membership now comprises 46 Full Members (bilateral and multilateral donors, organisations, UN agencies and Departments) and a growing number of Observer Members (currently 240) from NGOs and NGO umbrella organisations, the International Red Cross and Red Crescent Movement, selected consultants, academics and research institutes.

For further information on ALNAP contact: John Horton, Coordinator, ALNAP Secretariat, Overseas Development Institute, 11 Westminster Bridge Road, London SE1 7DJ. Tel: +44 (0) 207 922 0314 or Email: jhorton@odi.org.uk or alternatively access their website at www.odi.org.uk/alnap.

ALNAP commission”.

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The INFANT FEEDING IN EMERGENCIES group (IBFAN) is pleased to announce the release of a brochure on Infant Feeding in Emergencies. The brochure aims to raise awareness about infant feeding in emergencies. It highlights the importance of protecting, promoting, and supporting breastfeeding in emergency situations. The brochure is intended for policy makers, programme managers, and field workers from agencies involved in emergency relief, donors, journalists, and other interested parties.

Request for copies can be addressed to:
- Wemos, PO Box 1693, 1000 BR Amsterdam, The Netherlands. Email: wemos@wemos.nl
- IBFAN/GIFA, PO Box 417, 1211 Geneva 19, Switzerland. Email: info@gifa.org


IBFAN raises awareness on infant feeding in emergencies

New distance learning course on ‘Nutrition in a humanitarian context’

Inspired by Action Against Hunger’s successful in-house training, this newly launched course is designed for nurses, midwives, doctors, dieticians and nutritionists, working or thinking about working in the humanitarian field. The aim is to equip trainees with the analytical and technical skills with which to tackle nutritional issues, at a pace that is convenient to them.

Over a 6 month period, the course offers comprehensive training on the causes, prevention, diagnosis, and treatment of malnutrition, with the use of practical case studies.

The course fee is £300 sterling.

Interested applicants should contact: Sharon Wright, Action Against Hunger, 1, Catton Street, London, WC1R 4AB. Tel: +44 207 3858585 or E-mail: lwright@ahahuk.org

Closing date for completed applications is 30th April 2001 and the course is scheduled to commence on 14th May 2001.

Fighting hunger on all fronts: AAH speak out in a new publication

Action Against Hunger (AAH) discuss their experiences of humanitarian interventions aimed at eliminating or preventing hunger in the newly published report: The Geopolitics of Hunger 2000-2001 ‘Hunger and Power.’

Compiled by the Action Against Hunger international network, this publication draws on their experience, spanning twenty years, working with some of those populations most affected by humanitarian crisis.

AAH assert that each humanitarian crisis is complex and different and that in order to provide adapted, efficient and tailored responses to the needs that arise, it is essential to be able to accurately analyse the situations in which agencies operate and the true causes of hunger.

Most of this analysis comes to the same conclusion: hunger is used as a weapon against civilian populations who are denied the most basic of human rights, the right to food.

AAH highlight that their technical expertise and commitment alone are insufficient in such scenarios and that there is therefore a need to alert the wider public and call for international action beyond the humanitarian response to expose and oppose such crimes.

Key issues that are tackled include:

i) The use of hunger as a weapon.
   This is demonstrated through experiences in Sierra Leone, Somalia, Kosovo, and other countries.

ii) Confronting unjust food distribution: which strategies for humanitarian intervention?
   Humanitarian organisations may become pawns in geopolitical games whereby agencies must struggle to retain impartiality and independence when confronted with governments intent on serving their own political interests. Questions that are addressed include: How to react when confronted by criminal regimes? What are the principles to be respected and the code of conduct to be followed? What is the role of humanitarian organisations in the present world of international relations?

iii) Food policies to eradicate hunger.
   Humanitarian assistance alone cannot prevent global malnutrition. Nevertheless the role of such assistance should include analysis and resulting proposals for poverty eradication and advocating for efficient food policies.

Part three of the publication provides an analysis of policies that could be implemented to secure the right to food ranging from the Lomé Convention to policies on increasing productive capacity.

Also available from AAH is their: Action Against Hunger international activity report, 1999-2000.

The extensive report describes all Action Against Hunger’s international activities and relief programmes between 1999-2000. It aims to give an insight into their approach to fighting hunger through describing types of programme and design. The report also reviews Action Against Hunger’s charter of principles, its expertise and integrated technical approach, as well as the management of its resources.

Copies of The Geopolitics of Hunger 2000-2001 ‘Hunger and Power’ cost £16.50 and can be ordered directly from EDS, 3 Henrietta Street, Covent Garden, London WC2B 8LL. Email: orders@edspubs.co.uk

For further information on both publications: contact Action Against Hunger UK, 1, Catton Street, London, WC1R 4AB. E-mail: aahuk@ahah-uk.demon.co.uk

Update your bookmarks!

The ENN website has moved to a new URL: www ennonline net. As part of the move, the site underwent a complete redesign and we hope that the new site’s structure will make navigation easier. Due to exceptional demand, we also plan to make available all the documents published by the ENN in PDF format as well as zipped archives of the online issues of Field Exchange for easy offline browsing.
WFP-the essential ‘Food and Nutrition Handbook’

WFP have published, with collaboration from Nutrition Works, a ‘Food and Nutrition Handbook’ (2000). Aimed at all WFP staff who are involved in the delivery of food assistance, this document is designed as both a reference and training manual. It should enable staff to assess and analyse the nutrition situation in their country or region and help manage the design, implementation, monitoring and evaluation of interventions.

The handbook covers a range of topics that include: basic food and nutrition concepts, the process of assessing and analysing types of nutritional problems and their causes, practical applications of nutrition interventions, the range of nutrition related programmes supported by WFP, tools for planning an adequate ration, selective feeding modalities, general food distribution and the core principles of nutrition information, education and communication as complementary intervention strategies.

The Food and Nutrition Handbook is a valuable resource, easy to read and a great reference tool while in the field. WFP stress that this document complements but does not replace other key material e.g. UNHCR, WHO documents or SPHERE Minimum standards.

For further information contact Anne Callanan at the Nutrition Unit, WFP, Via Casapinta Guilia, 460/7, 00198 Rome, Italy. Tel: +39 06 65131 or Email: Anne.Callanan@wfp.org

US tries to head off UN plan to reform sanctions

In the past Field Exchange has published a number of pieces on the impact of international economic sanctions of food security in countries like Iraq, Cuba and Haiti (Issues 4 and 9). The developments summarised below may therefore be of interest to our readers. (Eds.)

Concerned about the humanitarian impact of sanctions on civilian populations, the UN secretary general, Kofi Annan, set up a special committee last April to examine sanctions policy. The committee was due to recommend a shift towards so-called ‘smart sanctions’ that are more clearly defined and better targeted. But the US, which is intent on maintaining tough sanctions against Iraq, with the backing of Britain, will almost certainly succeed in cutting out two key recommendations; one setting a time limit on sanctions and the other introducing majority voting on sanctions committees.

Critics claim that sanctions usually fail to undermine the targeted regimes and that the criteria for imposition and lifting of sanctions are too vague. In a draft copy of its report the committee says “sanctions regimes, in particular the security council resolutions that enact them, must be carefully designed, clearly establishing their goals, identifying the targets, tailoring the type of sanctions imposed so that they are adequate to the situations specifying clear criteria that need to be satisfied in order for the sanctions to be suspended or lifted.”

Other committee recommendations include; targeting the finances of leaders rather than the general population; greater punishment for countries found to be breaking sanctions; and a “carrot-and-stick” approach which would see a gradual lifting of sanctions in response to partial compliance with UN resolutions. The committee also states; “Sanctions regimes should be designed to minimise the potential for adverse humanitarian impacts and to maximise the ability for humanitarian goods and services to reach civilian populations.”

The committee recommends that food, medicine and medical supplies be excluded from sanctions regimes.

Dear Field Exchange,

I find it very interesting to see that Field Exchange is publishing a lot of informative articles on nutrition interventions in emergencies. At the same time it sets me thinking about ‘the invisible emergency’ that is going on back home in Bangladesh and raises questions in my mind about ‘when is an emergency an emergency.’

Bangladesh is a country of 128 million people with a land size approximately two times that of Ireland. Although, Bangladesh is not in the grip of what is topically called a complex emergency, the fact is that the nutritional status of the Bangladeshi population is amongst the worst in the world. In Bangladesh more the 50% of women are stunted while 50% of infants are born with low birth weight (less than 2500g).¹

Stunted growth amongst the women of Bangladesh is due to lack of adequate caloric intake throughout the course of life. The average daily calorie intake of Bangladeshi people is 2085 Kcals (88% of RDA).² Amounts for those poor households below the average are therefore by definition less while status of individuals within the family also leads to a reduced intake. Culturally women have lesser status in the family. Furthermore, their economic contribution to the family is not very visible so that intra-household food distributions favour men and male children. This is an everyday fact for women in Bangladesh.

The 1996-1997 Bangladesh Demographic and Health Survey revealed that over half (52%) of mothers are acutely malnourished (i.e. BMI<18.5)³ while 17% were less than 145cm tall. Women’s low height is associated with reduced pelvic growth which increases the risks of difficult childbirth and higher maternal mortality. In Bangladesh the maternal mortality rate is 4.5 per 1000 and is one of the highest in the world.³ Small women are also at higher risk of giving birth to low birth-weight children.³

These statistics are very disturbing. Equally disturbing is the impact of inter-generational malnutrition on the physical and intellectual growth of future generations which has in turn ramifications for national economic development and the cycle of poverty.

In Bangladesh there is not enough food for everyone but with proper interventions the prevalence of maternal malnutrition could be reduced. Globally, the problem is not lack of food but equity and appropriate intervention.

There is a pervasive tendency to ignore this type of invisible crisis and it’s underlying causes. Media attention will only be sparked by catastrophe. I also believe that acute emergencies must be addressed before chronic ones and am aware that the main focus of this publication is emergency nutrition interventions. However, while the type of widespread maternal malnutrition evident in my homeland may not fall into a conventional emergency category in my mind it is an undoubted emergency (albeit invisible) with a massive impact affecting the entire country.

