

Field Articles

- 2** Constraints to achieving Sphere minimum standards for SFPs in West Darfur: a comparative analysis
- 12** Breastfeeding Support Groups in Tajikistan
- 19** Comparing cash and food transfers: findings from a pilot project in Sri Lanka
- 23** Can height-adjusted cut-offs improve MUAC's utility as an assessment tool?

5 Research

- Community based approaches to managing severe malnutrition: case study from Ethiopia
- Sexual exploitation and food distribution in Burundi
- Niacin deficiency and pellagra in Angola
- Understanding HIV/AIDS and livelihoods: new cluster analysis
- Population movement as a livelihood strategy in northern Uganda
- Nutritional status of children and pregnant and lactating women in relief camps in post-tsunami Sri Lanka
- Measuring household food insecurity in emergencies: WFP's approach

13 News

- Making Sense of the Code: new training materials
- ODI website on cash in emergencies
- Evaluation of Field Exchange
- Livestock Emergency Guidelines and Standards (LEGS)
- Investigation of anthropometric training by NGOs
- Report on IFE Meeting now available
- Development of Rapid and Comprehensive Assessment Tools for Emergencies
- Update on the IPC Online Global Forum
- Nutrition in Emergencies short course
- New WHO growth standards: more harm than good?
- 'Top 10' underreported crises in 2006
- Public Health in Complex Emergencies course – 2007 dates
- IFE training planned in London

17 Views

- The Need to Improve Administration in Ethical Organisations

21 Evaluation

- Evaluation of international response to the Tsunami

26 Agency Profile

28 People in Aid

Many pieces in this issue of Field Exchange strengthen our understanding of best practice in nutritional emergencies. We highlight four in this editorial.

Victoria Sibson from Concern Worldwide describes efforts to establish why SFPs, implemented as part of CTC programming in Darfur, have often failed to meet SPHERE standards. Concern Worldwide undertook a study in two SFP locations with very different performance results. In El Geneina SFP, cure rates were only 26.9% and default rates were 47.5% while in Mornei SFP, performance was much better, almost reaching SPHERE targets. A number of contextual factors explaining the different programme outcomes came to light. For example, in El Geneina there is a larger internally displaced population (either in camps or living with residents) that has greater trading opportunities, so that the opportunity cost of participating in the programme is far greater than in Mornei. Other factors are the greater coverage of the general food distribution (GFD) in Mornei, better access to protected water sources and the existence of more complementary programming, e.g. health, livelihoods, etc.

These findings raised a number of questions for Concern. For example, does the widespread inability of many agencies currently working in Darfur to meet minimum standards for SFP performance indicate that the general ration needs to be increased, and whether cure, death and non-response (failure) rates should be used to judge programme quality alone, or are they also indicators of the quality of the supporting services (health, water and sanitation, food security, GFD, etc).

Concern's experience is very timely in that the ENN is currently completing a study on the effectiveness of emergency SFPs in a large number of emergency settings. The study has involved the analysis of data sets from 82 SFPs implemented by 16 agencies between 2002-5. One of the key aspects of this analysis is an examination of the principal factors which may predispose to programme success or failure. Findings will be summarised in the next issue of Field Exchange.

The ENN and Field Exchange have devoted considerable print space to the experiences of implementing cash transfers as part of emergency programming. In this issue WFP, IFPRI and Oxfam have collaborated to write about a pilot cash intervention in Sri Lanka following the 2004 December 26th tsunami. The article examines the relative merits of cash and food aid programme as part of an ongoing WFP Vulnerable Group Feeding programme. The same targeting mechanisms were used for cash and food beneficiaries, with the amount of cash disbursed equal to the local market value of the WFP food ration. The authors draw important conclusions about where one type of programme may be more appropriate than the other. For example, in areas where markets were functioning and accessible, cash transfer was more cost-effective and preferred by beneficiaries. The converse was also true. The appropriateness of cash programming was also found to depend on market access and functioning (whether they are competitive and integrated), and security. Food aid was found to be more appropriate in contexts where markets were not working well, where security conditions imposed higher market transactions costs for consumers, and in situations of high and unpredictable inflation. These, and other findings, are valuable additions to the emerging body of experience on cash programming being documented in a number of fora.

In the research section of this issue, there is a fascinating study dealing with the effects of

HIV/AIDS between 1993 and 2005 on individuals, households and communities in Zambia. The research focused on two locations in Zambia: Mpongwe – close to the Copperbelt towns, and Teta, a remote rural area. A unique aspect of the work was the fact that it used a 'cluster' approach to help understand how individuals and households had either adapted or disintegrated as a result of ill health, and specifically HIV/AIDS. A cluster can consist of various households, usually, though not necessarily, living in the same geographical area. A significant benefit of the concept is that it allows the most important relationships between individuals of different generations and gender, marital and kinship statuses to be identified and understood.

The study identified a number of factors that determine the relative vulnerability and resilience of a cluster to the impact of a death, e.g. length and degree of incapacity during AIDS-related illness, overall cluster composition, etc. Another key finding was that the inherent adaptability and flexibility of the matrilineal social system in Zambia enables it to accommodate deaths and changing economic and demographic circumstances. The authors set out a number of very significant lessons for those making policy and designing programmes. For example, in programmes working with the poor, targeting should be directed at resource-poor clusters rather than poor households and for targeting, a broad based multi-faceted definition of vulnerability is needed, i.e. one that is not just AIDS-related.

Another notable research piece in this issue is a summary of an important study instigated by WFP in conjunction with the government of Angola and various implementing partners to investigate the prevalence of niacin deficiency in post-war Angola. The study found that the expected decrease in pellagra incidence after the end of the civil war in 2002 had not occurred. This is the first report of a household population survey of niacin status in a region with a pellagra endemic and has demonstrated a serious prevalence of low and deficient niacin status in women – nearly one in three women were found to be niacin deficient. The authors assert that the identification of niacin deficiency as a public health problem should refocus attention on this nutritional deficiency in Angola and other areas of Africa where maize is the staple. While WFP is now providing fortified maize flour to vulnerable groups in Bie province, this study suggests that there may be a need for a national flour fortification initiative and other locally targeted interventions.

Over the coming months, we will be carrying out an evaluation of Field Exchange. Central to this evaluation is what you, the readership, think of Field Exchange - how you use it in your work, what do you like about the content and format and how do you think it could be developed or improved. A questionnaire has been included with this issue and more details are included in the news section on page 14.

As usual, there are also many other field articles, research, news and evaluation pieces in this issue of Field Exchange and we sincerely hope there is something to interest all readers. Enjoy!

Jeremy Shoham

Any contributions, ideas or topics for future issues of Field Exchange? Contact the editorial team on email: office@ennonline.net

Constraints to achieving Sphere minimum standards for SFPs in West Darfur: a comparative analysis

Dafur, Concern, 2007



A view of Mornei camp

By Victoria Sibson and Kate Golden



Victoria Sibson started work as a nutritionist with GOAL in Ethiopia in January 2004, from where she moved to Darfur in October 2004. She became MSF-H's Darfur nutrition coordinator in June 2005 and has been a Nutrition Programme Manager for Concern's West Darfur programme since June 2006.



Kate Golden is one of Concern's Dublin-based Nutrition Advisors. Prior to starting this post, she was the Programme Manager for the West Darfur Nutrition Programme (2006) and worked as nutritionist in Concern's South Sudan (2004/5) and Ethiopia (2003/4) programmes.

Many thanks go to Assistant Nutrition Programme Manager, Bahradin Hassan, for assistance in interpreting the data and to Concern's Nutrition Advisor for the Horn of Africa, Nicky Dent, for assistance editing. Most of all, thanks to Concern's West Darfur nutrition staff and volunteers, many of whom have been working tirelessly in the emergency nutrition programmes since mid-2004.

This field article investigates the contextual factors influencing performance of two SFPs in Darfur, and how these impact on achieving Sphere minimum standards.

The current conflict in Sudan's westernmost state of Darfur began in early 2003, although most humanitarian agencies only gained access to the area and began their response in mid-2004. The violence and displacement peaked in 2003. However, localised fighting has continued, as the underlying causes of the conflict (political and economic marginalisation of Darfur by the central government, proliferation of firearms from outside actors, competition for resources in a highly arid, resource poor area, among other factors) remain unresolved.

More than two million people, largely non-Arab agriculturalists, are believed to be displaced as a result of the conflict, with just over 700,000 of those living in camps or among host

communities in West Darfur. The internally displaced people (IDPs) remain highly dependent on external aid, as their livelihoods are severely restricted due to insecurity and loss of assets during their flight. Although the Darfur Peace Agreement was signed by the central government and two of the three main rebel groups, little progress has been made towards lasting peace. The African Union (AU) deployed a small force in August 2004, but their numbers and mandate prevent them from truly protecting IDPs. A tentative agreement has been reached to deploy a combined UN/AU peace-keeping mission with a stronger protection mandate that could facilitate the return of some IDPs to their homes, but the deployment is yet to be realised.

Figure 1 West Darfur and Concern's six SFP/OTP base locations



Nutritional context

This protracted humanitarian crisis necessitates the continued operation of supplementary and therapeutic feeding programmes in many areas of the three Darfur states. The September 2006 Darfur-wide interagency nutrition survey found an estimated global acute malnutrition (GAM)¹ of 10.6% in West Darfur, significantly higher than 2005's finding of 6.2%². Although low relative to GAM rates in other regions and countries, malnutrition rates still fluctuate outside acceptable parameters and are likely even higher in localised pockets. For example, in the West Darfur state capital, El Geneina, the GAM was estimated at just over 12% in May/June 2005 and in 2006, despite the presence of General Food Distributions (GFDs) and selective feeding programmes³.

Currently Concern is running a Community-based Therapeutic Care (CTC) programme, comprising a Supplementary Feeding Programme (SFP) for moderate acutely malnourished individuals and an Outpatient Therapeutic Programme (OTP) for uncomplicated severe acutely malnourished individuals. Children with complicated severe acute malnutrition are referred to Therapeutic Feeding Centres (TFCs) for in-patient stabilisation/rehabilitation that are run by non-governmental organisations (NGOs) or Ministry of Health (MoH). The programme is facilitated by a strong community mobilisation component, targeting six programme areas through 18 distribution sites (see map in Figure 1). Programme caseloads at the end of November 2006 are outlined in Table 1. The CTC programme is complemented in Seleia, Kulbus and Mornei by Concern programmes in water and sanitation, hygiene promotion, health, and livelihood security.

Measuring SFP performance

SFP performance is measured principally against minimum standards for the proportion

¹ <-2 weight for height Z-scores in the 6-59 month old age group

² Nutrition in Crisis Situations, Report no.11 UN SCN, November 2006

³ Concern nutrition surveys of el Geneina town

Table 1 SFP/OTP caseloads per site, end Nov 2006

Programme area	Sub location	SFP children under 5*	OTP	Total	June-November cumulative SFP cure rates	June-November cumulative OTP cure rates
Geneina	Durti	50	18	68		
	Ardamata	80	11	91		
	Riad	207	26	233		
	Abuzar	240	11	251		
	Total	577	66	643	26.9%	66.4%
Krenig	Krenig	139	6	145		
	Total	139	6	145	41.7%	72.2%
Mornei	Mornei	655	7	665		
	Romalaya	62	1	63		
	Total	717	8	725	60.5%	79.5%
Umshaleya	Umshaleya	324	10	334		
	Total	324	10	334	29.3%	59.4%
Kulbus	Wadi Bardi	38	5	43		
	Batro	16	6	22		
	Kulbus	36	7	43		
	Helelat	39	4	43		
	Dughush	31	6	37		
	Mastura	0	0	0		
	Total	160	28	188	30.2%	87.6%
Seleia	Seleia	99	15	111		
	hijilija	39	4	43		
	Manjura	16	11	27		
	Aro Sharow	40	16	56		
	Total	194	46	240	50.0%	53.3%
Total		2111	164	2276	40.9%	71.7%

* malnourished pregnant and lactating women and elderly individuals are also enrolled in the programme, numbers not presented here

of exits that are cured, died and who have defaulted⁴. The cure rates should meet or exceed 75%, death should be <3% and default <15% (Sphere minimum standards). These rates are calculated with total exits equal to the sum of cured, died, defaulted, transferred to OTP/hospital and failed. The widely used Medecins Sans Frontieres (MSF) nutrition guidelines interpret low cure and high death and non-responding (failure) rates as reflecting low programme quality, and high default as a sign of poor acceptability and/or accessibility⁵.

Concern's SFPs in West Darfur often fail to meet these key minimum performance indicators⁶. The cure rates are depressed by high default and are reduced further by the necessity of transfers to OTP/TFC when children deteriorate, and by the discharge of children as 'failures to respond' after four months, if they have not yet reached discharge criteria⁷. Poor SFP performance is a common problem facing most agencies working in nutrition in Darfur and several interagency meetings have been held for nutrition partners to discuss possible reasons⁸. In the Concern programme, depressed cure rates can generally be seen across locations, but significant differences in performance can also be seen between programme areas. The most striking contrast is between Concern's two programmes with the highest caseloads: El Geneina and Mornei. While the more urban El Geneina SFP, which serves a mixed population of IDPs and residents, generally has the worst indicators, the Mornei SFP, based in West Darfur's largest internally displaced population (IDP) camp and serving a population of roughly 90% IDPs, has the best (see Figures 2 and 3).

Understanding factors that constrain performance

In order to better understand the reasons for the poor performance of Concern's West Darfur SFPs, the programme carried out several investigations in September and October 2006. The investigations attempted to find commonalities and differences between El Geneina and Mornei - the two sites with the highest number of admissions and the most dissimilar performance. The main investigations were: interviews with caregivers of children discharged as failures from both sites; a survey of El Geneina beneficiaries to establish registration status for General Food Distribution (GFD); Focus Group Discussions with beneficiary caretakers on their perceptions of malnutrition, the programme and their children's progress in it; observations at SFP distributions; discussions with the SFP team and some analysis of trends from programme admission and discharge statistics.

Differing SFP Performance at two sites: El Geneina and Mornei

The El Geneina SFP performance is the poorest of the Concern programmes. Cure rates were

⁴ Concern's current protocols state that SFP children who are absent at three consecutive distributions are discharged as defaulters on the third occasion. (This default criteria is endorsed by UNICEF W. Darfur and used by most agencies).

⁵ MSF Nutrition Guidelines, Paris, 1995

⁶ Other measures of performance include average length of stay, rate of weight gain, and coverage but are not calculated regularly and are not a focus of this article.

⁷ Concern's current SFP protocols state that children not reaching a weight for height of ≥85% at two consecutive weighings before a maximum of nine consecutive fortnightly distributions, should be discharged as failed, if they have not already been exited in another category. Failures who meet admission criteria on the day of discharge are readmitted the same day.

⁸ e.g. 19/03/06, West Darfur state Nutrition working group meeting summary: Current Problems relating to the Poor Performance of the SFP in West Darfur, UNICEF

Figure 2 El Geneina SFP performance trends, June to Nov 2006

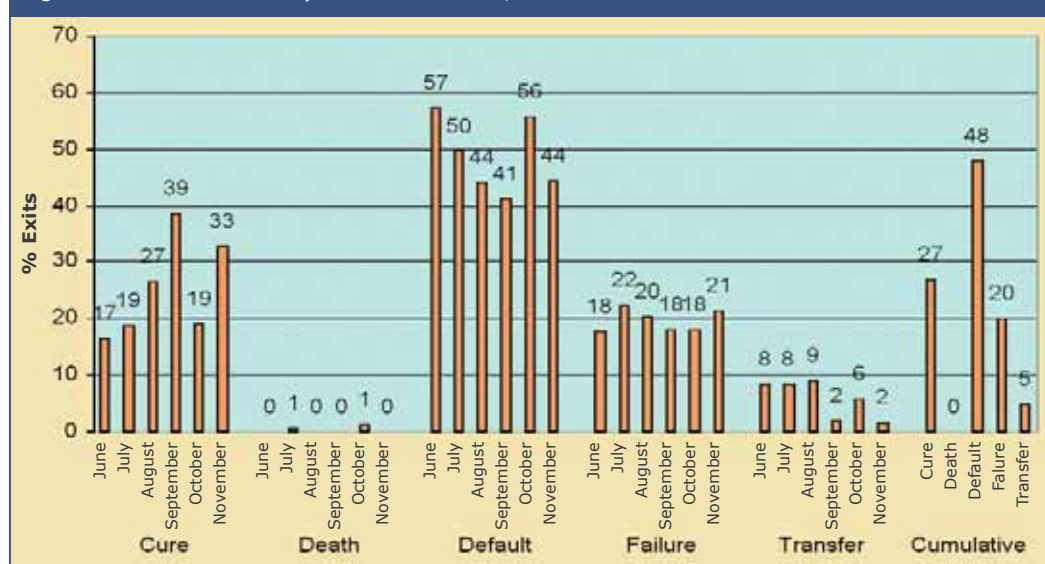
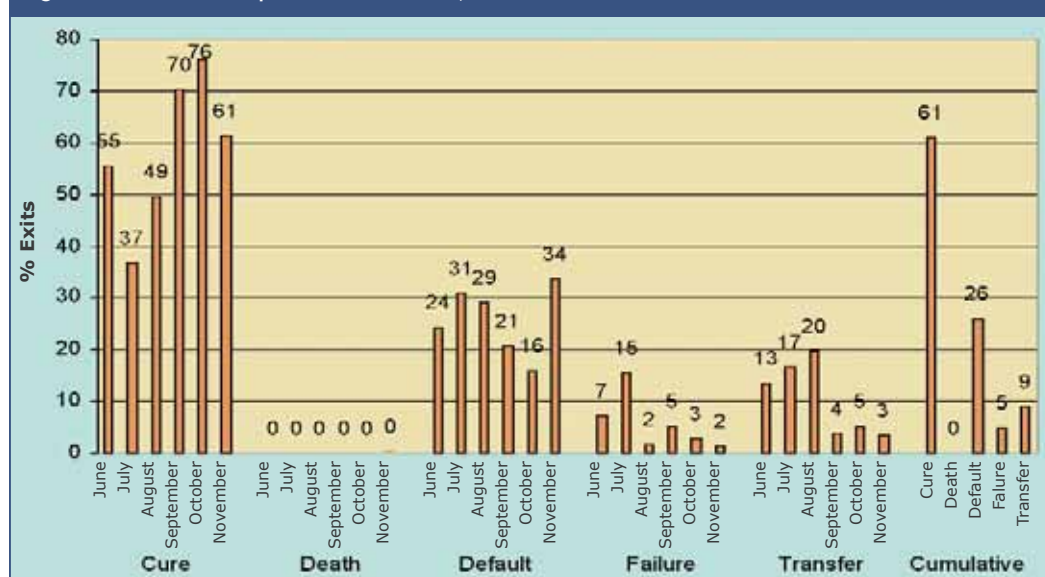


Figure 3 Mornei SFP performance trends, June to Nov 2006



extremely low from June to November, 2006 (cumulative cure rate for the period: 26.9%), largely due to high default rates throughout (cumulative default: 47.5%), particularly in the months of cultivation (June/July) and harvest (October/November) (Table 1 and Figure 2). Failure rates have also been high and steady throughout, stabilising at roughly one fifth of all exits by the end of November (cumulative failure: 19.9%). Transfers to OTP/TFC represented the smallest exit category after death⁹.

