August 2001 Issue 13

Field Exchange

Emergency Nutrition Network

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Dear Readers

The first in a new series of articles appears in this issue of Field Exchange. 'Embracing Cultures', written by Ariana Curdy will, over the next few editions take a look at some of the cultural issues that affect how we work in the emergency food and nutrition sector. Ariana kicks off the series looking at ways different cultures use and understand language, based on her early work experiences in Niger. The theme of cultural differences comes up again in a research study involving nurses recently returning from work in refugee programmes. The 'Critical Incident Technique' was used to determine the skills most valued by the nurses in carrying out their work effectively. Not surprisingly cultural sensitivity and flexibility in the face of different cultural values came up as important attributes.

One of the themes to emerge from our field articles is the value of complementing anthropometric data with good quality food security information, in order to help inform decisions about intervention needs and timing. An article written by Claire Chastre and Sonya Le Jeune (SC UK) uses three case studies (Liberia, Northern Darfur and Burundi) to demonstrate this. For example, in northern Darfur (2000) household food economy (HFE) data showed that food security was not currently compromised in spite of the poor harvest, indicating instead that the high rates of wasting recorded were largely due to a recent outbreak of measles. The authors suggest that without the HFE data the high rates of wasting could so easily have been attributed to lack of food due to the poor harvest.

In a second field article Fitsum Assefa (SC US) describes how an outbreak of scurvy in drought affected northern Afghanistan seemed to conflict with survey results showing low levels of wasting. However, other data collected indicated people were resorting to increasingly desperate coping strategies demonstrating how 'close to the edge' this population had become. Fitsum strongly recommends that systematic in-depth monitoring of the food/economic security situation, especially use of coping mechanisms, should be established in the area. This would then provide an analytic basis, from which appropriate responses are designed that are not only directed to saving lives, but also saving livelihoods.

The high quality and credibility of food economy data collected in northern Darfur as part of the SC UK Early Warning System (EWS) is the subject of an article by Steve Collins. Using this data, Steve formed a confident view about the extent of the emergency in the province in 2001. However, on presenting his findings to DfID back in the UK, it emerged that a rapid survey from another INGO had contradicted these results. The article questions the results from the rapid assessment in terms of the methodology used, the lack of time spent in the area, and limited use of baseline data. The ensuing delays in mounting a DfID response raises issues about how donor governments decide upon the credibility of survey findings during emergencies, especially when these are contradictory. What exactly are the procedures and protocols within donor organisations for reviewing the myriad of survey and assessment reports that land on donor desks as supporting evidence for funding requests from humanitarian agencies? There appears to have been very little study or review of this process. An evaluation of the Somali crisis in 1991/2 funded by the Dutch government, involved an analysis of criteria donors use to assess validity of problem identification by agencies. The evaluation concluded that 'agency track-record' and 'reputation' were a key to credibility of agency findings. Clearly, such criteria may not always be safe. A related difficulty is that agencies frequently use different methodologies to conduct assessments. A study in northern Iraq (see research section) examined 27 nutritional surveys and found huge variation in methodology and quality making comparability extremely difficult. While many donors have become increasingly sophisticated in appraising project proposals, e.g. the requirement for log frames in proposal writing, it is by no means certain that criteria for assessing problem identification are sufficiently rigorous and institutionalised.

Finally, Joyce Kelly, the newest member of our ENN team has been out and about attending a WFP workshop in Cameroon on Emergency Food Needs Assessment methods (see news section). It was a good opportunity to meet people in the field and as can be seen in the 'People in Aid' section, this also gave Joyce an opportunity to practise her photographic skills.

Food security early warning systems in the greater horn of Africa

A review[1]

The May edition of the *Greater Horn of Africa Food Security Update* presents the findings of a review of early warning in the Greater Horn. The review examined the various actors, their objectives, coverage, information generated and how this information can be accessed. Gaps in geographic and thematic coverage of the early warning systems (EWS) are identified and outlined in this article.

Geographic coverage

Coverage of EWS in the Greater Horn is incomplete. In Burundi there is no EWS. In other countries government systems may exist on paper, but do not always produce valid or reliable information. Even under relatively well-developed systems, the intensity of early warning data collection and analysis is variable depending on a number of factors; the livelihood system, the existence of complimentary EWS, geographic remoteness of some zones and insecurity.

Thematic coverage

EWS needs to be adapted to pastoral economies. It is now fairly widely accepted that part of the reason food insecurity in the Ogaden last year escalated to a crisis was because the EWS in place were weak and not adapted to pastoral areas, i.e. did not monitor water, movement of livestock and people, livestock health, etc.

Limitations of current early warning systems

Early Warning Systems lack information about underlying livelihoods and assets.

The EWS do not monitor the existence, and potential effects of HIV/AIDS. This is an omission as the longer term effects are closely linked to chronic vulnerability while the short-term effects may lead to problems not usually monitored by traditional EWS e.g. household labour availability.

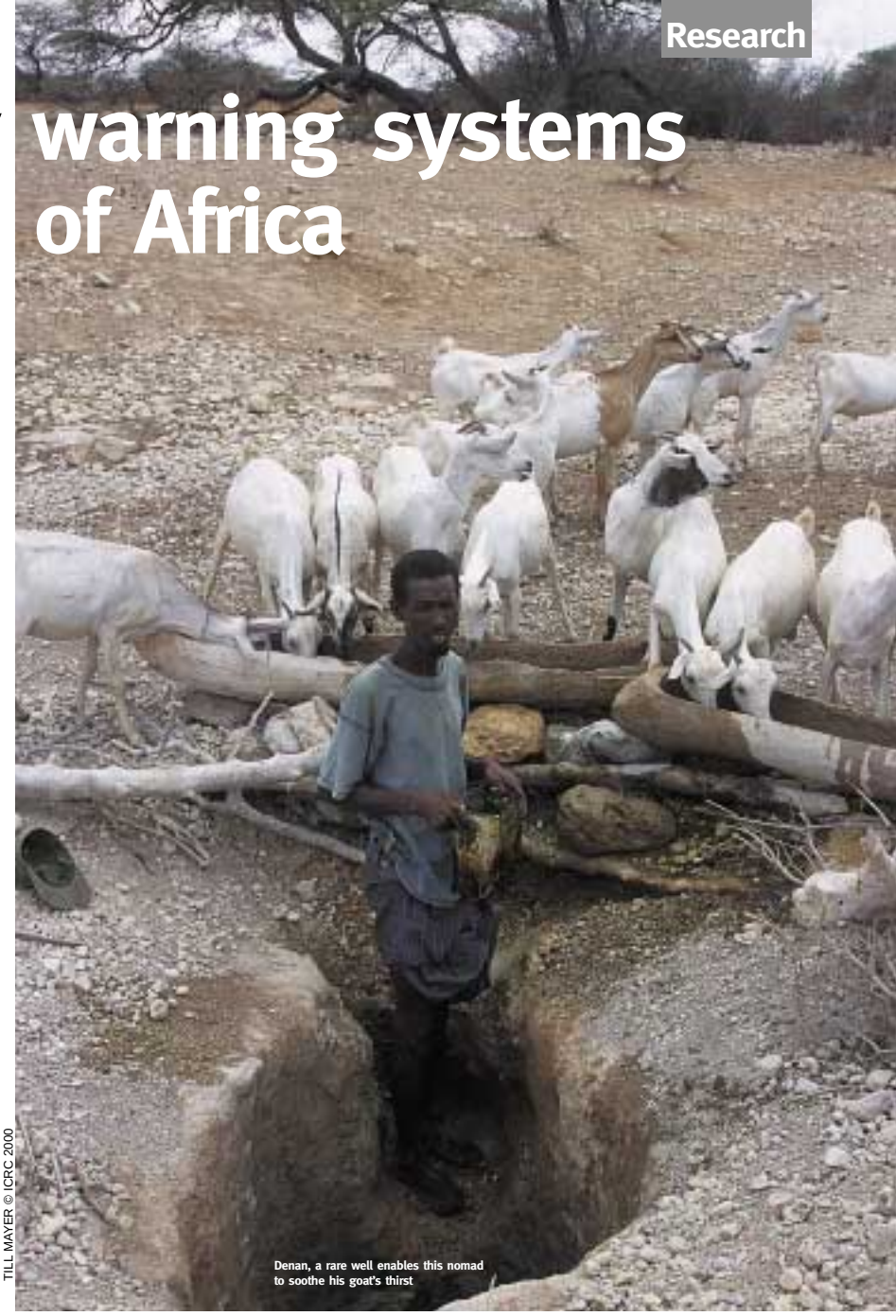
Conflict and macro-economic shocks are the root causes of a substantial proportion of both acute and chronic vulnerability in the region. Traditional EWS are orientated to climatic shocks. Conflict and macro-political or economic shocks may occur suddenly with little possibility for accurate prediction. Also, monitoring political and economic trends, particularly by external actors, is a much more sensitive issue than monitoring rainfall etc. IRIN[2] provides some information on political developments in the region but this does not lead to analysis or prediction. Political and economic forecasts are routinely made by the private sector, e.g. for profit think-tanks such as the Economics Intelligence Unit, although these sources of information are expensive and not widely available.

EWS are almost always aimed at monitoring rural populations despite rapidly increasing urban poverty and vulnerability.

Concerns about EWS

Linkages of food security information to trade policy and private sector decision-makers are poor. This limits the potential for private sector mitigation activities and response to disasters.

There are concerns about the accuracy and reliability of some data.
EWS in the region are heavily dependent on external resources. Few examples exist of sustainable government operated systems in the region.



TILL MAYER © ICRC 2000

Denan, a rare well enables this nomad to soothe his goat's thirst

Positive developments

There has been improved cross- border information sharing and the development of cross-border systems. For example, the development of a pastoral early warning system for Ethiopia region 5 (the Ogaden) is being deliberately linked to the Somalia Food Security Assessment Unit, given the links in livelihoods, environment and economies between the two areas.

There has been increased effort to co-ordinate and collaborate on the development of EW information gathering and analysis procedures and on the sharing of information. A good example is in Sudan where there has been a major effort to improve EW collaboration among governmental agencies, WFP and NGOs

In many of the areas already noted, new approaches are being piloted and in a few EWS these changes have been institutionalised. New approaches include monitoring of: HIV/AIDS, livelihood systems, and conflicts.

Information and documents relating to the May 2001 update can be obtained from: Nick Maunder at nmaunder@fews.net or Dan Maxwell at maxwell@care.org

ALFRED GRIMM © ICRC 1989

Sudan is a good example of where there has been a major effort to improve Early Warning Systems. Yirol cattle camp.

[1] The Greater Horn of Africa Food Security Update, May 2001. By Maunder N. and Maxwell D.
[2] IRIN, the International Refugee Information Network

JEAN PATRICK DI SILVESTRO © ICRC 2000

Recent programmes have been based on the idea of helping people recover livelihoods, rather than simply supporting survival. Above a women trading, Kinsha market.

Cash transfers in emergencies: a review of recent experiences

Summary of Review[1]

This recently published paper by the British Red Cross aims to answer the following questions:

- Can cash transfers improve access to food in the same way as direct food distribution?
- What effect does a cash distribution have on the local economy?
- Is cash assistance practically feasible?
- Does it have advantages over traditional forms of relief?

The authors examined a number of experiences of cash transfer programmes namely in Western Sudan (1984), Ethiopia (1984-85 UNICEF), Ghana (1994 Action Aid), Bangladesh (1998 SC UK), Guatemala and Nicaragua (1998 Red Cross), Albania (1999 UNHCR), Kosovo (2000 UNMIK) and Southern Africa Safety nets (2000 ESCOR)

Main findings

i) The body of evidence on cash based interventions is limited but growing as agencies (and donors) seem increasingly willing to use cash to complement 'traditional' forms of relief and rehabilitation.

ii) The rationale for earlier programmes of this type e.g. in Sudan, Ethiopia and Ghana, was that famines were due to an entitlement failure as well as failure of supply. Also the distribution of cash was more cost effective and quicker than distribution of food. More recent programmes have been based on the idea of helping people recover livelihoods, rather than simply supporting survival.

iii) The Ethiopian and western Sudan experiences lend qualified support to the idea that during a famine, cash distributions in pockets of deficit close to surplus producing areas can bring about an inflow of food at reasonable prices. The Ethiopian case provided solid evidence of the advantages in terms of cost and speed. The Hurricane Mitch agricultural support programme showed how cash can contribute as one key element in a mixed recovery package.

iv) The southern Africa safety net study indicated that beneficiaries tend to use cash for social and productive investment *only after* consumption needs have been met. Evidence of squandering cash on alcohol or gambling was not found in any of the case studies.

v) The Ethiopian experience demonstrated problems associated with cash delivery into an economy where food prices were already rising rapidly due to overall food shortage.

vi) Several districts in the Ethiopian and Albanian programmes found the administrative burden imposed by the programme (especially on the banking system) exceeded capacity thereby causing delays.

vii) The monitoring and accounting needed to be more stringent than that of food or non-food items, and was found to be inadequate in at least two of the projects.

viii) In some societies the exclusion of certain groups from economic activity or ownership (e.g. women in southern Africa) can make attempts at equitable cash distribution within household problematic.

In conclusion, these valuable lessons give cause for cautious optimism and pointers, as to circumstances in which cash relief can work to best effect. However, key questions remain:

- Under what circumstances will traders respond to an increase in demand?
- What level of purchasing power is necessary and at what distance from supply to ensure an inflow of food or other items?
- How do prices behave following an injection of cash?
- At what level of cash inflow does inflation become inevitable?
- How do beneficiaries (gender/economic status) in varying circumstances (emergency/non-emergency) spend cash?
- How can investment in livelihoods be encouraged while allowing beneficiaries the flexibility to satisfy their consumption needs?

The authors assert that only through carefully planned and monitored experimentation (and pilot projects) will these questions be answered. As learning improves on how to minimise risks and maximise benefits for communities confidence in cash based interventions will grow.

[1] Buying Power: The Use of Cash Transfers in Emergencies. British Red Cross. D. Peppiatt, Mitchell.J and Holzmann.P., November 2000.

The Coping Strategies Index:
monitoring food security status in emergencies

Research in Progress

The effective management of emergency food aid programmes requires information not only about needs, but also about impact. To date, measuring impact in emergencies is mostly limited to infrequent nutritional surveys, or expensive ex-post evaluations. Information on monitoring impact of general food distributions during an actual emergency operation is virtually non-existent, as are the tools to provide such information. WFP and CARE International are collaborating in Kenya to adapt a method of measuring food security outcomes under research circumstances into a time- and cost-effective monitoring tool that addresses the operational information requirements of food aid agencies during emergencies.

The Tools. Already briefly described in Field Exchange (Issue 8, November 1999), the Coping Strategy Index (CSI) enumerates both the frequency and severity of coping strategies of households faced with short-term insufficiency of food. The CSI goes beyond commonly used caloric indicators to incorporate elements of future vulnerability, and the deliberate decisions of households faced with food insufficiency. In brief, the CSI enumerates all consumption-related coping strategies commonly used by a population. Four general categories of coping are measured, with individual strategies defined specifically according to location and culture:

1. Dietary change (e.g. eating less preferred but less expensive food etc.);
2. Increasing short-term food access (borrowing, gifts, wild foods, consuming seed stock etc.);
3. Decreasing numbers of people to feed (short-term migration etc.);
4. Rationing strategies (mothers prioritising children/men, limiting portion size, skipping meals, skipping eating for whole days etc.).

The information is weighted according to the perceived severity of each behaviour, as indicated by community members in focus groups. The weighted scores are combined into an index that reflects current and perceived future food security status. Monitoring fluctuations in the index can give a rapid indication of whether food security is improving or deteriorating. When used in combination with context monitoring (early warning) indicators, and food aid end-use monitoring tools, the CSI provides an accurate indication of the way in which household food security is responding to food aid interventions. An example of the CSI (used in an urban setting) is shown in Box 1.

The Kenya Pilot Study. Earlier studies have showed that, under research settings, the CSI accurately reflects current food security status[1] and is also a good predictor of future food security status.[2] The pilot study in Kenya is intended to develop the concept into a low-cost monitoring tool to track the impact of food aid at the household level during emergency programme operations: to test the CSI against other measures of food security; to test whether changes in coping behaviours correspond to changes in the environment that affect food security (early warning indicators); and to test whether the index responds to the intervention of food aid. The pilot study is being conducted in two different livelihood zones-a pastoral area (Garissa district) and a marginal rain-fed agricultural area (Kitui district). Random samples are being selected from the same clusters in each district over three rounds, at different points during an emergency operation. Complementary qualitative information is being gathered using Participatory Learning Appraisal techniques.

The Intended Outcome. Ultimately, the objective is to develop a rapid, user-friendly tool that generates accurate information and is relatively quick and easy to analyse. A manual will also be developed for training field staff in the use of the tool. Although the intent is to develop a relatively standard approach, the tool will require some local adaptation, and guidelines for this adaptation will also be developed. The pilot test runs through August, 2001.

The tool itself should be finalised during 2001.

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[1] Daniel Maxwell, Clement Ahiadeke, Carol Levin, Margaret Armar-Klemesu, Sawudatu Zakariah, and Grace Mary Lamptey (1999). "Alternative Food Security Indicators: Revisiting the Frequency and Severity of 'Coping Strategies.'" Food Policy. Vol. 24 (4), pp. 411-429.
[2] Luc Christiaensen and Richard Boisvert (2000). "On Measuring Household Food Vulnerability: Case Evidence from Northern Mali." Working Paper Department of Agricultural, Resource, and Managerial Economics, Ithaca, New York: Cornell University.

Box 1. An (Urban) Example of the CSI Tool

Because **food is not enough, or money to buy food is not enough**, in the past month, how often have you had to: *(REPEAT FOR EACH QUESTION)*

Strategy	Every day (7)	3-6 x / wk (4.5)	1-2 x / wk (1.5)	<1 x / wk (0.5)	Never (0)	Weight	Total
1. Rely on less preferred and less expensive foods?						1	
2. Borrow food, or borrow money to buy food?						3	
3. Purchase food on credit?						2	
4. Rely on help from relative or friend outside household						2	
5. Limit portions at mealtimes?						2	
6. Ration the little money you have to household members to buy street foods?						2	
7. Limit your own intake to ensure child gets enough?						2	
8. Reduce number of meals eaten in a day?						3	
9. Skip whole days without eating.						4	
Total Index Score							

HIV and nutrition: recommendations for nutritional care and support

Summary of a review[1]

HIV/AIDS and malnutrition are inextricably interrelated. Research suggests that malnutrition increases the risk of HIV transmission from mothers to babies and the progression of HIV infection. In turn, HIV infection exacerbates malnutrition through its attack on the immune system and its impact on nutrient intake, absorption, and utilisation. This recently published review does not deal with emergency situations, however the findings clearly have relevance for emergency settings and the types of intervention mounted during emergencies.