Yours etc.

Lovely Amin
Policy Development and Evaluation Directory (PDED)
Concern Worldwide, Dublin
E-mail: lovely.amin@concern.ie

1 Human Development Report, 2000
2 Bangladesh Demographic and health survey, 1996-1997
3 The State of the World’s Children

I find it very interesting to see that Field Exchange is publishing a lot of informative articles on nutrition interventions in emergencies.
Outbreak of micronutrient deficiency disease: did we respond appropriately?

By Dianne Stevens, Patricia Araru and Buwa Dragudi, Save the Children (UK)

In September 2000 there was an outbreak of scurvy and what appeared to be dry beriberi in the west of Wajir District, North Eastern Kenya. This article sets out to describe the outbreak and the response by the international community and the government of Kenya. Lessons learnt from the experience are drawn out so we can better respond in the future to prevent and control micronutrient deficiencies in emergencies.

Background
Since 1990 Wajir has suffered from a succession of disasters with droughts in 1992 and 1996/97, El Nino floods in 1997/98 and ongoing tribal conflicts. With no significant rain since the El Nino rains the area is experiencing yet another drought. The majority of the population of Wajir are nomadic pastoralists of the Somali ethnic group. In February 2000 many pastoralists were forced to migrate long distances with their herds in search of water and pasture. Those who could not travel the long distances, mostly women, children and the elderly, were left behind. Many other pastoralists have been made destitute through loss of livestock as a result of the El Nino floods, drought and conflict. This is particularly so in the west of Wajir where there is a large displaced population from the Bagalla massacre of 1998. Since March 2000 there has been an influx of people into the west displaced from the conflict in the north of the district. Those left behind when herds migrate and the displaced have settled in peri-urban areas to benefit from relief and are dependent on food aid for their survival. All are at risk of food insecurity and malnutrition. A nutrition survey in late September in the west and north of Wajir District found high levels of malnutrition in children with a prevalence of 21.2% global acute malnutrition and 5.8% severe malnutrition1.

The Outbreak
In early September 2000 there were reports from the west of Wajir that people had been experiencing symptoms of weakness and pain in the lower limbs and joints and in some cases peripheral neuritis and immobility. A rapid assessment by the Ministry of Health (MoH) and Save the Children, UK (SC(UK)) with technical advice from the Centre for Disease Control and Prevention (CDC) identified suspected vitamin deficiencies. Discussions with the community revealed that the signs and symptoms observed had never been experienced before in this population. Interviews and clinical examination of 23 people affected found that the symptoms developed gradually and the duration of symptoms was from one to four months preceding the visit. All sexes and ages were affected.

Symptoms experienced
Most individuals affected experienced weakness, non-specific weight loss, peripheral oedema and an inability to stand from a squatting position. These symptoms could be attributed to protein energy malnutrition (PEM), vitamin C or thiamine deficiency. PEM was ruled out as all but one of the adults examined had mid upper arm circumferences greater than 18.5cm, the suggested cut off for moderate malnutrition in adults2.

Seventeen people experienced symptoms of scurvy - specifically bleeding gums and swollen leg muscles or knees. Seven people experienced symptoms specific to dry beriberi including stocking and glove sensory changes, loss of reflexes, and in two cases, foot drop. Five experienced symptoms of both scurvy and dry beriberi.

Access to food sources
Those affected had typically lost their animals and hence their livelihoods because of drought, conflict or the El Nino floods. All were living on the periphery of town centres and the majority were displaced. All had been eating an extremely limited diet of Government of Kenya relief maize and black tea from February to June and had no milk or meat (their usual diet) since the herds had migrated away in February. Relief maize provided by the government provided only 9% of energy needs. Donor response to the emergency was slow3 and a World Food Programme (WFP) general food ration (GFR) was not introduced until June. Pulses and oil were only added in July. Even with the GFR the diet remained deficient in energy, protein and micronutrients. The food aid allocation was not based on any assessment of the food security situation of the population.

Until the introduction of pulses to the GFR the typical diet contained no vitamin C and even with the introduction of pulses, the dietary intake of vitamin C was insufficient to prevent scurvy. The August dietary intake of vitamin C was 1 mg whereas 6.5-10mg per day is required to prevent scurvy. Thiamine intake was only 22% of the Recommended Daily Allowance until the introduction of the GFR and did not meet requirements until pulses were introduced in July.

Blanket SFP
In early September, a blanket supplementary feeding programme (SFP) was introduced providing a monthly ration of fortified corn soya blend (CSB) to all children under five and pregnant and lactating women. The inadequate GFR meant that the CSB was consumed by the entire household, and not just the intended beneficiaries, and as such only lasted for two weeks.

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1 Save the Children (UK) and Ministry of Health, Kenya, Nutrition Survey in North and West Wajir District, Kenya, October, 2000.
3 The Kenyan government’s economic and political performance has been a factor in donor reluctance to respond.
5 The Kenyan government’s economic and political performance has been a factor in donor reluctance to respond.
rather than one month. With the CSB the vitamin C content of the diet jumped from 5% to 185% of the recommended intake. The thiamine content of the diet was not significantly increased. All those with symptoms reported an improvement after the first distribution of CSB e.g. those previously bed-ridden were now at least able to walk a little.

The above estimates of nutrient intake assume that the whole general ration is consumed by the recipient and there are minimal losses with food preparation. However in Wajir, food preferences and preparation methods would have further reduced the intake of both vitamin C and thiamine.

Being water soluble, vitamin C is susceptible to destruction by heat. Much of the small amounts provided by the pulses in the general ration would therefore have been lost in cooking. Recipients were also wary of consuming pulses complaining of gastrointestinal problems.

The people of Wajir are unfamiliar with maize as a food and are unsure of how best to prepare it. Thiamine intake from the maize ration would have been reduced for a number of reasons:

• the practice of dehusking or milling the maize (most of the thiamine resides in the outer layers of the grain)
• loss in cooking (both thiamine and vitamin C are water-soluble)
• the widespread practice of drinking large amounts of tea (the tannin in tea is a thiamine antagonist and interferes with the absorption and digestion of thiamine)
• lack of vitamin C in the diet (Vitamin C, when consumed together with thiamine, increases thiamine bio-availability)
• A preference for tea meant that many households exchanged some of their ration for tea or sugar (3 kg of maize was typically exchanged for 250g of sugar).

There is no doubt that most of the symptoms reported and observed were attributable to scurvy. Outbreaks of scurvy have occurred regularly in similar populations in the Horn of Africa.

Reaction to findings

There was some scepticism about an outbreak of thiamine deficiency as in recent history outbreaks of beriberi have been limited largely to rice eating populations. Yet thiamine deficiency has occurred on some occasions in non-rice eating populations and given the extremely limited diet over several months it could not be ruled out in Wajir. The level of uncertainty meant that questions were raised about whether this was a more complex picture of multiple micronutrient deficiencies.

It was time to call in the experts to confirm the diagnosis, develop case definitions, determine the public health significance of the outbreak and advise on appropriate treatment and control of the outbreak.

The Response

While CDC (Centre for Disease Control) were initially considered for the assessment, concerns around an onslaught of technical teams and the need to allow national teams to gain experience led to the Ministry of Health (MoH) combining with the African Medical and Education Research Foundation (AMREF) to field an assessment team at the end of September. CDC offered support to AMREF if needed.

This assessment involved extensive investigation of 59 people who showed symptoms of micronutrient deficiency. Blood and urine samples were taken for micronutrient analysis. Initial impressions of the team based on clinical examination were of a multiple vitamin deficiency syndrome – predominantly vitamin C and B-complex deficiency. However, the symptom profile had changed significantly since the initial rapid assessment by the Ministry of Health and SC(UK) team. The sensory changes associated with dry beriberi were no longer evident and the team attributed this to improvements resulting from the introduction of a general food ration and blanket supplementary feeding.

Because of the complexity of the presentation of symptoms, case definitions for specific deficiencies were not possible. A broader case definition of "ascending or descending pain of the lower limbs (joints and or muscles) and difficulty walking within the last 3-5 months" was used by the team. An assessment of prevalence based on this case definition was not undertaken. This case definition was used to identify people with possible micronutrient deficiency disease in a nutrition survey conducted by MoH and SC(UK) in the north and west of Wajir in October. Out of 3380 people interviewed 27 cases were identified, the majority of which were in the west of Wajir. The low prevalence of 0.8% indicates that the outbreak was small and localized.

Recommendations

Recommendations by the MoH/AMREF team included:
• house to house vitamin supplementation
• an increase in the general food ration
• GFD should include a fortified blended cereal.

These recommendations were not circulated widely and the Ministry of Health was not pro-active in advocating for their implementation. Unfortunately the blood and urine samples were not analysed, probably because of a lack of technical capacity, and no confirmation of diagnosis of specific deficiencies has been made.

Response taken

Save the Children (UK) responded to the initial rapid assessment by:
• recommending an increase in the general food ration
• inclusion of a fortified blended cereal into the ration
• grinding of the maize prior to distribution
• treatment of those affected with vitamin supplements
• Admitting anyone presenting with symptoms into the SC(UK)/MoH targeted SFP. They would then receive a weekly ration of fortified CSB.

SC(UK) were successful in securing a donation of thiamine tablets and negotiated with WFP to grind the maize as well as consulting USAID to ensure CSB was fortified. Logistical problems meant that the
thiamine did not arrive until well after the symptoms of beriberi resolved. To this day the general food ration has not been increased, the maize has not been ground and CSB has not been added to the general ration. It is fair to say that problems in the food pipeline and the extent of the food aid requirements across the country rather than a disinterest by WFP was the reason nothing was done. Fortified CSB did arrive in the country and because of the outbreak of vitamin deficiency, Wajir was one of the districts targeted to benefit from the CSB which was channelled into blanket supplementary feeding programmes rather than the general ration. At the time of writing the blended food pipeline was once again in jeopardy. Despite the confusion in the diagnosis, little understanding of the extent and public health significance of the outbreak and both late and inadequate response, those affected improved simply by providing them with a nutritionally balanced diet in the form of a fortified cereal blend. Nothing more needed to be done.