In contrast, Mornei SFP cure rates had nearly reached minimum standards by the end of the same six month period (cumulative cure rate: 60.5%) and default had reduced to within the minimum standard (cumulative default rate: 26.0%) (Table 1 and Figure 3). Failure rates were also lower overall in Mornei than in El Geneina (cumulative failure rate: 4.6%). The transfer rate to OTP/TFC, however, was higher in Mornei (cumulative transfer rate: 8.8%), which can be largely explained by a documented increase in the incidence of acute watery diarrhoea in the camp in June/July. The proximity of the Concern Mornei site to the MSF TFC/hospital may have also encouraged transfers during this time.

Possible contextual factors contributing to differing SFP performance

Before considering investigation results, it is important to note that the El Geneina programme's lower cure rates and higher default and failure rates may be partially explained by wider contextual differences between the two programme areas.

In general, the El Geneina programme covers a larger, more diverse population of camp-based IDPs, IDPs living with and among residents, and non-displaced residents (roughly 200,000 in total). In contrast, the Mornei programme covers mostly IDPs within the Mornei IDP camp (population of roughly 80,000). El Geneina is an urban, semi-sprawling town, while Mornei is a densely packed IDP camp with more limited trading and lesser access to neighbouring areas. These factors may affect beneficiary behaviour in several ways. First, El Geneina beneficiaries appear more mobile than those of Mornei because El Geneina is larger and more spread out. It also has a more developed cash economy with more opportunities for income generation, although the opportunities are generally irregular. The mixed IDP/resident population of El Geneina also seems to face less uniform security restriction on their movement within and outside the town, due to the diversity of relationships among the different groups (e.g. tribal, etc). Second, people in El Geneina seem more likely to spend time pursuing income generating opportunities because the opportunities exist and perhaps because a larger percentage of the population is forced to earn cash to buy food, since many are not registered as IDPs and therefore do not receive the GFD.

As a result, it seems that carers of El Geneina beneficiaries may perceive a greater opportunity cost for attending SFP distributions where a relatively small amount of Corn Soya Blend (CSB)/oil/sugar porridge mix is distributed, when they could use the time and effort to pursue income generating opportunities. For

Mornei beneficiaries, with fewer income generating activities, however, it seems the cost benefit ratio weighs in favour of regular SFP attendance, resulting in more favourable performance indicators. It is interesting to note that the cost benefit of attending OTP distributions, where Plumpy'nut and more focused medical care are provided to a more obviously malnourished child, seems equally high in both Mornei and El Geneina. In both settings, OTP default rates are uniformly low and cure rates consequently higher (Table 1).

A wider livelihoods analysis (including cultivation practices) and further investigation in to differences in clinic access, quality of health care and factors affecting uptake of health care in each location would also be beneficial in understanding the observed performance differences.

Investigation results

Follow up of beneficiaries failing to recover

Follow up of failures highlights different contextual factors that limit individual progress. Interviews were carried out with the caretakers of nearly all the children exited from the SFP as 'failures' in September and October; 53 in El Geneina and 27 in Mornei¹⁰. Although the sam-

⁹ Importantly, the death rate represents only those deaths reported by community sources after follow-up by team. Due to SFP caseload, some but not all defaults are followed-up to rule out death as a cause; therefore, the number of SFP deaths could be slightly higher than represented here.

¹⁰ Failures in Mornei were much less frequent than in El Geneina during this period, accounting for only 3% of exits in October 2006 vs. 18% in El Geneina.

Table 2 Results of 'failure' exit interviews

	EL GENEINA (n=53)	MORNEI (n=27)
WFH% on discharge	<ul style="list-style-type: none"> Mean: 78.5% +/- 3.3%, Median 79% (range 72%-84.5%) Averages are <80% because the majority of children are being discharged from the programme malnourished 	<ul style="list-style-type: none"> Mean 79.2% (+/- 3.3%) / Median 80% (range 72%-84%) Slightly skewed distribution because nearly half of the children actually had WFH% ≥80% when finally discharged
Length of stay in the programme	<ul style="list-style-type: none"> Mean 107 days (+/- 19 days) 	<ul style="list-style-type: none"> Mean 212 days (+/- 119 days) Very long because some failures were children who had been discharged failed and readmitted multiple times
Sex	<ul style="list-style-type: none"> 71% girls, 28% boys Expected given the lower caseload of boys (see text) 	<ul style="list-style-type: none"> 59% girls, 41% boys Expected given the lower caseload of boys
Age	<ul style="list-style-type: none"> Median 24 months - younger, complementary feeding age children more likely to fail 	<ul style="list-style-type: none"> Median 16 months - younger, complementary feeding age children more likely to fail
Household head	<ul style="list-style-type: none"> 26% (n=13/50) female headed 	<ul style="list-style-type: none"> Only one child came from a female headed household
Household size	<ul style="list-style-type: none"> Mean 7 (+/- 3) 	<ul style="list-style-type: none"> Mean 5 (+/- 1.9)
Residence	<ul style="list-style-type: none"> Most failures from sites with highest caseloads 30% reported to be residents 70% said they were IDPs 	<ul style="list-style-type: none"> All but one child came from an IDP household
GFD	<ul style="list-style-type: none"> 25% (n=14/50) said they did not have a GFD card 	<ul style="list-style-type: none"> Every child came from a house in receipt of GFD
Main food source	<ul style="list-style-type: none"> 69% stated a reliance on GFD 8% stated a reliance on market purchase Remaining used own produce/received gifts/received payment in kind 	<ul style="list-style-type: none"> All caretakers reported reliance on GFD as their primary food source
Income	<ul style="list-style-type: none"> 83% households had an income Median daily income was equivalent to US\$2. The main sources were: <ul style="list-style-type: none"> Daily labour - 59% Family member with salary - 28% selling agricultural produce - 10% Petty trade - 3% 	<ul style="list-style-type: none"> Every household had an income (although not stated and sources were poorly specified, but petty trade appears to be important)
Water source	<ul style="list-style-type: none"> Hand pump - 58% Shallow well or wadi (seasonal river) - 42% 	<ul style="list-style-type: none"> All households reported using piped water
Clinic visits	<ul style="list-style-type: none"> Data was not collected in the El Geneina interviews 	<ul style="list-style-type: none"> Clinic use was high: 26 of the 27 failed children were taken at least two times in the month prior to failure, of which 10 were taken more than two times
Supervisor perceptions of cause of failures at end of interview	<ul style="list-style-type: none"> 40% of failures were perceived to be the result of unresolved or repeated sickness/underlying medical problems 36% to be household food insufficiency and probable sharing Other suspected primary reasons were regular absence (11%) and child dislike of the Corn Soya Blend (CSB) or lack of appetite (6%) 	<ul style="list-style-type: none"> 56% were perceived related to poor child care: mother reportedly busy, frequently absent, child not fed regularly. In two cases, abrupt weaning was cited as initial cause not yet resolved. Sharing as a problem was not mentioned Unresolved medical problems, lack of appetite and a problem cooking the CSB mentioned as secondary reasons



Teaching a mother how to prepare CSB porridge

Dafur, Concern, 2007



A child receives RUTF in the OTP of Mornei camp

Dafur, Concern, 2007

bringing girls over boys to SFP and/or greater likelihood of failure among girls.

Observations from Beneficiary Focus Group Discussions

Focus Group Discussions in El Geneina distribution sites confirmed and further explained some of the findings of the failure interviews. They also highlighted other possible factors contributing to high rates of failure, absence and default (Boxes 1 and 2). Chief among them was the indication that the SFP ration was being shared and not lasting the 14 days between distributions and that the targeted utilisation of the pre-mixed CSB (with oil and sugar) for the SFP child, compared to the CSB provided in the GFD, was not understood.

Observations of the programmes in action suggest that a degree of programme fatigue is likely to blame for poor performance indicators. This is most significant among the staff who may not be communicating to mothers clearly why their child is admitted, the aims of the programme (including how long the child is meant to be enrolled and when they should come) and indicators of the child's progress towards meeting that aim. This is in need of improvement.

It is also apparent that the stand alone nature of Concern's El Geneina OTP/may not have as much impact as the integrated programming approach of Mornei, where Concern is the camp manager and the SFP has close links to Concern livelihoods support, health and hygiene promotion and water and sanitation activities that address underlying causes of malnutrition. Although other actors are working in these sectors in El Geneina, coordination across agencies and the larger and more diverse population and area make success in this context more of a challenge.

These observations suggest that communication with caretakers needs to be improved, and that better inter-sectoral programming might be a key to optimising SFP performance

Difference in GFD coverage of SFP beneficiaries at the two sites

GFD coverage differences by site might be a key reason for the performance differential. The World Food Programme's (WFPs) GFD strategy in Mornei, a town of originally 7,000 and now swollen to approximately 78,000 with IDPs, has been to register all current Mornei residents for an 'IDP scale ration'¹². As such, it is widely accepted that GFD coverage in Mornei is nearly 100% (note all failed children came from households in receipt of GFD). In El Geneina however, the original pre-conflict resident population is much larger than the current IDP population, and only IDPs are targeted for GFD¹³. Of the 793

¹¹ That said, a significant 'crisis' in provision of water through the tap system was reported in June/July, with many households reportedly reverting to shallow wells, resulting in increased diarrhoea.

¹² The West Darfur ration scale differentiates residents from IDPs. The 'IDP ration scale' applied in El Geneina and in Mornei is 13.5kg cereal (100% full standard ration), 0.375kg pulse (25% full standard ration), 1.12kg CSB (75% full standard ration), 0.675kg oil (75% full standard ration), 0.075kg salt (25% full standard ration), and 0.225kg sugar (25% full standard ration). This provides about 90% of population requirement for energy (recommended 2100kcal/person/day); 112-123% protein and 70-79% fat (depending on cereal and pulse included). Amounts of calcium, iodine, vitamin A, riboflavin and vitamin C are deficient (data analysed using NutVal 2004).

¹³ An estimated 197,507 reside in the feeding centre catchment area (data from 2006 National Immunisation Day), while October distribution monitoring data from Save the Children US indicated that only 65,935 people (33% of total) in the catchment area received a ration.

Box 1 El Geneina Focus Group Discussions: Programme aims and compliance

Mothers did not know how long their child was meant to be enrolled in the programme.

Mothers were absent due to agricultural activity, because they moved to visit relatives in home villages or they forgot which day to come. Teams perceive many reasons given in home visits tracing absentees and defaults to be excuses used as the mother just did not want to come.

No mothers criticised the organisation of the distribution (e.g. there were no complaints of long waiting time or unkind staff).

CSB was cooked and shared with everyone. It was explained that the custom was that anything cooked over the fire must be shared. Sharing was more common among children, whether siblings or neighbours. Ready to use therapeutic foods (Plumpy'nut cited) was not shared as much because it is not cooked and mothers understand the concept that it is more like a medicine.

The two week ration only lasted 6/7/8 days.

The mothers spoken to said they liked the CSB and valued it.

Some mothers said they cooked SFP and General Food Distribution (GFD) CSB together and ate it as a family. Some said that the SFP CSB was given only to the children as it was sweeter than the GFD CSB that was kept for adults.

No women could repeat any messages given by WFP's Cooperating Partners on how to cook CSB provided in GFD, or who it was for specifically.

All the mothers knew how to cook the CSB but many said they only did so once or twice a day and rather than heating it up later for the beneficiary child, it was eaten in one or two sittings by that child and others.

While no mothers specifically mentioned that firewood access was a problem, when prompted they said charcoal was expensive and access to collect firewood was a problem as they feared attack/rape.

ple size was small and selection purposive (only caretakers of failures were interviewed), key findings highlight constraints to improved programme performance in each location (Table 2).

In both programmes, young girls comprise a larger proportion of the failures. This is probably due to a skew in the demographics of the caseload with increased admissions of female children during the complementary feeding period (6 months – 24 months) (data not presented here). Nutrition surveys in El Geneina and Mornei show no higher risk of girls becoming malnourished than boys, indicating that girls may only be more likely to be brought for enrolment. It is possible that they are more likely to fail than boys once enrolled, but a more complex statistical test would be required to assess this. In addition, it appears, unsurprisingly, that children from female-headed households and from larger families are more likely to fail.

Two main contextual differences were indicated in the failure interviews. First, the difference in GFD ration coverage (explained below) was reflected among the non-responders: 30% of El Geneina failures were reportedly residents and 25% came from households not in receipt of GFD, whereas in Mornei only one failure was a resident and all the failures were receiving the GFD. This suggests that sharing may be contributing more to failure in El Geneina, while

other factors may be contributing in Mornei. Secondly, access to/use of protected water sources appears poorer among failed children in El Geneina than in Mornei (where a central tap system is in place)¹¹, suggesting that water borne diseases may constrain individual children's progress more in El Geneina during the time period of investigation.

Information on income was hard to collect and the data from the two sites are not comparable. Nevertheless, answers in El Geneina suggest beneficiary households might, in general, have low and irregular income. As outlined above, the casual nature of income generating opportunities may have a negative effect on attendance and child progress.

Further investigations are now required, involving:

- Interviews with caretakers of cured children for comparison in the form of a beneficiary profile.
- In El Geneina, further investigation of the nature of the SFP children's illnesses, caretaker health seeking behaviour and uptake/outcome of clinic referrals from SFP.
- In El Geneina, investigation of the adequacy of protected water sources (access/availability) and reasons for preferential use of unprotected sources.
- Further investigation of the possible bias in

SFP and OTP El-Geneina beneficiary carers asked if they were registered for GFD in October, only 59% (n=468) said they had cards¹⁴. It seems likely that the lower GFD coverage among El-Geneina's SFP catchment households is a major cause for the lower performance observed¹⁵.

Recommendations

The investigations shared here were not planned as a research project. However, they have assisted in identifying means to try and improve programme performance, as well as guiding what further investigations need to be undertaken. As a result, Concern is undertaking the following activities:

Providing names of El Geneina SFP beneficiaries (residents, camp-dwelling IDPs and non-camp-dwelling IDPs) lacking GFD to WFP's implementing partner, Save the Children-US, for inclusion in the GFD, which is currently limited to camp-dwelling IDPs only.

Discussing with WFP the feasibility of registering El Geneina residents and non-camp dwelling IDPs for the GFD, and the insufficiency of the proposed further reduced 'resident ration scale' for resident households containing vulnerable children¹⁶.

Investigating probable causes of malnutrition in children from El Geneina resident households through more in-depth interviews and home visits.

Renewing programme focus on addressing the wider causes of malnutrition. As a start, Concern will conduct a Positive Deviant Inquiry to determine factors contributing to malnutrition vs. positive nutritional status among the GFD-reliant population in Mornei and will use results to promote positive behaviours among SFP beneficiary caretakers.

Increasing efforts to coordinate better with other service providers to address underlying causes and link El Geneina SFP beneficiaries to them.

Planning for reassessment of SFP performance following improved GFD coverage and the possibility of initiating livelihoods activities.

Re-initiating regular training for nutrition and outreach staff/volunteers on infant and young child feeding, causes of malnutrition,

personal and environmental hygiene, communication skills, community mobilisation.

Distributing BP100 donated by MSF-France as a supplement to the supplementary ration in El Geneina.

Distributing extra non-food items in addition to the premix and soap (starting with cooking pots for those cured and discharged) to increase the mother's cost benefit of attendance and child recovery.

Renewing programme focus on community mobilisation and engagement.

Concern CTC supervisors have been asked to ensure that:

- Communication with mothers on programme aims and benefits are improved and that staff take a problem solving approach with caretakers of children showing slow weight gain.
- Children who meet criteria for 'slow weight gain' are visited at home to determine causes prior to discharge.
- SFP teams improve education on appropriate infant and young child feeding practices and the importance of use of protected water sources.
- Children are properly screened and referred to clinic, referrals are followed through, and results of clinic visits are reviewed and incorporated into analysis of poor recovery.