Three overlapping process that lead to weight loss and wasting in people living with HIV/AIDS (PLWHA) are described, namely: reductions in food intake, nutrient malabsorption, and metabolic alterations. Several vitamins and minerals are critical for fighting HIV because they are required by the immune system and major organs to fight infectious pathogens. This document explores what is known about possible effects of these nutrients on HIV disease progression, mortality and on mother-to-child transmission (MTCT) of HIV.

The paper looks at research which indicates that in the early period of HIV infection, weight gain and/or body weight maintenance might be achieved. It addresses the extent to which nutrition counselling and interventions can slow or reverse the process, and subsequent consequences of weight loss and wasting in PLWHA. A number of examples of nutrition support programmes are presented, ranging from offering nutrition guidelines and dietary advice, to offering palliative and home based care and the provision of foods that are being offered to PLWHA in Africa.

Existing data suggests that nutrition interventions aimed at increasing energy and protein intakes of people living with HIV may help to build body reserves and reduce a persons vulnerability to weight loss and wasting (direct consequences of diarrhoea and other opportunistic infections). Improvements in micronutrient intake and status may also help strengthen the immune system and reduce the adverse effect of infection related oxidative stress while lengthening survival time. Both interventions may help people living with HIV to remain relatively healthy, prolonging the interval from initial infection to development of AIDS and improve their quality of life. At later stages of the disease, nutrition support is largely palliative and focused on the dietary management of conditions that affect appetite, digestion and comfort when eating. These interventions are focused primarily on maintaining intake during bouts of illness and recuperative feeding when acute symptoms subside.

The complexities of weighing the competing risks of HIV transmission through breastfeeding with the various risks of replacement feeding are also explored. Recent research on HIV and breastfeeding is reviewed, and recommendations for safer breastfeeding are made. The authors conclude with recommendations for further research in the fields of nutritional management of HIV/AIDS and strategies to reduce the risk of mother-to-child transmission of HIV.

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[1] HIV/AIDS AND NUTRITION: A Review of the Literature and Recommendations for Nutritional Care and Support in Sub-Saharan Africa. Piwoz.E and Preble.E November 2000

PHILIPPE MERCHEZ © ICRC 1996

Tens of thousands of Rwandan refugees were believed to have died from dysentery in the Goma camps in 1994/95. Above Goma, Eastern Zaire

Management of shigellosis in undernourished children

Summary of published paper[1]

Acute Shigellosis can be one of the major causes of mortality in emergencies. Between 46-63,000 Rwandan refugees were believed to have died from dysentery (*Shigella dysenteria* type 1) in the Goma camps in Eastern Zaire during 1994/5. World-wide, it is estimated that shigellosis accounts for about 15% of diarrhoea-associated deaths in children below 5 years of age.

To date there have been few reports on the impact of dietary interventions on the clinical course of acute shigellosis. Current management of the disease is primarily focused on antibiotic therapy with less emphasis on nutritional management. A recent randomised clinical trial examined the role of an energy-dense diet on the clinical outcome of malnourished children with acute dysentery due to shigellosis. Seventy five children aged 12-48 months with acute dysentery randomly received either a milk-cereal formula with an energy density of 4960 kJ/l (1185 kcal/l[2]) (test group) or a milk-cereal formula with energy of 2480 kJ/l (593 kcal/l) (control group) for 10 days in hospital. In addition the standard hospital diet was offered to all children and all received an appropriate antibiotic for 5 days.

There was no difference between the two groups in resolution of fever, dysenteric stools and stool frequency. However, vomiting was more frequently observed among the test group children during the first five days. There was a statistically significant increase in the mean weight for age in the test group compared to the control group after the 10 days of dietary intervention. In addition there was a statistically significant resolution of rectal prolapse in the test group after five days of dietary intervention. The observed difference in proportion of children with a rectal prolapse is most likely to be related to the nutritional improvement in the test group.

In conclusion, this study indicated that supplementation with a high energy diet did not have any adverse effect on the clinical course of acute shigellosis, led to improved weight gain and reduced the incidence of rectal prolapse in malnourished children.

URSULA MEISSNER © ICRC 1997

It is estimated that shigellosis amounts for about 15% of diarrhoea associated deaths under 5 years of age. Mother and child, Goma Eastern Zaire

[1] Effect of an energy-dense diet on the clinical course of acute shigellosis in undernourished children: Mazumder .R et al. British Journal of Nutrition (2000) vol 84, pp 775-779
[2] 1kcal = 4.184kJ

Linkages between HIV/AIDS and food insecurity

A review

The April 2001 Greater Horn of Africa Food Security Update presents the most recently available regional data on the HIV/AIDS pandemic. It reviews linkages between HIV/AIDS and livelihoods, food security and nutrition and summarises important policy challenges. Key points made in the update are the following.

Eastern and Southern Africa are at the epicentre of the AIDS pandemic. More than two thirds of all HIV-infected people live in Sub-Saharan Africa - some 25 million people. Four countries in eastern Africa reported prevalence levels above 10% in late 1999. While the pandemic was primarily perceived as a health crisis in its early years, linkages are now widely acknowledged between HIV/AIDS and a broad range of other concerns - not least of which is food security.

HIV/AIDS attacks the most productive and economically active members of society, often killing both parents in a household while leaving children and the elderly behind in extreme conditions of vulnerability. It also erodes institutional capacity to respond because of the loss of human resources. Furthermore, it increases pre-existing social and economic vulnerability; while it kills the rich and poor alike, it is the poor who are most vulnerable. Women are at greatest risk of exposure and are biologically more vulnerable, particularly young women and girls.

Infection rates tend to be higher in densely populated areas which also tend to be the most productive agricultural areas. Over time, HIV/AIDS may be expected to define significant new geographical areas of vulnerability.

The principal ways that HIV/AIDS exacerbates food insecurity and poverty are outlined as follows:

- Impoverishing families of infected people in the short to medium term, e.g. through loss of income-earning labour in agriculture and other livelihoods as sufferers grow sick and eventually die. There is also the loss of other productive or financial assets as households are forced to cope with loss of income and increased expenses (e.g. medical bills or transport to health facilities)
- Increasing longer term vulnerability, e.g. forcing young children, especially girls, to stop schooling to work or to care for a sick parent or relative
- Through diverting public health resources away from other common diseases
- Poverty increases the risk of AIDS. For example, labourers forced to migrate to different areas to earn money may be at increased risk of exposure as prevalence rates are usually higher, particularly in urban areas. Secondly, poverty-linked malnutrition leads to the earlier on-set of AIDS and increases the likelihood of opportunistic infection.

Other links between HIV/AIDS and food security exist. Emergency situations lead to increases in HIV transmission. Rapid increases in rates of transmission are frequently associated with the presence of armies. In situations where people are displaced there is often a high level of sexual violence with women forced to trade sex for food, protection or other basic needs.

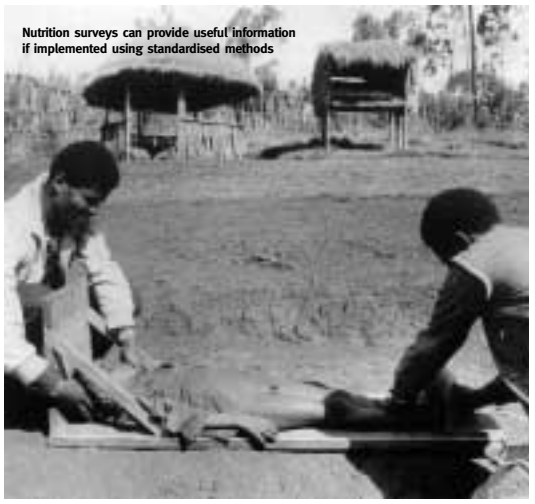
This update highlights many challenges to breaking the vicious cycle between HIV/AIDS and food insecurity including making HIV/AIDS awareness and prevention a top priority in emergency responses. Developing an understanding of the benefits and dangers of development interventions on the prevalence and transmission of AIDS (e.g. benefits and potential harm of promoting migrant labour, etc.) is essential.

Several recommendations are outlined, including vigorously promoting prevention of infection and the protection of women and girls during emergencies, particularly in situations resulting in displacement of people.

Information and documents relating to the April 2001 update can be obtained from: Nick Maunder at nmaunder@fews.net or Dan Maxwell at maxwell@care.org.

Nutritional surveys in Iraq: a call for improved quality

Summary of published paper[1]


Nutrition surveys can provide useful information if implemented using standardised methods

Many reports on Iraq have claimed to demonstrate a rise in death and disease rates since the Gulf War of January/February 1991 and the economic sanctions that followed. There has however been a great deal of disagreement regarding the magnitude of morbidity and mortality increases and their cause. A recent study reviewed twenty-seven surveys on the nutritional status of Iraqi children in the 1990s.

The study found that many once-off small scale nutrition surveys have been of little value. These studies, although limited in resources and population access in a tense political environment, could have contributed far more if they had used standardised and comparable measurements methods, had specified the method of sample selection used and had assured data accuracy by providing appropriate training and field supervision for data collectors. Even more useful would have been some co-ordination among researchers to assure that the one-time studies built on, and were comparable to, previous studies.

Far more valuable were five large-scale studies. These contributed, not only to identification of levels of malnutrition, but also permitted characterisation of health education and promotion needs, and helped prioritise spending in the oil for food programme. In addition, they showed the limited impact of goods provided by the 'oil for food programme' in the first fifteen months of implementation.

Future surveys need not suffer from many of these limitations. If implemented using standardised methods and well-defined populations, small studies can provide useful information on nutrition trends. With even a small amount of co-ordination, such studies can be used to assess previously surveyed populations to provide a time series or un-surveyed groups, so as to acquire supplementary information for better characterisation of the overall population. The large, reliable studies can be stored in public access data banks. This would provide baseline information for those interested in providing follow-up studies in a local area.

The study concluded that 'given the depth of the humanitarian crisis in Iraq, the large population exposed to malnutrition, and the long duration of sanctions, we now have an opportunity to learn from past shortcomings to improve humanitarian assessment and action'.

[1] Studies of young child malnutrition in Iraq: Problems and insights, 1990-1999: Garfield. R. Nutrition Reviews, Vol 58, no 9, pp 269-277

Emergency relief workers: what skills do you need to be effective?

Summary of published paper[1]

A recent study investigated the types of skills most valued by relief workers in order to achieve their goals. Using the Critical Incident Technique (CIT[2]), a sample of fifteen nurses returning from work in refugee camps were interviewed.

Methodology

Participants had engaged in emergency relief work within the past three months to five years. All were women with a mean age of 39 years. The study was undertaken with the co-operation of an umbrella organisation for returned development workers in Ireland which forwarded a letter to the addresses of a randomised quota sample of 100 people on their database. One limitation of the study was that participants were self-selected. Willingness to take part in the research may therefore reflect some bias in terms of cultural values, personal experiences, self-perception, recall of events, age and gender.

The first stage of identifying Critical Incidents is to define personal work objectives of the interviewee. Interviewees were then asked to describe one positive and negative incident which had an impact on them. In a more detailed interview, the question was then asked 'taking this incident as an example of the sort of work your job requires what would you say are the main abilities or characteristics that somebody should have in order to perform well in the job?'

Two examples of incidents are included in Boxes I and II.

The broad categories of 'necessary' skills identified by the interviewees were as follows:

- Coping skills, e.g. maintaining a sense of humour, ability to relax and detach when off duty and knowing personal limitations
- Relationship skills (most frequently mentioned)
- Communication skills e.g. diplomacy/tactfulness, good social skills, willingness to negotiate
- Analytical skills
- Self-skills (assertiveness, adaptability and flexibility were most frequently cited).

The authors concluded that the job related skills identified were mainly to do with how things get done rather than with what is done, i.e. they reflect a concern with process skills rather than technical skills. The four specific skills that achieved the highest endorsement were: sense of humour, sensitivity to the values of other cultures, patience, and diplomacy/tactfulness. Few professional training or pre-departure courses can claim to provide a grounding in these skills.

Openness to learning, being able to ask for advice, willingness to negotiate, adaptability, flexibility, initiative, tolerance and resourcefulness were all cited as important ways of working. These all reflect a fluid approach to working as opposed to relying solely on more crystallised technical skills. Such skills are likely to promote tolerance of ambiguity. Given the confused, hectic and often unstructured nature of much relief work, tolerance in both social and work relationships are very important for an individual's work performance and well being.

In conclusion, this research represents the first attempt to assess job skills in emergency relief work and has identified skills, behaviour and attitudes that proved critical to the achievement of objectives towards which people worked. The critical incidents identified as part of this study could serve as a basis for role playing in training course and in the recruitment process for agencies. Critical incident analysis can provide a mechanism for returned aid workers to integrate real experiences into the training of others.

Box I: Negative incident

One nurse was engaged in assessing the feeding and basic medical requirements of refugees. Approximately 3000 people per week would pass through the feeding centre. A six-month old infant had been identified as being in urgent need of nutritional assistance and was provided with a gastro-nasal feeding tube. The mother subsequently removed the feeding tube and the infant died. It emerged that the mother had decided that available resources would best be given to her other children who had, in her opinion, a more realistic chance of surviving. The interviewee was shocked and distressed at first but eventually came to terms with what happened as best she could.

The principal skills identified here included the ability to respect the dignity, customs and traditions of others and to recognise the limits of the job. Other skills identified were related to coping on a personal level. These included being able to express one's emotions, developing good interpersonal relationships with colleagues and being able to 'nourish' oneself after a day's work without feeling guilty.

Box II: Positive incident

A satellite telephone dish was stolen from outside the residence of a donor organisation. An investigation was carried out by the local assistant co-ordinator of the project, who attributed blame to the 'opposing' tribe. This individual directed that the wages of the indigenous workers would be cut by 25% to pay for the cost of the new dish. The interviewee felt very strongly that this was an unjust course of action and found that other expatriates who agreed were disinclined to challenge this unilateral decision of the assistant co-ordinator. The indigenous workers organised a protest and the decision to cut the wages was rescinded. Instead a reward was offered for the return of the dish. The dish was returned a week later. It seems that the item had not been stolen by a member of the 'accused' tribe. A considerable amount of damage was done to the relationship between the indigenous and expatriate workers due to the way in which the matter was handled.

The necessary skills identified from this incident included the employment of fair practices in dealing with co-workers, assertiveness, showing sensitivity to the feelings of others and the ability to resolve conflict.

[1] Critical Incidents in Emergency Relief Work: McKay.M and MacLachlan.M (2000). Development in Practice, Vol 10, No 5, November 2000.
[2] The CIT is a technique for collecting information on incidents that the respondent feels have been critical to his or her experience of the job.

Strengthening analysis of the nutrition situation through linking food security and nutrition information:

Pitfalls and potentials

By Claire Chastre and Sonya le Jeune

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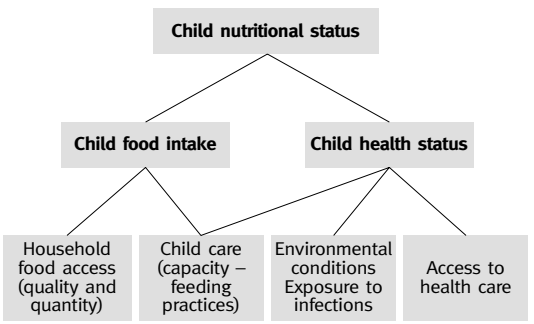
Sonya le Jeune is the SC(UK) Food Security Programme Manager in Liberia.

It has become the practice in several countries[1] to routinely combine nutrition surveys with a food security component in order to contextualise anthropometric results, leading to more informed and appropriate intervention design.

This type of approach can sharpen our understanding of the causes of malnutrition. However, care must be taken to guard against the following assumptions - "there is food insecurity therefore there is child malnutrition" and "there is child malnutrition therefore there is food insecurity."[2]

This paper considers the main features of nutrition surveys and food security assessments, in particular household economy assessments, and looks at what conclusions can realistically be drawn from a joint analysis when conducted within a conceptual framework such as the causal model presented below (adapted from UNICEF).



Nutrition surveys

Rapid nutrition surveys are routinely conducted in emergencies. These surveys are usually based on anthropometric measurement of a representative sample of children aged 6 - 59 months.

Nutrition surveys usually assess prevalence of acute malnutrition (measured with the weight/height index) amongst children 6-59 months at the time of the survey. Surveys also collect information on health status, for example morbidity, mortality and vaccination rates as well as general contextual information on food consumption.

Food security assessments

There are many different approaches to food security assessment.[3] Here we consider the household economy analysis (HEA) which provides a comprehensive framework for food and livelihood security analysis. The methodology is based on understanding the various options/strategies that people employ to secure access to food and income. It explores how typical households from different wealth groups in a given area live in a normal year. It also looks at how households cope when events/'shocks' occur and how sources of food and income change.

The three case studies below demonstrate the advantages of combining nutrition surveys and food security assessments.

Case study 1: Liberia (Vahun County, 1998), Combined Information Influencing Targeting of resources.

Both nutritional survey and food security assessment were conducted simultaneously.

The nutrition survey found that one specific age group amongst the 6 - 59 months group presented a higher malnutrition prevalence than the others. Meanwhile, the food security assessment indicated that newly-arrived refugees were more food insecure than the residents and the old caseload refugees. Based on a combined analysis of the food security, nutrition, water and health data, the main factors associated with malnutrition were identified as poor access to food amongst the new arrivals and insufficient access to safe drinking water resulting in a high incidence of diarrhoea amongst children. This analysis led to programmes such as food aid distributions, improvement in the water supply and an increase in capacity to treat malnutrition. It also led to increased targeting of the home-visiting programme. Due to limited resources it was not possible to visit all the households with children in the age range most vulnerable to malnutrition, i.e. under fives. Instead, home visits were targeted at recently arrived refugee households only.