**Lessons**

Micronutrient deficiencies in emergency situations may well appear as a complex picture of multiple deficiencies. Deficiencies of one nutrient are unlikely to occur in isolation. This complicates assessment and looking for specific signs and symptoms can lead to delays in arriving at a firm diagnosis. A diagnosis and case definition (possibly covering multiple deficiencies) are required to determine the extent and public health significance of the problem. This will help determine and advocate for the most appropriate public health intervention.

Assessment and diagnosis of multiple micronutrient deficiencies is a specialised field and requires the input from experts to arrive at a rapid assessment and response. Most field personnel are unlikely to recognise that a deficiency exists in the early stages of presentation. Diagnosis by biochemical analysis requires the technical know-how and resources found only in specialised laboratories. There may therefore be a tension between bringing in outside expertise and utilising and strengthening local professional capacity. We need the experts but must ensure that they work with governments and leave some capacity behind when they leave.

Nutritional surveys are a common assessment tool used in emergencies and yet generally they do not give enough attention to the assessment of micronutrient deficiencies. By training field personnel in the signs and symptoms of micronutrient deficiency diseases (by including a few questions in the survey to help identify the onset of deficiencies) and through actively seeking cases, nutritional assessments could be better used to identify that a problem exists.

**Prevention of deficiency outbreaks**

Micronutrient deficiencies can be easily prevented by the provision of a balanced diet and yet outbreaks of deficiency diseases have regularly occurred in refugee populations dependent on food aid. Years of experience and expert consultation over the past two decades have led to several initiatives to reduce the likelihood of micronutrient deficiency outbreaks occurring during emergency programmes. Perhaps the most significant initiative has been the introduction of a stipulation in the WFP/UNHCR Guidelines for estimating food and nutritional needs in emergencies (1997) whereby a fortified blended cereal should be included in the ration of all food aid dependent populations unless other appropriate commodities can be provided.

However, in the case of Wajir, food aid arrived too late and when it did arrive, the GFR did not meet the nutritional needs of the population. It appears that there was insufficient awareness of the risks of micronutrient deficiency diseases have regularly occurred in refugee populations dependent on food aid. Years of experience and expert consultation over the past two decades have led to several initiatives to reduce the likelihood of micronutrient deficiency outbreaks occurring during emergency programmes. Perhaps the most significant initiative has been the introduction of a stipulation in the WFP/UNHCR Guidelines for estimating food and nutritional needs in emergencies (1997) whereby a fortified blended cereal should be included in the ration of all food aid dependent populations unless other appropriate commodities can be provided.

We recommend that key humanitarian agencies should, with the support of the RNIS monitoring system, take steps to raise awareness among their staff of the important risk of micronutrient deficiencies and better co-ordinate food aid to ensure that it is prompt, adequate and appropriate.

There is no excuse for what happened in Wajir. The problem is understood and the solution is simple. Outbreaks of micronutrient deficiency disease in food aid dependent populations should be a thing of the past and not of the 21st century.
Oxfam Great Britain has been working in Kenya since the 1960s, and in Wajir District since the 1980s, implementing relief and long-term development programmes.

Oxfam Great Britain has been the lead agency for food distribution in Wajir since June 2000. Oxfam GB also implements drought mitigation and response activities across Kenya in various sectors, including water, livestock and nutrition. While agreeing with the main points of the SC(UK) article on Wajir, I do think that there is a need to place the problem in perspective.

A serious drought has been affecting Kenya since 1999. Many communities describe the drought as the worst they can remember. Emergency food aid operations began in some districts by December 1999. The joint World Food Programme - Government of Kenya operation (EMOP) initially targeted 1.7 million people in 18 districts from March to June 2000. Distributions began in the four worst affected districts (Turkana, Moyale, Marsabit and Mandera) in March/April, and by June twelve districts, including Wajir, were receiving food. With the failure of long rains in April, the situation worsened and the EMOP expanded to cover 2.2 million people in 19 districts from June - December 2000.

Decisions on where and how to intervene were taken based on the best available local information, including reports from the coordination system, assessments, local situation reports and early warning bulletins. Throughout this process attempts were made to use standard criteria for intervention across districts. Many of the districts, Wajir in particular, have been plagued by a series of climatic emergencies in the past decade, and suffer from very high levels of chronic poverty. In this context, it was very challenging to try to distinguish between the effects of chronic vulnerability and drought shock. Seasonal factors are also complex - in a normal dry season in North-eastern Kenya, child malnutrition rates often peak at a
development of Kenya Food Security Coordination System (KFSCS)

Oxfam GB had planned for blanket distributions of Unimix to vulnerable populations in Wajir in June 2000, but was not able to implement this until August due to resource constraints. Nevertheless, given the seriousness of the drought, the fact that the humanitarian situation is not much worse is a reflection of just how much has been learnt from the past.
Rapid impact on malnutrition through a multi-faceted programme in Wolayita, Southern Ethiopia

By Kate Sadler

Kate Sadler undertook her MSc in Public Health and Nutrition at LSHTM. She has spent over 3 years working for Concern Worldwide in Burundi, Rwanda and Ethiopia. Currently in Ethiopia, she is supporting ongoing emergency feeding programmes as well as developing community health and nutrition programmes for the post-emergency recovery phase.

Background

Damot Woyde Woreda is located in North Omo Zone, Southern Nations, Nationalities and Peoples Regional Government (SNNPRG). It is 385 km South of Addis Ababa. The Woreda is characterised by a rugged, mountainous topography with valleys and gorges and is divided into 48 kebeles. It has a population of 172,877 (Woreda Council 2000) and has a high population density, with between 125 - 742 people per square kilometre in the mid- and highland areas.

The region of Wolayita has been identified for a number of years as a food insecure area. This is caused by a combination of factors - high population density with higher than average family size (7-8 per household), small land holdings and serious soil erosion. Furthermore, a reliance on rain fed agriculture by the majority of farmers and an area which receives erratic rainfall, adds to an already fragile situation.

Concern Worldwide has worked in Damot Woyde since 1984, both in emergency relief and integrated rural development, although left the area in 1998 in line with government policy. In 2000 on the request of regional authorities, Concern once again began emergency assessments to identify needs arising from the most recent drought.


Following three successive poor harvests including the complete failure of the main Belge harvest (Jun/Jul 99), acute food insecurity was once again becoming a reality in Damot Woyde. In April 2000 the Belge rain was already 2 months late and the prospect for a harvest looked poor. The sweet potato crop, which is traditionally used to mitigate the effects of the hungry season, had failed for the third consecutive season and maize, usually harvested green in June/July, had not been planted at all. Although much of the land had been tilled there was nothing visibly planted, as the soil was completely dry. Even the coffee trees were burnt from the extreme heat. Most of the ensete in the fields seemed to be harvested. In normal circumstances only matured ensete is harvested when it has been growing for 6-7 years. The early harvest of this crop reduces further the value of an already nutritionally poor food. People reported that they were on one meal a day and this was mainly ensete. They were very worried that their children were also only getting ensete to eat. In addition, the availability of water and pasture for livestock was severely reduced. Many households reported recent animal deaths and that they were unable to sell livestock as demand was so low.

A two-stage 30 cluster nutrition survey conducted by Concern between the 14th and 19th April 2000 identified worrying levels of both global and severe acute malnutrition at 25.6% (<-2 z-score and/or oedema) and 4.3% (<-3 z-score and/or oedema) respectively.

Response

In order to address this situation Concern became operational with the following objectives:

Programme Goal

To prevent the deterioration of the nutritional status of the under 5 population and pregnant/lactating mothers in Damot Woyde Woreda and to contribute towards the nutritional recovery of any in this target group found to be moderately or severely malnourished.
1. To treat current high levels of malnutrition.

By the middle of May Concern had opened 3 therapeutic feeding centres which gave 24-hour nutritional and medical care for all severely malnourished children. A team of 5 experienced expatriates (including 3 nurses, 1 nutritionist and 1 paediatrician) and approximately 320 national staff, many of whom had worked for Concern previously, ran the centres. By the end of September 874 children had been treated with the results presented in table 1.

Targeted supplementary feeding was started simultaneously for all moderately malnourished children less than 5 years old and pregnant and lactating mothers. This involved a fortnightly mobile distribution to 10 separate decentralised sites across the Woreda. Treatment included a 3.5kg ration of Therapeutic Food Complement (TFC) for all severely malnourished and to minimise re-admissions to targeted feeding programmes, a general food ration was essential for those in need. Concern assisted the Woreda Council with this objective by:

• Local purchase and distribution of general food (12.5kg of grain per person per month) to 54,000 of the most vulnerable people in the Woreda for four months (June to September). Beneficiary lists were drawn up by the Woreda authorities and subsequently verified by a Concern team to ensure all recipients fulfilled the criteria for vulnerability.

• Providing a small quantity of fuel and repairing the Woreda truck.

• Providing training on food aid targeting to the Woreda Council and assisting in post distribution monitoring.

3. To improve prospects for household food security.

Some of the most important seeds required by farmers, including teff, sweet potato, wheat, maize and beans, were distributed to 11,000 of the most vulnerable households. Seeds were purchased locally. This enabled many impoverished farmers to plant in July for the Meher season.