Outstanding questions

The investigation raised several other questions related to the appropriateness of the current model:

- Does inability of multiple agencies to meet minimum standards for SFP performance indicate that the general ration needs to be increased?
- How does inclusion of CSB in the general ration affect its perceived value among caretakers? Could education on use and targeting of CSB included in the general ration for children, be an effective alternative to SFP?
- To what degree does illness contribute to malnutrition in relation to household food insecurity in these contexts? Would cash transfers or social protection schemes for IDPs be more appropriate if Sudan, overall, has a surplus of grain production?
- Should cure, death and non-response (failure) rates be used to judge programme quality alone? Or should other indicators of the quality of the supporting services (health, water and sanitation, food security, GFD etc), and the appropriateness of a food-based SFP be developed / considered?
- Are admission criteria appropriate? It seems that many mothers of children with a Weight for Height (WFH)% at the upper end of the eligibility criteria do not perceive their children to be malnourished. If they do not perceive their children to be malnourished, those children will not be given extra food; i.e. the ration will be shared.

Given the widespread failure of Darfur SFPs to reach minimum Sphere performance standards, a number of main points were raised for further discussion with MoH/UNICEF/WFP including: a review of the adequacy/impact of the current GFD ration and its targeting strategy in El Geneina and a review of the current size of the SFP ration as an increase may be required to account for uncontrollable sharing and familial clustering of malnutrition¹⁷. Alternatively,

the GFD ration could be increased, and, due to the culturally engrained practice of food sharing, this may be more cost-effective and have a greater impact than increasing the SFP ration¹⁸. Finally, improved inter-sectoral programming and coordination among agencies, particularly for targeting and referral, is needed to address effectively the causes of malnutrition, to be led by the coordinating UN agencies.

For further information, contact Victoria Sibson, email: victoria.sibson@concern.net and Kate Golden, email: kate.golden@concern.net

¹⁶ The proposed resident ration scale for Mornei or El Geneina comprises: 6.75kg cereal (75% full standard ration); 0.375kg pulse (25% full standard ration); 0.75kg CSB (50% full standard ration); 0.45kg oil (50% full standard ration); 0.075kg salt (25% full standard ration) and 0.225kg sugar (25% full standard ration). This provides about 50% of the population requirement for energy and half of the recommended ration of 2100 kcal/person/day

¹⁷ It is recommended a take-home supplementary ration should provide 1000-1200 kcal/person/day (Management of Nutrition in Major Emergencies, WHO Geneva, 2000). The current WFP ration is on the lower end of that scale, providing 1017 kcal/person/day from 200g CSB, 20g oil, 20g sugar/person/day, providing 1017kcal (14% energy from protein and 28% from fat)

¹⁸ It must be noted that other agencies in Darfur have distributed much larger rations to SFP beneficiaries with limited impact on performance indicators, e.g. MSF-H 2005 South and South-West Darfur (personal communication).

¹⁴ This is lower than the percent having GFD cards found in September (525/724 or 73%), which reflects active case finding and admission among the resident population in late Sep/early Oct.

¹⁵ A 2005 MSF-H internal investigation of SFP performance, including South and West Darfur, supports this suggestion: "that SFPs have the best impact on child recovery where access and food aid is relatively stable" (Evaluation of Supplementary Feeding Programmes in Darfur, Uganda and Somalia, MSFH October 2005)



A breastfed baby in El Geneina camp



Preparing premix in Mornei camp

Box 2 El Geneina Focus Group Discussions: Perceived causes of malnutrition and reasons for admission

Some mothers thought that CSB caused diarrhoea and could not explain why adequately.

Some mothers could not easily explain why their child was in the programme and could not conceive that their child had a need for extra food.

The admission decision was perceived as closely related to the child's health. Some mothers were confused why their child was admitted to SFP while another gets Ready to Use Therapeutic Food.

When asked why they came to the programme, most mothers said they were referred by Concern and other staff.

The understanding that breastfeeding while pregnant is bad for the child was extremely common. Mothers could not explain why the child gets sick when he/she is weaned.

Community based approaches to managing severe malnutrition: case study from Ethiopia

Summary of published research¹

A recent published paper describes Save the Children US's (SC US) experience of setting up a community therapeutic care (CTC) programme in the Southern Nations, Nationalities and Peoples Region (SNNPR), Ethiopia, following a drought in the lowlands of the region in 2003. The emergence of the problem was identified through the Disaster Prevention and Preparedness Commission (DPPC) regional early warning system. In response, SC US implemented programmes to provide emergency health and nutrition support to three adjacent woredas. They began by opening 16 therapeutic feeding centres that were often rudimentary tent structures adjacent to existing health centres and were intended to bring critical services to communities who were distant from hospitals. Because of the gravity of the problems, the increased need for nutritional response in the region, and the emerging literature that CTC offered comparable success rates with lower per-patient costs and greater coverage, SC US, technically assisted by Valid International, proposed a pilot CTC approach in one woreda to supplement the TFCs. This was eventually expanded into three woredas.

The first essential step was to enlist the cooperation and participation of local people. SC US used a participatory planning process in which local woreda officials, traditional birth attendants (TBAs), local volunteer community health workers, community-based reproductive health agents and other local officials were invited to a meeting to discuss the problems of malnutrition in their area and strategies that might be used to address these problems. SC US staff then identified local outreach workers to assist in the CTC process.

By mid-September 2003, the first CTC programme was functioning. Each of the programmes had several components;

- A stabilisation centre
- Outpatient therapeutic programme (OTP) for severely malnourished children with no significant medical complications, good appetite and only minor oedema

- A supplementary feeding programme (SFP) for children with moderate malnutrition and for pregnant or lactating women
- Health and nutrition education
- An outreach programme to follow up vulnerable cases in the home and community based screenings and community mobilisation activities.

By the 16th week of operations, in one woreda for which reliable data are available (Arbegona), 66% of severely malnourished children had been sufficiently rehabilitated to graduate to less intensive supplementary feeding. Eight-eight per cent of all admissions were discharged having attained an adequate weight for height and only 8.9% needed referral to a medical facility. Default rates were low (2.3%) and less than 1% died. Survey results during and after the emergency phase showed a marked reduction in mortality of children under five years. In September 2003, the daily under-five mortality rate was 1.47/10,000 and the rate of severe acute malnutrition was 1%. By March 2004, these rates had improved to 0.45/10,000 and 0.6%, respectively.

The SC US programme admitted 5,799 severely malnourished children over a five month period, 3,765 of whom progressed to supplementary feeding. An additional 7,961 were directly admitted to supplementary feeding. The default rate was low, indicating community acceptance of the approach. A coverage survey in Hulla and Arbegona districts found OTP coverage of 78.3% with SFP coverage of 86.8%. This compares very favourably with the SPHERE Project guidelines, which target rural coverage rates at more than 50%.

Participation by the beneficiary communities was robust. Local officials participated in the planning and implementation of the programme from the outset, from organising distribution centres to encouraging their community members to participate. Regional and zonal health officials understood the importance of improved coverage and therefore allowed the CTC programme to be piloted. Community leaders and people with influence in the local community participated in the initial discussions and helped identify the communities to be targeted. Outreach workers were recruited from the communities that they served and were thus able to overcome any reluctance to acknowledge the declining nutritional status of children. Twice monthly food ration distributions and anthropometric assessments were performed in highly public settings ensuring transparency in the process. Local service providers – TBAs and reproductive health agents – received additional training that may improve their effectiveness in service delivery in the long term.

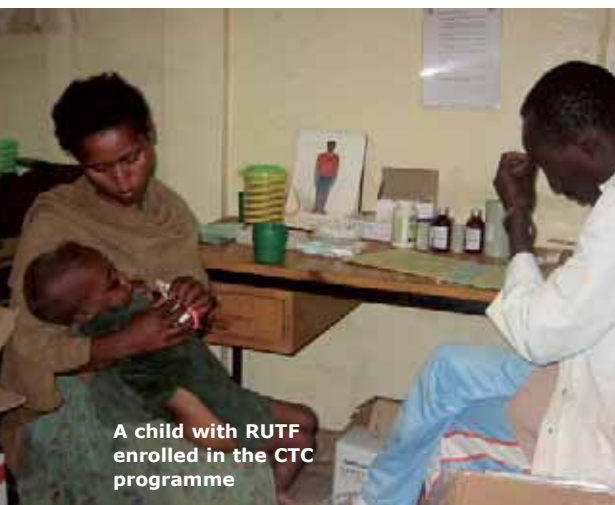
Because of the strong emphasis on community management of problems, CTC program-



A mother attends the CTC programme



A child with RUTF enrolled in the CTC programme



A child with RUTF enrolled in the CTC programme

ming provides an ideal opportunity to bridge the divide between relief and development. The issues that remain in SNNPR are many and diverse: water and sanitation systems are inadequate, high birth-rates and small landholdings exacerbate population pressures, poor health infrastructure makes primary health care delivery problematic, and low agricultural productivity in relation to population size makes chronic food insecurity and periodic emergencies inevitable. These are all problems that development programmes can address. SC US believes that the positive community involvement that the CTC programme has fostered is a sound foundation for the implementation of participatory development strategies, as part of a comprehensive development programme.

¹ Chaiken, S, Deconinck H and Degefie T (2006). The promise of a community-based approach to managing severe malnutrition: A case study from Ethiopia. Food and Nutrition Bulletin, vol 27, pp 95-104.

Sexual exploitation and food distribution in Burundi

Summary of published research¹

CARE International has been a key partner of the World Food Programme (WFP) in Burundi since the outbreak of the civil war in 1993, distributing emergency food aid to refugees, returnees, internally displaced people (IDPs) and others. As the security situation in the country has improved, the programme has moved from generalised emergency feeding to semi-regular targeted distributions. Implementing partners and local government officials are supposed to identify households that meet pre-established vulnerability criteria, and are thus included in the beneficiary lists.

In light of various irregularities uncovered by field teams, CARE conducted a study between October 2004 and June 2005 to document whether sexual relations were being used as a means to access food aid, to identify the reasons and mechanisms behind such abuse if it was taking place, and to develop strategies to reduce the risk to beneficiaries. The findings have been written up in a recent article summarised below.

Partnering with a local theatre group called Tubiyage ('Lets talk about it'), which has extensive experience in facilitating community discussions on ethnic conflict, sexual violence, HIV/AIDS and other sensitive subjects, the research team used interactive theatre techniques to introduce the subject in focus groups and public fora, and to elicit testimonials from victims.

In the focus group discussions and semi-structured interviews, both victims and perpetrators confirmed that sexual harassment and exploitation were present in the food aid process. Exploitation took place in secret and was never discussed openly, certainly not during the public validation of beneficiary lists when irregularities are supposed to be identified. Widows and other single women, either without husbands or without grown-up sons, were found to be particularly vulnerable, as they had no adult males in the household to protect their reputation, and no money to bribe the village heads to include them on the lists. Fear that they would be excluded from the lists was the main factor that led women to submit to requests for sexual favours.

Perpetrators were generally those who established the beneficiary lists. The participants in the theatre presentations and focus groups also unanimously confirmed the presence of bribes and other forms of corruption.

Participants in the study suggested procedures to reduce the incidence of sexual harassment and exploitation of food aid beneficiaries. These included;

- Always having an employee of WFP or CARE present during the creation of lists to ensure transparency.
- Electing mixed committees of beneficiaries, including women, to monitor list creation and food aid distribution.

- Ending the involvement of the local administration in the creation of lists.
- Ensuring that list validation is done publicly in every village with the active participation of women and young people.

The role of the local administration remains a complicated question. While the study identified local officials as the primary drivers of abuse, experience shows that side-stepping them completely can cause significant conflict between participatory structures and local authorities and leads them to undermine actively project activities. In the context of post-conflict Burundi, where local officials have been elected for the first time, the government and donors such as WFP are insisting on more, not less, collaboration with the local authorities.

The study has proved to be a powerful tool for advocacy with WFP. Since sharing its findings, CARE has been allowed to devote more human resources to monitoring the development and public validation of lists, and the agency has been experimenting with new approaches. These include separate validations with men and women, and involving local partners, such as the Burundian Red Cross and the Catholic Church Diocese Committees, who are helping CARE agents to monitor targeting and list development at the village level.

¹ Zicherman, N (2006). 'It is difficult to escape what is linked to survival': Sexual exploitation and food distribution in Burundi. Humanitarian Exchange, volume 35, pp 30-32, November 2006.

Niacin deficiency and pellagra in Angola

Summary of published research¹

A recent study initiated by the World Food Programme (WFP), in conjunction with the government of Angola and various implementing partners, set out to investigate the prevalence of niacin deficiency in post-war Angola and the relationship with dietary intake, poverty, and anthropometric status. Interest in the epidemiology of niacin deficiency in the context of the HIV pandemic has re-emerged because of evidence that tryptophan metabolism, and thereby niacin status, may be particularly vulnerable during HIV infection and play a role in the pathogenesis of AIDS.

Admission data from 1999 to 2004 from the pellagra treatment clinic in Kuito, Angola were analysed. New patients admitted over one year of age were examined and urine and blood samples were collected. A multi-stage cluster population survey collected data on anthropometric measures, household dietary intakes, socioeconomic status, and clinical signs of pellagra in women and children. Urinary excretion of 1-methylnicotinamide, 1-methyl-2-pyridone-5-carboxymide, and creatinine was measured and haemoglobin (Hb) concentrations were

measured with a portable photometer. There were a number of constraints to the survey; population figures were out of date and failed to take account of displacement and migration, while land mines on roads and in other areas meant that certain locations were excluded from the survey area.

The survey found that incidence of clinical pellagra has not decreased since the end of the civil war in 2002. Low excretion of niacin metabolites was confirmed in 10 out of 11 of all new clinic patients. Survey data were collected for 723 women aged 15-49 years and for 690 children aged 6-59 months. Excretion of niacin metabolites was low in 29.4% of the women and 6% of the children, and the creatinine-adjusted concentrations were significantly lower in the women than in the children ($P < 0.001$, t -test). In children, niacin status was positively correlated with the household consumption of peanuts ($r = 0.374$, $P = 0.001$) and eggs ($r = 0.290$, $P = 0.012$) but negatively correlated with socioeconomic status ($r = -0.228$, $P = 0.037$). Because peanuts

and eggs are known to be rich sources of niacin, the protective effect of these foods was not unexpected.

The expected decrease in pellagra incidence after the end of the civil war has not occurred. This is the first report by a household population survey of niacin status in a region with endemic pellagra, and has brought to light a serious prevalence of low and deficient niacin status in women. Nearly one in three women were found to be niacin deficient. The identification of niacin deficiency as a public health problem should refocus attention on this nutritional deficiency in Angola and other areas of Africa where maize is the staple. While WFP is now providing fortified maize flour to vulnerable groups in Bie province, this study suggests that there may be a need for a national flour fortification initiative and other locally targeted interventions.

¹ Seal, A et al (2007). Low and deficient niacin status and pellagra are endemic in post-war Angola. American Journal of Clinical Nutrition, vol 85, pp 218-224

Signs of pellagra observed during survey



Collecting blood samples during survey field work



A Seal, Angola, 2004

A. Seal, Angola, 2004

Understanding HIV/AIDS and livelihoods: new cluster analysis

Summary of published research¹

A recent Overseas Development Institute (ODI) briefing paper describes the findings of longitudinal research carried out in Zambia in 1993 and 2005 to establish the effects of HIV/AIDS over time on individuals, households and communities. The research focused on two locations in Zambia, Mpongwe - close to the Copperbelt towns, and Teta, a remote rural area. Ten days were spent in the communities collecting data using participatory methods. The study was unique in that it used a 'cluster' approach to help understand how individuals and households had either adapted or disintegrated as a result of ill health, and specifically HIV/AIDS.

A cluster can consist of various households, usually, though not necessarily, living in the same geographical area. A significant benefit of the concept is that it allows the most important relationships between individuals of different generations and gender, marital and kinship statuses to be identified and understood. In the approach, data are collected from individuals, but the information is used to identify clusters and to place individuals within them. The 1993 study developed a typology of clusters according to relative resilience and vulnerability. The types formed a continuum from commercial (Cluster Type 1s) to resource-poor (Cluster Type 4s). The aim of the 2005 re-study was to trace the original clusters and see whether they had changed status within the cluster continuum and to understand what had caused the moves. More specifically, it was concerned with the role that AIDS had played in any shifts.

The study found that the category of person(s) who had died in the cluster was found to be a key determinant of the effect on the level of resilience of the cluster. If, for instance, it was a primary producer, the future of the cluster was likely to be threatened. Analysis showed that in Mpongwe, although there were 1.5 AIDS deaths per cluster in the 12 years, maize production had increased. However, this was mainly amongst the wealthier or those higher up the cluster continuum. Livelihoods had suffered in Mpongwe due to animal disease. In Teta, where AIDS deaths per cluster were only 0.72, the effects on individuals and clusters were not heavily evident in 2005. What was in evidence was the change in farming systems, with less reliance on maize and a return to more traditional crops.

Generally, factors affecting the relative vulnerability and resilience of a cluster to the impact of a death were:

- Length and degree of incapacity during AIDS-related illness
- Health status of surviving spouse
- Characteristics and stage of life-cycle of the primary producer
- Overall cluster composition
- Livelihood and agricultural production opportunities.