Case study 2: Northern Sudan (Northern Darfur State, 2000) Combined Information leads to more appropriate interventions

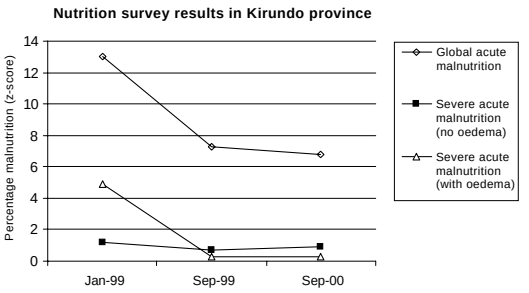
A nutritional survey was conducted at the same time as a household economy assessment. The HEA predicted that there would be a food deficit at some point in the future, based on poor cereal production, high grain prices and low groundnut prices. The anthropometric survey showed a current high rate of global malnutrition as well as signs of Vitamin A deficiency. The nutrition survey also indicated that there had recently been a measles epidemic. If the malnutrition rates had been interpreted in the absence of the HEA data, the high rate of wasting may have been attributed mainly to food insecurity as there had been a harvest shortfall and the role of the measles epidemic as a major contributing factor may have been overlooked.

Case study 3: Bugesera (Kirundo province, Burundi) Using combined data sources to predict oncoming crisis can ensure preventative programmes are in place earlier.

The province of Kirundo[4] in Burundi experienced three consecutive years of inadequate rainfall and reduced crop production. Three nutritional surveys and two Household Food Economy (HFE) assessments were conducted between January 1999 and January 2000. The HFE assessments covered the area most affected by the drought within Kirundo province: the Bugesera agro-ecological zone.

Results

The first survey (Jan. 1999) showed higher overall levels of malnutrition mainly reflecting a high prevalence of oedema while subsequent surveys indicated a lower but stable prevalence of malnutrition with low levels of oedema.



HFE data showed that food and cash income from production is traditionally earned during the first seven to eight months of the year. This was the case in 2000 although the two main harvests were reduced compared to normal. The poorest households coped through a set of strategies; reduced food consumption (while protecting their children's food intake), eating food they would not normally eat and increased migration in search of labour. These strategies allowed households to cover their minimum energy requirements over the first eight months of the year.

The July 2000 HEA assessment anticipated for the remaining months of the year an increased reliance on the labour market to access food and income (in an almost saturated labour market) and an increase in basic commodities prices. Findings also indicated that the poorest households would be confronted with a food deficit over the last four months of the year in the absence of an intervention.

During the last part of the year, when food security was expected to be at its worst, only half of the recommended food aid was distributed due to shortage of food stocks in country. In addition, the area was hit by epidemics in November.

Analysis

Coping strategies protected the children's food intake. Therefore the nutrition status of children had not yet been affected by September 2000. It is however possible that nutritional status of the poorest households had been adversely affected but that this was masked by the fact that the nutritional survey findings were aggregated for the whole population.

The predictive value and seasonal dimensions of Food Economy Analysis (FEA) should be taken into account when planning a nutritional survey. It was justifiable to request a nutritional survey in September 2000 as at that stage it was not clear how much the households' reduction in food intake had impacted on children's nutritional state. However, the interpretation of the results needed to take into account the fact that the survey was conducted just after the most food secure part of the year and just before food insecurity was expected to worsen (in the absence of intervention).

In the case, of the January 1999 survey the harvest that month had probably had little time to impact significantly on the nutritional status of children. The high rates of oedema may have been a function of

changes in diet and/or the end of the food deficit period. Following the September 2000 nutrition survey, it is possible to predict that nutritional status would have worsened again (as happened in neighbouring provinces) given the food distribution problems and the epidemics that occurred.
This example shows how nutritional surveys in the absence of food security analysis have a limited value in terms of prediction and planning interventions.

Linking Household Economy Analysis and nutrition information

Malnutrition is the result of a variety of possible factors, only some of which are food related. By analysing the food related causes in isolation of the other possible factors we risk misinterpreting the results. Analysis is therefore strengthened by combining food security and nutritional data. However, caution is necessary when considering the results from nutritional surveys and household economy assessments together because they have different features/characteristics (summarised in the table below).

	HEA	Nutrition survey
Unit of analysis	Household	Individual (child 6–59 months)
Data categorisation	Breakdown by socio-economic category	Prevalence relates to the entire 6–59 months or breakdown by age groups (i.e. no breakdown by wealth group)
Time period covered by the results	Tells of the situation over previous months Can make projections over coming months Describes seasonal variation	Reflects the situation at one point in time (snapshot)

- Anthropometric surveys describe an outcome (nutrition status), HEA describes processes.
- HEA assessments take the household as the unit of analysis whereas nutritional surveys use the individual (child 6 - 59 months). A cause-effect relationship cannot be assumed without considering the intermediary level: the intra-household food distribution and the child's food intake/utilisation. Without any intra-household information, for instance, one cannot rule out the possibility that food insecure households may preferentially feed the younger children during difficult periods.
- HEA data is analysed by wealth group, whereas nutrition surveys relate to ALL children within the population. Therefore the results are not directly comparable.
- It is equally crucial to take into account the timeframe and the dates at which the assessments were conducted. For example, if a household food deficit translates into inadequate food for the child, the impact of this on the nutritional status might not be seen straight away.

Conclusion

Food security and nutrition information can complement each other, as illustrated by the case studies attached. However, when combining nutrition and food security assessments, in order to understand better the causes of malnutrition, the field worker needs to assess the reliability and the coverage of the data in order to be confident about interpretation. Otherwise it is easy to misinterpret results. With this in mind, a well conducted joint analysis of the food security situation in conjunction with a nutrition survey can lead to better programming and more appropriate interventions.

[1] Sudan and Burundi as examples
[2] Experience shows that this is not always the case. For example in Rwanda, discussion with parents in food insecure households revealed that they tended to reduce their food intake to ensure sufficient for their children. In North Sudan, a high level of malnutrition was in part explained by an earlier measles outbreak.
[3] Food Security Assessment in Emergencies: Report of an Inter-Agency Workshop. Amsterdam, 2-3 December 1997. MSF-Holland
[4] The majority of the people in the province are engaged in agriculture and pastoralism.

Emergencies in developed countries: are aid organisations ready to adapt?

Published Letter[1]

A recent letter in the Lancet has called into question the appropriateness of aid organisations using developing country models for humanitarian response during complex emergencies in more developed countries. The authors assert that priorities and standards have arisen out of the hard learnt experiences of aid organisations responding to complex emergencies in developing countries, primarily Africa and Asia. Then came the crisis in the Balkans during the 1990s. Relatively healthy populations with demographic characteristics and epidemiological disease profiles similar to those of other Western countries were suddenly forced to flee en masse from their homes. This did not fit the standard definition of an acute complex emergency and the developing country model of humanitarian response should have been adapted for an emergency in a developed country.

Crude Mortality Rates among refugees displaced from Kosovo to Macedonia and Albania were relatively low, never reaching a daily rate of one death per 10,000. Few large epidemics of infectious diseases occurred in the Balkans. Due to the high incidence of rape and traumatic exposures, assessments for reproductive health and psychological morbidity were needed. Elderly people seemed to be more at risk of under-nutrition than young children yet they were rarely considered a vulnerable group.

Most aid organisations responded to the crisis in a predetermined manner and some did not adapt to the specific needs and characteristics of the situation. Organisations used pre-positioned medical kits, with some containing anti-malarial drugs and other inappropriate medication. Medication for treating chronic diseases was often lacking. Because children younger than 5 years were not found to have an increased prevalence of wasting, it was assumed, often incorrectly that under-nutrition was not present in the population.

The Balkan crisis underscored the importance of context-specific approaches to humanitarian assessments and programme implementation. New definitions for acute and post-emergency phases of complex emergencies must be developed taking into account variables other than mortality rates alone. The specific demographic characteristics and epidemiological disease profile of each displaced population must be considered and appropriate programmatic responses developed accordingly. The authors conclude that although the development of codified priorities and standards has been an important achievement in the field of humanitarian assistance, these should be seen for what they are; minimum standards which need to be adapted by aid organisations according to realities in the field.

1 Emergencies in developed countries; are aid organisations ready to adapt? Spiegel P. and Salama P., The Lancet, vol 357, pp714 March 3rd 2001.

Infant feeding in emergencies: new resources

Operational guidance for Emergency Relief Staff and Policy-Makers

During an interagency meeting held in November 1999 on infant and young child feeding in emergencies, a need for interagency consensus on operational guidance was highlighted. While a number of specific technical documents already exist (e.g. WHO, Linkages, Sphere Guidelines), there was an obvious gap in practical guidance that can be used by both policy-makers and relief staff.

In order to address this, the interagency working group on Infant Feeding in Emergencies has prepared a document entitled 'Infant and Young Child Feeding in Emergencies: Operational guidance for Emergency Relief Staff and Policy-Makers' (www.ennonline.net). The document is concise, practical and provides a list of reference material including websites for further information. Multi-agency support for the document will strengthen its effectiveness. Indications of support for the document have therefore been asked for by September 30th 2001 by which time the document will be finalised.
To date, the document has the provisional support pending final revisions of: Action Against Hunger/Action Contre la Faim, Department for International Development (DfID), Emergency Nutrition Network, Fondation Terre des Hommes (Suisse), GIFA, GOAL, Institute of Child Health, LINKAGES, MSF Holland, Oxfam GB, Save the Children UK, Save the Children US, TearFund, UNHCR, UNICEF, WHO.

Training Modules for Infant feeding in Emergencies

Training modules on 'Infant Feeding in Emergencies' have also recently been compiled. The purpose of these materials is to prepare emergency relief staff to support appropriate infant feeding and to describe the process of applying operational guidance. This work is the product of collaboration between WHO, UNICEF, LINKAGES, IBFAN, ENN and further contributors.

The training materials are divided into two modules.

- Module One is based on advocacy and orientation, aimed at decision makers, all field staff and national health staff. Core materials for this module are designed for one-hour training orientations. Additional optional materials are available if required. The full set of materials includes presenter's notes, overheads and copies of the manual for each participant.
- Module Two is targeted to health and nutrition staff. This module aims to increase technical knowledge and practical skills of health workers. The module is developed for use in a variety of environments and provides materials for approximately four hours of training. Ideally presenters need to have expertise in both emergencies and in breastfeeding.

The materials for Module One are now available for download on www.ennonline.net. Feedback is requested from all users before the finalisation of the pack. Module Two has yet to be finalised, but should be disseminated by the end of 2001.

WFP committed to improving quality of food needs assessments

by Joyce Kelly
Joyce is the Field Exchange correspondent participating at the workshop

Participants at WFP Workshop in Yonde, Cameroon. See also 'People in aid' section (Joyce Kelly)

In 2000, WFP established the *Office of Humanitarian Affairs* (OHA). As part of its role in management, co-ordination and implementation of the SERC (Strengthening Emergency Response Capacity) project, the OHA team facilitate the training of WFP personnel. In June 2001 OHA organised a workshop on 'Food Needs Assessments in Emergencies' for programme personnel in the African region. The workshop took place in Yaounde, Cameroon. Participants from programmes in Burundi, Côte d'Ivoire, Democratic Republic of Congo, Mauritania, Congo-Brazzaville, Mali, Benin, Niger, Rwanda, Tchad, Madagascar, Burkina Faso and Cameroon attended the four-day event.

The primary objective of this workshop was to give a broad outline of the different approaches used in assessing food needs in the five main types of situations that WFP personnel may work in:

- Following a sudden emergency e.g. natural disaster, where WFP or a partner institution are not present and no detailed baseline information is available.
- Following a sudden emergency where baseline information is available through WFP presence in the area or another partner institution.
- Chronic emergencies or where there has been a long lead time to development of food shortage e.g. drought areas .
- Monitoring or mid-term reviews of current programmes and food security situations.
- In-depth food and nutrition assessments e.g. once emergency has stabilised.

Key points that were initially identified relating to WFP assessments were as follows:

- WFP teams may be under immense pressure to design an appropriate response within a very short timeframe, often within a couple of days. This reduces the amount of time available for in-depth initial needs assessment.
- The basic questions need to be answered more or less immediately, e.g. population in need, size and type of ration needed, etc. After this, information collection activities should continue through post-distribution monitoring and ongoing assessment while the immediate needs are being met.
- Assessment approaches need to be multi-disciplinary.

Some assessment tools were then demonstrated in order to facilitate understanding of qualitative and quantitative approaches.

Case studies were then used to illustrate issues and principles that need to be considered before embarking on a food security assessment. These included:

- There may be multiple consequences of a 'shock' on the local economy. For example, a drought does not simply affect crop production but also affects livestock, migratory habits, etc.
- A general reduction in food availability is not the only cause of malnutrition. More often than not, hunger is caused by a lack of *access* to food commodities.
- Different households have different strategies of coping.
- The majority of crises lead to extreme poverty and increased future vulnerability. Protecting assets may be even more valuable in order to prevent future hunger.
- Certain members of society may 'benefit' from the misfortune of others e.g. cattle traders during a prolonged drought.
- It is often difficult to predict what strategies the individual, household and community can employ and at what point such strategies may be exhausted and with what consequences.

Methodologies within WFP

WFP are in the process of strengthening their 'in-house' assessment skills. Participation from a wide range of programme staff in the workshop raised awareness that assessments need to be context-specific and that there are a variety of field 'tools' that can be employed to maximise understanding of the situation.

Case studies from South Sudan and Burundi illustrated the quality and quantity of information that can be obtained in difficult emergency situations using the food economy approach. Although this workshop was not an actual training in food economy methodology, the merits of this approach were discussed and WFP remains committed to incorporating this technique more and more in its operational assessment procedures.

Armed with a small library of resource material, participants returned to share what was learnt with their respective colleagues. Similar workshops are scheduled to be held in the near future.

For further information on the workshop contact Bill Fielding via email: bill.fielding@wfp.org or Marie-France Bourgeois at email: mariefbourgeois@hotmail.com. For further details on OHA activities contact WFP Rome at Via C.G.Viola 68, Parco dei Medici, 00148 Rome, Italy. Tel: +39-06-6513 2628. Fax: +39-06-6513 2840. E-mail: wfpinfo@wfp.org

WFP pilot study on community level fortification mills

A pilot study to investigate the feasibility of expanding small-scale milling operations is being supported by WFP in Bangladesh. Three 'fail-proof' milling (fortification) units will support the WFP Vulnerable Group Development (VGD) programme in Bangladesh. WFP will be able to provide the VGD beneficiaries with fortified *atta* (whole wheat flour) instead of wheat grain using this technology. Partner NGOs will manage the mills and women in the VGD programme will be employed in the production process. The micronutrient premix will contain vitamin A, iron, folate and B-vitamins.

This equipment is said to be a breakthrough in community-level fortification efforts as it features a device, which determines that fortification is safely applied, preventing excess fortification. Negligence or mistakes can only lead to a worst case scenario of under-fortification. The device is entirely mechanical and costs in the order of US$ 4000 for a mixing capacity of 1 MT/hr[1]. This is the first time that WFP will use this process.

This device should make it possible to introduce fortification on a wider scale in small-scale milling operations in refugee and emergency programmes. Until now safe fortification has been difficult and expensive.

WFP hope shortly to publish the results of this experience.

For further information contact Pieter.Dijkhuizen@wfp.org

[1] MT/hr : metric ton per hour

Food security:

minimum standards to be included into Sphere

Oxfam GB organised an inter-agency workshop on minimum standards in Food Security, which was held at St Hilda's college in Oxford between the 2-3rd July 2001. The workshop was attended by Food Security specialists from NGOs, UN and bilateral agencies and academic/research institutions.

The main objectives of the meeting were:

- to determine the need for minimum standards in food security;
- to reach consensus on the nature of food security standards (there are currently minimum standards on food aid in the Sphere Handbook but not on food security);
- to determine whether a revision of the food aid standards is necessary;
- to determine whether the food aid standards can be incorporated in a food security chapter;
- to develop an action plan for the development of food security standards.

The first morning of the meeting was largely devoted to presentations. The first presentations outlined the purpose, use and structure of the Sphere Humanitarian Charter and Minimum Standards in Disaster Response, which included a review of the food aid standards. This was followed by presentations on approaches to food security assessment in emergencies. Presentations were made on analysing a food insecure situation (MSF-H), the household economy approach (SC-UK), a livelihoods approach (CARE, Oxfam), ACF's approach, and on Early Warning Systems (Environmental Change Institute, University of Oxford). Working groups then discussed common elements between the different approaches.

On the second day, additional presentations were given by a representative of the WFP Vulnerability Analysis and Mapping (VAM) unit and by a representative of FAO's Food and Nutrition Division. Working groups discussed the risks and opportunities of developing minimum standards for food security and reached general consensus that it was necessary to develop such standards. After agreement on the need for food security standards, working groups tried to formulate examples for food security assessment, monitoring and evaluation and food security support standards.

Whilst there was consensus on the need for food security standards and the need to revise the food aid standards, there was no consensus on whether food aid standards could be incorporated into a chapter on food security standards. Several other possibilities were proposed, which included keeping food aid as a separate chapter but revised and slimmed down, including food security in the nutrition chapter, or having three separate chapters on nutrition, food security and food aid. Based on the feedback from participants and through a participatory process, this effort will commence by late 2001.

Representatives from the Sphere project were pleased with the outcome of the meeting and will report the findings of the meeting to the Sphere management team. They also notified participants that revisions to the existing Sphere project Minimum Standards would need to be completed by 2003. A full report of the meeting is expected to be available in the next few weeks.

For further information contact: Elham Monsef at Oxfam House, 274 Banbury Road, Oxford, OX2 7DZ. Phone +44 (0)1865 312610 or email: EMonsef@oxfam.org.uk

Assessment of adult malnutrition

Assessment of Adult Malnutrition was the subject of a special meeting held during the SCN's 28th session in Nairobi in April 2001.[1]

The aim of the meeting was to reach a common understanding of recent recommendations[2] on the assessment of malnutrition in adults and to identify practical steps to improve practice. Following individual presentations, and plenary discussion with an expert panel, the working groups came up with the following interim recommendations for operational agencies in six areas.