Acute Malnutrition Measured by Weight for Height

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Global Malnutrition</td>
<td>25.4%</td>
<td>6.4%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Severe Malnutrition</td>
<td>4.3%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Table 1

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Averaged across 3 centres</th>
<th>Month</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Sept</th>
<th>TFC Target**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery rate (as % of exits)</td>
<td>91</td>
<td>96</td>
<td>99</td>
<td>100</td>
<td>&gt; 75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality rate (as % of exits)</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>&gt; 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Default rate (as % of exits)</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>&gt; 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average weight gain (g/kg/d) Marasmic</td>
<td>-</td>
<td>-</td>
<td>14.6</td>
<td>16.0</td>
<td>&gt; 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average weight gain (g/kg/d) Kwashiorkor</td>
<td>-</td>
<td>-</td>
<td>10.7</td>
<td>8.2</td>
<td>&gt; 8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Humanitarian Charter and Minimum Standards in Disaster Response. (Sphere, 2000)
** Reporting did not include this information at the start of the programme.
A second survey was undertaken three months after the first. This survey identified a dramatic improvement in the rate of moderate and acute malnutrition in Damot Woyde Woreda. The third survey in October showed a stabilisation in the rate of malnutrition as well as identifying a relatively more positive food security environment. By October, malnutrition accounted for only 6% of all deaths recorded during the survey. This compared with 32% in July. The major causes of death had changed from malnutrition and malaria to malaria and cough/respiratory disease (43% and 29% of all deaths respectively).

This improvement in the nutritional status of the population was generally thought to be attributed to two main factors: Concern’s nutrition interventions and improved food security.

Nutrition Intervention
Since April 2000 Concern had implemented therapeutic and supplementary feeding, community outreach in all kebeles to identify and refer all at risk individuals and general food distribution to 54,000 of the most needy individuals.

By October, Concern had closed the last of its therapeutic feeding centres and children identified as severely malnourished are now referred to the nutritional rehabilitation unit in nearby Sodo hospital. Concern’s supplementary feeding programme is ongoing although the proportion of those discharged who fully recovered is increasing. This is thought to reflect the overall improvement in the food security situation of the Woreda.

Improved Food Security
With the arrival of rain in May animal health visibly improved in the area and by late June many households began harvesting small quantities of beans and kale from their fields. In October post distribution monitoring indicated that the majority of the seed distributed had been planted and was maturing successfully. In addition, most households were eating two meals a day of maize or wheat, beans, cabbage and coffee and in some cases sweet potato, milk and sorghum. For the majority, the main source of food was the market with income coming from daily labour, credit and the sale of grass, firewood and in the rarer cases agricultural produce such as cotton, green maize, cabbage and milk.

While a large proportion of the dramatic decline in malnutrition between April and July was due to the arrival of rain in May and the general improvement in the food security and animal health situation seen by June, evidence from near-by Woredas indicates a significant impact of the Concern intervention in Wolayita. In neighbouring Bedewacho Woreda, which did not benefit from early assistance from an INGO, a nutrition survey in August found that malnutrition rates remained relatively high at 16.8% GAM and 4.8% severe wasting.

Lessons Learnt
- The programme implemented a number of activities simultaneously which, as well as treating those already sick, attempted to address the wider food problem.
- Activity implementation was generally considered to be timely - feeding began within 2 weeks of the survey, when food access was extremely low.
- The programme was able to use many experienced national staff who had worked previously in nutrition programmes for Concern. With relatively little training and supervision they were able to implement programme protocols effectively.
- Experienced expatriates on the team enabled high quality of service provision from the start of the programme. This was especially true for the therapeutic feeding centres for which the presence of a paediatrician, a nutritionist and 3 nurses almost certainly kept mortality rates low and recovery rates high throughout.
- Dissemination of information and advocacy at a regional level was extremely important to ensure that areas in need received due attention and timely intervention.
- Admission criteria for pregnant and lactating women to the supplementary feeding programme were too generous resulting in a slow recovery rate and a high non-recovery rate.

Conclusions
- The stabilisation in the rate of malnutrition is a good indication that Concern’s nutrition intervention has achieved its programme goal and that generally short-term household food security status has improved. Future nutrition and food security status however will remain fragile.
- Concern has ceased all general food distributions and pending the end of year harvest, any future food distributions are the responsibility of DPPC/WFP.
- Although the majority of the population are currently harvesting, many farmers are having to use a large proportion of their harvest to recover from the previous food crisis i.e. pay off debt, purchase agricultural seeds and tools.
- Household diet and sources of income remain limited, especially in the poorest households.
- The health, especially vaccination status of much of the population remains very poor.

Future Priorities
- Supplementary feeding should continue in order that the large number of beneficiaries who remain in the programme can reach their target weight. Programme phase-out should begin in Jan 2001 with finalisation of the hand-over strategy to the Ministry of Health.
- The nutritional rehabilitation unit in Sodo Hospital should continue to be the referral facility for severely malnourished children from the Woreda. This unit would benefit from continual support in the form of monitoring visits and training opportunities.
- Continue food security monitoring and implement a fourth survey in 6 months time to ensure that nutritional status has remained stable.
- In order to sustain nutritional recovery a community health and nutrition programme, developed in conjunction with the Woreda Ministry of Health, is now a priority. As well as addressing immediate needs such as low vaccination coverage and poor health centre capacity it should begin to develop strategies which will improve longer-term food and health security.
- Criteria for admission, monitoring and discharge of pregnant and lactating mothers should be re-evaluated and developed for this population group. Further research is required in this field.

Concern would like to acknowledge OFDA, Ireland Aid, Fyffes and Ethiopian who have generously supported the above programmes.

1. All care administered followed standard WHO/MSF/Concern protocols.
2. All pregnant women in the third trimester were admitted to the SFP. This is difficult to verify as many were not receiving antenatal care and did not have a card with estimated time of delivery recorded. Many of the women were admitted based on appearing to be in the 3rd trimester.
3. A country-wide shortage of grain: even though many donors had pledged grain for Ethiopia by April 2000, a gap of at least three months was anticipated before these pledges reached the required destinations. Lack of fuel and transport at Woreda level for grain distribution; Damot Woyde Woreda Council had very little capacity to distribute grain once it arrived in Woreda warehouses.
4. Shashemene only 2 hours to the north remained a surplus producing area where food was available for local purchase - this contrast in the food security of neighbouring areas is common across Ethiopia and is an important issue to be considered when discussing famine preparedness and prevention.
5. This ration complied with the National Policy for general food distribution.
6. This ration complied with the National Policy for general food distribution.
7. All care administered followed standard WHO/MSF/Concern protocols.

*Figures are taken from the National Policy for general food distribution.*
International Emergency and Refugee Health Branch in CDC

By Jeremy Shoham

Most people have heard of the Centre for Disease Control and Prevention - known as CDC. Based in Atlanta, Georgia, CDC is part of the Department of Health and Human Services in the US government and deals with matters of public health. CDC’s work mainly involves public health in the US (more than 95% of CDC funding). The International Emergency and Refugee Health Branch (IERHB) within the CDC is less of a household name. Formed within the last three years, this branch has now become the formal centre of CDC humanitarian emergency activities overseas. The focal person for IERHB nutrition activities within IERHB is Bradley Woodruff. Up until 1996 he worked in the CDC Hepatitis Branch but joined the unit dealing with humanitarian emergencies (a precursor to IERHB) in 1996. Field Exchange interviewed Bradley by phone.

Bradley recalled that CDC’s involvement in emergency work overseas began with the Biafran crisis at the end of the 1960s. This introduction to international emergency work was marked by the tragic death of a CDC staff member who was killed in a plane crash while on mission. In the late 1970s CDC sent various staff to assist with epidemiological work in the Kmer refugee camps in Thailand. The first staff member to be employed specifically for full-time work in humanitarian emergencies was Mike Toole in the mid 1980s. Mike’s extensive experience of refugee and other emergency programmes made this appointment a coup for CDC. Mike worked alone until the early 1990s. The appointment of additional full-time ‘humanitarian emergency’ staff resulted in the coalescing of their activities into a unit (1994). Staff from this unit assisted UNHCR and UNICEF in their responses to the refugee crisis in Zaire following the genocide in Rwanda. CDC staff realised that NGOs were relatively ill-prepared to respond to such a large emergency. As a result, OFDA funded training of staff from US PVOs (US NGOs). CDC were involved in writing curriculum and evaluating the pilot training. The formal formation of a branch within CDC dealing with humanitarian emergencies - IERHB, only occurred in 1998.

IERHB now has 9 full-time staff including 5 medical epidemiologists, a statistician/epidemiologist, a public health administrator, and administrative support. The branch has access to all CDC staff which ensures wide-ranging technical expertise and laboratory support.

Focus of activities

The main areas of IERHB activity are:

- Emergency response
- Training and Capacity Development
- Operational Research
- Programme Evaluation
- Information Dissemination

Brady explained that IERHB works with organisations that need epidemiological or public health expertise and provides technical assistance upon request. Collaborating organisations include branches of the US government (OFDA, USAID etc.), UN agencies, international and local NGOs and governments. Most of the NGOs are US NGOs “as European NGOs tend to have more ‘in-house’ epidemiological expertise” - although Bradley felt that this was changing.

The types of work undertaken by IERHB include:

- epidemiological surveillance
- rapid health assessment
- health and nutrition assessment surveys
- outbreak investigations
- disease control programmes
- training in public health and epidemiology
- evaluation of health services

IERHB and nutrition

All IERHB staff have nutritional epidemiological expertise and can undertake or advise on nutritional assessments. Staff tend to work overseas for 4-12 week periods. Bradley acknowledged that “this makes it difficult to get involved in long term problem solving”.

Bradley explained that IERHB do not get very involved in assessing food security leaving approaches like household food economy and livelihood analysis to other agencies with greater expertise. He did however admit to a sense within IERHB that there is a need to start thinking about how to better integrate food security and anthropometric assessment information.

The branch is also asked to undertake epidemiological work on micro-nutrient deficiency outbreaks. They were asked by UNHCR and WFP to investigate the riboflavin deficiency outbreak amongst the Bhutanese refugees. The excellent laboratory back-up of CDC makes IERHB ideal for this type of work.

Bradley affirmed that being involved in nutritional surveys and assessments can place IERHB in politically sensitive situations as “results may not always be what agencies want to hear”. However, “CDC/IERHB’s reputation and track-record is such that most agencies trust the objectivity of findings”.

IERHB is a WHO collaborating centre for emergency preparedness and response which means that WHO can theoretically call them up at any time for help. IERHB also assist in training staff from the US government, UN agencies, NGOs, universities, and ministries of health in foreign governments. Staff also attend scientific meetings and assist in curriculum design. In the nutrition field, training is limited to epidemiology and assessment. IERHB are not involved on the nutritional intervention side.