Another key finding of the study was that the inherent adaptability and flexibility of the matrilineal social system enables it to accommodate deaths and changing economic and demographic circumstances. For example, once a spouse dies, the widow or widower can easily become absorbed into another cluster, not only by drawing on kinship ties but also through marriage.

The ODI paper sets out a number of lessons for those making policy and designing programmes. For example;

- In programmes working with the poor, targeting should be directed at resource-poor clusters rather than poor households.
- For targeting, a broad based multi-faceted definition of vulnerability is needed, one that is not just AIDS-related.
- While national food security policy has focused on maize intensification, crop diversification remains important for household food and nutritional security.
- Diversification within and outside agriculture contributes to resilience because it allows farming systems to be adjusted depending on whether and when labour is available.
- Education about HIV/AIDS is using culturally inappropriate communication channels, particularly by failing to differentiate between HIV and AIDS.
- Appropriate messages need to be targeted at appropriate people. Thus, older women in rural Zambian societies are the channels for transmitting cultural norms about sex and sexuality.

¹ ODI (2006). Understanding HIV/AIDS and livelihoods: The contribution of longitudinal data and cluster analysis. ODI Briefing Paper, August 2006



Population movement as a livelihood strategy in northern Uganda

Summary of published research¹

In March and April 2006, a research team from Tufts University's Feinstein International Centre carried out a study on livelihoods and human security in Kitgum district in Northern Uganda. The three areas included were the Orom trading centre/IDP (internally displaced people) camp and surrounding parishes; the Agoro trading centre/IDP camp and nearby villages; and Labuje IDP camp and Pager village. The study found a high rate of movement between internal displacement camps and semi-settled villages. The most commonly cited reason for moving was to gain better access to land to grow crops, collect natural resources and raise livestock. The two other main reasons were to move out of the camps in search of better living conditions and to search for greater independence and self-reliance. The study found that people had many compelling reasons to remain outside the camps, but many maintained a presence in the camps for at least part of the time. Most people returned to the camps when under threat of attack or when harassed by the military.

Specific security threats and protective responses in the semi-settled villages varied according to location, geographic features and local conditions. Three types of protective strategy took place. The first is demonstrated by villagers in Orom, who operated their own protection force consisting of armed men and adolescent males. They protected livestock and food stores at night, provided security for people walking to the trading centre, acted as sentries in the fields and in some villages accompanied women on traditionally



Discussion with a group of young women in Teta, Central Province, Zambia.

F. Samuel, Zambia, 2005.

Nutritional status of children and pregnant and lactating women in relief camps in post-tsunami Sri Lanka

Summary of published research¹



Cattle in Agoro, Uganda

Christopher Carlson, Uganda, 2005

female-specific tasks, like collecting water and firewood. A second strategy involved movement. For example, in four villages in a parish of Orom, residents climbed the mountainside each night, sleeping under animal hides tanned to look like rocks, or pressed against the base of trees disguised as stones. A third strategy was for residents of both camps and semi-settled villages to act collectively to increase their security. For example, women and girls from the camps travelled in groups to collect firewood and wild foods, while men usually moved out in groups to make charcoal.

The Tufts team found that households in semi-settled villages were, overall, better able to achieve their livelihood objectives than those based entirely in the camps. In most cases, establishing or maintaining a presence outside of the camps, even when this is only on a daily basis, affords better land access. Land tenure is more secure, people are able to access larger plots and collective farming is the norm. This translates into improved food security. The effect of improved living conditions on children and livestock in the semi-settled villages is also pronounced.

The Tufts study concluded that people in northern Uganda are on the move, whether to decongestion camps, between semi-settled villages and camps or to original villages or nearby locales. Much of this movement is voluntary, and is part of adaptive livelihood strategies aimed at balancing livelihood objectives with security.

The authors conclude that once more information on the process of decongestion and the range of factors that cause people to move from an established camp is available, organisations should follow the lead of communities themselves and seek to support those systems that facilitate improved livelihoods and better security. Ultimately these will enable people to return to their land. These systems may include voluntary movement, the division of households, re-establishing collective labour systems and communal land-holding, maintaining links to established camps and innovative protective strategies.

¹ Stites, E (2006). Movement as a livelihood and protective strategy in northern Uganda. Humanitarian Exchange No 36, December 2006, pp 11-14.

The post-tsunami survey reported below describes a decline in nutrition and health status amongst women and children, and makes recommendations to address these. However the investigators failed to recognise the relevance and adequately assess the influence of infant and young child feeding practices on the increased morbidity they observed in under two year olds, and explore what role the emergency response had in this. The signs are all there. Their data shows that three quarters of infants aged 6-12 months and 89% of children aged 12-24 months of age (the latter being the group with the highest prevalence of diarrhoea and wasting) had received milk powder in the previous 24 hours. This was despite the fact that most infants and young children were reported as breastfed. The focus group discussions described how hygienic preparation of milk was a problem in the camps. The highest rates of severe malnutrition (1.8%) were among under 1 year olds, who seemed to be living on breastmilk, powdered milk and biscuits. The authors did not assess exclusive breastfeeding rates in infants under six months, yet they concluded that "breastfeeding practices were satisfactory in infants under six months". This study highlights how the use of standard indicators to assess infant feeding practice and technical expertise in their interpretation is fundamental to assess impact appropriately. The authors recommendations also reflect the tendency to focus on commodity based responses to infant and young child feeding – adequate food rations, vitamin supplementation, supplementary feeding, with no mention of skills based support for breastfeeding, or the need to ensure a protective aid environment where indiscriminate distribution of milk powder does not feature (eds).

The December 26th tsunami that hit coastal areas of Sri Lanka in 2004, killed 30,527 people, displaced 773,636 and injured a further 15,686. The damage to infrastructure was of similar magnitude. More than 96,000 houses were destroyed and 26,538 partially damaged. To accommodate the displaced, 739 camps were established in temples, schools and churches. Survivors lost their loved ones and their assets and became dependent on relief assistance. Some suffered the devastating effects of exhaustion, bereavement, ill health and injury.

UNICEF, together with WFP, supported a nutrition survey, conducted by the Medical Research Institute of the Ministry of Healthcare and Nutrition, in camps housing displaced people. This involved a cross-sectional 30-cluster survey, where 30 children under five years of age were surveyed in each cluster, along with all pregnant and lactating women in selected camps. Mid upper arm circumference (MUAC) was used to assess the nutritional status of pregnant women (MUAC \leq 230 mm for acute malnutrition and \leq 207 mm for severe acute malnutrition). In lactating women, Body Mass Index (BMI) was calculated (BMI $<$ 18.5 considered underweight and $>$ 24.9 as overweight).

Before the survey, under-nutrition was the primary development challenge for Sri Lankan children. A Demographic and Health Services (DHS) survey in 2000 indicated that 14.0% 13.5% and 29.4% of children under five were wasted, stunted and underweight, respectively². In comparison, the post-tsunami study assessed a total of 878 children and found 16.1%, 20.2% and 34.7% to be wasted, stunted and underweight.

The prevalence of each indicator was higher in boys than in girls. During the two weeks before the survey, 69.5% of the children had acute respiratory tract infections and 17.9% had diarrhoea. Although the general food distribution was well in place, the food supply lacked diversity and 70.9% of the children did not get appropriate supplementary food. The prevalence of under-nutrition among pregnant women and lactating women was 37% and 31% respectively. The highest prevalence of wasting was among children between 12 and 23 months of age (31.2%). This age group also experienced the highest prevalence of acute respiratory tract infection and diarrhoea. Although this study found a level of wasting higher than the trigger point of 15% used by the World Health Organisation (WHO) to indicate a public health concern, there was a very low level (0.8%) of severely wasted children. The highest prevalence of severe malnutrition was in infants under 1 year (1.8%).

Only 33.2% of children between 12-23 months had received their vitamin A megadose (routine vitamin A megadose supplementation is provided for children 9-18 months of age in Sri Lanka through the maternal and child health clinics). While 83.2% of infants 6-12 months of age were currently breastfed, nearly one quarter (23.6%) had received milk or milk products in the previous 24 hours. Milk powder was supplied by the government. While 99% of infants under six months were described as currently breastfed (not using 24 hour recall), exclusive and predominant breastfeeding rates were not measured. More than two thirds of the children did not receive micronutrient-fortified supplementary foods.

The authors of the study recommended that a one-day vitamin A megadose supplementation campaign for children aged 6 months to 5 years be launched in tsunami-affected areas; that supplementary food be supplied for all children under five years and to pregnant and lactating women in the areas for a minimum of one year; that nutrition surveillance systems be established in affected areas; and that social services departments and camp managers be advised to provide nutritionally complete food rations for children.

¹ Jayatissa, R, et al (2006). Assessment of nutritional status of children under five years of age, pregnant women, and lactating women living in relief camps after the tsunami in Sri Lanka. Food and Nutrition Bulletin, vol 27, no 2, pp 144-152.

² In children, the cutoff point for stunting, wasting, and underweight was a z score below - 2SD of the reference value

This field article describes Action Against Hunger's experiences with Breastfeeding Support Groups in Tajikistan, set up to address the poor nutritional status in infants and young children reflected in their nutrition surveys and feeding centre admissions, and using knowledge, attitudes and practices survey to inform the programmes development.

Tajikistan is a land-locked mountainous country of 143,100 sq/km, situated in central Asia and is bordered by Afghanistan, China, Uzbekistan and Krygystan. The country is divided into 4 oblasts, namely, the Regions of Republic Subordination (RRS) in the centre, Khatlon in the south, Sughd in the north, and GBAO/Badakhshan in the east. It is a largely rural country, where two-thirds of the population works in the agricultural sector¹. Tajikistan is principally dependent on cotton as the main crop of cultivation. The agricultural industry suffers from lack of modernisation. Furthermore, the land reforms have limited the land left over for cultivation and diversification².

With the collapse of the Soviet Union in 1991, the country faced civil war in the 1990s. The peace accord in 1997 helped improve the security situation, but the country continues to face slow economic development. Tajikistan is the poorest of the five Central Asian Republics. It is estimated that 64% of the population lives below the poverty line³ and that 20-33% of the population falls under the 'extremely' poor category⁴. Since 2002, the government has been committed to a Poverty Reduction Strategy resulting in a reduction of poverty of 19%⁵. Although macro-economic indicators are improving, the household level situation remains precarious. Unemployment rate is estimated to be around 40%⁶ while migration of skilled and unskilled workers to Russia and other neighbouring countries in search of better opportunities is common.

Additionally, lack of investment in and maintenance of the country's infrastructure has severely affected the efficient running of several vital social services. The health sector faces various challenges including shortages in public financing and migration of skilled medical personnel. It is also plagued by lack of modernisation. Access to several basic social services, such as water and sanitation and education, has been limited due to a lack of essential supplies and proper maintenance.

Malnutrition rates

The total population is reported to be 6.4 million (UNICEF, 2004) and according to the 2000 census, under five children comprise 17.4 % of the total population. The infant mortality in 2003 was estimated to be at 65 per 1000 live births, while the under-5 mortality rate was 79 per 1000⁷. Additionally, several surveys have assessed the nutritional status of children. In the period prior to 2005, persistently high rates of acute malnutrition were reported in the Khatlon region. The 2005 national nutrition survey, although indicating a lower prevalence of

global acute malnutrition (GAM) compared to 2004, is still higher compared to 2003 (see Table 1 below)⁸. In 2006, the overall rate of GAM in Tajikistan was reported to be 7%⁹. Thus, although the overall situation in Tajikistan appears to be improving, our programme activities and surveys, which will be discussed in detail in the following sections, indicate that there remains much work to be done to enhance health and nutrition knowledge and practices of women in order to improve nutritional status of children.

There are several reasons for the poor nutritional status seen among children less than 5 years old. These include household food insecurity and micronutrient deficiencies¹⁰ and poor childcare and nutritional practices. For example, infants are introduced too early to poor nutritional value foods and only 25.5% of infants are exclusively breastfed¹¹. Mothers stop breastfeeding for several reasons including work pressures and the need to care for families⁴. Furthermore, from the age of six months onwards, infants are often fed the same foods as adults, including sweetened tea and bread.

Knowledge, Aptitude and Practice Survey

Poor nutritional practices and their consequences are observed by AAH staff and reflected in surveys. About one quarter of the children admitted to the AAH-managed Therapeutic Feeding Centres (TFCs) in Tajikistan are less than 6 months of age. Mothers accompanying these infants are supported to re-lactate in order to provide the infants with the best source of nutrition. Furthermore, the levels of malnutrition among children 6-29 months are consistently higher than other target age groups¹². This is the age when children increasingly rely on complementary foods. Our work with rural women suggested that women were facing significant breastfeeding and complementary feeding difficulties. In order to obtain more information on these difficulties, we conducted a baseline KAP survey (Knowledge, Aptitude and Practice) on breastfeeding and complementary feeding practices in 10 districts of Khatlon Oblast in 2004.

The 2004 KAP survey indicated that although almost all (99.6%) women reported having breastfed their children, nearly 72% of women reported giving tea to their babies within the first 6 months of life. However, 89% of women reported that breastmilk is the best food to give to infants less than 6 months of age. There is thus a failure to link knowledge with actual practice in breastfeeding. Furthermore, the survey found that women wanted breastfeeding support groups to further their knowledge on appropriate breastfeeding and complementary feeding practices. Thus, KAP survey recommendations included:

- Implementation of Breastfeeding Support Groups in the surveyed villages.
- Provision of education on breastfeeding, complementary feeding, and specific nutrition and health and hygiene messages.

Breastfeeding Support Groups (BFSG)

In response, AAH established Breastfeeding Support Groups (BFSGs) at a local level, where it is easier for women to seek support. These groups aim to educate mothers, women of childbearing age, young girls and grandmothers on the benefits of breastfeeding infants and young children. Mothers-in-law are encouraged

to participate in the groups, as they have a significant influence on young married women.

AAH Tajikistan currently operates 25 BFSGs in eight districts in Kurgan Tyube and Kulyab provinces of Khatlon region of Tajikistan. (19 BFSGs under an ECHO funded project and 6 BFSGs under CIDA funded project). The BFSGs are supported by a BFSG and Health Education Programme Officer and five midwives. They work in collaboration with local medical house staff. Each village has two BFSG rooms. The groups meet on a regular basis each week, with regular ACF support staff visiting 2-4 times per month, depending on the group's requests.

In addition to breastfeeding and complementary feeding topics, the midwives also conduct health education on other subjects of importance to pregnant and lactating women, such as nutrition, anaemia, water borne diseases, respiratory tract infections, immunisation, iodine deficiencies, child care, intestinal parasites, family planning and HIV/AIDS. The midwives are also equipped with materials to conduct cooking demonstrations of appropriate complementary foods. Health education materials that are nationally approved are used to ensure coherence of messages coming from the Ministry of Health and other non-governmental organizations (NGOs).

From January and February 2006, gardening education was included as a component of BFSG activities. This is conducted by an ACH agronomist. Overall, 539 women have attended the training sessions so far. The agronomist conducts education on the importance of fruits and vegetables, methods of land preparation for planting vegetables, choosing the best seeds, harvesting and preservation methods. Seeds and tools are also distributed to regular participants.

The midwives conduct regular home visits to all newly delivered mothers and other women who are unable to attend the regular meetings or who have difficulties with breastfeeding. The midwives tend to be flexible depending on the seasons. For example, during the cotton season (May to November), most women spend a considerable part of their days in the cotton fields. Therefore the midwives meet with the women in the fields in order to conduct short meetings while they gather for the weighing of the cotton.

There are at least two active women in each village who promote the activities of the breastfeeding groups among village women. The group leaders are mainly nurses and laywomen from the village. They actively participate in each session by helping to identify

¹ Action Against Hunger Report, 2003. Land Reform in Tajikistan: From the Capital to the Cotton Field.

² UNICEF. Conference Report. 2004. The Situation of Mother and Child Health in Tajikistan.

³ UNDP Human Development Report, 2004

⁴ Falkingham J et al, 2002. A Profile of Poverty in Tajikistan. London School of Economics and World Food Program. Pre-crop Assessment Mission Report and Cereal Yield Forecast for 2002; Tajikistan, Dushanbe, WFP.

⁵ 83% in 1999 against 64% in 2003

⁶ ICG Asian Report No.51, 2003. Tajikistan: A Roadmap to Development.

⁷ Multiple Indicators Study, 2006. Findings from Tajikistan, Preliminary Findings Report

⁸ AAH nutrition in Khatlon in 2005, AAH-MoH NNS 04, AAH and consortium of NGOs NNS 03 (footnote 9 missing)

¹⁰ UNICEF, The situation of mother and child health in Tajikistan

¹¹ National Nutrition Survey, 2006. A Study of the nutritional status of children aged 6-59 months and reproductive women in four regions (Oblasts) of Tajikistan

¹² Action Against Hunger Nutrition Survey, 2004.

Table 1 Global acute malnutrition rates (z score) in Kurgan Tyube and Kulyab (2003- 2005)

	2003	2004	2005
Kurgan Tyube	5.4%	11.1%	7.1%
Kulyab	7.1%	9.9%	9.3%

women in the villages who are pregnant and women who have difficulties in breastfeeding or complementary feeding.

The 2004 KAP survey indicated that more than half of the women were taught to breast-feed by a medical person (55%). This finding reinforces the need for medical staff to be up-to-date with breastfeeding knowledge and to know how to support appropriately those women who are having difficulties with breastfeeding. With this objective in mind, the BFSG Programme Officer conducts training/ refresher training of medical staff in local health structures in areas where the BFSG rooms are located.