- When to consider assessing adult malnutrition
- Pre-requisites for surveying adults
- Survey methodology
- Indices
- Selective feeding
- Research needs

When to consider assessing adult malnutrition

Assessment of adult malnutrition should be considered under the following circumstances:

- if the crude mortality rate (CMR) increases in relation to the under 5 year mortality rate;
- if many adults are present at existing supplementary feeding centres;
- where there are very high rates of under 5 malnutrition in the absence of an epidemic outbreak;
- if there is reasonable doubt that the child malnutrition rates do not reflect the nutritional status of the general population;
- if the populations are entirely reliant on food aid and if data are required as an advocacy tool to leverage resources.

Prerequisites for surveying adults

In all situations a thorough contextual assessment and analysis is required prior to carrying out an adult anthropometric survey. Adequate expertise, clear objectives and sufficient resources are all pre-requisites to undertaking such surveys.

Survey Methodology

A nutritional causal analysis must always be undertaken in conjunction with adult[3] anthropometric surveys. Adult surveys require adaptation of the standard sampling used in under 5 year anthropometric surveys. The choice of methodology should take into consideration potential selection bias (adults are often away). Surveys of older adults only may be appropriate in some situations

Indices

The recommended indices that should be used are Cormic adjusted BMI (population specific or Norgan correction) & MUAC. Using MUAC alone may be a useful rapid alternative in a very acute situation. Functional outcomes (e.g. step test, hand grip) should be collected in conjunction with anthropometric data.

Presentation

Currently there is no consensus on exact cut-offs of anthropometric indices for adults. Therefore it was recommended that a range of cut-offs are reported. The definition of the indicator must always be described and frequency distributions presented.

Selective feeding

Alternative strategies to selective feeding programmes should always be considered. Where selective feeding programmes are implemented, admission and discharge criteria should be based on anthropometric indices, social factors and clinical signs. Indicators for monitoring should include weight gain (minimum target 5g/kg/day) and functional ability.

Research Needs

The following research needs were prioritised:

- Investigate functional significance of proposed indices (mortality & morbidity)
- Investigate differences (changes in MUAC by sex, age, ethnic group and context
- Investigate the aetiology of adult malnutrition including adult nutritional oedema. Health and food security indicators should be considered in this investigation
- Develop anthropometric and functional methods to differentiate between acute and chronic undernutrition.
- Develop anthropometric methods for assessment of undernutrition in the 18-25 year group, in older persons and in adolescents.

For copies of the report of this special meeting on the assessment of adult malnutrition in emergencies email either: Fiona O'Reilly at fiona@ennonline.net or Brian Jones at accscn@who.ch or see http://www.ennonline.net/docs/scnreport.html

[1] The session was made possible through the support provided to the Food and Nutrition Technical Assistance (FANTA) Project by the office of Health and Nutrition of the Bureau for Global Programs Field Support and Research at the US Agency for International Development.
[2] Collins S. et al., Woodruff B., Duffield A. Assessment of Adult Malnutrition in Emergencies. ACC/SCN July 2000.
[3] Adults defined as over 20 years of age.

Global crisis – global action: an international effort to combat the spread of HIV/AIDS

Alarmed by the accelerating epidemic and its global impact, the United Nations General Assembly convened a special session on HIV/AIDS at the highest political level (UNGASS). Held between the 25th to 27th June 2001 in New York the overall aim of the special session was to intensify international action to fight the epidemic and to mobilise the resources needed. Acknowledging that the response has so far been a fraction of what is needed , Dr. Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) stated that "the real task now, is to increase, massively, the political will, resources, systems and social commitment needed to turn the tide of the epidemic."

Delegates from over 180 countries included representatives from the UN, Heads of State, government ministries, the World Bank, International NGOs, academic institutions, AIDS activists, leading experts and the private sector came together and through interactive Round Table groups tackled the following issues : i) Prevention and care, ii) HIV/AIDS and human rights, iii) Socio-economic impact of the epidemic and the strengthening of national capacities to combat HIV/AIDS and iv) International funding and cooperation.

The outcome

The meeting ended with member states adopting the Declaration of Commitment on HIV/AIDS "Global Crisis - Global Action". This document examines strategies and issues including; leadership, prevention, HIV/AIDS and human rights, reducing vulnerability, and HIV/AIDS in conflict and disaster affected regions.

It was acknowledged that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic; but that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic.

Update

17 July 2001 - The UNAIDS Secretariat and the International Fund for Agricultural Development (IFAD) have concluded a Memorandum of Understanding for a cooperation agreement. The MOU will provide a clear framework for the complementary roles which can be played by IFAD and UNAIDS. By combining their efforts, both parties aim to alleviate the impact of HIV and AIDS on rural poverty and insecure livelihoods, and to reduce vulnerability to AIDS through sustainable rural development."

22 July 2001 - The "Group of Eight" summit ended in Genoa, Italy, with world leaders committing US$1.3 billion to the global AIDS and health fund. Calling HIV/AIDS "a common enemy that knows no frontiers and threatens all people",

Note: All information, statements and documents relating to the UN General Assembly Special Session can be found at website www.un.org/ga/aids.

The facts

More than 21 million people have died of AIDS since the1980s, over 75% of them in sub-Saharan Africa.

Some 36million people are currently infected with the HIV virus- over 25 million of them in Africa -and most of them do not know it.

In 16 countries, more than 10% of adults, aged 15-49, are infected with the HIV virus.

In 7 countries, all in southern Africa, at least one adult in five is living with HIV.

In the most affected countries, half of all 15-year-olds alive today will eventually die of the disease, even if infection rates drop in the next few years.

If infection rates remain high, more than two-thirds of these young people will die of AIDS.

More than 13 million children have been orphaned by AIDS, and that figure may reach 30 million before the end of the decade.

AIDS is having a serious impact on many societies and economies, destroying the hard won development gains that have been made in recent years.

Countries like Brazil, Thailand and Uganda have shown that strong national plans, social openness and community participation can indeed reverse spiralling infection rates.

EPICENTRE

Epicentre: consultancy register being updated

Epicentre is currently updating their list of consultants. They require experienced epidemiologists and nutritionists for consultancies which are normally of 2-3 weeks duration. Interested persons can send an updated curriculum vitae to the address below. In a covering letter potential consultants should highlight skills in rapid assessment and anthropometric surveys, epidemiological surveillance and disease outbreak investigations, and also indicate periods of availability.

For further details please contact
Vincent Brown, Epicentre, 8, rue Saint Sabin, 75011 Paris, France. Tel: (33) (0) 1 40 21 28 50
Fax: (33) (0) 1 40 21 28 03. Email: vbrown@epicentre.msf.org or access their website at http://www.epicentre.msf.org

Nutritionist

51 Week Appointment

ROYAL BOTANIC GARDENS KEW

In collaboration with Human Nutrition Research, Medical Research Council, Cambridge, we are seeking a Nutritionist to work on a project called *Famine foods - filling the development and data gap*.

We require an innovative and energetic person to help bridge the fields of human nutrition, botany and development/aid relief in East and North East Africa by researching the micronutrient content and value of dryland wild plants.

The main responsibilities will be to:

- Seek and collate sources of data on the nutritional content of wild plants in arid and semi-arid Africa
- Learn how to, then enter data (including remotely) onto Kew's Internet SEPASAL database of useful plants
- Highlight further information and research needs with relief and development organisations working in Africa
- Disseminate results in hard copy and electronically

Candidates should have at least first degree level education in nutrition and demonstrably good knowledge of the issues surrounding nutrition, development and the operations of aid/relief in Africa.

Extensive experience of working in emergency food and relief situations is essential, as is excellent oral and written communication skills. A strong interest in natural resources is desirable.

Although the post holder reports to Kew, the actual place of work will be flexible.

Salary from £17,700 per annum.

Application form only, available from Personnel Dept., Royal Botanic Gardens, Kew, Richmond, Surrey TW9 3AB. Telephone 020 8332 5184 or our 24 hour answerphone on 020 8332 5150. E-mail jobs@rbgkew.org.uk
Please quote job ref 1154
Closing date: 28 September 2001

Nutritionists, food specialists, food logisticians

NutritionWorks and International Health Exchange are setting up a register for food and nutrition specialists seeking work in developing countries.

If you have expertise in: public nutrition, nursing/nutrition, food security, food aid, food logistics; and are available for either long- or short-term postings or consultancies we would like to hear from you.

Posts may include the management or implementation of food distribution and feeding programmes (therapeutic and supplementary), food security assessments, nutritional surveys, project planning and evaluations.

The register is currently accessed by: Action Against Hunger, Concern Worldwide, Oxfam, Save the Children, UNHCR, The World Food Programme, World Vision and many others.

Candidates will be interviewed and feedback and advice are offered.

For further information and an application form, please contact Pat Brooke, International Health Exchange, London SE1 7AE, UK.
Tel: 00-44-207-620-3333. Email: pat@ihe.org.uk

ACC/SCN working group on nutrition in emergencies

The annual UN ACC/SCN meeting was held in Nairobi, Kenya between 2-5 April 2001. The Working Group on nutrition in Emergencies meeting was held on the 5th. Highlights of the meeting are included below.

As a follow up to the working group recommendations in 2000, a special meeting was organised and held during the SCN's 28th session in Nairobi in April 2001 (see summary of meeting on Assessment of Adult malnutrition, same page). Other follow-up initiatives reported on, and discussed at this years meeting were as follows:

- Much work on producing operational guidance and training materials on infant feeding in emergencies was undertaken through interagency collaboration and presented during the working group meeting.[1]
- The need to prioritise the gaps in knowledge, skills and practice in emergency nutrition was identified in last year's meeting. This led to the design of a matrix questionnaire. It was agreed that once the format of the matrix has been further revised and developed, agencies will complete it by providing information on specific agency guidelines, training materials etc. The process will enable specific gaps to be identified and therefore provide an advocacy and planning tool for the Working Group.
- During last year's meeting, the working group expressed concerns about the cost and inaccessibility of the WHO publication 'Management of severe malnutrition: a manual for physicians and other senior health workers. The manual is now available on the WHO website (www.who.org). WHO is preparing training modules to accompany this.

New Proposals launched at the meeting

- Community Based Therapeutic care

Dr. Steve Collins (Valid International) presented a proposal for community based therapeutic care (CTC).

Community therapeutic feeding is the treatment of severe malnutrition at home, using Ready to Use Therapeutic Food (RUTF), mother to mother support, follow-up of cases and a strong networking system. The RUTF provides the nutritional equivalent to Formula-100 and can be given to children with uncomplicated severe malnutrition (those with a good appetite, no persistent diarrhoea and no major medical complications) and to early discharges from local, small TFCs or local clinics, after initial complications and severe infections have been treated and appetite has returned.

A principle underpinning CTC is the integration of emergency nutrition interventions with longer-term programmes by establishing community-based structures that can be re-activated in future emergencies. Although the need for, and strengths of, 'traditional' therapeutic feeding centres (TFC) are acknowledged (particularly for anorexic, hypothermic, hypoglycaemic, dehydrated and septicaemic cases), concerns regarding the related high costs, necessary resources and coverage of such feeding centres were presented. Potential negative impacts of TFCs, such as the removal of the mother from the family, the decrease in household economic production and the increase in public health problems due to cross infection were also highlighted.

Research on CTC programmes is currently limited. Concern Worldwide and Oxfam have undertaken trials in Ethiopia in 2000. Dr. Steve Collins concluded his presentation by reinforcing the need for more 'imaginative' nutritional interventions during emergencies and the belief that the Community Based Therapeutic Care will add flexibility to current practice. Implementation must involve conscientious data collection to evaluate the overall impact.

- SCN/RNIS Publication on The Meaning and Measurement of Acute Malnutrition in Emergencies.

Dr. Helen Young presented a proposal for a new SCN/RNIS publication on "The Meaning and Measurement of Malnutrition in Emergencies: the origins of good practice and actual practice". The main objective is to produce a technical review of the scientific basis and origins of current field practice. The document will aim to serve as a reference point for agency policies, guidelines and training initiatives. The document will be prepared for a wide range of users including nutrition specialists in Government, UN agencies, NGOs universities, research institutes and advisory bodies and will be distributed through the SCN.

- Capacity Building in Training Initiatives in Emergency Nutrition

Dr. Helen Young presented an overview of a number of training initiatives that are currently being undertaken in the humanitarian nutrition sector. These initiatives are part of a wider strategy to professionalise the response to disasters. The World Food Programme/Tufts University Food and Nutrition Training Initiative is one example of a major training initiative that is ongoing. This training initiative was undertaken in a number of stages: beginning with a review of the needs for training within WFP; the development of the WFP Food and Nutrition Handbook; development of training materials; implementation of four regional workshops and subsequent satellite workshops. Other training initiatives that are currently being undertaken or that are in a development phase include; UNICEF's Health and Nutrition Training; SPHERE, and training undertaken by MSF, AAH/ACF, Merlin/NutritionWorks/IHE, ICRC, HELP and Interaction/Columbia University.

Training, is considered one important and essential tool for capacity-building. While many training initiatives to date have generally been driven from agency head-quarters, there is a need and scope for institutionalising training capacity on a regional basis. The Africa Nutrition Capacity Development Initiative, which was presented at the SCN Working Group on Capacity Building meeting, provides one potential forum through which training initiatives can be channelled. The priorities of this regional initiative are; advocacy, client-focused training, action-oriented research, and promotion of regional collaborative responses and networking. There is potential for harmonising current training efforts through collaborative training initiatives. A number of initial actions for moving forward a comprehensive collaborative training initiative that would encompass a regional focus, may involve (i) preparing a central directory of training materials, (ii) determining the level and type of interest in such an initiative (iii) an initial meeting to discuss longer-term training strategies.

Co-ordinating Mechanisms for the Working Group

The Working Group on Nutrition in Emergencies will continue to receive support from both the RNIS Coordinator and the Emergency Nutrition Network (ENN) Coordinator. A task force made up of approximately 10 people will continue to lead the activities of the Working Group in 2001-2002.

Thematic groups within the Working Group have been identified to spearhead specific areas of work:

1. Capacity Building,
2. RNIS Technical review
3. Infant feeding
4. Refugees
5. Assessment of adult malnutrition

The next SCN symposium is on the topic of "Nutrition in the Context of Crisis and Conflict" and will be held during the SCN annual session in Berlin from 11-15 March 2002.

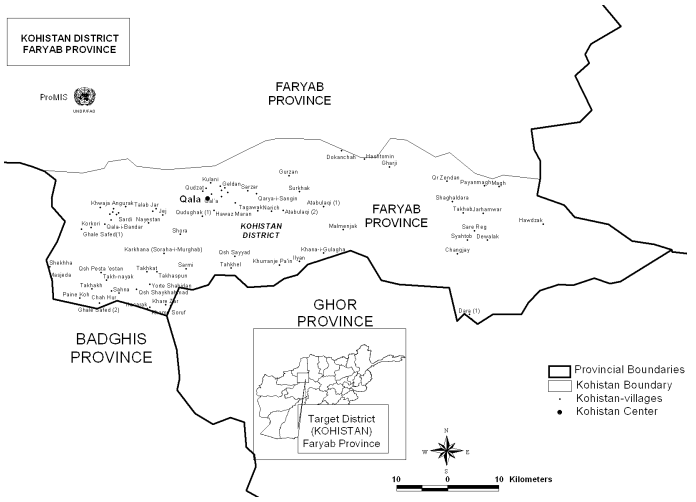
The minutes of the meeting are accessible on the website at http://acc.unsystem.org/scn/Publications/AnnualMeeting/SCN28/28emergencies.htm.
For further information or full minutes by email contact either Brian Jones at UN ACC Sub-Committee on Nutrition
C/o World Health Organization, 20 Avenue Appia, CH 1211 Geneva 27, Switzerland. Telephone: +41-22-791 04 56
Fax: +41-22-798 88 91EMail: accscn@who.int or Fiona O'Reilly at ENN, Unit 2.5 The Tower, Trinity Enterprise Centre, Pearse Street Dublin 2 Ireland Telephone 353 1 6752390 Fax 353 1 6752391 Email fiona@ennonline.net

[1] See 'Infant feeding in emergencies: new resources' (page 9)

Scurvy outbreak

and erosion of livelihoods masked by low wasting levels in drought affected Northern Afghanistan

By Fitsum Assefa



Fitsum Assefa is a nutritionist who recently joined Save the Children, United States (SC/US) as nutrition/food security advisor to the newly established Emergency Response Unit. She has been involved in nutrition and food security programmes in a number of African and Asian countries, mostly in emergencies, and previously worked with MSF-Holland and Concern worldwide.

FITZUM ASSEFA

Signs of scurvy: blackness of the legs indicative of haemorrhage

FITZUM ASSEFA

Peri-follicular haemorrhage typical of scurvy

Kohistan is one of the most remote districts of Faryab Province in Afghanistan. It is in the south of the province bordering Badghis and Ghor provinces and is an eight-hour car journey from the provincial capital of Maimana to the district capital Bandar. The area is normally inaccessible by car for about six months of the year, due to snow and rain. However, the recent mild and dry winters have allowed access for more than eight months each year.

Since 1995, SC/US has run primary health care and women's micro-credit programmes in the four districts that make up the Andkhoy region of the northern part of the province. In the second half of 2000, SC/US initiated drought response activities in northern Afghanistan, primarily in the Andkhoy region. The response included emergency cash loans, cash for work activities and 'complementing' WFP's wheat ration with pulses and oil. In March 2001, SC/US conducted a rapid assessment in southern Faryab. The assessment confirmed the seriousness of the situation in the predominately rain-fed areas. Subsequently, SC/US decided to expand drought response activities into the southern part of Faryab province, co-ordinating closely with WFP-supported wheat distribution activities. SC/US conducted a nutritional survey at the beginning of April.

Background to the Nutritional Survey

The total population of the district is estimated to be 57,630 and is clustered in two main areas.

The district economy is reliant on the production of rain-fed wheat and barley. In the past, the district was self-sufficient in grain and in most years exported to other parts of Afghanistan. Other important agricultural activities in the district include the cultivation of oil crops (mainly sesame), fruits (mainly melons), and fodder crops. Raising sheep, goats and cattle is a very important source of cash as well as food. Oxen are important for traction.

Health services are almost non-existent and there are no doctors working in the whole district. There are only a couple of drug vendors at the district capital, Bandar. There is no routine EPI program and there has never been a measles vaccination campaign. The most common illnesses include diarrhoea, acute respiratory infections, tuberculosis and measles.

Access to drinking water is very poor for most villages in the highland areas. In some villages people (usually women and children) have to walk (up to five hours) up and down the mountains to collect water from the river.