Research activities of IERHB

A number of nutrition related research programmes have been completed by IERHB. One study in Tanzania examined the report that iron dosages three times a week were effective in treating moderate and severe anaemia.

There has also been research into optimal anthropometric measures of malnutrition in adolescents. This research came about following the reported high levels of severe anaemia and malnutrition in adolescents in Kakuma refugee camp. A study in Kakuma and three Dadaab camps in Kenya found that, using WHO anthropometric criteria, prevalence of wasting amongst adolescents was very high whereas under five wasting and mortality levels were low. At the same time food security in the camps appeared to be adequate. There were similar findings amongst Bhutanese refugees.

This led IERHB to question the applicability of the WHO guidelines on anthropometric assessment of adolescents and to IERHB’s involvement in the recent SCN publication on optimal ways to measure nutritional status of adolescents (see this edition of Field Exchange).

Another study completed by IERHB has involved looking at outcome indicators (mortality and morbidity) in 52 camps in stable situations (after emergency related mortality has stabilised) in relation to nutrition and health indicators. The aim of this study is to determine which variables lead to best outcome. Results are soon to be published.

On-going research in the branch includes developing field-friendly techniques for measuring iron, vitamin A and iodine status. A recent survey conducted by IERHB found a 4% prevalence of biotin spots amongst adolescents but when blood samples were taken back to CDC prevalence of low serum biotin was over 30%. Bradley felt that this showed how important it is to develop field techniques for serum assays as clinical diagnosis can be so problematic. “Basically, we need to develop something like a haemocue but for Vitamin A.”

IERHB are also hoping to conduct research into standardising case definitions of scurvy. As many as three case definitions have been used by the same agency. Bradley is hoping for an opportunity to conduct simultaneous clinical and biochemical assessment.

IERHB wish to expand their R & E activities and are currently talking with Epicentre in France and two US universities about potential collaboration.

It appears that other parts of CDC may be more susceptible to political pressures than IERHB. For example, CDC efforts to conduct research into needle exchange programmes to prevent spread of HIV in the US and epidemiological studies of the effectiveness of gun control programmes were resisted in the past for political reasons. Bradley could not think of two reasons why IERHB activities might be curtailed: conflict with US foreign policy and security concerns. As examples, “Travel to Iran was not allowed due to foreign policy towards Iran while work in Burundi has been disallowed in the past for security reasons”. However, the fact that CDC’s main constituency are state health departments, which have a great influence on CDC’s overall operation, means that CDC generally have a fair degree of autonomy over what they do while IERHB have even less political interference because their work is based overseas and therefore rarely poses a threat to political interests. CDC has no legal regulatory authority, either within the US or overseas.

Bradley believes that there is still limited understanding internationally of CDC’s work and that “CDC provides a unique centralised repository of epidemiological expertise”. Only a few other countries, such as Canada and France, have similar centres and these centres may not have the same degree of involvement in overseas work. Bradley also believes that increasing awareness of CDC and its work is stimulating other countries to think about developing similar in-house government epidemiological expertise and that this can only be a good thing.
Money for work in East-Timor

By Mike Parker

Mike Parker has worked in the Humanitarian Aid and Development sector for nearly ten years. He has worked in a number of roles ranging from working with grass roots education groups in southern Africa in the early nineties to larger scale government health and finance programmes. This article arises from Mike’s experience in East Timor from May to November 2000.

In the last 500 years East-Timor has been invaded by the Portuguese, Japanese and Indonesians. The final period of colonisation involved a genocidal campaign of terror orchestrated by Indonesia. The west turned a blind eye to the invasion and repression in East-Timor. Out of a population of approximately one million an estimated 250,000 people were murdered over a twenty-five year period.

Suharto’s regime did little to develop East-Timor, continuing the Portuguese policy of exploitation. The regime built roads to help plunder the country of its teak and coffee. In the 80’s large deposits of oil were found in the Timor Gap, the stretch of water that separates East-Timor from Australia. This attracted the attention of a circling pack of western interests.

In late 1999, to prevent further atrocities by Indonesian backed militias and assist the people of East-Timor in defending the outcome of their referendum, in which the people of East-Timor chose independence, the UN intervened primarily with the use of Australian peacekeepers.

Reconstruction begins

The money for work programme in East Timor in which I was recently involved, was funded directly by the US government via USAID and as such represented a change in policy, in that much of USAID’s assistance in other parts of the world is usually in the form of loans and technical aid. It was anticipated that the positive spin-offs of this project would be:

i) The promotion of the US dollar over other currencies that were likely to replace the Indonesian Rupiah i.e. the Australian dollar

ii) A reduced risk of inflation and resulting instability in the economy by virtue of introducing a strong currency

iii) An enhanced ability for East Timor to continue trading by virtue of having a hard currency, thus providing a comparative advantage with their nearest trading partner i.e. Indonesia.

My own role as one of 12 UN finance/procurement officers meant being the contact point at district level for these funds. Our function was to collect the money, distribute it, account for it, create budgets with the project co-ordinator, provide a narrative of the project and supervise the work groups with the various project managers. The scheme was known locally as the ‘Temporary Employment Project’ or TEP’s.

The scheme was a challenge in many ways. Although similar to ‘Food for Work’ in providing a way to stimulate reconstruction, it was different in that it gave beneficiaries at the micro-economic level control over the development of the market, i.e. the spending decisions that determine the relative price of goods and items produced.

TEP’s started in April 2000 and were launched by a campaign over the radio, in newspapers and on public notice boards. Therefore, when the work started in May 2000 there was at least some knowledge out in the communities, as was witnessed by the large numbers of people that turned up at various UN district offices looking to join work groups.

Of course, there were questions concerning the work and how people were to be paid, particularly with regard to payment in US Dollars. We made pay-day every Saturday. The decision to pay on a weekly basis in our district was taken with local partners. It meant that:

1. There was regular reinforcement / familiarisation with the US currency.

2. We had contact with people doing the work and could get to know their problems quickly (e.g. if there were not enough tools and supplies to complete the job within the time-frame).

Furthermore, it helped to develop a relationship between the UN and people in East-Timor. We became familiar with many of the local chiefs and headmen and were able to talk about the work at project sites. It also meant that we were able to monitor the progress of the work against plans that we had submitted to US AID in Dili prior to grant allocation.

3. The money went into the community as soon as possible and did not sit in our safe. We believed that it was advisable to pump money in quickly to ensure rapid re-construction and re-establishment of trade. This did happen visibly, with the local markets growing and attracting more traders, although it was difficult to measure the volume increase and to gauge the relationship of TEP’s to this increase.

4. Each payment meant that we held less money and therefore were potentially less of a target. Fortunately, no insecurity was experienced as a result of holding or distributing the money. The movement of money around to various sites where groups were working was a security concern. At first people came into town to collect their pay, but due to (a) large
groups, malling around waiting to be paid and (b) the need to gain a better idea of the work that was going on, we decided, where possible, to pay at the sites. This did decrease tension, allowing us to see the work on a regular basis and therefore monitor progress against the project plan. Occasionally, it was necessary to hold back money, where it was clear that no work or very little work had been done. This never happened without discussion as to why we were taking this action.

**TEPs - The work itself**

Most of the work centred around the town and the reconstruction of various community structures, which had been damaged by fighting and neglect, but did not include UN occupied buildings - although the distinction was sometimes blurred. A great deal of the work involved road maintenance and clearing the metre deep gatters essential to direct run-off away from the roads so as to prevent further road erosion. Most of the roads had been left in a state of neglect by the Indonesian authorities. The local hospital was rehabilitated, as was the health clinic in Betano. A workshop was opened-up and work commenced on a dilapidated fish farm.

**Pay differentials**

Some of the workers were skilled and therefore paid at a higher rate. We also paid the supervisor at a slightly higher rate. All these rates were set by USAID. For example, a worker received $3.21 per day, a supervisor and skilled worker $4.17 and a manager $6.00.

**Women's groups**

It was important to ensure that women were included in the scheme. They therefore had their own groups, most of which were involved in community rehabilitation works like the health clinic in Betano and the community centre in Same. One criticism of the programme was the limited number of women’s groups and the scope of their work. Of the forty or so work groups only 5 were women’s groups.

Furthermore, it seems that some of the women would then hand their money over to their husbands, but we had no real information on the distribution of this money and what it was spent on or what difficulties might have arisen.

**Strengths of the programme**

The US dollar stability added strength to the East-Timor economy. It allowed for a continuation of trade in favour of the East-Timorese economy as desperate Indonesian traders sought security in dollars. With the introduction of the dollar inflationary pressures were experienced by those holding Indonesian Rupiah. The Australian dollar, a possible alternative to the US dollar was also experiencing problems with a 5% loss in value against the US dollar over a 6 month period. Thus, those holding US dollars were able to gain as they traded US dollars against Rupiah and the Australian dollar. But this only benefited those who were working and being paid in US currency.

The money was easier to store and handle than a warehouse of consumables and therefore needed less resources in order to support - just myself, a couple of armed police officers, a safety deposit box and transport. This contrasted with a food aid programme using, for instance, rice or wheat which would have to be transported along treacherous roads that were often impassable. Also, such foodstuffs would need careful storage so as to prevent spoilage.

**Weaknesses of the programme**

Limited time for programme implementation stipulated by donors created problems of effective monitoring, as the project had a start date of April 2000 and a finish date of September 2000. Although all parties had the desire to see the money ‘out there’ as soon as possible, the time-frame was a factor that led us to centralise much of the work near the local district centre. As a result, the sub-districts were less well served - something we rectified with subsequent tranches of money, with the sub-districts being given priority.