One of the objectives of the BFSG programme is to promote local capacity building. The active lay-women are also being trained by the midwife on health education topics. The objective is to enable the volunteers to continue the breastfeeding support group activities on their own in order to ensure sustainability of the programme once ACF phases out its activities in Tajikistan. There are currently 54 volunteers working in Kulob and Kurgan Tyube BFSG villages.

In partnership with the Ministry of Health and local maternity houses, ACH has played an active role in the World Breastfeeding

Week celebrations held each year in August. Additionally, Health Days are conducted where women already trained in the breastfeeding groups are encouraged to conduct theatre plays, present songs, and demonstrate healthy food choices to promote breastfeeding and health and hygiene messages.

Since 2005, more than 7,400 women have regularly attended the BFSGs. There are many success stories that are encouraging (see case studies). The current situation in Tajikistan is no longer considered to be an emergency. Therefore the focus of ACF programmes tends towards local capacity building and preventive measures. BFSGs play a vital role in both promoting health and preventing malnutrition among children less than 5 years and are working well. The KAP survey, planned for the first quarter of 2007, will show what level of improvement in knowledge and practice of breastfeeding and complementary feeding practices among women has taken place. It is hoped that the medical staff and active women trained in promoting breastfeeding and appropriate complementary feeding and health and hygiene practices will continue their important work in the future.

For further information, contact Marie Sophie-Simon, AAH USA, email :mss@aah-usa.org

Making Sense of the Code: new training materials



A 'do-it-yourself' training package on the International Code of Marketing of Breastmilk Substitutes (the Code) is now available. It was developed drawing on the extensive experience that International Code Documentation Centre (ICDC), the International Baby-Food Action Network (IBFAN) and UNICEF have had with training government officials, NGOs and health professionals.

It consists of a Trainer's guide with 11 teaching modules and teaching charts (also on CD) and handouts. It offers a complete orientation on the International Code of Marketing of Breastmilk Substitutes and its implementation at national and international level. It explains why the Code is necessary, how it came about, and its scope. It gives details about the Code's provisions relevant to control of promotion to the public, through the health care system and through the retail system. It highlights responsibilities health workers have under the Code and provisions related to education, information and labelling of products under the scope of the Code.

Two modules are specifically devoted to the role of the Code in protecting optimal infant feeding practices in the context of HIV/AIDS and emergencies.

This training package is intended for those who are keen to create Code awareness and understanding in their countries, ministries and organisations, and for those who want to make Code monitoring and implementation an integral part of their advocacy and programming.

The package is devised for a three day training course (can be extended as needed).

The price for a full set of training materials (inclusive of CD, charts and postage) is US\$100 and US\$50 excluding the charts.

If your organisation or institution would like to incorporate Code training into an existing training programme or establish training on this topic, contact:

International Code Documentation Centre (ICDC), P.O.Box 19, 10700 Penang, Malaysia, fax: +60-4-890 7291, e-mail: ibfanpg@tm.net.my or IBFAN-GIFA, Avenue de la Paix 11, 1202 Geneva, Switzerland, Fax: +41-22 798 44 43, e-mail: info@gifa.org

Success stories

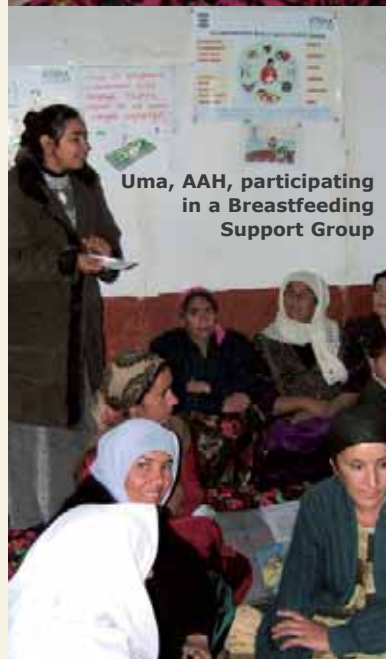
In Hosilot village in Kholkozobod, a young woman, soon after delivery, found her breasts swollen and painful. Her mother, mother-in-law and relatives advised her to warm her breasts with salt and to stop breastfeeding her newborn, as the milk would not be good. However, the woman, who had already attended our BFSG sessions, simply asked for a syringe and expressed her breastmilk into a cup. When her breasts became soft, she asked her mother to get her baby. She then gave the expressed milk to the infant using the syringe. She did the same for the second breast. Other relatives in the room were surprised as this was the first time they had seen a mother expressing breastmilk. Her mother and mother-in-law were proud and happy for her.

In Alauddin village of Farhor district, two BFSG participants were admitted at around the same time to the Farhor Central Maternity hospital for delivery. The first woman who delivered had no problems during her delivery, while the second woman underwent caesarean to deliver her child. As she was not strong enough, she remained in the recovery department while her newborn baby was transferred to the new babies ward and started on formula milk. When the first woman found out that the nurse was feeding the baby of the second woman with formula milk, she asked the nurse to stop feeding the child with formula milk, saying that she knew the economic condition of the other woman and she would not be able to afford formula milk. Instead she offered to breast-feed the infant herself. She convinced the staff that she had enough milk to feed her own child and the other woman's child. She further explained about ACF midwife's advice on the importance of breastfeeding. The staff were surprised at her knowledge and her willingness to feed another woman's child. After obtaining the permission of her husband, she started feeding the other baby as well. The second mother, after recovery from surgery, felt sick and uneasy due to pain in her breasts. She was aware of possible problems because of the knowledge she gained at the BFSG sessions. So with the help of the staff nurse, she expressed her breastmilk, which she then fed to her baby. At the same time she was relieved from the pain. Both women are continuing to breastfeed their children.



A mother breastfeeds her baby

Tajikistan, U Palenjanpan/ACF, 2006



Uma, AAH, participating in a Breastfeeding Support Group

Tajikistan, U Palenjanpan/ACF, 2006

ODI website on cash in emergencies

The Swiss Agency for Development and Cooperation (SDC) has launched an information platform on cash transfer projects in humanitarian aid. The aim of this platform is to share experiences from, to provide management instruments for, and to allow networking among practitioners concerned with Cash Transfer Projects.

It includes the newly revised SDC Cash Workbook for practitioners, suitable for beginners to senior staff working on Cash Transfer Projects, both at headquarters and project level.

The 'Club of Cash Transfer Practitioners' allows experienced individuals to offer their names to institutions searching for experts, while an online blog allows practitioners to share information informally and raise questions or concerns.

The site is provided by Project Team CASH, a knowledge management body within the Humanitarian Aid Department of SDC. Visit the website at <http://www.sdc-cashprojects.ch>

Evaluation of Field Exchange

Over the coming months, we will be carrying out an evaluation of Field Exchange. A detailed evaluation questionnaire is included with this issue of Field. We will also be contacting our readership by email and telephone and posting the questionnaire on our website. If you would like to contribute comments to this evaluation – even just a few words – don't hesitate to contact us by letter/phone/email.

To help us, we would appreciate if you could take a few minutes to check or add your email/telephone contacts with ENN, which you can easily do online.

Email comments to:
eval@enonline.net
or marie@enonline.net

Call us at: +44 (0)1865 324996 or
+44 (0)1865 249745 (we can call you back)

Send written feedback to:
Marie McGrath/ENN Evaluation,
ENN, 32, Leopold Street, Oxford,
OX4 1TW, UK

Check your contact details at:
<http://www.enonline.net> and
choose Update my details

Livestock Emergency Guidelines and Standards (LEGS)

The development of international guidelines and standards for the design, implementation and assessment of livestock interventions to assist people affected by humanitarian crises is now underway. The Livestock Emergency Guidelines and Standards (LEGS) grew out of recognition that livestock are a crucial livelihoods asset for people throughout the world, and livestock interventions are often a feature of relief responses. Yet in spite of many individual agencies' experience, there are no widely available guidelines to assist donors, programme managers or technical experts in the

design or implementation of livestock interventions in disasters. LEGS mirrors the process for developing the Sphere Guidelines and will be based on multi-agency contributions, broad reviews and collation of practitioner experience.

The LEGS website contains background information on the process and how to contribute: <http://www.livestock-emergency.net>

If you would like more details, contact the LEGS Coordinator, email: coordinator@livestock-emergency.net



Livestock support in South Sudan

Tim Leyland, South Sudan

Investigation of anthropometric training by NGOs

In Issue 29 of Field Exchange, we highlighted some of the constraints to anthropometric assessment of infants in emergency contexts related to weighing scales¹. Measurement error can also affect reliability, precision and accuracy but can be minimised by training and standardisation. An MSc student at the London School of Hygiene and Tropical Medicine is currently investigating what anthropometric training is carried out by different non-governmental organisations (NGOs) working in emergencies, the gaps in training, and constraints faced. One of the outputs of this research will be the produc-

tion of a guide to anthropometric training based on current recommendations, and informed by field needs and experiences.

The researchers are keen for input from NGO headquarters' staff and field teams. If you have any comment or would like to contribute, contact Naomi Tilley, Department of Epidemiology and Population Health, LSHTM, email: NAOMI.TILLEY@lshtm.ac.uk

¹ Angood C, 2006. Field Exchange 29, December, 2006. Weighing scales for young infants. A survey of relief workers. P12-13



Report on IFE Meeting now available

Issue 29 of Field Exchange included a summary of an international strategy meeting on Infant and Young Child Feeding in Emergencies (IFE) held in November, 2006 in Oxford. The proceedings of the meeting are now available online at <http://www.enonline.net> or in print from the ENN, email: ife@enonline.net for requests.

Translated Operational Guidance on IFE now available



The Operational Guidance on Infant and Young Child Feeding in Emergencies for programme and emergency relief staff (Ops Guidance) provides concise, practical (but non-technical) guidance on how to ensure appropriate infant and young child feeding in emergencies. Version 2.1 (February, 2007) has just been produced by the IFE Core Group, to reflect recent field experiences on implementation and developments in policy guidance since version 2.0 was completed in May 2006.

Version 2.1 of the Ops Guidance is currently available online and in print in English and French. Spanish, Portuguese and Arabic versions will be completed in March 2007 and Russian, Bahasa (Indonesia) and Kiswahili updates/translations soon afterwards.

If you would like to receive print copies, contact ENN, email: ife@ennonline.net

ODI website on cash in emergencies

The Overseas Development Institute (ODI) website on cash in emergencies is being revamped. They are calling for related reports, evaluations and other resources to include online. Reports currently available include a paper that has emerged from a three year research project on cash in emergencies, which will be summarised in the next issue of Field Exchange.

View at: http://www.odi.org.uk/hpg/Cash_vouchers.html or send relevant materials to: Paul Harvey, Humanitarian Policy Group, Overseas Development Institute, 111 Westminster Bridge Road, London, SE1 7JD, UK. Tel: + 44 (0) 20 7922 0374 email: p.harvey@odi.org.uk

Development of Rapid and Comprehensive Assessment Tools for Emergencies

At a recent meeting of the Inter Agency Standing Committee (IASC) Nutrition Cluster (see box) in Rome, work on assessment in emergencies was shared. An assessment sub-working group (SWG) of the Nutrition Cluster is mapping existing assessment, monitoring and surveillance tools for nutrition in order to recommend to the Cluster optimum tools for use. As part of this work, two tools are being developed – an Initial Rapid Assessment (IRA) tool, and a follow-on Comprehensive Nutrition and Food Security Assessment (CNFA) tool.

The IRA tool is in development, and has been shared for input with other clusters concerned with water, sanitation and hygiene (WASH) and health. This tool is designed to be a multi-sectoral assessment instrument used in the first seven days after the onset of an acute emergency. The tool could also be adjusted for a preliminary rapid assessment in a slow-onset emergency. The IRA tool is now approaching two stages of testing – non-field and field based (the latter ideally in the acute onset stage of an emergency). Both stages will rely on the involvement of non-governmental organisations (NGOs) and United Nations (UN) field offices, particularly in cluster countries (see box), willing to test and feedback on the IRA tool. Guidance on field-testing will be provided by the SWG lead.

Work on the CNFA tool is due to begin this month. This tool will be used at a later stage (2-6 weeks post acute emergency onset). The purpose of this tool will be to complement data collected with the IRA through a more comprehensive assessment of the situation and needs in the nutrition and food security sectors, and to assess the coverage, nature, quality, appropriateness, strengths and weaknesses of public health response measures instituted after the onset of complex emergency.

If you would like learn more about the tools and to get involved in their field testing, contact Mija Ververs, Food Security and Nutrition, Disaster Preparedness and Response Department, International Federation of Red Cross and Red Crescent Societies, P.O. Box 372, 17, Chemin des Crêts, CH - 1211 Geneva 19 Switzerland. Tel: +41 22 730 4449 IFRC, email: Mija.Ververs@ifrc.org or Oleg Bilukha, Medical Epidemiologist, International Emergency and Refugee Health Branch, NCEH/CDC. Tel: +1-404-498-0904, email: obb0@cdc.gov

What is the IASC Nutrition Cluster?

The Inter Agency Standing Committee (IASC) Cluster leadership approach is one element of the Humanitarian Reform package, designed to enhance humanitarian response capacity, predictability, accountability and partnership. The UN Office for the Coordination of Humanitarian Affairs (OCHA) plays a key role in supporting the Humanitarian Coordinator – who has overall responsibility for coordinating the cluster approach at the country level – through coordination, information, advocacy and resource mobilisation, and policy development.

One of the key aims is to ensure sufficient global capacity is built up and maintained in nine key gap sectors/areas of response identified. Cluster responsibilities have been assigned by sector to lead organisations, which then work with relevant partners formed to develop preparedness and response capacity. Clusters and their lead agencies dealing with relief and assistance to beneficiaries are in a number of technical areas with cross cutting aspects including:

Technical areas:

Nutrition UNICEF
 Water/Sanitation UNICEF
 Education..... UNICEF
 Health WHO
 Shelter (conflict, IDPs) UNHCR
 Shelter (natural disasters) .. IFRC 'Convenor'

Cross-cutting areas:

Camp Coordination & Mgmt (conflict, IDPs) UNHCR
 Camp Coord & Mgmt (natural disasters) IOM
 Protection (conflict, IDPs and affected) UNHCR
 Protection (natural disasters) UNHCR/OHCHR/UNICEF
 Early Recovery UNDP

Common service areas:

Logistics WFP
 Telecommunications OCHA/UNICEF/WFP

Cluster members include UN agencies, NGOs, and academic/technical organisations whose operations relate to relevant field activities. The cluster approach operates at global, regional and country levels. The pilot countries where the cluster approach for nutrition is currently being implemented are Democratic Republic of the Congo, Liberia, Somalia and Uganda. In addition to a global and pilot country cluster approach, the cluster approach is applied in new major disasters, such as in Mozambique in response to the recent floods and cyclones.

For further information on the cluster approach and its activities, visit the website: <http://www.humanitarianinfo.org/iasc/> and select 'cluster', or contact Bruce Cogill, Global Nutrition Cluster Coordinator, tel: +1 212 326 7400 email: bcogill@unicef.org

Update on the IPC Online Global Forum

The Integrated Food Security and Humanitarian Phase Classification (IPC) is an innovative set of tools (including a reference system and supporting protocols) for improving food security and humanitarian situation analysis, highlighted in issue 28 of Field Exchange¹. Although originally developed for Somalia through the Food and Agricultural Organisation's (FAO) Food Security Analysis Unit (FSAU), the FAO and strategic partners are now developing it at the global level.

Major agencies, organisations, NGO's, academic and research institutions engaged in food security and humanitarian work have now recognised the value of the IPC framework for reaching technical consensus and issuing a clear statement about the severity of a crisis and assessing implications for humanitarian response. In this context, the IPC Online Global Forum was set-up to foster dialogue on technical and institutional issues among a widely dispersed group of participants, including food security experts from FAO, WFP, OCHA, WHO, FEWSNET, FSAU, ODI, DFID, the EC, USAID², Save the Children UK, Oxfam, Tufts University and many more. Participants examined key technical issues with the immediate aim of revising the current IPC manual, but with the longer term objective of seeing how they can work together in its future development and

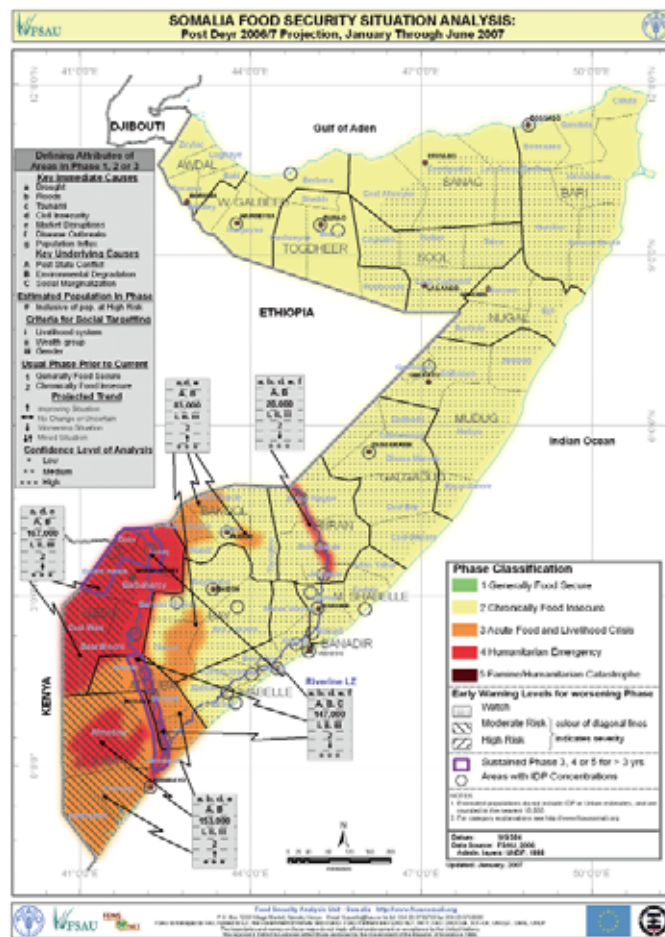
roll-out. Another objective of the IPC Online Global Forum was to create an online community of experts who could support using the IPC in several pilot countries.