WFP had started food distributions in other more accessible parts of the province. They also attempted a 'once-off' wheat distribution for part of the population in Kohistan in November 2000. However, this was in a location at least 2 days walking distance (one way) from the centre (Ser-e Haus) of neighbouring Pushtunkot district. Only a few people from the surveyed area are thought to have benefited from this distribution, as the cost of time and transport to carry the food was considered to be very high.

From the limited information collected during the earlier rapid assessment (March, 2001), it appears that the drought in the past three years has had a devastating impact on the food and economic security of the district, especially for those dependent on rain-fed agriculture. The villages in Lafraye, Mulghee, Khoitoor, Pusiarcha and Sarisang were reported to be the worst affected[1].

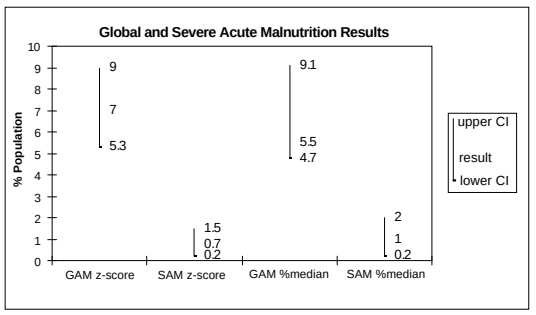
Though the situation in the whole of Faryab Province, especially Kohistan, has been recognised to be serious, there were no previous comprehensive population-based assessments conducted. Therefore SC/US initiated this survey with a view to assessing nutritional status, food security and mortality.

Methodology of Assessment

SC/US used the standard methodology for a two-stage cluster sampling based on a sampling frame of 44 villages. The sampling frame included all the villages in the district that had more than 20 households, were accessible within a maximum of one day walking, and were under government control. A total of 378 households, a population of 3,165, were covered in the survey. Half the survey teams were Afghani women with middle/higher level education. The provincial authorities issued permission both for the overall survey as well as the involvement of women.

Prevalence of acute malnutrition[2]

The cumulative prevalence for moderate and severe wasting and/or kwashiorkor are illustrated as follows:



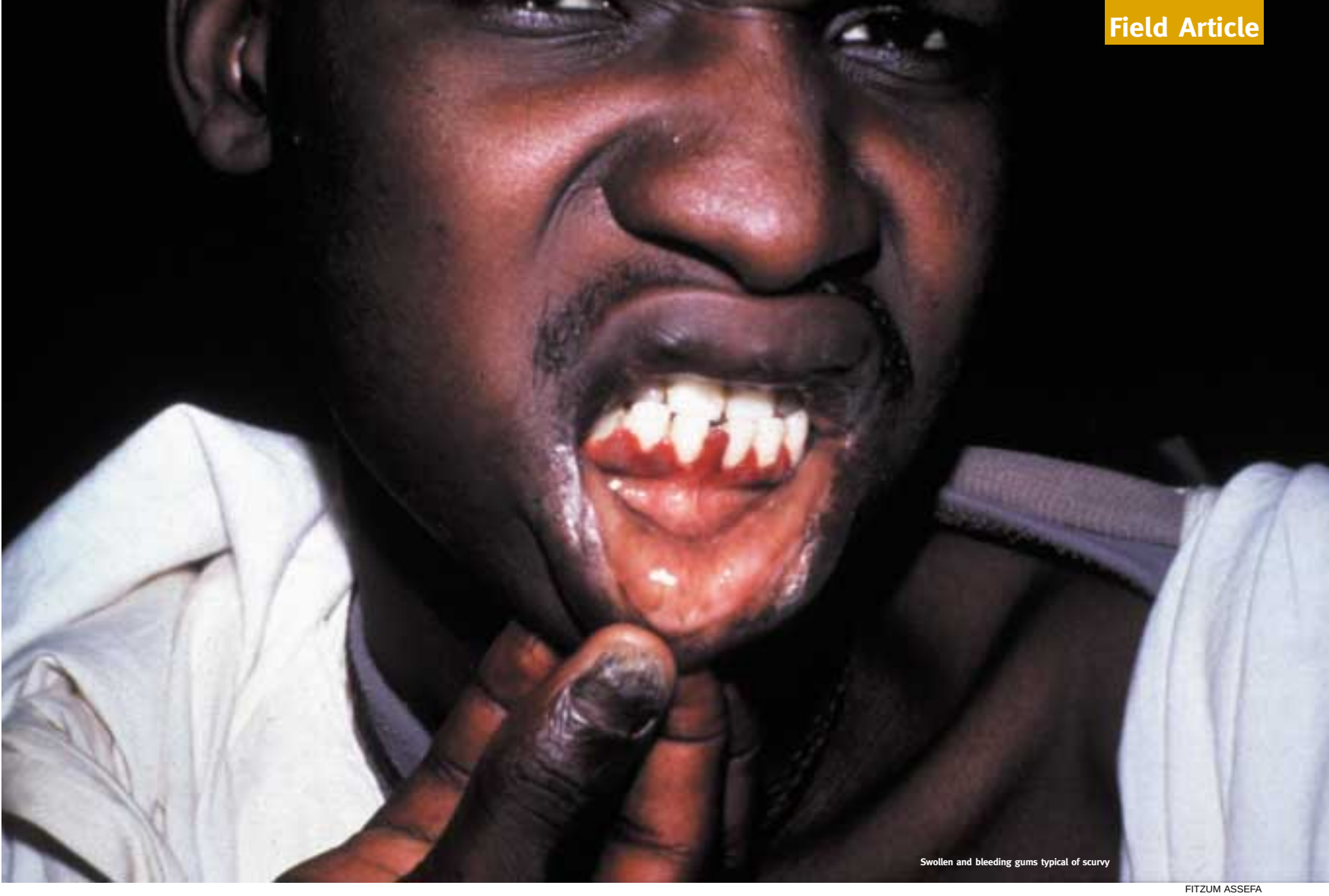
Approximately 40% of the severely malnourished were kwashiorkor cases. There was no significant difference found in the prevalence of malnutrition between boys (7.1%) and girls (7.0%), p=0.4. Whilst there is no previous baseline information on the nutritional situation of the district, wasting rates in many parts of rural Afghanistan are normally expected to be around 5%. According to the findings of this survey, 7.0% acute malnutrition did not appear to be a problem of public health significance.

Micronutrient status

In contrast, the micronutrient status of the population was very poor. A widespread prevalence of vitamin C deficiency disease locally known as *"Seialengia"* (black legs) was observed during the survey probably complicated with other mineral and vitamin

[1] According to the local population, the district has had three consecutive years of rain/snow failure, which has affected cereal harvests as follows: 50% reduction in 1998, 85% - 90% reduction in 1999, 95% - 100% reduction in 2000. An 80 - 90% reduction is predicted for the 2001 harvest.

[2] CI= 95% confidence interval with calculated cluster effect.



Swollen and bleeding gums typical of scurvy

FITZUM ASSEFA

deficiencies. The disease was especially common in Lafraye and Melgee sections. In some of the villages in these sections the deficiency disease is estimated to have affected up to 10% of the population.

The disease affected people of all ages and gender but to a lesser extent children under the age of 2 years. About half of the most severely affected patients were adolescent boys (10 - 18 years) while the elderly were also one of the most affected groups both in terms of frequency and seriousness of the disease. *Seialengia* mainly affected the poorer families with usually more than one case per family. The incidence of the disease was reported to be higher from mid-December to mid-February. Victims were bed-bound for weeks. Although some people reported that they were showing signs of recovery, none of the affected had completely recovered. Some people who were able to get medicines from drug vendors in Bandar (mainly vitamin C tablets and vitamin B-complex injections) were showing a faster recovery.

In most cases all the signs and symptoms of scurvy, as described in textbooks, were manifested: blackness of the legs (indicative of haemorrhage), gum swelling and bleeding, joint pain and swelling especially of the knee and ankle joints, backache, pigmentation and hardness around the hair follicles especially on the legs (suggestive of failure of the hair follicle eruption). Most cases had developed hard crust-like black skin on the knee and ankle joints, reportedly because they have not been washing for weeks as the area was too painful to touch, and sometimes resulted from the herbs they put on them (see picture).

Most *Seialengia* patients also had angular stomatitis (cracks at the corner of the mouth), swelling and discolouration of the tongue and lack of appetite.

Dietary investigation

The consumption of fruits and vegetables by most of the population had been minimal since last summer. The level and severity of the deficiency disease suggests extremely low intake of vitamin C in the winter months. At the beginning of March wild green leaves became available and later other plants. Consumption of these was extensive. Incidence rates in the previous month were declining, suggesting that wild leaves were making a significant contribution. However, the *Seialengia* cases were hesitant to eat the leaves thinking it would aggravate their problem and/or due to general lack of appetite. The methods used in cooking/processing the wild plants are thought to significantly reduce vitamin C intake from this source. Leaves are cooked for long periods and the water in which it is cooked is not consumed.

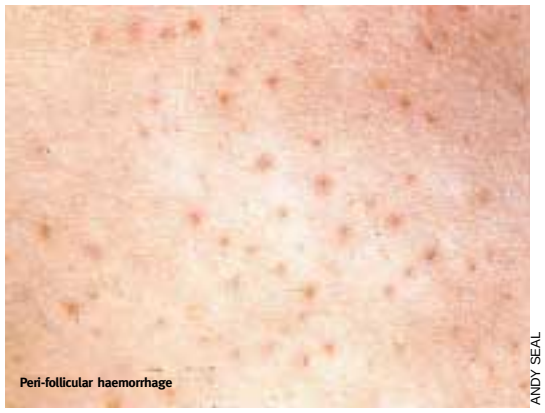
In conjunction with the World Health Organisation (using vitamin C tablets provided by WHO), SC/US treated around 250 *Seialengia* cases with appropriate treatment doses in the 29 cluster villages during the survey.

Food Security and Coping Strategies

According to respondents, before the drought, an average family in Kohistan owned around 15 goats, 25 sheep, 2 oxen, 2 cows and 2 donkeys. As a result of the drought many people had sold most of their animals, dramatically reducing the average family animal ownership to only 1.1 goats, 1.8 sheep, 0.3 cattle/oxen and 0.7 donkeys.

The average number of meals in the previous 24 hours was 2.7 (72.2% of the households consumed three meals while 28.8% reported a recent reduction of meals to two, especially for adults).

It appears that grain stocks from previous years had made a significant contribution in mitigating the impact of the drought, at least in the first two years. Selling livestock was an important coping mechanism employed by most people. At the time of the survey however, there were very few animals left to sell and very few other economic opportunities existed (i.e. selling labour, selling crafts, etc.). People were resorting to 'risky' coping strategies with very low returns such as selling land, displacement, begging



Peri-follicular haemorrhage

ANDY SEAL

Afghani boy with swollen and bleeding gums

FITZUM ASSEFA

Summary of current WHO Guidelines
'Scurvy and its prevention and control in major emergencies' WHO/UNHCR, 1999

Provisional criteria for determining severity of public health problem of vitamin C deficiency

In the absence of laboratory facilities the following guidelines may help determine appropriate intervention.[5]

	Severity of public health problem		
Indicator	**Mild**	**Moderate**	**Severe**
Clinical signs	≥1 clinical case <1% of population in age group concerned	1-4% of population in age group concerned	≥5% of population in age group concerned

Requirements of vitamin C

The daily requirement is estimated at 30mg (FAO,WHO, 1970). For active adult males the daily requirement has been suggested as 40mg due to the relatively rapid turnover of vitamin C and enhanced needs resulting from stress and physical exercise.[6] With a diet completely lacking in vitamin C, body stores will last approximately 2-3 months. The extent to which scurvy contributes to mortality is uncertain. However, as vitamin C is associated with protection against infection and enhances iron absorption (WHO 1976), deficiency may have a significant impact on mortality especially in this situation in Afghanistan where primary health care facilities are negligible.

Treatment protocol for scurvy

In cases where a population is at high risk of scurvy or where cases of scurvy have already been identified and all the other options for intervention are not immediately feasible, vitamin C supplements need to be considered.

The WHO recommended treatment of scurvy is through the administration 1 g of ascorbic acid daily for 2-3 weeks. Although smaller doses for shorter periods may relieve immediate symptoms and signs, the larger doses and more prolonged treatment are recommended to prevent relapse.[7] In the longer term, it may be difficult to maintain consumption consistently and coverage may be limited.

Prevention strategies for vitamin C deficiency.[8]

Where there is local production of fruits/vegetables:

- Add fruits/vegetables to the ration
- Encourage barter or purchase by providing 10% extra ration
- Home gardens could be established where and when feasible (distribution of seeds and education)
- Nutrition education should be a component of every intervention
- 'Wild foods' can be exploited (roots, leaves, wild fruit) and may contribute substantially to vitamin C intake.

In areas where vegetables, tubers and fruits cannot be easily produced or procured locally as in this situation in Afghanistan, alternative strategies for prevention of vitamin C deficiency include:

- Distribution of foods fortified in vitamin C (e.g. fortified flour).[9]
- Distribution of fortified cereal/legume blended food (120 mg vitamin C per ration). All members of the household should be targeted.
- Distribute fortified vitamin C enriched foods e.g. tomato paste, orange juice powder, dried fortified peppers. These are relatively expensive and unlikely to be readily available.

Note: Scurvy and its prevention have also been discussed in detail in the following articles in Field Exchange, Issue 5:
- Appropriate vitamin C fortification levels for CSB
- Micronutrients: the basics
- Reduce scurvy risks through germination

[5] Derived from: Sauberlich et al., 1974, Desenclos JC et al. 1989.
[6] Olson and Hodges (1987).
[7] The management of nutrition in major emergencies. WHO, Geneva, 2000.
[8] Scurvy and its prevention and control in major emergencies, The Micronutrient Series, WHO, 1999.
[9] See also News piece in this issue on WFP pilot project on fortifying flour with essential micronutrients.

and taking loans with high interest rates. The redistribution of resources among relatives was widely practised, but it was not clear for how much longer such support could continue.

According to respondents, extensive labour migration to Iran is not a usual or preferred income source under normal circumstances, as the type of work available is considered physically difficult, degrading (mainly work on construction) and often poorly paid. However, at the time of the survey almost every family in the district had sent at least one man to Iran, and more men were still leaving. Although most men were reported to have left for Iran much earlier, it seemed that the number of men who had left in the last four months (since the start of Ramadan) was significant. The adult population (older than 15 years) female to men ratio has changed from 1.1 before Ramadan to 1.6 at the time of the survey. Of those who had left, none had yet started sending money back. The workers first had to pay back significant loans used to get them to Iran[3].

The severe impact of the drought was also reflected in changes in some cultural and traditional values. Many villagers reported that daughters were being given to marriage at a lower than normal age (about 5% of the interviewed households were using bride price as their main source of current income). The daughters' bride prices have decreased from the norm of at least $1,800 or up to 100 goats/sheep plus 3-6 cows to less than $300 or 20 goats/sheep.). Under normal circumstances, the girl only leaves her family when the bride price is completely paid. Currently, some daughters are being given to their husbands before payment is completed - it was also reported that a few families have given their daughters in marriage for free as they did not have enough to feed them (though it was difficult to verify this information). The other interesting pattern is that men in the district are not able to afford the bride price because of the economic crisis. Therefore, many girls are marrying men from other parts of the province or country - an unusual practice[4].

Findings/Lessons learnt

- Micronutrient deficiencies can occur in the absence of raised levels of malnutrition (as defined by prevalence of wasting).
- The pattern of scurvy seems to show that adolescent boys (10-18 years) and the elderly are most affected.
- Signs of protein energy malnutrition (wasting) have been a late indicator of the food crisis,
- Coping strategies have allowed the population of Kohistan to consume sufficient calories to prevent protein energy malnutrition. However, the diet has lacked sufficient micronutrients to prevent outbreaks of scurvy and other micronutrient deficiencies.
- The coping strategies employed have become increasingly desperate and socially disruptive, while at the same time undermining sustainable livelihood patterns. Given the fact that coping strategies are being exhausted, and considering the poor prospect of the next harvest, acute malnutrition could increase rapidly in the near future and/or people will become displaced before they get malnourished. Furthermore, the impact of the coping strategies on long-term livelihoods has not been properly investigated or analysed.
- There has been a lack of representative and reliable information, partly due to problems of access to the affected communities due to political and cultural factors. There has also been a lack of co-ordination and standardised approaches among the different agencies conducting nutrition and food security assessments, limiting the comparability of information between places and over time.

Conclusion

A number of relief workers in Afghanistan have been involved in large-scale nutritional emergencies, mainly feeding centres, clinics etc. in the Horn of Africa. I heard many discussions whereby direct comparison with experiences in the Horn led to the conclusion that the situation in Afghanistan was more or less fine. However, this is a very different situation. The last drought in northern Afghanistan was 30 years ago and lasted for only one year, enabling people to deal with it easily. In contrast, the current drought has lasted 3 years, economic circumstances have deteriorated markedly and people have had to use up all their assets to survive. If such droughts re-occur every decade or so, then it is not inconceivable that an 'Ethiopian highlands' type situation may occur whereby small shocks lead to high levels of malnutrition and mortality as large numbers of people live on the edge of destitution. Responses to this drought should therefore include efforts to prevent this happening.

Recommendations

- Recognising the enormous logistical difficulties of reaching the affected population WFP should ensure the provision of wheat and include complementary foods such as pulses, oil and blended/fortified foods for the population. WHO recommends a daily ration of 100g of fortified CSB in order to prevent scurvy in emergency situations.
- There is an urgent need to treat scurvy patients, using appropriate WHO recommended dosages of vitamin C.
- The response to this situation should include interventions aimed at minimising the long- term risk to livelihoods. Systematic in-depth monitoring of the food/economic security situation, especially use of coping mechanisms should be the key to trigger appropriate responses that are not only directed to saving lives, but also saving livelihoods.

[3] (up to $300, with 100% interest rate, compared to the normal cost of only $150)
[4] Recently the SC/US team encountered a 13 year old girl in Andkhoy district who was "sold" from Kohistan for $120.