On occasions, there was nothing to buy i.e. not even rice, due to crop failure that had in part been due to the forced internal displacement of people around the country. Large areas of previously cultivated land remained unused and much of the irrigation infrastructure was in need of substantial rehabilitation. Furthermore, not all sub-districts were ‘money’ oriented, relying more on barter and subsistence farming. In the latter stages of the TEPs this was taken into account so that ‘food for work’ schemes were established alongside TEPs in those areas where there was a greater need to provide basic foodstuffs rather than cash, e.g. in Aileu, some 50kms south-east of Same.

**Opportunities created by the programme**

Savings and investments by individuals and government and the development of cross-border trade.

**Programme Threats and Concerns**

i) Possible armed robbery, which although always a threat never actually occurred, probably due to the high degree of honesty amongst the East-Timorese and the presence of large numbers of police and troops to provide escorts.

ii) Misinformation concerning the dollar i.e. the idea that the US dollar would suffer a similar fate to that of the Portuguese Escudo which experienced a loss of value that led to people’s savings being wiped-out ‘overnight.’

iii) Irregular supplies of dollars - this never actually occurred but was a concern.
Joint WFP/UNHCR evaluation of Kenyan refugee programme

Summary of report

In September 1999, WFP and UNHCR conducted a joint evaluation of their assistance (Protracted Relief Operation (PRO)) to Somali and Sudanese refugees living in camps in Kenya. At the time of the evaluation there were approximately 120,000 refugees (mostly Somali), in Dadaab, with the remaining 80,000 (75% Sudanese) in Kakuma. The focus of the evaluation was the existing PRO although the team also assessed the impact of the long-term assistance provided since 1991. The main findings are summarised in this article.

Economic Environment

The refugee programme in Kenya has for nine years been characterised in terms of protracted relief with little possibility of breaking the mould of dependency. Regional wars have shown no sign of abating while the forecast for large-scale repatriation have not been promising with resettlement providing a solution for relatively few refugees.

Traditionally, refugee self-reliance is contingent upon external economic opportunities, e.g. integration, trading, mobility, employment. In Kakuma and Dadaab, enforced containment and the lack of durable solutions forced the evaluation team to examine the extent to which an internal economy might be viable.

General distribution

Large amounts of staff and time were involved in supporting the distribution process, particularly in Kakuma. For security reasons, food distribution in both camps was carried out on a bi-monthly basis. The result is that implementing partners utilise staff and resources exclusively for distribution to the detriment of other programmes. In Kakuma, for instance, school attendance drops during distribution while other programmes and services, e.g. shelter and social services, are undermined by the fact that transport and staff are monopolised twice a month for five days.

The solution lies in a combination of (a) increasing the capacity of the distribution centres, (b) moving to a once-monthly distribution, and (c) having alternative EDP storage to reduce in-camp transport costs.

Empty food containers

WFP has used empty food containers (sacks and oil tins) in a number of innovative ways in Kakuma and Dadaab. In Dadaab, for instance, between October 1998 and July 1999, WFP distributed 778,069 sacks and 210,770 tins for various purposes. The sacks (with a market value of 8-10 KSh each) were distributed to girls in schools to encourage enrollment and regular attendance. From 1993 to 1999 girl attendance in primary schools rose from 1,524 to 8,285, in part attributable to this incentive programme. Sacks and tins were also distributed within the various income generating and skills programmes to encourage female attendance.

The most impressive use of empty containers has been in Dadaab where WFP raised 2.52 million KSh by selling them to CARE, then using the money to construct 33 classrooms. In addition, tins were used in constructing school walls and latrines. In Kakuma, tins were used for home roof construction by unaccompanied Sudanese minors.

Trade in food commodities

The general consensus among refugee and agency representatives is that self-reliance on anything more than a piecemeal basis is not a viable option for people within a closed and barren environment. Integration as a durable solution has not been pursued by the Government of Kenya, though the evaluation team found a surprising level of economic integration between refugees and local populations. In Dadaab in particular, a large number of Kenyans act as ‘middlemen’ for trade in food commodities between the camps and regional towns. In Kakuma, Turkana people will purchase small quantities of rations from refugees, then sell them at the local markets.

CARE in Dadaab and IWF in Kakuma have encouraged skills development and income generating activities, some of which have an external market value. In Dadaab, loans are given to some refugees setting up business in the market which in turn relates to the ‘export’ of food items. It is estimated that up to 20 percent of WFP food items are sold by refugees so as to obtain other essential commodities (including different foods). What is not known, however, is the manner and scale of such trade and how this impacts upon the refugee community as a whole. The evaluation team believes it is necessary to have a much clearer picture of the internal economy of the refugee camps and the external economy vis à vis Kenyan traders.

Food-for-work

The team found it useful to designate three refugee categories based on wealth and access to resources: (i) those with trading opportunities, (ii) those with job opportunities and (iii) those with no income opportunities. It is clear that those in a relatively higher earning bracket are few. A strategy of discriminatory food distribution is simply not feasible because (a) the most vulnerable form a large majority, (b) although not a tested hypothesis, resistance to discriminatory food distribution may provoke security incidents and (c) the social dynamics of the camps would probably ‘rebalance’ food distribution in such a way that the most vulnerable would be no better off.

Targeting food through alternative mechanisms such as food-for-work - including, for instance, skills development and environmental improvement - might, nevertheless, be possible on a limited scale. The scope for pilot projects of this kind is more apparent in Kakuma than in Dadaab. For example, water catchment projects for extending vegetable gardens is an area in which the Sudanese community in particular might benefit. However, any infrastructural improvement works should be undertaken with the close co-operation and involvement of the local Kenyan authorities and efforts made to include the most destitute Turkana in such schemes.

Income generation

To obtain non-food items refugees must sell part of their food rations. Most of the NGO training programmes are not geared towards ‘marketable’ skills within the camps, but rather towards employment skills ‘upon return’. The production of low-cost basic items such as shoes, clothes, soap, etc. has not been a priority. Skills training should be re-oriented in this direction, with some incentives provided for those participating in training.

Refugees and the local population

Since the establishment in 1991 of the Kakuma refugee settlement the local population has grown from about 5,000 to 30-40,000. In Dadaab, the population has grown from about 800 in 1992 to more than 10,000 (18,000 in the district as a whole) today. In Dadaab, ethnic allegiances (usually along clan lines) and related trading has ensured something of a symbiosis between camp and local populations. This is not the case in Kakuma. Here, the local Turkana population, following years of successive drought and lack of investment in infrastructure, are considerably worse off than refugees. Indeed, food distribution in Kakuma creates a magnet for Turkana pastoralists (particularly women and children) keen to benefit from small-scale labour, petty trading and even begging.

The environmental damage caused by refugee settlement in Kakuma may have been more severe than in Dadaab. WFP’s Vulnerability Analysis and Mapping (VAM) Unit in September 1999 concluded that food-for-work projects in areas such as reforestation, water management and sanitation would improve conditions for the local population while lessening tensions between them and the refugees.

* The SCP-KF Food Economy Updates indicate that this group has increased in the last three years to about 10-15 percent.
Feeding the unborn babies

By Severin Kabakama

The programme which is still ongoing was implemented in order to reduce the prevalence of low birth weight and improve pregnancy outcome. Prevalence of low birth weight in the camps at the start of the intervention was 30% (Low Birth Weight is defined as weighing less than 2500g at birth). The main causes of LBW are malaria, HIV infection, worm infestation and lack of adequate nutrient intake during pregnancy. Women enrolled in the programme are given a dry take-home ration from the second trimester (from 16 weeks gestation age) to delivery. Approximately 30,000 pregnant women in eleven refugee camps are involved in the intervention.

The World Food Program (WFP) provides the supplementary ration while UNICEF through operational partnership with implementing agencies, closely monitors the implementation of the programmes and its outcome.

Ration size and quality

The daily ration comprises 200g of CSB (Corn Soya Blend), 20g of vegetable oil and 20g of sugar per pregnant woman providing a total of 1018 Kcal (38g of protein). This is distributed every two weeks at the nutrition supplementation Unit. In total it is assumed that a pregnant woman receives about 3180 Kcal per person per day (a drop of about 20%).

The weighing, mixing and distribution of the supplement is normally carried out by the pregnant women themselves, who have been recruited onto the programme through their attendance at antenatal clinics where verification of gestation age is necessary.

The distribution process

Names are called out by a nutrition attendant with each beneficiary receiving a “premix” for 14 days - about 3.36Kg. As large numbers are always involved (approximately 400 for a camp of 38,000 refugees), a roster for each block/village in the camp is used to avoid congestion and time wasting. Nutritional education (emphasising the nutritional value of the supplementary ration) and cooking demonstrations are frequently conducted at the distribution site.

Main findings and lessons learnt

The programme has contributed to a reduction in low birth weight in the camps. Prevalence of LBW has decreased from 30% to 8.5 - 10% in different camps. These results are similar to a study in Gambia in 1997 where a 50% reduction in LBW was observed after supplementation with groundnut-based high energy biscuits (providing 1000 kcal per person per day). The success of the program is mainly due to close cooperation between the pregnant women themselves, the service providers at the antenatal clinic and the personnel at the supplementary feeding units.

Added impacts and benefits of the programme

• the women organise themselves and take a strong leadership role in nutritional aspects of the programme.
• an increased number of pregnant women receiving malaria prophylaxis, de-worming and iron supplementation (at the ante-natal clinic).

• an earlier enrolment in the ante-natal programme resulting in earlier identification of pregnancy risk factors.

Programme Constraints

• It has been difficult to evaluate programme effectiveness as allocation of a dry take home ration has meant that actual consumption by intended beneficiaries is uncertain, i.e. some of the ration may be consumed by other household members.
• The effectiveness of the programme has been compromised due to interruptions in the general ration food pipeline (i.e. to be optimally effective supplementary feeding programmes need to supplement an adequate general ration). For example, as of July 2000, there has been a 40% cut in the general ration.

This was the first time the general ration supply had been compromised during the programme. While the supplementary feeding of pregnant women has continued during this period there has been a drop in overall intake from 3180 Kcal to 2522 Kcal per pregnant women per day (a drop of about 20%).
The move from Phase 1 to Phase 2 should take place at mid-day, in order to achieve a gradual increase in the amount of food consumed. Some agencies have a separate phase for this transition with a total of three phases in the centre. However this may introduce a risk that patients stay longer than necessary ‘in transition’, and that the crucial individual monitoring of patients in transition is replaced by a standard nutritional protocol.