The IPC Online Global Forum took place between 14 February 2007 and 16 March 2007. Discussions included:

- Overall Purpose and Limitations of the IPC
- IPC Phase Classifications and Early Warning Levels
- Reference Outcome Indicators
- Strategic Response Framework
- Communicating IPC Analysis with Maps and Population Tables
- IPC Process of Analysis
- Institutional Aspects and Implications for Future Development and Roll-out

The discussions were introduced and led by leading food security and humanitarian experts including Gary Eilerts from FEWSNET, Cindy Holleman from FSAU, Wolfgang Herbinger and Joyce Luma from WFP, Chris Leather from Oxfam, Dan Maxwell and Peter Walker from Tufts University, and Paul Harvey from the ODI. Discussions were then summarised in synthesis reports that identified priorities for moving forward with the technical development of the IPC and institutional implications.

A workshop report including discussion summaries, key findings and next



steps will soon be published. Key issues that arose during the online forum will be discussed and consolidated in a face to face meeting among technical partners that will take place in Rome from March 21 –22, 2007.

For further information, contact: Denise Melvin, email: Denise.Melvin@fao.org or visit the IPC website at: <http://www.fsasomali.org>

¹ See news piece, Field Exchange, issue 28
² Abbreviations for World Food Programme (WFP), the UN Office for the Coordination of Humanitarian Affairs (OCHA), World Health Organisation (WHO), Food Early Warning System Network (FEWSNET), the Overseas Development Institute (ODI), the Department for International Development (DFID), the European Commission (EC), the United States Agency for International Development (USAID)

Nutrition in Emergencies short course



A five day course in Nutrition in Emergencies is being run by the Centre for Public Health Nutrition, University of Westminster, London, UK (10-14th September, 2007).

The short course provides participants with technical knowledge and up-to-date information regarding delivering nutritional support to those affected by humanitarian emergencies. The course topics include food security, malnutrition, supplementary and therapeutic feeding programmes and other interventions.

The course aims to give participants an overview of nutrition in humanitarian emergencies, including the type of malnutrition, direct and underlying causes, how they are assessed, and common nutritional interventions.

Participants are drawn from a range of backgrounds although the course is particularly aimed at nutritionists, doctors, nurses and programme managers who work in developing countries.

The course is run by the University of Westminster in collaboration with NutritionWorks and costs £650 sterling.

For more information, contact Mark Armstrong, tel: +44 (0)20 7911 5883 or email Kate Godden, email: k.godden@westminster.ac.uk

New WHO growth standards: more harm than good?

Summary of published letter¹

A recent letter in the LANCET questions whether the new WHO growth standards², reported in issue 28 of Field Exchange, may do more harm than good. The authors argue that most mothers and health professionals are concerned about their infant's growth, particularly for the first six months. If they believe their infants are not growing adequately, they are more likely to introduce supplementary foods, including 'top ups' with infant formula or even switching to formula completely. It is further argued that 'insufficient milk' is the most common reason for the early cessation of breastfeeding and mothers often self-diagnose this on the basis of perceived slower growth.

The new WHO growth standards show the maximum growth rates that can be achieved with breastfeeding under optimum conditions. But, for the first six months of life, the new WHO growth standard weights,

for boys and girls, are heavier than those produced by the NCHS (National Centre for Health Statistics) for every Z score from -3 to +3. The difference is greater for weights below the mean, and it is in this region of the chart that mothers are more likely to be anxious about the growth of their infants.

The authors state that the new WHO growth standards are a triumph of modern statistical technique but go on to ask whether the real purpose has been lost in technology. They conclude that what is really needed is a growth reference that presents growth rates that can be realistically achieved during the first six months of life, and maximises the duration of exclusive breastfeeding.

¹ Binns. C and Lee.M (2006). Will the new WHO growth references do more harm than good? The Lancet, volume 368, Nov 2006
² <http://www.who.int/childgrowth/en/>

'Top 10' underreported crises in 2006

According to Médecins Sans Frontières (MSF), the impact of tuberculosis and the devastation caused by wars in the Central African Republic (CAR) and Chechnya are among the top 10 most under-reported medical emergencies of 2006. "The violence and suffering that MSF medical

staff witness is too often seen as a norm that does not merit media attention," said Jean-Michel Piedagnel, executive director of MSF UK. Despite intense efforts to raise the profile of the ongoing conflict in the CAR, the country received almost no media attention in 2006, said MSF's report. Since November 2005, fighting has occurred between government troops and various rebel groups in the north west of the country and as many as 100,000 civilians have been forced to flee their homes.

The 'Top Ten' most under-reported crises of 2006 is available at <http://www.msf.org>

Public Health in Complex Emergencies course – 2007 dates

The Public Health in Complex Emergencies Training Programme (PHCE) is an internationally recognised, two-week long residential training programme conducted three times a year. It is the result of a collaboration of five organisations:

- Faculty of Health Sciences at the American University of Beirut, Lebanon
- Asian Disaster Preparedness Centre, Thailand
- Makerere University Institute of Public Health, Uganda
- World Education, Inc., USA
- International Rescue Committee, USA

Dates for the 2007 courses are:

- April 16-28 – American University of Beirut, Lebanon
- August 13-25 – Asian Disaster Preparedness Center, Bangkok, Thailand
- December 3-15 – Institute of Public Health, Makerere University, Kampala, Uganda

Details are now available from <http://www.phcetraining.org> where you can download applications from the website or apply online.

For further information, contact: Lorna Stevens, International Rescue Committee, Health Unit – PHCE, email: Lorna.Stevens@theirc.org

IFE training planned in London

The Centre for International Health and Development (CIHD) at the Institute of Child Health, London runs a number of courses on infant feeding that examine infant feeding from an international perspective, and are in accordance with the WHO/UNICEF Global Strategy on Infant and Young Child Feeding. Recently in London (21st March 2007), a one day orientation/training on Infant and Young Child Feeding in Emergencies (IFE) was outlined in a small working group of IFE Core Group members, independent nutritionists, NGOs, and the Infant Feeding Consortium that runs the CIHD courses. The one day training will be incorporated into the Breastfeeding Policy and Practice Course (see below) scheduled for 18 June – 13 July 2007 in London (exact date of the IFE day to be confirmed), and will be open to non-course participants.

Drawing particularly on the Operational Guidance for Infant and Young Child Feeding in Emergencies¹ and on IFE training materials² developed by the IFE Core Group, the day will be designed with a cross-section of participants in mind. As well as medical and nutrition staff, we welcome the attendance of programme managers, water and sanitation staff, health personnel, donors and NGO staff. Experience in supporting breastfeeding is not necessary.

Cost will be subsidised/free but places will be limited to 20. If you are interested and would like to learn more, contact Ali Maclaine, ENN, email: alimaclaine@btinternet.com

or Marie McGrath, ENN, email: marie@ennonline.net

Breastfeeding: Practice and Policy Course

Places are still available on the four week Breastfeeding: Practice and Policy Certificate Course 18 June – 13 July 2007. Divided into two 2-week modules, the course is designed for doctors and other senior health professionals who are involved in national or local infant feeding programmes as clinicians, trainers, advisers, programme coordinators or advocates for optimal infant feeding. Teams from the same country are particularly welcome. The course is conducted in English. Teaching includes lectures, seminars, role-play, group work, sessions with mothers and babies in the classroom, visits to health facilities and set assignments. Participants are presented with a WHO/UNICEF/CIHD Certificate upon successful completion and full attendance of the course.

For details on fees, on taking the course as separate modules, email bfeed@ich.ucl.ac.uk or visit the website at <http://www.ucl.ac.uk> where full application forms and full details are available.

¹ Operational Guidance on IFE for Emergency Relief Staff and Programme Managers. Version 2.1, February 2007. Available online in English, French and Portuguese. Print versions available from ENN, email: ife@ennonline.net. Further translations, including Spanish, Arabic, Indonesia-Bahasa, (version 2.0 currently online), Kiswahili, soon available.

² Module 1 for programme staff and Module 2 for health and nutrition staff are available online at <http://www.ennonline.net>

The Need to Improve Administration in Ethical Organisations

By Claire Martin and Emmett Murphy

A central goal for every ethical organisation is to focus on maximising the impact of its programmes. However, very few have acknowledged the relationship between this goal and the quality of the organisation's administration systems and procedures. Administration has traditionally been given a low profile in the formulation of an ethical organisation's programmes. Inefficiencies in administration are rarely seriously challenged, even when they serve to disempower the organisation's employees. This is often due to demands from the public and the media for minimal investment in administration. There is a need for a new perspective that recognises that maximising administrative efficiency is essential for maximising programme impact and ensuring the long-term sustainability of the organisation.

A programme's impact must be seen as a dynamic interaction between external and internal factors¹. There is no universal strategy for dealing with external influences beyond the organisation's control. However, every ethical organisation can empower itself by affording a higher priority to internal influences, such as administration. An organisation that commits to improving the efficiency and effectiveness of its administrative capacity will unlock a series of benefits that will improve its potential for creating a sustained expansion of impact.

Enhancing cost-effectiveness

Funded organisations face a 'burdensome level of bureaucratisation'² that adds complexity to administration and reduces the time available for working on programme implementation issues. The cost-effectiveness of the organisation and its programmes can be negated by an inability to efficiently administer its daily activities. A careful evaluation of this deficiency in ethical organisations should lead to recognition that administration is the backbone of the organisation, with its own requirement for specialised systems and staff. A considered investment in improving administrative efficiency will improve overall cost-effectiveness by introducing a leaner cost structure. Staff



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by defraying inefficient support costs³. It is important for donors to be able to easily inspect a programme and review its progress. Ethical organisations must be sensitive to the need to manage programmes as rigorously and professionally as possible. Consequently, efficient administrative practices make an organisation far more appealing to potential donors.

Funded organisations may be resentful of overwrought reporting obligations, while donors can be frustrated with a funded organisation's inefficiencies and delays in responding to queries. An investment in administration can reward the organisation with improved donor relations through the introduction of greater clarity into the relationship and the freeing up of more staff time for focusing on core programme activities. Information flows will be improved, thereby bringing better understanding to both sides. This will reduce tensions and increase trust in the relationship.

Demonstrating impact

The ability to demonstrate programme impact is often lacking⁴. Performance information is especially difficult to manage in larger organisations that operate in a complex hierarchy of associated partners and internal divisions, with multifarious targets and objectives. One of the main limitations on the ability to demonstrate impact is a deficient administrative capacity that restricts the timely flow of information amongst stakeholders. An improvement in this capacity will improve information exchange and access to knowledge, provide new instruments that make it easier to substantiate achievements and communicate them effectively, and help to instil a culture of organisational learning by providing the resources necessary for reflection and improving future performance.

Scaling-Up

Ethical organisations need this new knowledge to be able to demonstrate to donors the need for institutional development. The long-term success of an ethical organisation is dependent on its capacity for growth, an inherent instinct of any organisation that wants to expand its impact⁵. The sustainability of the organisation depends on robust administration when scaling-up, making new partnerships or taking on new activities. The internal implications involved in such organisational change cannot be overlooked. Shortcomings in administration

can cripple an organisation that attempts to adapt to these added organisational pressures and commitments.

Overcoming uncertainty

Predictability is a crucial determinant of organisational growth and sustainability for any organisation. This is even more pertinent for organisations facing extreme time pressures and erratic flows of income. Many ethical organisations work in volatile environments, where speed of response is paramount, but rely on short-term funding cycles for their income. Efficiency in administration can help to remove some of the uncertainty they face by improving the flexibility of their organisation. Rather than be hampered by deadlines and laborious paperwork, they can be more responsive to evolving situations and fluctuations in the disbursements of funding. The long-term success of a programme depends on an organisation's ability to provide predictable, flexible and responsive administrative support.

Empowering employees

Uncertainty can also negatively impact on staff morale. Employees can suffer from increased stress and anxiety due to short funding horizons for their programmes, but also from administrative ineptitude. The more time an employee works on administration for a programme, rather than their area of expertise, the more that employee's job satisfaction decreases. Ethical organisations recognise that the skill, dedication and expertise of their employees is their most important resource. Therefore, it is crucial for the long-term success of these organisations that this resource is safeguarded and nurtured. An investment in administration that emphasises the need for specialist administrative staff, systems and procedures, will result in a happier and more productive workforce. Furthermore, the organisation's ability to recruit high quality employees in the future will be enhanced.

Conclusion

Administration is the backbone of any well-functioning organisation. Its proficiency should be of concern to, and emphasised by, every stakeholder in an ethical programme. An enhancement of administrative capacity will induce many benefits throughout the organisation and help to establish efficiency as a precept for all internal and external activities. A former burden and drain on resources can develop into a competitive advantage, which will enable the organisation to expand more effectively the impact it can make and assure the long-term sustainability of its programmes.

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will find more time and money available for focusing on their core competencies, and daily operations will be instilled with more coherency, fluidity and prudence.

Cost-effectiveness is particularly vulnerable to the complexities of coordination. The costs of coordination are most severe for organisations that rely on funding from multiple donors or operate a variety of programmes in different regions. They face an endless accumulation of regular internal and external reports, negotiations and evaluations, which can cause bottlenecks and delays. This represents an arduous transaction cost for these funded organisations. Therefore, an organisation that becomes more cost-effective by investing in streamlining the coordination of all of its commitments will gain competitive advantage over other funded organisations.

Improving donor relations

This competitive advantage becomes even more pronounced when considering how donors decide in which organisations to invest. Donors always have a preference for working with organisations that demonstrate an ability to be efficient in their operations and in their dealings with donors. Donor organisations, especially those in the private sector, donate money where it will make the most on-the-ground impact, not where it will be consumed



Crucial has facilitated the set-up of administration systems for Valid Nutrition's local production of 'Ready-to-Use Therapeutic Food' in Malawi

¹ Edwards, M (1999). NGO Performance - What Breeds Success? New Evidence from South Asia. *World Development*, Vol. 27, No. 2 (1999), pp. 361-374, p. 363

² Roberts, SM., John Paul Jones III and Frohling O. 'NGOs and the Globalisation of Managerialism: A Research Framework'. *World Development*, Vol. 33, No. 11 (2005), pp. 1845-1864, p. 1850

³ Smillie, I and Minear L (2003). The Quality of Money: Donor Behaviour in Humanitarian Financing. Feinstein International Famine Centre, (April), p. 29, http://hwproject.tufts.edu/new/pdf/donor_behav.pdf

⁴ Davies, R. Monitoring and Evaluating NGO Achievements. In Desai, Vandana and Robert B. Potter (eds.), *The Arnold Companion to Development Studies*, (Arnold Publications, London, 2002). Also at www.mande.co.uk/arnold.htm

⁵ Uvin, P, Pankaj S. Jain, and L. Brown D. (2000). Think Large and Act Small: Toward a New Paradigm for NGO Scaling Up. *World Development*, Vol. 28, No. 8, pp. 1409-1419

Comparing cash and food transfers: findings from a pilot project in Sri Lanka

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This field article shares the findings of a pilot cash transfer project that gives valuable insight into household expenditure and consumption patterns in cash-receiving and food-receiving households over a three-month period in Sri Lanka.

Thematic research on cash and food transfers has increased significantly since the late nineties. However, comparative research on cash and food transfers remains limited and claims about the relative advantages of one or the other are often based on comparisons of programmes implemented in different contexts.

In 2006, the World Food Programme (WFP), Oxfam (GB) and the International Food Policy Research Institute (IFPRI), through a unique collaboration, implemented a Cash Transfer Pilot Project (CTPP) in Sri Lanka in the aftermath of the tsunami. The key objective was to compare the impact of cash and food transfers on beneficiary households' food and livelihood security and on the local economy. A wider objective was to learn how best to determine the feasibility and appropriateness of cash-based programmes in emergency food-security assessments.

The role of WFP was to supply the resources necessary for the implementation of the pilot. Oxfam GB provided technical implementation expertise and IFPRI undertook project impact analysis¹. The collaboration drew on the relative expertise of each agency and included the joint design of the project and the Monitoring and Evaluation (M&E) approach².

Background

The eastern, northern, and southern coastlines of Sri Lanka suffered heavily from the tsunami in 2004, with at least 38,000 deaths, approximately 5,000 people missing, and 500,000 people displaced. Many of the worst affected areas on the east coast were fully or partially under the control of the Tamil Independence Movement (LTTE), and had been subjected to years of conflict and, in some areas, frequent displacement. World Bank led assessments indicated damage of around \$1.5 bn³. Resulting unemployment was substantial, with estimates of one million job losses. WFP started emergency food distribution within days after the tsunami struck. Initially this consisted mainly of imported food, as it was prior to the harvest and local prices were not internationally competitive at that time. However, following predictions of a good 'Maha' rice harvest, the Government of Sri Lanka discouraged rice importation. Furthermore, various non-governmental organisations (NGOs) (such as Oxfam, Save the Children UK, and the British Red Cross) raised concerns that import-based food aid, especially rice, would distort local markets and made strong arguments for cash-based interventions⁴.