HelpAge International

Interview by Jeremy Shoham with Nadia Saim

Name	HelpAge International
Address	Head Office, PO Box 32832 London N1 9ZN, UK
Telephone	+44 (0)20 7278 7778
Fax	+44 (0)20 7843 1840
Email	hai@helpage.org
Internet	Http://www.helpage.org
Year formed	1983
Chief Executive	Todd Petersen
Director	Mark Gorman
Overseas staff	22 expats / 200 local
HQ staff	46
Annual Budget (2000)	
Income	£11.398m
Expenditure	£11.526m
Direct Charitable Expenditure	£10.8m

HelpAge International (HAI) is a global network of not-for-profit organisations founded in 1983 as an independent charity by a consortium of national organisations.[1] Its mission statement is to work with and for disadvantaged older people world-wide to achieve a lasting improvement in the quality of their lives. From the original five founding agencies world-wide membership has grown to 43 full members, 24 associate members and 2 institutional members.[2] HAI's secretariat is based in London. There are four regional development centres (Asia (Thailand), Africa (Kenya), Caribbean (Jamaica) and Latin America (Bolivia)). HAI also works in East and Central Europe, has eight country development programme offices and a world-wide emergencies programme. In 2000, sixty percent of income came from Help the Aged UK and 40 percent from other agencies. These included DfID (9%), EC (14%) and the National Lottery Charities Board (4%).

Field Exchange interviewed HAI's emergency officer, Nadia Saim, in their London office located near Kings Cross. Nadia, whose earlier professional experience includes accountancy, fundraising and development of training programmes for the physically handicapped, started working for HAI two and a half years ago. She has occupied the HAI emergency desk for more than half that period.

Response in Emergencies

Nadia explained how the eight country development programmes had started in an emergency phase when HAI became involved. Help the Aged is a DEC (Disasters Emergency Committee) member and responds to DEC requests. HAI implements emergency responses with other members of the DEC where possible. Currently, HAI are involved in emergency programmes in Mozambique, Gujarat, Malawi and Peru. A typical HAI emergency response involves short-term measures targeted at older people followed by longer-term rehabilitation initiatives. For example, following the earthquake in Gujarat, HAI provided food rations for 7,500 older people and their families, in addition to blankets, plastic shelter and cooking equipment.

The current rehabilitation phase involves shelter, agricultural and handicraft support measures for 1,500 older people.

As part of the immediate emergency response HAI will often provide a full food ration (general ration) for older people (and their families) who are not in a recipient population group from food distribution organisations like WFP or other NGOs. They will either do this through local partners (e.g. India), or country development programme (e.g. Mozambique), or set up a programme from scratch (e.g. Kosovo). This type of programme may present problems. For example, in Gujarat other members of the community felt that they also needed food aid. HAI therefore, in some areas, had to go through a longer consultative process with the community before the programme was accepted.

HAI identify vulnerable older people using different criteria in any given emergency, e.g. those over 60 years of age who are isolated and can't care for themselves or those who have to look after grand-children. As part of the needs assessment HAI will discuss with beneficiaries the type of food ration that is appropriate and culturally acceptable. Very often this means that older people receive a ration which is quite different to the ration being given out by agencies like WFP. For example, in India HIA distributed rations included wheat, rice, millet, sugar, oil, pulses, masala and tea.

Until recently HAI have only been involved in distributing general rations to older people. A recent departure from this has been the implementation of a supplementary feeding programme for malnourished older people and other vulnerable groups in Ethiopia.

Including older people in existing programmes

A core part of HAI work involves advocating for inclusion of older people in other agencies programmes, and raising awareness of the contribution that older people can make to the community, especially following an emergency. For example, following the floods in Mozambique HAI successfully lobbied for inclusion of older people in Caritas's supplementary feeding programmes and in Oxfam's seed distribution. HAI try to get other agencies "to see the old as part of the family and to be included in the mainstream services rather than have special services created for them". However sometimes it can be difficult to convince agencies. For example, HAI found it very difficult to get WFP to accept that older people should be included in supplementary feeding programmes in northern Iraq. It is also proving difficult to get other agencies to modify existing programme delivery to cater for the special needs of older people, e.g. providing special food types or improving access for the older people.

Advocacy with results

One recommendation from the recent DEC evaluation of the Mozambican emergency response was, that HAI should in future determine the success of their advocacy efforts to have older people included in agency emergency interventions.

Over the years HAI have done a great deal of lobbying of UNHCR. This seems to have borne fruit as last year UNHCR finalised a policy on older refugees drawing heavily on the recently published HAI best practice guidelines.

These best practice guidelines were based on an HAI study in four countries (Bosnia, Bangladesh, Rwanda and the Dominican Republic) during 1999. It also drew on experiences from 21 emergency programmes. The aim of the study was to draw out the experiences of older people in emergencies and find out how best to meet their needs. The main findings were:

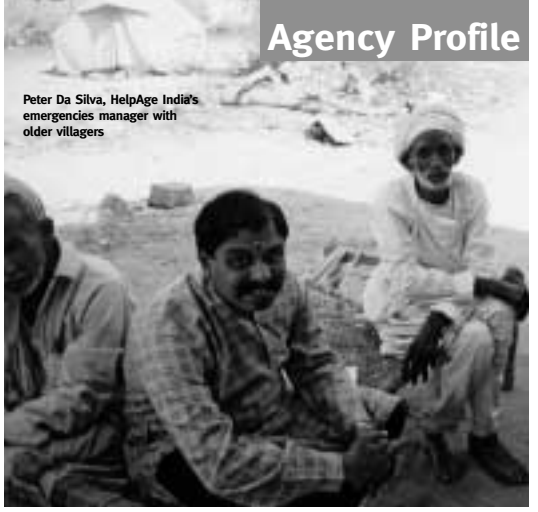
- older people were often 'invisible' to humanitarian agencies. Out of 60 agencies questioned, 32 agencies gave children their highest priority and 22 gave older people their lowest priority or no priority at all
- older people have specific needs during emergencies, e.g. lack of mobility means they need help getting to distribution points, food needs to be palatable/chewable, they may need a fast track queuing system, they often find it difficult to cook and would like to be able to join families that are cooking food, etc.
- They want to be included in income generating activities so that they can re-build their own lives

The guidelines were written with the specific aim of helping relief agencies meet the special needs of older people in emergencies.[3]

This isn't the first piece of research conducted by HAI. An earlier and perhaps better-known study conducted by HAI on how to identify malnourished older people was initiated in 1992. This research was undertaken in conjunction with LSHTM[4] and after 6 years resulted in a guideline on best techniques for measuring under-nutrition in the older people.[5]

Contribution of older people to society

In the emergency sector Nadia sees the main challenges still facing HAI as "breaking the barriers of invisibility which engulf older people" and "getting others to recognise the enormous economic and social contribution older people can make". For example, " older people have a historical knowledge of the community and can identify the most vulnerable. They also know different coping strategies that can be employed in times of crisis. Also, experience has shown, for example in Rwanda, that in times of civil unrest, age confers advantage in terms of conflict resolution skills."



Peter Da Silva, HelpAge India's emergencies manager with older villagers

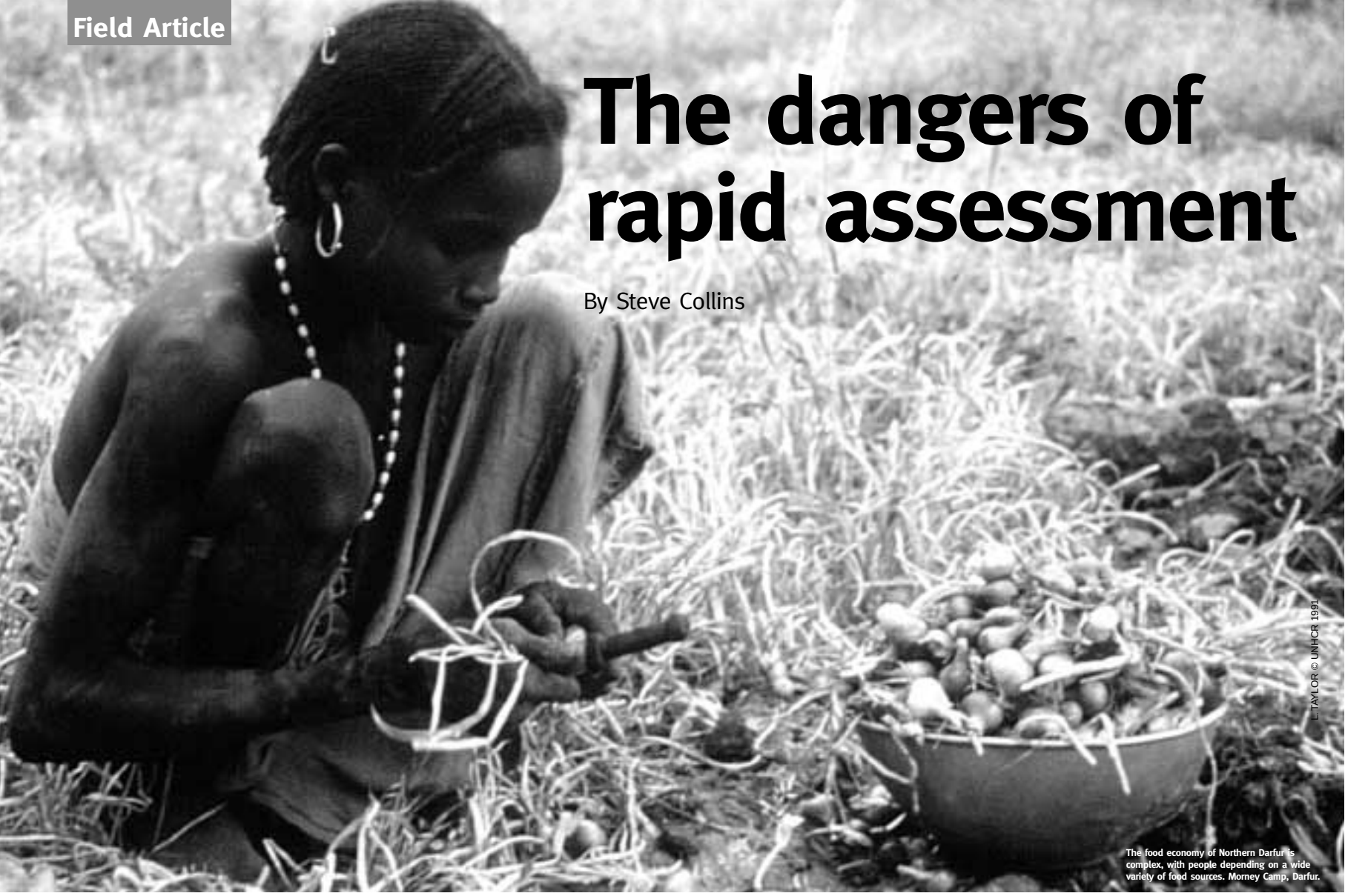
Older villagers meeting during programme assessment

Note: HAI are in the process of publishing a recent study on 'Addressing the nutritional needs of older people during emergency situations'. A summary of this report was included in Issue 12 (April 2001) of Field Exchange. For further details contact: Dolline Busolo, Regional Nutritionist, HelpAge International, Africa Regional Development Centre, P.O. Box 14888 Westlands, Nairobi, Kenya. Tel: 254 2 444289/4469691/449407. Fax: 254 2 441052 or Email: helpage@net2ooke.com

[1] Help the Aged UK, HelpAge India, Help the Aged Canada, HelpAge Kenya and Pro Vida Columbia
[2] Full members are national, not for profit organisations which provide services for, or represent older people as the main focus of their work. Associate members include organisations interested in older people as one aspect of their work. An institutional member is for example the department of an academic institution working on older people policies and research.
[3] Older People in Disasters and Humanitarian Crises: Guidelines for Best Practice. HelpAge International (2001)
[4] London School of Hygiene and Tropical Medicine
[5] See Field Exchange, issue 3, Jan 1998

The dangers of rapid assessment

By Steve Collins



L. TAYLOR © UNHCR 1991

The food economy of Northern Darfur is complex, with people depending on a wide variety of food sources. Morney Camp, Darfur.

Dr. Steve Collins is a Nutrition Consultant working for Valid International. He undertook this assignment on the request of Save the Children UK and visited Darfur between 28th April and 13 May 2001. He specialises in assessments and setting up emergency nutritional interventions, evaluations and researching severe adult malnutrition and community therapeutic feeding. His previous work experience has included emergencies in Sudan, Somalia, Angola, Liberia, Burundi, Rwanda, DPRK, Balkans and Haiti.

I was recently in Northern Darfur, Sudan, where SCF-UK had employed me to analyse and present data from five nutritional surveys and combine this with food security / economy data collected by their early warning system (EWS).[1] In my opinion, the data SCF had collected was exceptional, both in terms of its high quality and its broad historical and geographical scope. They had undertaken one complete nutritional survey in each of five separate food economy zones, all conducted by well trained teams and implemented according to internationally recognised standards. Detailed food economy and food security data stretching back over ten years supplemented this. The historical records of market prices, terms of trade, harvests, and other sources of income, etc. provided a baseline and enabled the cross-sectional nutritional data to be set in context. This facilitated a clearer understanding of the situation.

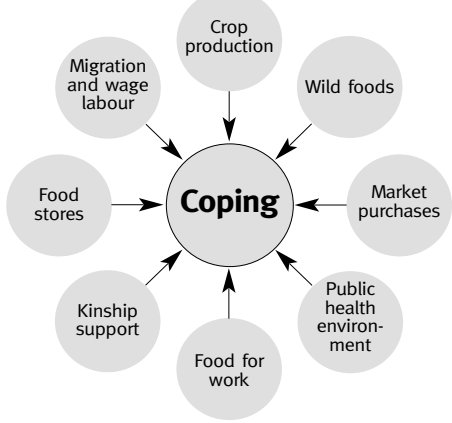
The results were very worrying; 24% global malnutrition, six months to the next harvest and clear signs that coping capacities had been exhausted (see graphs). The following table outlines the prevalence of malnutrition throughout the state.

Table 1 - Nutritional status by food economy zone and displacement

food economy zone	sample size	global malnutrition	95%CI	severe malnutrition	95% CI	mean WFH z-score
Goz	769	**31.3**	27.2 - 35.5	**3.0**	1.9 - 4.7	-1.6
Pastoral	760	**26.1**	22.4 - 29.7	**1.7**	0.7 - 2.7	-1.5
Non - wadi	750	**18.9**	15.6 - 22.3	**1.1**	0.7 - 3.2	-1.3
Jebel	760	**20.8**	17.8 - 23.8	**2.0**	0.7 - 3.2	-1.3
Tumbac	740	**20.3**	17.1 - 23.4	**2.7**	1.5 - 3.9	-1.2
Displaced	180	**26.1**	20.0 - 33.3	**4.4**	2.1 - 8.9	-1.38

Normal livelihood patterns

The food economy of Northern Darfur is complex, with people depending upon a wide variety of food sources. There is also a wide range of mechanisms that the population employs in order to cope with a variable pattern of food security. People farm cereal, raise livestock, collect wild foods, farm cash crops and traditionally migrate to find work. A strong kinship system, where richer members of clans support their relatives, cements the coping mechanisms together. Interestingly, local crop production is not the most significant source of food in any of the 6 food economy zones.



The October 2000 food economy analysis indicated that there was a food deficit of 26,057 MT. The deficit was anticipated to be greatest in the pastoral, goz and tombac food economy zones and among poor households in these zones. In these three zones, poor households were predicted to not be able to meet over one third of their food needs, indicating a very serious situation.

Erosion of Coping mechanisms in 2001

Crop production

Analysis from the early warning system data indicated that after a bumper year in 1998, crop production in both 1999 and 2000 was low. This is illustrated in the following graph. In addition to crop failures, the drought caused wide spread failure of Koreb, the predominant wild food in Darfur.

Figure 1 - Average crop production in northern Darfur

[1] El Fasher, Kutum, Mellit, Nyala, El Geneina & Umkeddada
[2] Dotted lines are projected prices based upon changes over the previous four months.

Market prices

Analysis from data collected in the six principal markets in Darfur indicated a deteriorating situation. All prices included in this report are unadjusted for inflation.

The following graph presents the average market prices of millet and goats in the six major markets in Darfur. The market price for millet had risen by almost 50% over the previous four months and in March 2001 was higher than during the peak of the hungry season during the crisis in 1997. The signs indicated that the rate of increase in millet prices would continue. The animal market had fared slightly better and although prices were low they had not yet reached the depths of 1997.

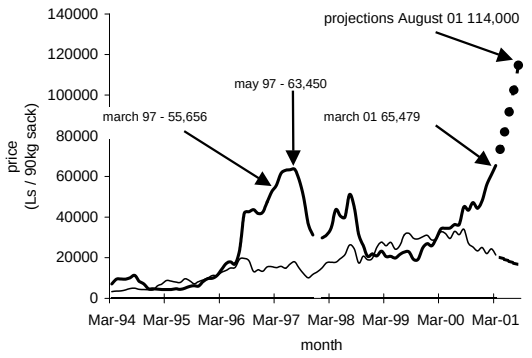


Figure 2 - Millet and goat average prices, 1994 - 2001[2]

Terms of trade between grain and goat were slightly better than it was at the peak of the crisis in September 1997, but were declining rapidly as demonstrated in figure 3:

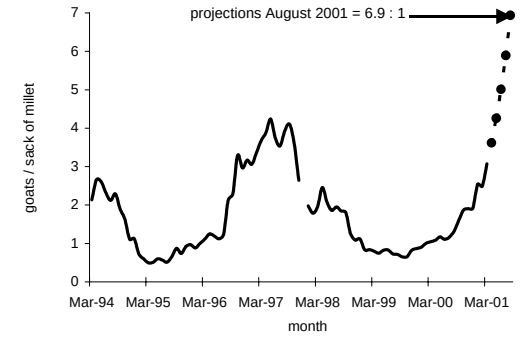


Figure 3 - Terms of trade between goat and sacks of millet, 1994 - 2001.[3]

In the pastoral food economy zone, market prices are intimately related to the rate of malnutrition, and changes in market prices tend to precede changes in malnutrition. The following graph clearly illustrates this fact.