A premature transition from phase 1 to phase 2 can lead to over-feeding syndrome, congestive heart failure (see above) and increased oedema (or persistent oedema in phase 2).

The syndrome associated with over-feeding is caused by hyperglycaemia combined with electrolyte imbalances. This leads to kidney, heart and intestinal overload, which can lead to a fatal congestive heart failure. Typical causes of over-feeding are:

- Excess volume of food (and liquid) during one meal (e.g. early transfer to phase 2; an adult patient eating more than prescribed)
- A high protein diet (> 16% of Kcal provided by protein)
- A diet high in sodium (either through the use of excess RESOMAL or ORS or from food offered by family members)

The signs of over-feeding syndrome include:

- an increase or the (re-)appearance of oedema
- in severe cases, the rapid development of congestive heart failure

**All age groups**

The principles of treatment (food and drug types) are applicable for all age groups - children, adolescents, adults and the elderly. Differences include:

- for adults treatment with antibiotics is not systematic but is carried out only on prescription, i.e. on indication of symptoms or having specific complaints for which treatment is prescribed by the designated medical person
- measles vaccination is not necessary for adults
- systematic malaria testing of adults is not necessary

Dosages of medical and nutritional regimes will differ depending on the weight and age of individuals. For dietary treatment adults should be placed in groups according to weight and phase of treatment in order to (as much as possible) give adults similar amounts of food. This is to reduce workload for staff and reduce risk of over/under-feeding of the patient.

**Quantity of food in Phase 1 and Phase 2 (per day)**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Phase I</th>
<th>Phase II (Minimum quantity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child - 50 yr.</td>
<td>100 kcal/kg/day</td>
<td>200 kcal/kg/day individual calculation</td>
</tr>
<tr>
<td>Adolescent 10-18yrs</td>
<td>55 kcal/kg/day</td>
<td>100 kcal/kg/day</td>
</tr>
<tr>
<td>Adult + elderly 18yrs</td>
<td>40 Kcal/kg/day</td>
<td>80 Kcal/kg/day</td>
</tr>
</tbody>
</table>

**Signs of congestive heart failure:**

- increased in respiratory rate
- increased pulse rate
- engorged jugular veins
- increased oedema (i.e. puffy eyelids)
- pulmonary congestion (crackles in lungs)
- cold hands and feet, cyanosis in fingertips and lips

Monitoring of weight during rehydration will help early diagnosis, e.g. sudden increase of body weight

**IV and Naso-gastric tube**

Food and drugs should be administered orally or by naso-gastric tube. A naso-gastric tube should be used when there is:

- complete anorexia
- severe dehydration
- inability to drink and eat (too weak, consciousness impaired)
- severe or painful mouth lesions (candidiasis)
- repeated, very frequent vomiting

Patients with a naso-gastric tube should be placed in an area which facilitates close monitoring by medical staff.

**Naso-gastric tube administration**

- Care should be taken to explain the necessity of the naso-gastric tube to the mother or patient so it is accepted and not pulled out.
- Before each meal by tube, first try to breastfeed or feed by mouth.
- To avoid the risk of broncho aspiration, patients with a naso-gastric tube should be positioned in a semi-sitting position (45 degrees)
- Naso-gastric feeding should not be carried out for more than 3-4 days. Before each use, always check placement (that tube is still in the stomach), to avoid risk of broncho-aspiration.

The tube should be changed every 48 hours.

The use of intra-venous fluids or transfusions is not part of the normal treatment. The only indication for infusion in severe malnutrition is when the risk of acute cardiac failure is high due to circulatory collapse (severe dehydration or septic shock) or a life-threatening anaemia.

In some cases, intramuscular (IM) injections are necessary. Care should be taken to carefully select the site of each IM injection.

**Programme Issues**

Setting up a TFC is justified when there is a food crisis or famine with large numbers of severely malnourished patients. The sole objective of the TFC is to reduce mortality due to malnutrition in the community. Outreach workers should conduct a personal search for patients in the community as well as trace defaulters. Additionally, efforts should be made with the community to identify and tackle the causes of the food crisis and malnutrition.

In non-emergency situations there may be a limited number of severely malnourished individuals (children, adolescents and adults). These individuals will often have a history of disease and social and economic marginalisation. These patients also need treatment which should be offered in existing hospitals. The principles that are outlined above for TFC’s also apply to hospitals; however hospital staff will need thorough training in treatment of severe malnutrition. In addition discussions with individuals and their families should take place to identify the causes of malnutrition and possible solutions for that individual. It should also be recognised that it may not be possible to have an active case finding, defaulter tracing nor a programme component aimed at reducing severe malnutrition in the community through hospital programmes. This may need to be negotiated with the Ministry of Health and Community Health Programmes (if these exist).

In situations where there are only a few cases of adult malnutrition, they can be treated in TFCs which target children or in a hospital.

**Design of TFC**

Ideally a TFC has a 24-hour care unit where cases in the first phase are treated and where patients in the second phase with medical complications are treated. However, when first opening a TFC, especially where there are large numbers of patients (e.g. in a famine situation), the TFC should at first set up day-care only. As soon as the situation stabilises and capacity is adequate, then 24-hour care can be started. When the number of patients is large, the nutritional component of the treatment can be standardised on the basis of individuals being placed in weight categories/groups and groups requiring intensive or less intensive monitoring. These simplifications make it easier to provide patients with adequate care at a time when resources may be stretched without compromising management or exhausting the staff.

Authors of the MSF nutritional guidelines: Sophie Baquet, Saskia van der Kam, Jane Little, Veronique Priez, Fabienne Vautien.
Development of Kenya Food Security Coordination System (KFSCS)

by Robin Wheeler

Robin Wheeler has been WFP’s Regional Vulnerability Analysis and Mapping (VAM) Officer for the Horn of Africa based in Nairobi since October 1998. He was the USAID/FEWS Country Representative in Ethiopia (1996-98) and Niger (1991-93), and held positions with USAID as a government advisor in Guinea (1994-95) and an emergency coordinator in Niger (1993).

While Kenya is one of the more developed countries in Africa, it has lagged far behind most in development of a national early warning system and coordination in the food security sector. As late as 1998, the Government of Kenya (GoK) had two donor funded early warning/food security projects - Arid Lands Resource Management Programme (ALRMP) and Drought Preparedness, Intervention and Recovery Project (DPIRP) - covering the ten almost exclusively pastoral districts in Northern and Eastern Kenya. However, the GoK had little capacity for comprehensive early warning or coordination of food security activities in other areas of the country. In addition, within the central government, it was very unclear as to who/which structure had responsibility for early warning and food security coordination and analysis.

Outside of the GoK, a plethora of international organisations (donors, UN agencies and NGOs) were independently conducting their own early warning and food security data collection and analysis. The result of these activities and systems was:

- i) a large amount of inconsistent and sometimes misleading information that was confusing to decision makers;
- ii) the development of parallel systems - one in the GoK and others among international organisations - for implementing food security related emergency and mitigation activities.

This situation was unacceptable to donors and many others who felt that as a result of the poor coordination, the effectiveness of interventions was limited and financial and other resources were being used inefficiently.

Formation of the Kenya Food Security Steering Group

In late 1998, the World Food Programme (WFP) and the GoK in agreement with donors and other partners decided to change the function and structure of an existing WFP-chaired, semi-monthly forum to share information on emergency interventions to make it much more systematic, efficient and action-oriented. It was also decided to broaden the forum’s scope to include early warning and comprehensive food security situation updates and analysis. To this end, the members of the revitalised forum, which became the Kenya Food Security Meeting (KFSM), agreed to create and nominate members for a steering group. This steering group first called the Kenya Food Security Information Steering Group and later renamed the Kenya Food Security Steering Group (KFSSG) at the request of the GoK, led the effort to develop a systematic, comprehensive and multi-agency early warning, food security status monitoring and assessment system for Kenya.

The KFSM meets monthly, includes representatives from over 50 different organisations (GoK departments, UN agencies, donors and NGOs) and is open to all organisations with an interest in food security. The KFSSG is a subset of the KFSM and currently includes representatives from three GoK departments, three UN agencies, three NGOs and two donors. Membership of the KFSSG is restricted to organisations which have demonstrated a clear commitment to a collaborative approach and which possess technical, policy or administrative capability in the area of food security and drought management. The GoK requested the name and scope change of the KFSSG (from KFSISG) because it was extremely happy with the progress made and felt that the mandate of the KFSSG should be to coordinate more than just the information system.

Formation and Role of Geographic Review Teams

The other structures that were created early on in this process were the Geographical Review Teams (GRTs). The GRTs ensure that up-to-date early warning and food security status monitoring data and reports covering the entire country are available to the KFSM and KFSSG on a monthly basis. They provide an opportunity for organisations that may have relevant data for a small area (such as NGOs) to furnish and discuss that information in a geographically specific group that ensures it is considered in the production of the situation report for the larger zone. This alleviates the necessity of having every local organisation present at the KFSM and endless reports at the KFSM on organisational specific assessments, activities and initiatives. There are five GRTs that cover different administrative-livelihood zones - northwestern pastoral, northeastern pastoral, agro-pastoral, marginal agricultural and high potential/dairy districts - across the country. The GRTs have a focal point and are composed of organisations with capacity and/or interest in activities in the zone covered by the GRT. They are charged with collecting and analysing all relevant data, developing a consensus among the members of the GRT, putting together a situation report based on this consensus position and presenting that report at the KFSM. They also have responsibility for reporting on the major interventions, reviewing proposals for funding for activities and providing recommendations for action and/or interventions still needed in their zone.