Pilot cash transfer project (CTPP)

WFP Sri Lanka undertook a series of Emergency Needs Assessments (ENAs), which considered the scale of the response from organisations and the Government of Sri Lanka,

and the ability of households to re-establish their livelihoods. The last ENA assessment in May 2005 advised that there should be a reduction in food assistance from 900,000 to 350,000 people, i.e. a shift to a more targeted intervention (Vulnerable Group Feeding [VGF] programme) starting mid August 2005, following the completion of the General Food Distribution⁵. Based on a feasibility assessment, a pilot cash transfer project (CTPP) was proposed as part of the VGF response. An additional study commissioned by WFP⁶ in May 2005 identified key issues in assessing the appropriateness of cash transfers and the feasibility of such interventions in Sri Lanka, as well as providing inputs into the design of the CTPP. Delays in the completion of the General Food Distribution, due to setbacks with the local procurement of rice, supported the case for a three months VGF programme, in which 12,000 out of 312,000 beneficiaries⁷ received cash in lieu of a full food ration between October/November 2005 and January 2006⁸.

The same household targeting mechanisms were used for cash and food beneficiaries. These included:

- Families whose houses were completely damaged by the tsunami
- Families from partially damaged households in the buffer zone⁹

¹ Oxfam seconded a Programme Manager with cash implementation experience to WFP for the duration of the project, and an Oxford-based food security and livelihoods adviser provided regular technical inputs. Oxfam's participation in the project should not be perceived as endorsing WFP involvement in cash programming, but rather as assisting with the analysis of the relevance of cash assistance to WFP's mandate.

² N. Edirisinghe (2005). Anticipation of the effects and comparative advantages and limits of proposed cash transfers in lieu of food in Sri Lanka's tsunami-related emergency through the use of specific assessment tools. Prepared by the WFP Strengthening Emergency Needs Assessment Capacity (SENAC) project, supported by ECHO. <http://www.wfp.org/odan>

³ Data taken from WFP Needs Assessment, January 2005. <http://www.wfp.org/odan>

⁴ Oxfam International (2005). Making the case for cash: Humanitarian food aid under scrutiny. Oxfam Briefing Note, available at: http://www.oxfam.org.uk/what_we_do/issues/conflict_disasters/bn_cash.htm.

⁵ Tsunami Recovery Programming & Needs Assessment Follow-Up Mission Sri Lanka, WFP May/June 2005. Available at: http://www.humanitarianinfo.org/srilanka/infocentre/assessments/others/doc/WFP_NA_May/WFP_NA_May.pdf

⁶ See footnote 2

⁷ This is equivalent to 3,276 households. On average, there are five members per household.

⁸ The food ration (per person per day) included 400g of cereals (rice/wheat flour), 60g lentils, 20g oil, 20g sugar, and 40g Corn Soya Blend, providing some 2000 kcal per day.

⁹ A zone defined by the government, up to 200 metres from the sea, where rebuilding houses is prohibited for safety reasons.

- Families in the buffer zone with no damage to their houses but who had lost their main livelihoods
- Families considered as destitute.

The amount of cash disbursed was equal to the local market value of the WFP food ration, taking into consideration average seasonal market price fluctuations in the area. The total transfer value amounted to 150 Sri Lankan rupees per beneficiary per week, or US\$1.5¹⁰.

The cash was distributed on a fortnightly basis to targeted households from randomly selected communities in three districts of Sri Lanka (Batticaloa in the east, Galle and Hambantota in the south)¹¹. The Samhurdhi community bank network, normally used for social welfare payments, community-based savings schemes, and more recently, large-scale government tsunami cash payments, provided the cash-delivery mechanism.

WFP transcribed the cash-beneficiary household head's name, identity card number, and household size (provided by local government officials) onto coupons that indicated the amount due per person, total household entitlement, and a calendar for indicating cash collection days. All coupons were 'signed-off' by the officials, with any unclaimed cards returned to WFP. The cash was redeemable from banks on presentation of the coupon and the identification card. Failure to redeem cash within the collection period, spanning three consecutive days, would result in non-payment.

For the food-beneficiary households, the food-delivery mechanism was not modified for this pilot. Local officials submitted lists of targeted household names to WFP, and in return received an appropriate number of blank coupons for completion. On receipt of the coupon at the distribution point, households received allocated food. Forms indicating receipt of food would normally be signed, as would coupons. When there were inadequate amounts of all or some foods for distribution, households would be informed. As there were no fixed days for collection, beneficiaries were not penalised for non-attendance.

Key findings

The CTPP has allowed comparative analysis of household expenditure and consumption patterns in cash-receiving and food-receiving households over a three-month period. However, these patterns should not be extrapo-

lated over a longer period of time, or expected in other contexts, for which they may not be representative.

The appropriateness of cash depends on a secure environment where markets are functioning

Communities in the more densely populated and less conflict-affected south of the island had very good market and bank access. This resulted in less time spent collecting cash and accessing markets, and as market prices were stable, the 'value' of the cash transfer did not depreciate. There were no restrictions or limitations on consumer and trader movements or products sold in the area. Almost all cash-receiving households in this area preferred receiving cash to food.

In the more poverty-stricken LTTE-controlled east, access to banks and markets was inferior. At the time of project planning, the availability of public transport and traders within the target area led to the assumption that market access was adequate and that traders would respond to any increase in demand induced by the cash transfer.

However, an unforeseeable deterioration in security within the area resulted in more vigorous controls at roadside government checkpoints. Traders were restricted in the amount and types of produce that were allowed into the area, and consequently food prices increased and the actual value of the cash transfer eroded proportionately. Further, movement control and higher transportation costs also imposed higher transactions for consumers in purchasing food. For these reasons, all households in this area indicated preference for food rather than cash transfers.

This highlights the importance of not only an initial assessment but also ongoing monitoring of both the security and market environments, so programmes can be adapted if and when necessary.

Cash beneficiaries diversified their diet and bought non-food items

Overall, when households did receive cash, they diversified their diet. They spent more on dairy products, meat, packaged foods, and non-food essentials such as clothing and footwear, and they bought cereals with a higher market value than the ones supplied by WFP. These increased expenditures were financed by reductions in the consumption of key staples.

For both household groups (cash-receiving and food-receiving), calorie consumption declined over the project period, partly because important Hindu and Muslim festivities took place during the baseline survey. In this period, households would have incurred additional festival-related costs and in the instance of Muslim households, there would have been changes both in types of food consumed and consumption patterns. In the poorer, more remote and conflict-ridden communities in the east, the decline in per capita daily calorie intake was significantly steeper for cash-receiving households (a decline of 535 calories) than for food-receiving households (a decline of 290 calories), suggesting that cash transfers there had a net negative effect on household calorie intake. This was partly due to the higher level of unmet non-staple and non-food needs of the poorer households in this area and also due to higher liquidity afforded by cash (cash gave households the opportunity to purchase goods which would otherwise have required them to



General food distribution to IDPs in the Tsunami devastated areas of Sri Lanka

save up over a period of time). Also, as already mentioned, transaction costs imposed by remoteness and conflict had the effect of eroding the value of cash transfers relative to food transfers.

The decrease in food intake could also have been due to the fact that there remained some scope for reduction in the consumption of staples without compromising basic calorie intake. Even at the end of the cash distribution, average per capita daily energy intake was slightly above 2,100 kcals for both cash-receiving and food-receiving households.

Little apparent impact on livelihoods

Although cash-receiving households cited investment in home improvement and businesses as priorities, there was no significant difference in actual expenditure in these areas between cash-receiving and food-receiving households. This could perhaps be attributed to both having knowledge of government/NGO plans to rebuild houses, and expectations of NGO livelihood projects continuing in the future.

Another possible explanation could be that the amount of cash was insufficient for the purchase of livelihood assets or investment in small-scale business. The cash transfer was worked out on the basis of the value of the food ration rather than the value of the basic livelihood assets that needed to be rebuilt.

In the east, the impact evaluation also found that cash beneficiaries reduced their engagement in casual labour over the implementation period. However, further understanding of household motivation to seek casual labour during this period is required before a definitive conclusion on the effects of cash transfer on work-related decisions is made.

Working through local banks was effective

⁹ A zone defined by the government, up to 200 metres from the sea, where rebuilding houses is prohibited for safety reasons.

¹⁰ The exchange rate at the end of 2005 was 1US\$ =Rs.100.

¹¹ As ethnic diversity in cash recipient households was desired, careful district selection was required.



Mother and Child Nutrition (MCN) Clinic, Mullaitivu, Sri Lanka

The Samhurdhi banks were suitable partners for distributing cash because of previous experience in large-scale cash distributions, their extensive geographical coverage, and their knowledge of the targeted communities. Bank staff members were paid according to the number of days worked, they were trained, and most importantly, they were involved in the design of the disbursement system and coupons. They were efficient, had low logistical costs, and accounted for all the cash transferred from the WFP bank account. Nearly all cash beneficiaries involved in monitoring the process expressed satisfaction with the bank services. In contrast, over a third of food beneficiaries were dissatisfied with the food distribution system, reporting long queues. Spoiled food and under-scooping were also reported by a small percentage of beneficiaries. Food-related logistical costs were significantly higher and unlike cash, a percentage is expected to be lost in 'losses and leakages'.

Cash was more cost-efficient, but cost-effectiveness depends on context

Cost-effectiveness compares expenditure (costs) and outcomes (effects) associated with an action. Cost-efficiency relates to the cost of delivering the transfer (transportation, administration, delivery costs) compared to value generated.

The cash disbursement system was more cost-efficient (5 per cent cheaper) than the food system in all geographical areas. This cost-efficiency calculation considered the costs to WFP of providing cash and food assistance (calculated as a cost per beneficiary), and the value of the cash and food assistance to the beneficiaries. Expenses related to logistics included external and local transportation, handling and storage, but not WFP human resources. The lower cost of delivering cash was largely due to the existence of a well functioning bank network compared to the relatively high-costs of moving food. It is likely that when staff costs are considered, the cost-efficiency of cash will be more pronounced. However, this should not be taken as a valid statement on cost-efficiency in other contexts, where delivering cash might be more expensive due to factors like insecurity and lack of financial infrastructure.

The cost-effectiveness of food was higher in the east in areas where the security was deteriorating, markets and banks were difficult to get to, and where market prices were prone to higher fluctuations. Conversely, the cash was more cost-effective in areas with integrated and

competitive markets, better bank access and lower market-price fluctuation. Neither food nor cash transfers reflected beneficiary transportation costs¹², nor did cash transfer take into account price fluctuations. Both are cost elements that affect cost-efficiency and effectiveness calculations.

Fears that cash expenditure would lead to adverse social impact and gender inequity in resource decision-making were not realised

At the project planning stage, there were reservations that replacing food with cash would have a negative impact on food-security and decision-making. It was feared that the male member of the household would control the cash entitlement and would be more likely to purchase items like alcohol. The results show that these assumptions were unfounded. The level of joint decision-making between husbands and wives was slightly higher in cash-receiving households compared to food-receiving households. Alcohol consumption, although it increased marginally in both household types over the implementation period, increased less for cash households. In households with a high level of female control¹³, there was a slightly higher expenditure on diverse food items and packaged goods, and a reduction in the purchase of alcoholic beverages compared to other households.

The findings of the Sri Lanka project are similar to those of projects elsewhere

The pilot project findings are similar to those of projects elsewhere, for example in the Horn of Africa (Kenya, Somaliland, Uganda) and Asia (Pakistan, Afghanistan, Bangladesh)¹⁴. These projects also found that a large proportion of cash is spent on basic food and non-food items, particularly when small amounts of money are received on a frequent basis. Other studies showed that expenditure on livelihood assets is more likely to result from projects of longer duration, where larger amounts of cash are disbursed and where cash is a complement to food aid (rather than replacing food aid).

Conclusions

In areas where markets were functioning and accessible, cash transfer was more cost-effective and preferred by beneficiaries. In those areas where markets were less functional or accessible, food assistance was more cost-effective and preferred by beneficiaries.

The appropriateness of cash programming depends on market access and functioning

(whether they are competitive and integrated), and security. Food aid is more appropriate in contexts where markets are not working well, where security conditions impose higher market transactions costs for consumers, and in situations of high and unpredictable inflation. Opportunities exist for using both interventions in parallel or in a phased approach depending on seasonal and contextual changes over time and space. This is especially relevant to emergencies, where market access could be a limiting factor. In the immediate aftermath of a shock, food intervention may be more appropriate. Cash-based interventions may be gradually introduced as markets recover and could potentially be used as an exit strategy.

When livelihood recovery, protection, or support are project objectives, analysis should include the identification of livelihood groups and the seasonality of their livelihood activities. The size of the transfer needs to be based on the value of assets that need to be rebuilt, which in turn should determine the scale and duration of the project¹⁵.

Analysis of both cost-effectiveness and cost-efficiency of interventions should be standard practice in food and cash interventions in order to get a wider body of evidence on the relative costs and impact of these two approaches.

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¹² Transport costs were significant for food beneficiaries, as the majority received a single bulk delivery of 12 weeks of food ration.

¹³ These are households in which the women control the money to purchase food from the market.

¹⁴ S. Jaspars (2006). From Food Crisis to Fair Trade – Livelihoods analysis, protection and support in emergencies. ENN Special Supplement No. 3. <http://www.enonline.net> See ODI website for additional publications on cash programming: <http://www.odi.org.uk/>.

¹⁵ This is clearly highlighted in P. Creti and S. Jaspars (2006). Cash Transfer Programming in Emergencies. Oxfam, <http://publications.oxfam.org.uk/oxfam/display.asp?isbn=0855985631>.



General food distribution to IDPs in the Tsunami devastated areas of Sri Lanka



S Jaspars, 2005

Devastation in Sri Lanka post tsunami

Evaluation of international response to the tsunami

Summary of report¹

The Indian Ocean earthquake and tsunami killed over 227,000 people with 1.7 million displaced. A massive media-fuelled global response resulted in an estimated US \$13.5 bn in international aid. A recent synthesis report of the five Tsunami Evaluation Coalition (TEC) thematic evaluation reports has been posted on the TEC website. The report addresses primarily the initial phase of the international response, up to the first 11 months after the disaster. Main findings are summarised below.

Constraints and Achievements

Main constraints to the response include pre-existing weaknesses in disaster-affected national and local capacities, ongoing armed conflicts in Sri Lanka and Indonesia, ill advised, confusing and sometimes bureaucratic official policies and procedures, politicised and centralised decision making, and concerns about corruption and distrust of local leaders. Other identified constraints were described as rooted within international agencies themselves, including quantity and quality of international personnel, inappropriate programme methods and tools, and weak engagement in or management of coordination. The lack of significant, predictable, non-earmarked, multi-year funding for developing appropriate international capacities was also a major drawback.

However, on the positive side, large amounts of funding allowed rapid initial recovery activities and some innovative practices, including a wider use of cash grants than has been the case in other emergencies in developing countries. Also, the gap between relief and rehabilitation, common in disaster response, was avoided. Within a few months, there was palpable evidence of recovery. By six months, in Aceh, Indonesia, some 500,000 people had a solid roof over their heads while in Sri Lanka, over 80% of damaged fish markets, boats and fishing equipment were rapidly restored.

Accountability, ownership and recovery

Practically all immediate life-saving actions and initial emergency support in the first few days were provided by local people, often assisted by the wider national public and institutions. The international response was most effective when enabling, facilitating and supporting these actors and when accountable to them. Overall, international relief personnel were less successful in their recovery and risk reduction

activities. Exceptional international funding provided the opportunity for an exceptional international response. However, the pressure to spend money quickly and visibly worked against making the best use of local and national capacities. Furthermore, many efforts and capacities of locals and nationals were marginalised by an overwhelming flood of well-funded international agencies. Treating affected countries as 'failed states' was a common error. Other identified weaknesses included rarely coordinated or shared assessments, supply driven, unsolicited and inappropriate aid, inappropriate housing designs and livelihoods solutions, poor understanding of the development role of income and tax generation, and stereotyping of option for women, small farmers and small entrepreneurs.

Other problems identified included brushing aside or misleading authorities, communities and local organisations; displacement of able local staff by poorly prepared internationals; dominance of English as the working language; misrecognition of local capacities; poaching of staff from national and local entities, and limited participation of the affected population. While affected people were appreciative of achievements and good practices, there were frequent complaints that non-governmental organisations (NGOs) only dealt with village officials and that poorer people were marginalised. At best, the international response restored the 'status quo ante' while at worst, it strengthened those who were better off and/or more articulate.

Funding

Generous funding not only exceeded the absorption capacity of an overstretched humanitarian industry and deprived it of its customary excuse for built-in systemic short-comings, but also led to the proliferation of new actors with insufficient experience, as well as established actors venturing into activities outside of their normal area of expertise. Both governments and international organisations failed to ensure that funding was 'needs-based'. Imbalances, non-needs driven motivations (including supporting NGOs based in a donor's own country, regardless of whether they had any comparative advantage over other NGOs), poor end user traceability and inadequate monitoring were evident among official donor responses. Slow, overlapping, poorly shared and imprecise assessments were a constraint.

Some major donors by-passed United Nations (UN) mechanisms such as the UN Disaster Assessment and Coordination (UNDAC), by deploying their own assessments. Also, the allocation of funds was fairly evenly split between relief and recovery, which did not reflect the reality that recovery needs were by far the most important.