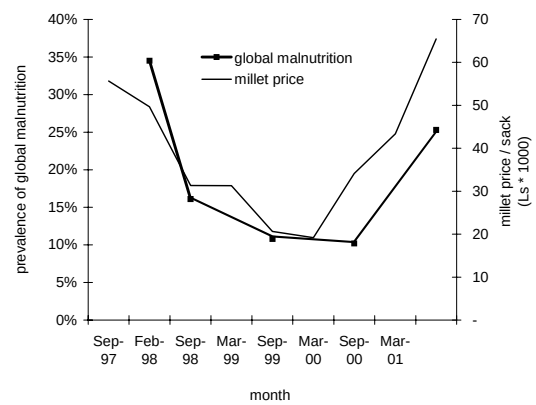


Figure 4 - the relationship between average market prices and malnutrition in Malha, 1997-2001

Labour wage rates

The past six months had seen the average wage for labouring decrease substantially. The concurrent high price of millet meant that in March 2001, 27 days of labour were required to buy one sack of millet, compared to 13 in March 1999. Trends in purchasing power in relation to labour payments are outlined below.

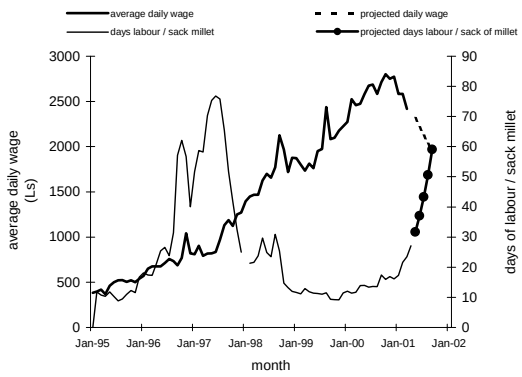
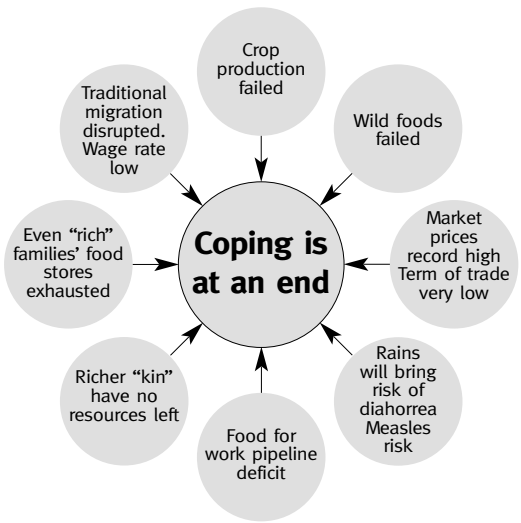


Figure 5 - Daily wage for unskilled labour in towns and relative purchasing power i.e. daily labour : millet, 1995 - 2001

Kinship and the capacity of the rich to support their relatives

Support from family / kin represents the last and most profound element in the population's coping strategy. Information clearly indicated that this final mechanism was breaking down. This breakdown was occurring at the beginning of the hungry season, six months before the next harvest.

The principle factors undermining coping strategies are illustrated as follows:



Initiating response

On returning to London we approached the donor organisation DfID, to present the findings and a proposal for an intervention aimed at maximising the amount of food aid to be delivered to Darfur before the rains rendered much of the state inaccessible. Given the comprehensiveness of the SCF data, I expected a broad agreement on the need for action and a positive outcome from the discussions. I was therefore rather taken aback when DfID responded that the SCF data didn't agree with the findings of another NGO that had recently conducted a rapid assessment in the state.

Differing methodologies with conflicting assessment results

This other assessment consisted of a team of two expatriate doctors, a local health assistant and a driver visiting 27 locations across a state the size of France in 21 days. The team held meetings with the local authorities, visited the health facilities, and water points, held discussions with families and screened under-5 children using MUAC (Mid-Upper-Arm Circumference) measurements taken via 'convenience samples' from groups thought to be at high risk (e.g. displaced). The team systematically tried to focus its attention on the most vulnerable areas and families with the aim of describing the situation of the most at-risk rather than giving a general picture of the situation. Given their attempts to focus on the most vulnerable their results were surprising. Of the 424 children that they measured, only 1% had a MUAC <110mm, 5% was between 110 - 125mm and 12.5% between 126 - 135mm. A very different picture to the results of the SCF surveys.

Rapid assessments and 'selective' sampling

A likely explanation for these differences is that the assumption that the displaced are the most vulnerable was false. In Darfur, this assumption was an oversimplification as, the displaced living around the wadis are those who still have cattle remaining, and are in fact the richest segment of the population. This clearly illustrates the dangers of rapid assessments and convenience sampling. One erroneous assumption can completely alter the interpretation of the whole data set.

I recognise that in many situations there may be no time for systematic sampling and we all at one time or another resort to 'convenience samples'. Although we are all aware of the biased nature of these samples and put a "disclaimer" that the results cannot be generalised etc., how many of us then come to believe our own results, especially once they are analysed and presented in a nice table? This was true of this rapid assessment in northern Darfur which initially stated clearly that the MUAC results were not "statistics and do not pretend they are representative of the general nutritional status". Later this position changed in the report to "Even if these numbers do not represent statistics, it shows the low presence of severely malnourished children even among populations facing very hard condition of life for several months (or years)." I wonder whether the same conclusions would have been drawn if they had realised that they were selectively sampling the richer households.

In the field such misleading results are bad enough, they can do even more harm when they filter back to donors as they can be used to justify political positions. In this case the findings from this small non-representative sample negated the results of a random stratified sample of 3779 children using weight for height measurements and complemented by ten years of involved early warning data. Happily the DfID staff later went to Darfur for themselves and quickly decided to fund a response.

Valuable lessons highlighted

In my opinion, there are important and simple lessons to learn from this. Rapid assessment and convenience samples will and should continue to form an important element in emergency responses. Often there is no time to wait for a formal survey and to do so would waste precious time and delay response. However, it is imperative that such assessments are conducted as broadly as possible (i.e. draw on a wide variety of sources) and the results obtained discussed with others in the field who may have valuable complementary insights, knowledge and data. Dissemination and sharing at field level should occur before any reports filter back to central offices and thence to donors. Although, statistical and nutritional acumen and intelligence are necessary elements in any rapid assessment team, these cannot compensate for local knowledge. A good rapid assessment is one that accesses as broad a cross-section of local knowledge as possible. In Darfur, there was a wealth of information available and closer consultation with other agencies operating in the state, both during and after the assessment, could have prevented much confusion and delay.

References
Save the Children Fund (UK) and Development and Rehabilitation Committee of North Darfur, October 2000 Village and Household Survey and Food Needs for 2000/2001
Save the Children (UK). How bad does it have to get?. The nutritional status in N Darfur in the spring of 2001, El Fasher data from SC-UK EWS/Nutrition Unit, El Fasher, N. Darfur report compiled by Steve Collins

[3] Dotted line is projected terms of trade based upon rate of change during the past four months.

MALI, LAURENT DUVILLIER © ICRC 1996

Embracing cultures

Ariane Curdy acquired a multidisciplinary University degree in household economy and nutrition (dipl. oec. troph., JLU Giessen). She first worked for MSF France (until 1988), and then joined ICRC's HQ in Geneva as a nutritionist. Over the past 14 years, she has completed over 40 missions, working in countries in Africa, Central and Southeast Asia, Central America, Middle East, the Balkans and the Caucasus. Ariane completed a Masters Degree in International Management in Amsterdam. Since then she has become an independent consultant working on intercultural issues (CTRL: CulTure ReLations). Ariane approached the ENN and suggested writing a series of articles for Field Exchange. Given Ariane's reputation and extensive experience of emergency nutrition in the field we accepted without reservation. She explains below the purpose and scope of the series - 'Embracing Cultures'.

Whenever we work for an international humanitarian organisation, we will probably be forced to deal with cultures others than our own. This necessitates interacting socially and communicating meaningfully, but also being aware and tolerant of the differences in behaviour and thinking patterns. Each culture has its own way of dealing with human relations, addressing tasks, understanding leadership, negotiating, making decisions ... or simply managing time. Misunderstandings are therefore frequent, although not always obvious. This series of articles will relate first-hand experiences of cultural differences and/or misunderstandings in the field, and will hopefully provide useful information and tools at the same time. I hope these experiences will help other fieldworkers identify and overcome similar intercultural issues and problems in the field.

'Never trust a camel with blue eyes'

During my university years, I dreamt of working in Latin America or Asia. But upon graduation, I was offered a first assignment to Niger instead! This first mission of 18 months had a striking effect on me: I fell in love with Africa.
Initially, I considered myself lucky to work in a French-speaking country, imagining that communication would be no problem for a native French speaker. Although I easily picked up Hausa, a relatively straightforward language, I soon learned that sharing the same language was no guarantee of mutual understanding.

It all began with little, and rather funny, misunderstandings on a social level. The first few months of my mission, I really enjoyed the permanently shining sun. Every morning, I'd step out of my compound, and comment on how beautiful the day was only to be met by puzzled looks. Yet when the rainy season finally started, it was my Nigerian colleagues who greeted me in the morning with an "Ahhh, what a beautiful day" and a big smile. What is more basic than to talk about weather? Our perception of the weather was just so different!

Likewise, when I worked with Tuaregs, I was often told "Oh, you have blue eyes". At first I was flattered and took this as a compliment. However, I later met a camel driver who told me that camels with blue eyes, a kind of albino camel, are real nuisances. They suffer from bad eyesight at night and consequently often get lost when camel caravans move in the dark. From that day onward I kept my dark sunglasses on whenever I talked to a Tuareg!

These little incidents showed me that different backgrounds and past experiences imply that we didn't always share the same perceptions. We were not giving equivalent meaning to the same information. In the workplace there were lots of potential for miscommunication. At times, what I assumed my colleagues would understand from what I said, and what they actually understood were worlds apart. Although these incidents mostly remained hidden, they still created unspoken misunderstandings and confusion on both sides.

Another source of misunderstanding comes from the way information is transmitted. With the first rains, grass started to grow around my hut. I loved this green touch, and didn't react to the various comments of my many visitors that I should cut it. That is, until I walked home one night and had a scary encounter with a snake in front of my hut. Next morning, when I related my adventure, everybody said "but we had told you to cut the grass". For them, the statement "you should cut the grass' had clearly implied this would avoid attracting snakes. For me, it had simply meant the grass was long and needed cutting. How come? The Nigerians are a so-called High Context (HC) culture:[1] in their communication most of the information is either in the physical context (grass = snakes) or internalised in the person (one always cuts the grass for this reason). Only very little of the information is in the coded, explicit, transmitted part of the message. As a native of a Low-Context-Culture (LC) Switzerland, I am used to transmitting and receiving messages as an explicit code (grass attracts snakes; cut it). Subsequently, I began to have an improved understanding of the dialogue in the endless meetings I was attending as part of my job. My initial perception in these meetings was that people related in an indirect, evasive and even "aimless" way (HC), whereas I kept on trying to be as precise, specific and transparent as possible. But slowly, I got used to the "palavers", and realised that HC communication is an art that can be very efficient. However, for an outsider, much time has to be devoted to "self-programming" first.

The challenge to establish a mutual and efficient understanding between people grows as the number of cultures working together increases. In the town's hospital, three international organisations were working in the paediatric ward. A middle-aged Chinese paediatrician was in charge of the service, supported by an American nurse, while a French nurse of Lebanese origin was running the feeding centre. Nigerian nurses were joining this multinational team for regular shifts. To have four different medical approaches within one structure was one major source of tension. In addition to not sharing any common language, communication problems about these differences created frustration and were a further source of tension. If major clashes were avoided, this was in a large way due to the regular presence of the Chinese translator, who not only mastered all languages, but also knew how to "bridge" the different communication approaches and prevent them colliding with each other (China and Niger (HC) vs. USA and France (LC)). This skill remains an art rarely taught to expatriates leaving for field missions.

Misunderstandings related to different forms of verbal communication are often apparent. But this only represents one of the many types of cross-cultural differences aid workers face when working in the field.

[1] See Edward T. Hall, Beyond Culture, Anchor Books 1989

A cash for work programme in Uganda

Summary of a mid-term review

Oxfam have recently completed a mid-term review of a cash for work programme implemented in Eastern Kitgum in Uganda. The micro-projects involved construction of roads and houses as well as the de-silting of dams. The *Acholi* people (target population) were victims of recurring raids and displacement at the hands of the Karamajong and Lords Resistance Army (LRA). Constant looting led to the loss of productive assets over a prolonged period of time. The cash injection was believed to be an appropriate and necessary response enabling beneficiaries to choose the means of their own recovery.

Benefits of the programme

Participating households used cash to buy food, pay school fees, purchase school uniforms and productive assets like goats. It is too early to gauge the effect on local traders, however there are indications that business is starting to benefit from the cash injection. There are no signs of micro-inflation in local markets although it is still too early to make conclusive statements.

The roads were reported to be of benefit to the community in terms of improving access to markets, schools and hospitals, bringing traders to villages, and for security reasons. Improvements in water resources (dams and wells) had the obvious impact of increasing quality and quantity of water sources close to villages. Despite some shortcomings, the shelter component of the programme has helped vulnerable families re-establish themselves and benefited others engaged in brick making.

The projects have strongly encouraged participation of women and communities have reported empowerment through their earning of cash. The negative impact is the increased workload on women especially for those types of work which men do not assist with because of the traditional division of roles. There was no resistance to women maintaining control of the cash earned during the programme from the men.

Programme weaknesses

The number of person-days (on average 11 days per household) allocated to vulnerable households is not sufficient to enable full recovery of livelihoods. An increased number of earning days would considerably increase the impact of the project.

While programme implementation is progressing well, planning prior to the proposal was not very thorough. Consequently some of the original targets will not be met. Choice of micro-projects was not based on a full community consultation. For example, the road construction proposal underestimated the number of person days required. Thus important aspects of the work like ditching and sloping had to be omitted in order to ensure others along the planned route benefit from the project. Even so, the original target of 240 km of community road will not be reached (120-150 km is the revised projected target).

The project planned for 500 *mabati* houses (rectangular houses with roofs of corrugated iron sheeting) to be built for the most vulnerable families whose houses were destroyed during the raids. The justification being that the Karamajong would not be able to burn them down in subsequent raids. The reality is that the budget for iron sheets, together with transport, consumes over 50% of the budget for this programme component. Subsequently, the benefits for those working on the shelter programme is marginal in terms of the cash for work they receive and the number of houses actually built is minimal. The construction of traditional housing with thatched roofs would have increased the number of houses for rebuilding and more cash would have remained in the local area. A significant cause for concern is that the *mabati* houses would be directly targeted for looting by the Karamajong as only the wealthy build this type of house. This may negate part of the original programme rationale.

Targeting

In general the targeting worked well in terms of identifying the most vulnerable members of the affected communities. There were few instances of vulnerable families being left out or of manipulation/corruption of the system. However, targeting did create tensions between those households and areas that were included and those left out. As all communities were affected to some degree it was concluded that the tensions created outweighed the benefits of targeting (distinguishing need) between parishes and villages.

'Facilitating' an improved outcome

The review team found incidences of communities trying to exploit the system of payment for attendance (daily payment) by appearing at the work site without putting in any serious work. This relates to the ownership of the project and their initial selection by Oxfam rather than the communities, but also relates to confusion over the payment system and its link to achievement, i.e. quality and quantity of output. An agreement on payment for a given amount and quality of work needs to be made with the communities with payment made on work completion rather than on number of days worked. This would also give communities flexibility to organise their labour force for a task that would ultimately benefit all, especially women.

Greater collaboration with the district authorities could improve impact, through technical advice and provision of materials. The other major achievement would be to enable the local authorities to incorporate these works into their ongoing plans, thereby conferring some responsibility for maintenance.

The long-term sustainability of these micro-projects has not been sufficiently thought through. A combination of ensuring adequate quality, more community ownership and greater collaboration with the District and Local Council would enhance the final output considerably.

The communities are learning from exposure to the programme but have not benefited from a more strategic approach with emphasis on building their capacity to manage projects from inception to reporting. If the project is to devolve more responsibility to the community, as is recommended, then a clear analysis of the competencies required to manage the micro-projects is needed. A skills audit would then elucidate the capacity needs and a capacity building plan can be developed.

McLean C. et al. Oxfam Mid-Term Review of Eastern Kitgum Emergencies Livelihoods Protection Project (Cash for Work). This evaluation can be obtained from Graham Carrington at G-Carrington@dfid.gov.uk or Oxfam GB at Oxfam House, 274 Banbury Road, Oxford, OX2 7DZ. Phone +44 (0)1865 312610.

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School in the Dagahaley camp, Ethiopia. Most men and women stated that they observed that households with educated daughters did not suffer the full consequences of the drought..

Universal appreciation for women's involvement in food aid

Summary of a report[1]

The previous issue of Field Exchange reported on a WFP assessment of community-based targeting (CBT) in Marsabit district in Kenya from a gender based perspective. WFP have just completed a similar type of assessment in the emergency affected Baringo district of Kenya. In addition to the community based targeting of the general ration, the assessment also considered the expanded school feeding programme and views on food for work (FFW) programmes.

Key findings

Most of the relief committees have active and equal gender participation. Elected women are now acting as agents of change as a result of their exposure to making decisions in a public arena and receiving and allocating WFP resources. This has opened the way for women to transcend their traditional subordinate role and be treated as equals.

The presence of women on relief committees is exposing the practical value of literacy and numerical skills for women, thereby creating community role models highlighting the value of education. Most men and women stated that they observed that households with educated daughters did not suffer the full consequences of the drought. This encourages them to send girls to school; they feel it is a way girls can obtain knowledge and skills to better enable them to provide extra resources to the household. Furthermore, the income transfer of the School Feeding Programme reduces the opportunity cost of sending girls (who are perceived as valuable household labour) to school. In addition, it reduces the cost of feeding the girl, removing pressure for early marriage. The expanded School Feeding Programme has therefore reduced the school dropout rate for girls.

All communities had a keen interest in Food for Work. They recommended that the projects should be scheduled to coincide with the hunger gap when food is most scarce and women have more time to participate in such activities. Another community recommendation was that women need to fulfil their routine early morning chores so that FFW projects planners should consider the timing of the work schedule in order to accommodate this.

Men and women suggested different types of activities for the FFW. Men suggested projects such as restocking, water holes, seed distribution, irrigation canals, building of dams and roads and development of livestock and honey markets. Women focused on construction of levees (barriers) to prevent soil erosion, distribution of farm tools and seeds, micro-credit schemes, building of schools and clinics, and training in animal healthcare.

If you would like to know more about WFP's experiences in this area, contact David Fletcher, World Food Programme, Nairobi, Kenya. Tel: 254 2 622230. Fax: 254 2 622334/622263 or email: David.Fletcher@wfp.org.