Outcomes of Improved Co-ordination

The creation of this Kenya Food Security Coordination System (KFSCS) greatly facilitated the development of important joint initiatives. Multi-agency food security assessments became the norm, and coordinated field assessments are conducted on a regular basis. WFP and the NGOs agreed to transport GoK food aid as well as that from WFP. The GoK has made substantial pledges to WFP EMOPs (Emergency Operations) and the GoK has agreed that all the food is placed in a single pipeline. The KFCS agreed that the Community Based Targeting Distribution system (CBTD) should be used for the EMOP and the GoK made the CBTD system the law of the land. As a result, the previous ineffective and sometimes corrupt targeting and distribution system administered by GoK District Commissioners was shelved and the much more effective, grass-roots based CBTD system run by elected, gender-balanced relief committees was adopted and implemented throughout the country. A series of missions have indicated that the KFSCS and CBTD initiative combined have revolutionised food aid targeting and distribution in Kenya and ensured that vulnerable populations in all areas covered by the EMOP have received adequate food. In addition, a large number of Kenyans like the new systems and feel empowered by it.
A Model for Co-ordination in Other Sectors

In May-June 2000, the UN system was required to produce a Consolidated Appeal (CAP) for Kenya covering the July-December 2000 period. The food sector was well coordinated so that WFP, the GoK and their partners had already reached agreement on what resources were required and the numbers that would go into the CAP. However, there had been little consensus developed on needed interventions in other sectors. Therefore, at the request of the UN agencies concerned with these other sectors and the GoK, the KFSCS was used and multi-agency Sectoral Groups for Agriculture and Livestock, Health and Nutrition and Water and Sanitation were created within the system to meet and develop consensus reports and numbers for the CAP for these sectors. The result was that the UN CAP and GoK appeal were exactly the same and donors generally responded very well, funding many previously unfunded initiatives. Following completion of the CAP it was decided that these Sectoral Groups should be maintained and strengthened, so that the same kind of consensus that existed in the food sector could be extended to other emergency interventions and preparation of documents like the next CAPs would be facilitated. As such, these Sectoral Groups now provide technical backstopping and set standards within their respective sectors for data collection, analysis, assessments, surveys and interventions.

The UN System in Kenya in conjunction with the KFSCS produced another consensus-based CAP for the January-June 2001 period in December 2000. The background analysis and contingency scenarios in that document were derived from a Kenya Food Security Situation Report produced by the KFSSG during that same month. The information contained in this document came from the KFSSG members, GRTs and Sectoral Groups.

Lessons Learned

Key principles

In terms of lessons learned, the major principles used in creating the KFSCS, which led to its success and may be transferable to other countries are:

1. Development of a forum (the KFSM in Kenya) and a system that enables all interested and relevant institutions to have input into the development of the system, have access to the same complete early warning and food security information and collaborate and coordinate their activities in the sector;

2. Creation of a steering committee for the system, with dedicated members, which drives it and ensures that it continues to develop in a positive way;

3. Establishment of GRTs which ensure that relevant field information is brought into the system on a very regular basis and institutions, such as NGOs, which cover small geographical areas, but may have very detailed and relevant information, have input, yet do not take large amounts of time giving independent reports at the country-wide forum;

4. Creation of sector groups that ensure that technical detail is considered, but not in the larger forum, and that the relevant group of technical people are involved in the discussions and decision making required in the sector;

5. Involvement in the system of government or in cases where government is lacking, other authorities on the ground; and

6. A willingness by all involved to think broadly and go beyond the immediate needs of their individual agency working towards getting the overall tasks done in the most effective and efficient way possible, using the principle of comparative advantage.

Tanzania has already used these principles gleaned from the Kenya example to begin creating its own food security coordination system, while southern Sudan and Uganda have both expressed interest and are about to begin efforts to create similar systems based on these principles.

In the longer term, it is certainly hoped that the GoK will develop a national early warning system with long-term capacity and extensive coverage of the country as well as national structures with a clear mandate for coordination in the food security sector. However, the support and involvement of the international community throughout this process will be necessary, and the development and operations of the KFSCS have filled a dangerous vacuum that existed and would have prevented an adequate response to the devastating drought that has crippled Kenya during the last three years.

Remaining Challenges

The experience in development and operation of the KFSCS has been largely positive, but it has not been without its difficulties and challenges. While the analysis and dissemination of food security information is now generally well coordinated at the national level, relevant, up-to-date, monthly food security information is still lacking from some areas of the country. This is particularly true for the marginal agricultural and agro-pastoral areas of Kenya and can be attributed to poor NGO coverage of many of these areas, and sometimes an inability or unwillingness by some field-based projects and NGOs to contribute regularly to the system.

The involvement/participation of organisations within the KFSCS is completely voluntary. During the current emergency, strong participation in the system by a myriad of organisations has at least been partially driven by a healthy dose of vested interest, since donors tied much of their emergency funding to participation in the KFSCS. As we hopefully move from an emergency to recovery and back to a developmental phase in Kenya in the next year or so, it will be a challenge to ensure adequate involvement by key organisations in the different structures of the KFSCS and maintain the momentum of the last two years.

The KFSCS and its subgroups have accomplished a great deal over the last two years, but its efficiency and effectiveness have been hampered by the lack of any permanent or seconded staff. All members of the KFSSG, and for that matter the KFSCS, have full-time jobs with their respective agencies, and KFSSG activities are additional to their already full workloads. Until the KFSSG has at least a permanent secretariat and preferably at least one technical advisor, it will be limited by the ability and willingness of its members and organisations to continue working overtime to achieve global objectives in addition to their own organisational objectives. In the longer run it is unlikely that the KFSCS will be sustainable without some permanent staff. The KFSSG has recognised this and has proposed that, to begin with, two staff from the GoK be seconded to the KFSSG to act as its secretariat.

While most agencies in the food security sector are enthusiastic members of the KFSCS, some organisations insist on continuing to perform independent assessments with non-standard methodologies and, particularly in the non-food sector, intervening in a un-coordinated way. This makes their assessment findings difficult to compare with data from the KFCS, and can lead to different results and confusion about the real situation on the ground as well as unnecessary duplication and interventions with over-lapping purposes.

With strong support from WFP and the GoK, the KFSCS extended its coordination to food aid targeting, logistics and distributions at all levels in areas covered by the WFP Emergency Operation (EMOP). During February 2001 this involved 22 districts and 86 percent of the land area of Kenya. As noted above, the GoK has provided a large portion of the maize for this operation through pledges to the WFP EMOP. However, the GoK has also continued food aid distributions on its own in ‘pockets’ of approximately 23 other districts in Kenya, not covered by the EMOP and until recently, not part of the monthly KFSSG/Food Aid Estimates Sub-Group (FAS) review of needed allocations. In coordination with its partners, the GoK has recently tried to rectify the continuation of a dual food aid targeting system by bringing information on these allocations/distributions to the attention of the FAS, and asking that global food aid targeting in the GoK provided-for districts be performed in the same way it is for EMOP districts. The GoK has also been attempting, with varying degrees of success, to implement CBTD in these areas. In addition, the January 2001 Food Security Assessments in Kenya, coordinated by the KFCS, covered 15 EMOP districts, and, at the request of the GoK, the five districts receiving the most food aid from the GoK.

Kenya Food Security Coordination System

Kenya Food Security Meeting (KFSM)

Kenya Food Security Steering Group (KFSSG)

Sectoral Working Groups (SWGJs)

Geographical Review Teams (GRTs)

Food Aid Estimates Sub-Group

Health and Nutrition Sub-Group

Water and Sanitation Sub-Group

Agriculture and Livestock Sub-Group

Education Sub-Group*

Northwestern Pastoral Team

Northeastern Pastoral Team

Agro-Pastoral Team

Marginal Agricultural Team

High Potential Team

* Education sub-group only in place since January 2001.

Notes:
• The boxes within the system – downward arrows indicate guidance, while upward arrows indicate sharing of information from the relevant working group.
• All donor, GoK, UN and NGO partners may participate at all levels of the coordination system.
Left Column, top to bottom: Susan Mwangi (AMREF) hard at work; Ambra Longatti (Caritas Italiana) and Abel Samperiz (Intermon - MRDA) in the meeting room at Intermon; Esther Wamai (nutritionist, Christian Children’s Fund); Dolline Busolo (regional nutritionist, HelpAge) happy at work; Peter Mutori (project officer, Kakuma refugee camp) and Bobby Waddell (Representative, LWF) enjoying the photo shoot; Dr. Imanol Berakoetxa, coordinator of the Somalia Aid Coordination Body - before filing.

Middle Column, top to bottom: Paula (Concern) and Kathleen (GOAL) on a well deserved day off; Evaline Were-Diang’a and Allen Kute (VAM) analysing food security information, WFP Nairobi; Emily Neidine and Alison MacColl (FIO, Somalia) in denial of the photographer; Edward Otsa (planning, monitoring and evaluation officer, ADRA Kenya) delighted to discover Field Exchange.

Right Column, top to bottom: Clemensia Mwiti (nutritionist, World Vision, Kenya) at the office; Tanya Khara (nutritionist, Concern Worldwide) writing up their Turkana assessment; Helen Young (Tufts University) and Zlatan Milisic (WFP-OLS coordinator) at the nutrition training held in Kenya (photo: Anne Callanan); Eva Magondu and Manisa Zaman holding the fort while colleagues Penina Muli, Senewa Montet and Sarah King carry out nutritional surveys, The Emergency Health and Nutrition Group, UNICEF Kenya.

All photographs taken by Joyce Kelly in Nairobi, Kenya, February 2001, unless otherwise stated.
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 ENN is located in the Department of Community Health and General Practice, Trinity College, Dublin, Ireland.

The Team
Fiona O’Reilly is the ENN Co-ordinator, and Field Exchange co-editor. Fiona has been involved in the area of nutrition, health and development for the past 10 years, half of which has been spent working in emergency situations.

Jeremy Shoham is co-editor for Field Exchange and the ENN technical consultant. Jeremy has been working in the area of emergency 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.

Joyce Kelly joined the ENN in January 2001 and works as part of the Field Exchange editorial team. She has been involved in health, nutrition and food security programmes for seven years, half of which has been spent working in emergency situations.

Kornelius Elstner works part time with the ENN.