[1] WFP Gender Assessment, Baringo District, Kenya EMOP 6203.01, February 2001.

Practical experiences and lessons learned in using supplemental suckling technique

Following on from the article on infant feeding in emergencies, which appeared in the March 2000 issue of Field Exchange, we wish to add our thoughts on the use of the supplemental suckling technique, drawing on our experience from the therapeutic feeding centre in Kabaya district hospital, in Gisenyi, Rwanda, which Save the Children (UK) was supporting.

The recommended suckling technique involves attaching a naso-gastric tube to the mother's breast at one end and a cup of milk at the other end, below the level of the baby's mouth (see M. Corbett, Field Exchange, issue no. 9). This procedure aims to re-establish the mother's breastmilk supply and to ensure that her milk doesn't dry up while the baby is recuperating in the feeding centre. Therefore when the baby is discharged, she should have a normal milk supply to continue to feed the baby normally.

Feeding centre staff can become discouraged if they face unexpected obstacles when using a new technique, so it is important to be aware of potential difficulties in advance, as shown in the table on the right. With patience and perseverance we were able to overcome the problems. Advance planning also helps for example in anticipating and meeting material, training and staffing needs.

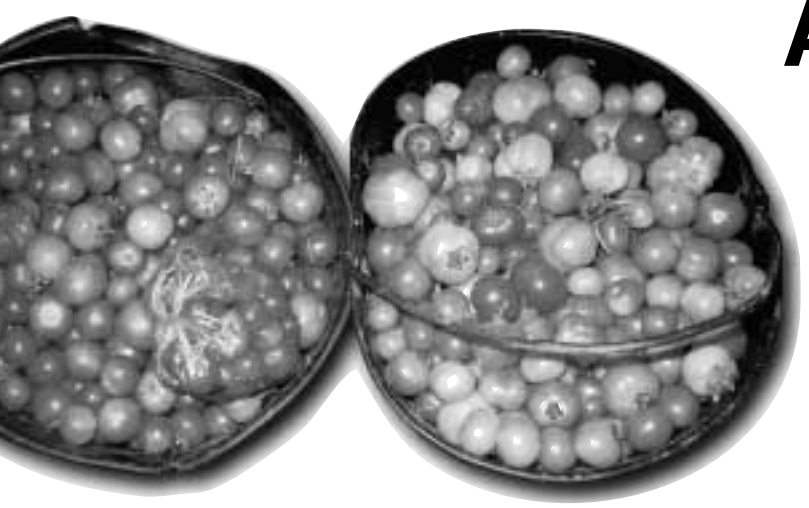
Yours etc.

Judith Cowley, now Health Programme Advisor, Swiss Development Co-operation, Rwanda
Jeanne d'Arc Nyirajyambereba, Nurse Nutritionist, SC-UK, Rwanda
Sonya LeJeune, Nutritionist / Food Security Officer, SC-UK, Rwanda

Potential problem	Points for consideration
High staff-patient ratio required	Mothers need a lot of help, encouragement and reassurance in the beginning, especially first-time mothers. Also feeds are very frequent.
Cultural difficulties	The nursing staff need to handle the mother's breasts while attaching tubes etc. This may be culturally inappropriate for males, even in the nursing environment. Here in Rwanda, it is even unusual for female nurses to have such intimate contact with a patient.
Large Supply of materials required	Each baby will need at least 8-12 tubes per day. Each feed requires a new tube to avoid risk of contamination, because the tubes cannot be sterilised. In standard emergency feeding kits for example, there would not be sufficient sterile naso-gastric feeding tubes to cope with a large number of babies for whom you wanted to use this technique.
Latching on	Some babies find it difficult to latch onto the breast when there is a tube present because they can feel it. If the tube is fixed in place AFTER the baby has latched on, the older ones in particular notice it coming towards them and get disturbed. Also some babies are so weak when they arrive in an emergency feeding centre that they cannot suck easily. For babies that refuse the breast, for whatever reason, a possible solution is to use a manual breast pump or to hand express into a small sterile medicine pot and then to cup-feed the baby. These pots are easier to use than normal size cups which are often too big for the baby's mouth.
Breastfeeding position	Often in an emergency setting, the mother is obliged to perch on the edge of the bed, which isn't conducive to maintaining the best position. This was particularly a problem with first-time mothers who are not used to holding the baby in the right position for breastfeeding. However if the mother lies on her side, this helps to keep the baby at right angles to the breast.

breastfeeding in Sierra Leone

(JOYCE KELLY © 2001)



A food-based strategy to improve nutrition in emergencies

Improvement of Household Food Security through Home Gardening and Nutrition Education in Southern Somalia

By Alison MacColl

Alison MacColl is working as Liaison Officer in the FAO Somalia programme. Alison worked as a nutritionist with UNICEF Sudan Country Office on nutrition and household food security projects prior to moving to the Somali programme.

The input of Mr. D. Gustafson, FAO Representative, Mr. Renato Marai, FAO Emergency Co-ordinator, Ms. Emily Mwadime, nutrition consultant and the Nutrition Programmes Service of FAO Headquarters to the preparation of this article is acknowledged.

Since February 2000 the Food and Agriculture Organisation of the United Nations (FAO) has been implementing a project to improve household food security through home gardening and nutrition education in southern Somalia. The FAO funded project supports women from vulnerable households living in the Juba and Shabelle riverine areas of Somalia, through the establishment of small scale vegetable gardens and the provision of food and nutrition education, to decrease micronutrient deficiency, increase income, and improve agricultural and nutritional practices. Vegetable seeds kits and tools have been distributed to 20,000 women coupled with training in agricultural and nutritional practices.

Background

A large part of the Somali rural population is nomadic with limited or no experience in permanent agriculture. Their diet is based on meat and milk, supplemented with purchased cereals. During the last fifty years, many have moved and settled in Mogadishu and in the major centres of the Lower Shabelle and Juba valleys, and consequently many are now urban settlers or rural farmers. In the rainfed areas, the most important crop is sorghum, often inter-cropped with cowpea or groundnut. Some vegetables are cultivated with the little water available, although in the irrigated areas vegetables are grown extensively for the markets in Mogadishu and other main markets.

The inter-riverine areas of the Juba and Shabelle valleys provide fertile land for agriculture. However conflict over the past decade as well as fluctuating environmental conditions, has led to an increase in underlying vulnerability and the erosion of sustainable livelihoods. Malnutrition rates among children in certain areas of Somalia remain unacceptably high, with poverty a main feature of the vulnerable population.

Assessment of need

The group targeted for this intervention was the Bantu farming communities. These communities have traditionally been agropastoralists or riverine farmers and have been at increased risk due to the continued influx of pastoral groups. As pastoralists have settled and become rural farmers the demand for land has increased and the Bantu communities have been further marginalised. The minority Bantu farming communities who live along the rivers have become particularly vulnerable to food insecurity and malnutrition due to a combination of decreasing access to land and livestock and periodic severe floods.

A large proportion of their diet is composed of cereals; sorghum, maize and rice which they produce themselves or in times of scarcity purchase from the market. Vegetables are not considered a basic food. However, household gardening does play a role in the traditional family life and this activity is usually reserved for women. The produce is consumed by the family and sold in markets.

Amongst these communities, inadequate food supply, poor feeding practices and limited knowledge of the importance of vegetables and fruits were identified as the major underlying causes of malnutrition. Prior to initiating the project, a baseline survey was conducted in the targeted communities in order to build understanding of attitudes towards the proposed project aims and activities, overall food availability and consumption, child feeding practices, health and nutrition problems. In each participating community the elders, contact persons and women showed great interest in the proposed project. Local feeding habits, especially child feeding practices were generally poor and diets were unbalanced. Vitamin-rich foods such as vegetables were uncommon in their diets and green vegetables, in particular, were not readily available in the market. The insufficient number of meals per day for children and low intake of vegetables indicated the likely existence of micronutrient deficiencies e.g. Vitamin A deficiency and anaemia.

FAO's role in an emergency situation

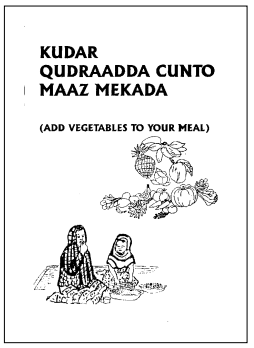
FAO is often active in emergencies through its Special Relief Operations Service (TCOR[1]) which provides emergency assistance in the agriculture, livestock and fisheries sectors for the improvement of food and nutritional security. FAO also assists developing countries in the establishment of preparedness and post emergency measures, formulating and implementing short-term rehabilitation programmes as well as in the traditional responses to nutrition emergencies including rehabilitation of the malnourished. In addition, household food security and nutrition considerations often receive attention as a means to improve the impact of emergency agricultural interventions at the household level. Although this project for improving household food security through home gardening and nutrition education is complementary to such interventions, it goes further by aiming for sustainable nutrition improvement through building the capacity of fieldworkers and communities to improve their household food security and to make the best of the foods that are produced.

Project description

The project was carried out in partnership with the international NGO, InterSOS. The main component of the project was training women in nutrition and agriculture coupled with the distribution of vegetable seeds (carrot, pumpkin, onion, spinach, tomato, and watermelon) and the provision of hand tools. InterSOS selected and employed appropriately qualified field workers, i.e. those with a background in agriculture or nutrition/health, from the local communities.

Workshops were organised to train the field workers and the participatory methodology employed allowed exchange of information and team building among the participants as well as adaptation of the content to

The brochure used in the project



the local situation. The training addressed improved methods for vegetable production, the control of pests and disease with an emphasis on biological control, vegetable processing, utilisation and preservation, the importance of vegetables in the diets, basic health practices and group mobilisation techniques. Seven teams of one health worker and one agriculture extension worker were trained, who then trained and distributed seeds and tools to the beneficiaries - a total of 20,000 women.

Prior to conducting the training of the beneficiaries, discussions were held with the community elders to identify the households most in need of assistance, and to assess the main constraints so that the training could make best use of the limited time that was available. A variety of training techniques was used including classroom teaching and demonstration, practical field activities as well as vegetable preparation and cooking demonstrations.

Vegetable seed kit and tool distributions took place as an integral part of the training programme. The seeds were selected to provide a combination of vegetables to combat micronutrient deficiency (carrot, pumpkin, spinach, and tomato) and those cash crops that could provide an income return (onion, watermelon). As some vegetables were new to the beneficiaries, it was necessary to explain the importance of these vegetables in the diet as well as providing information on production.

Training and educational materials

In addition to the training of the beneficiaries, about 20,000 well illustrated brochures were distributed to equip the target women with basic knowledge on vegetable gardening, vegetable preparation and cooking, growth monitoring, breastfeeding, better weaning practices, hygienic eating habits and boiling/storage of drinking water. The brochures used simple diagrams with short statements in Somali and English to make them understandable to a wide variety of people. Two separate booklets were produced, one, in Somali, to give information on simple steps in the preparation of vegetables and the second one, in Somali and English, to inform field workers about the nutritional role of vegetables and simple vegetable preparation methods. The field workers' training manual also contained information on nutritive value of foods, feeding practices, nutritional disorders, hygienic food related practices and community organisation focused on improving community nutrition. The training materials were developed by the project in close collaboration with the Nutrition Working Group of the Somalia Aid Co-ordinating Body (SACB).

Experience gained during project implementation identified the need to increase the nutritional awareness among school children. Forty-six teachers of primary schools from the Lower Shabelle region were trained and a classroom nutrition guide for teachers of upper primary school children was developed. This guide is being incorporated into a Somali science textbook as part of a UNESCO programme to provide textbooks for schools.

The response of community elders and targeted beneficiaries has been very positive. Vegetable nurseries observed in some villages in the lower Juba region are a positive indication of the project's success in encouraging vegetable production and consumption. Furthermore, vegetables from the target farms are being sold in the nearby markets. Most women interviewed in the target community now acknowledge the importance of including vegetables in the diets of their children. However, it has not been possible to determine how much of this 'new' knowledge has actually been translated into action.

Lessons learnt

There are a number of lessons that can be learned for future interventions of a similar nature.

- Strengthening the capacities of field workers and community members to implement the project improves project sustainability, as trained field workers from existing NGOs and the community remain at location allowing for follow-up of activities
- Sustainability is also encouraged by strengthening inter-sectoral collaboration, in this case through the involvement of the inter-sectoral Nairobi-based SACB nutrition working group, in the preparation of the training materials, by combining agriculture and health staff within the field teams, and by working with local institutions in the implementation of project interventions
- Field workers require adequate training. Five days were insufficient for practical activities to be combined with the comprehensive lessons in agriculture and nutrition. To maintain the motivation and interest of the field workers more follow- up is required as they work with the beneficiaries
- More time is needed for the training of the beneficiaries. One day was insufficient for practical demonstrations to be combined with the agriculture and nutrition messages. More active follow-up, to reinforce the ideas and recommended practices, is required.

Follow-up

- To promote sustainability, consideration needs to be given to seed production techniques which ensure a local supply of seeds
- To achieve the project objective of increasing household income, it will be necessary to conduct more 'promotion' work in the urban or market areas in order to create a demand for vegetables, particularly those that are new to the Somali people, for example, carrots and spinach
- The project results will be further analysed and used as a basis for integrating household food security and nutrition objectives into FAO emergency project templates and Consolidated Appeal Process (CAP) proposals
- The training materials that have been developed can be readily adapted for use in other countries in the Horn of Africa. The nutrition manual provides a good basis for the development of training manuals in different emergency situations and the manual is to be adapted for use in refugee camp situations. Replication of the approach and adaptation of the training materials is being considered for Angola, Democratic Republic of Congo, Sierra Leone and Sudan.
- Exchange of information and collaboration with other agencies working in this field will contribute to further improvement of this integrated nutrition and agriculture approach in nutrition emergencies.

Carrots, one of the vegetables selected

Somali family with their crop

Farmer preparing land

Training session in southern Somalia

Spinach, one of the vegetables chosen to combat micronutritent deficiencies

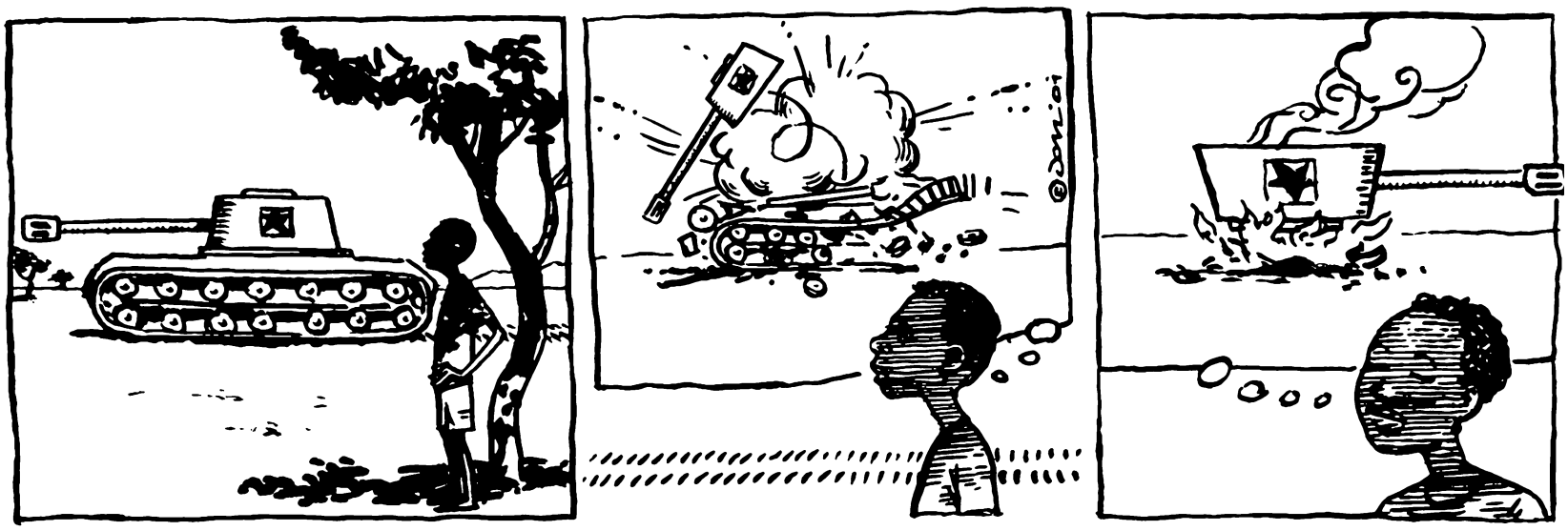
ALL PHOTOGRAPHS BY ALISON MACCOLL

[1] TCOR is the Special Relief Operations Service, a service of the Technical Co-operation Department, FAO

Participants to the workshop on 'Food Needs Assessments in Emergencies' (alphabetical order): Achilson Randrianjafizanaka, Christian Nzeyimana, Claude Kakule Mukanda, Comlan Francois Sonon, Cornellie Oko, Elvira Pruscini, Emmanuel Tossou Danhounsi, Foday Braima Turay, Francis Bere, Gerogette Ndongmo, Guy Adoua, Halima Idi-Issa, Jean-Baptiste Nkusi, Jean-Pierre Nereyabagabo, Joyce Kelly, Marie-France Bourgeois, Martin Bagrim Kibassim, Miranda Sende Mohaman, Ngoulaye Janvier, Nicole Steyer, Oura Rigobert, Pascale Crapouse, Patrice Kalisa, Paul Buffard, Peter Sale, Rachel Manga, Thomas Mokake and Valerie Ceylon.

Above: Dr. Alphonse Lhay Toko. **Left:** Jesco Woloko
Row below from left to right: Daniel Sibetcheu and Marc Nankap | Marc Ndjekounda | Valerie Ceylon.
Middle row from left to right: Elvira Pruscini, Thomas Mokake and Paul Buffard | Achilson Randrianjafizanaka and Jean-Pierre Nereyabagabo | Nicole Steyer.
Bottom row from left to right: Miranda Sende Mohaman and Peter Sale | Marie-France Bourgeois | Bill Fielding.

Pandamonium by Jon Berkeley



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Gode, famine and drought affected countryside. Till Mayer © ICRC 2000

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

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

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

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

The ENN is located in the Department of Community Health and General Practice, Trinity College, Dublin, Ireland.

The Team

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