The limited number of organisations with the capacity to absorb the scale of funding available was a constraint, as was the lack of system-wide definitions and standards for reporting of funds.

Total funding for the tsunami response was over US \$7,100 for every affected person, which contrasts starkly with funding of only US\$3 per head actually spent on the flood affected population in Bangladesh in 2004. The current international appeals system delivers variable amounts of funding bearing little correlation with real needs on a global level. The lack of adherence to core funding principles almost three years after adoption of the Good Humanitarian Donorship (GHD)² principles is striking.

International relief capacity and quality

The tsunami response highlighted major weaknesses in international staff profiles, staff quality and continuity. Poaching of staff from national or local organisations can have mixed results, debilitating the contributions of those organisations to recovery, while perhaps strengthening international agency local capacity and developing the poached individuals. The engagement of international actors with local capacities was most effective and efficient when it was built on sustained partnerships with the local actors that existed before the disaster.

The appointment of a high profile Special Envoy for the response was seen as a positive step. Also, coordination showed a marked improvement in late 2005. However, three issues stood out: the proliferation of agencies made coordination more expensive and less effective, generous funding reduced organisations' need to coordinate, and the perceived need for quick, tangible, agency-specific results fuelled competition for visibility, beneficiaries and projects.

The military played a key role in the response. They will most likely, despite their high cost, continue to do so globally. There is

Evaluation

however, little joint planning and training between the military and traditional humanitarian actors and field coordination between both camps remains weak.

There was a profusion of assessments and most were conducted by agencies for their own needs and did not influence collective decision takers. Better national and local preparedness would have made a big difference. A single authoritative joint-assessment, at least between the UN, the Red Cross and authorities was sorely missing.

The recurrence of many of the problems seen in Rwanda and other emergency responses, and the failure of agencies to meet their formal commitments to, for example, SPHERE or GHD principles, suggest that the various quality initiatives are not having a sufficient impact.

Lack of information flow from the affected people to the donor population on the quality of the response means that there is little external pressure for improvement in the humanitarian system. A regulatory system is needed to oblige agencies to put the affected population at the centre of measures of agency effectiveness and to provide detailed and accurate information to the donor public and taxpayers on the outcomes of assistance, including the affected populations' views of that assistance.

Recommendations

There are four main recommendations emerging from the TEC evaluation. They are aimed primarily at international actors.

- i) The international humanitarian community needs a fundamental reorientation from supplying aid to supporting and facilitating communities' own relief and recovery priorities.
- ii) All actors should strive to increase their disaster response capacities and to improve the linkages and coherence between themselves and other actors in the international disaster response system, including those from the affected countries themselves.
- iii) The international relief system should establish an accreditation system to distinguish agencies that work to a professional standard in a particular sector.
- iv) All actors need to make the current funding system impartial, and more efficient, flexible, transparent and better aligned with principles of good donorship.

¹ All reports are available on the TEC website: www.tsunami-evaluation.org
² See online at <http://www.goodhumanitarianidonorship.org>



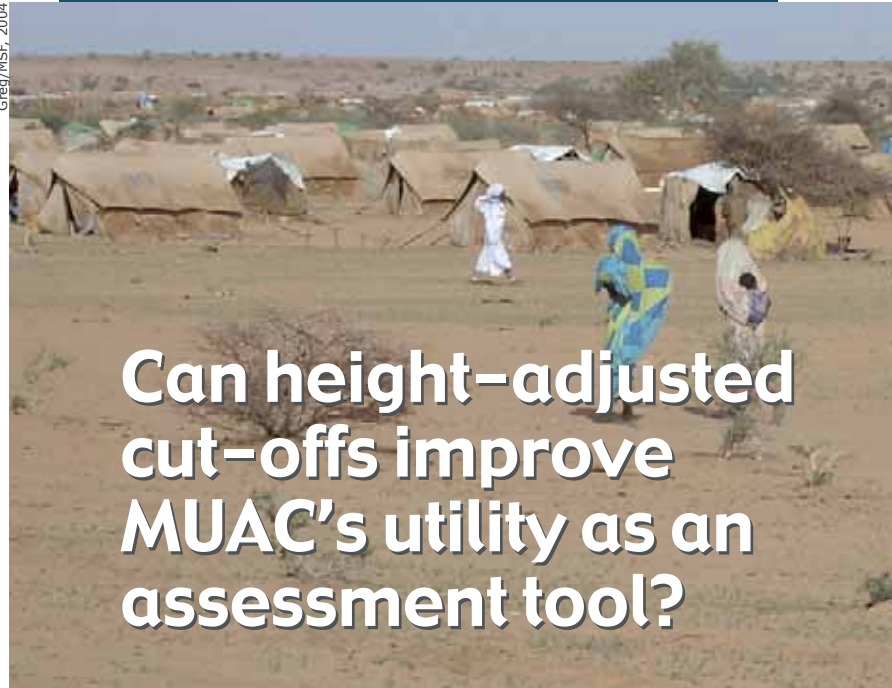
Replacement of boat engines and fishing nets lost in the tsunami, Sri Lanka

A woman making wire bags as part of an All India Disaster Mitigation Institute (AIDMI) Cash For Work Project

Sri Lanka, <http://www.tsunami-evaluation.org>

India, <http://www.tsunami-evaluation.org>

Greg/MSF, 2004



Can height-adjusted cut-offs improve MUAC's utility as an assessment tool?

By Michel Van Herp, An Verwulgen, Bérengère Leurquin, and Pascale Delchevalerie



Michael Ven Herp is a medical doctor and epidemiologist and has ten years field experience with MSF in South America and Africa. He is currently an epidemiologist in the medical department of MSF-B, involved in infectious diseases and surveys encompassing nutrition, mortality, access to health care, efficacy and compliance.



Bérengère Leurquin is a paediatric nurse and has 4 years field experience with MSF in Angola, South-Sudan, Afghanistan, Ivory-Coast. For the past two years she has she has worked as a nutrition advisor in the medical department of MSF-B.



An Verwulgen is a paediatric nurse, and has six and a half years field experience with MSF in Kenya, South Sudan, Angola, and Rwanda. She analysed the databases under the guidance of Michel Van Herp.



Pascale Delchevalerie is a paediatric nurse and epidemiologist. She has 10 years field experience with MSF in medical and nutritional programmes in Asia and Africa. For the past 2 and a half years, she has worked as a nutrition advisor in the medical department of MSF-B.

Thanks to the field teams who carried out the surveys and to Nancy Harris for her support in editing the text.

Anna Karin Sjöblom/MSF, Niger, 2005



Mother and child in TFC in Tanout, Niger



This field article looks at the relationship between MUAC and WH and finding that MUAC correlated most closely with W/H indices in shorter children, suggests the possibility of height specific MUAC cut-offs, distinguishing between assessment and screening.

While quick and convenient to use, Mid Upper Arm Circumference (MUAC) measurement has limitations in the assessment of malnutrition. In certain contexts, notably the Horn of Africa, MUAC sometimes underestimates the problem on an individual and global basis compared to other anthropometric indices. Médecins Sans Frontières (MSF) first noticed this in nutritional surveys in Ethiopia (Somali region)¹, where MUAC underestimated prevalence of malnutrition compared to weight for height (W/H) indicators. In Chad, a MUAC < 125 mm was used by home visitors to refer children for W/H measurements and consideration for admission to a feeding centre. However, after an anthropometric survey², calculation of the sensitivity of the 125 mm cut-off showed that 65.8 %, of all malnourished children and 42.9 % of severely malnourished were missed, as compared to W/H % of the median (WHM). With a cut-off of 135 mm, 32.9 % were still missed. These findings resulted in an adjustment of the screening strategy: the cut-off was increased to 145 mm, and W/H was calculated on the spot to exclude children who would not meet admission criteria in the feeding centre. Another example comes from Niger (2005), where rapid MUAC assessment was undertaken without other anthropometric indices being measured. The prevalence of malnutrition identified by this method was at odds with information from other sources, e.g. nutritional programmes reporting a significant increase in admissions, suggesting greater prevalence of malnutrition than that identified by MUAC assessment.

These findings raised questions about the validity of MUAC in rapid assessments (to estimate the nutritional status of populations) and as a screening tool (to select individuals requiring further assessment, e.g. W/H measurements, to determine eligibility for admission to nutritional programmes).

How were MUAC cut-offs in current use selected?

An Epicentre study of 64 nutritional surveys³ (n=34,933) showed that the MUAC mean increases with age: 132mm at 6 months (~ -1Z of the National Centre for Health Statistics (NCHS) reference of 143 mm), 148mm at 59 months (~ -1.5Z of the NCHS ref of 174 mm). It is therefore difficult to select a single cut-off for all children under 5 years of age.

An MSF-Holland analysis of five nutritional surveys⁴ (n=2,656) demonstrated a clear correlation between MUAC and W/H as expressed by Z-score (WHZ), with better correlation in populations with higher prevalence of acute malnutrition ($r = 0.65$ if $\geq 10\%$, $r = 0.57$ if $< 5\%$).

Single MUAC cut-offs of 125mm (global) and 110mm (severe) were proposed for all children under 5 years (regardless of ethnicity), and it was further suggested that these criteria could be used for quick assessment to assess the need for a survey. However, due to a significant number of false positives and negatives with MUAC, it was recommended that MUAC not be used as an entry criterion for nutritional rehabilitation programmes, but it could be used as the first stage of a two step screening process with a relatively higher cut-off (135mm). In 1994, a meeting of all MSF medical directors ratified these MUAC cut-offs for use in rapid assessments.

Finally, an Epicentre analysis of 114 nutritional surveys (December 2002; n=66,446) compared MUAC (< 125mm) to WHZ < -2 or < 80% WHM. Overall, MUAC overestimated malnutrition as compared to WHZ in 45% of the surveys, and underestimated malnutrition as compared to WHM in 8 %. In the analysis by age group, the under-estimation was greater in children ≥ 29 months and also in boys (13%) than girls (4%). Greater underestimation also occurred in higher prevalence contexts.

All of the above studies were based on one-time surveys. The effect of situational factors such as hunger gaps, epidemics, chronic malnutrition, etc., and the evolution of correlations between MUAC and other indices over time were not examined. Nor did these studies assess the possible effect of selection criteria age (6-59m) versus height (65-110cm) on outcomes. Our study provides a preliminary exploration of these factors.

Objectives and method

The objective of this study was to further analyse existing surveys, conducted in areas where MUAC underestimates malnutrition,

with the aim of assessing the relationship between MUAC and WH indices over time. A secondary research question arose from the finding that MUAC correlated most closely with W/H indices in shorter children, thus suggesting the possibility of height specific MUAC cut-offs.

Twelve databases of nutritional surveys (n = 10,226) were used for this analysis. The surveys were conducted in Denan/Ethiopia (6) between May 2000 and September 2001, Korma and Serif Umra/Darfur (4) in 2004/2005 and Tine and Iriba/Chad (2) in 2003/2004. The standard methodology of UNHCR/WFP/MSF was followed. Only children with a length/height between 65cm and 110cm were included. Data analysis was undertaken using the computer program EPI INFO 6, version 6.04d.

The cut-off point of W/H - 2 Z-score, or 80% of median, or oedema, was used to classify global acute malnutrition. Height for Age (H/A) - 2 Z-score or 90% of the median⁵ was used to determine global chronic malnutrition. MUAC was compared with global acute malnutrition expressed in W/H in % of median or oedema and Z scores⁶.

In the Chad and Korma surveys, no children with oedema were found. In the other surveys, the % of oedema was between 1.3 and 0.1, with a total of 37 oedema cases out of 10,226. These low numbers should not influence the results.

Findings

Overall, for the majority of the surveys (9/12), the under-estimation of MUAC prevalence compared to WHM prevalence was statistically significant. Malnutrition prevalence as per WHM varied from 23% to 41% for Denan, 8% to 13% for Sudan and from 12% to 18% for Chad.

¹ Nutritional surveys and retrospective mortality assessment, Denan, Ogaden, Ethiopia, MSF-Belgium. May 2000 to September 2001.

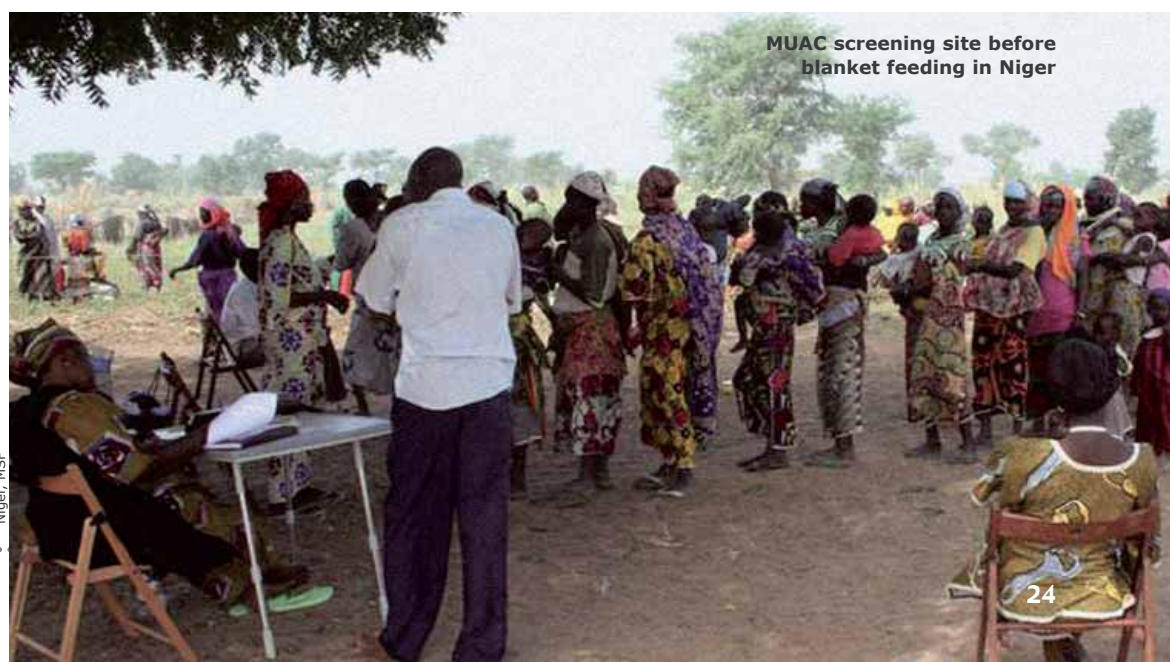
² Jeroen Beijnsberger, Michel Van Herp, Pascale Delchevalerie. Enquête Nutritionnelle, de Mortalité Rétrospective et de Sécurité Alimentaire, camps de réfugiés Soudanais de Touloum et Iridimi, région d'Iriba, Est-Tchad, Octobre 2004.

³ Manoncourt S, Coulombier D, Pécout B, Desvé G, Moren A (Epicentre, MSF- France), Comparaison des informations fournies par différents indicateurs de malnutrition aiguë calculés au cours de 64 enquêtes nutritionnelles réalisées auprès de populations en situation précaire, MSF Medical News, vol 3, N°2, May 1993.

⁴ Koert Ritmeijer, Arine Valstar, Austen Davis (MSF - Holland), 'Middle Upper Arm Circumference (MUAC): what are the uses and constraints at the field level; a meta analysis of MSF survey data', MSF Medical News, vol 3, N°2, May 1993.

⁵ Issues in the assessment of nutritional status using anthropometry. Bulletin of the WHO 1994; 72:273-83

⁶ A comparison with z scores was included in the beginning, however on further discussion and analysis, comparison was only done with % of the median that is typically used in the field.



MUAC screening site before blanket feeding in Niger



Height measurement in Ethiopia

Dieter Telemans



MUAC measurement in the Congo

MSF, 2004



Simplified QUAC stick in Niger

Anna Karin Sjöblom / MSF, 2005

The Denan curve was the most informative because it entailed the longest time series. Except for the first survey, the difference between prevalence in MUAC and W/H was statistically significant. The crude mortality rate (CMR) and under fives mortality rate (U5MR) was extremely high in the first survey, but returned to normal in the following ones (see Table 1 and Figure 1).

Influence of age or height

When the surveys were further analysed on the basis of age, it was noted that the discrepancy between MUAC and W/H occurs mainly in children above 2 years (see Figure 2). In Denan, the under five mortality was very high leading to under-representation of the 6-24 months age group in the sample (8-15 % instead than 33%), and, as a consequence, influencing underestimation of MUAC due to a greater preponderance of older children in the sample. The same phenomenon occurred to a lesser extent in the Darfur and Chad series ($\pm 20\%$ of 6-24 months).

As age assessment is often imprecise, children are usually selected on the basis of height, which serves as a proxy for age. Typically 65 – 110 cm represents children of 6 months to 5 years in age and 85cm represents age 24 months (this is also the cut-off point above which children are measured standing). However, in countries affected by chronic malnutrition, there will be a discrepancy between age and height. In the Denan series, with a cut-off of 85 cm, 27% of the children were declared to be above 24 months and 41% equal to 24 months (age rounding effect). With a cut-off at 80 cm, 12.5% were declared to be above 24 months and 42.5% equal to 24 months. In this context, with the second cut-off, fewer children > 24 months are included, while most children \leq 24 months are captured (see Figure 3 for exact numbers).

For the groups < 85cm and < 80 cm, MUAC underestimated malnutrition compared to W/H in the majority of the surveys (11/12) but the discrepancy was not statistically significant. In the < 80cm group, the MUAC prevalence curve lies closer to the WHM prevalence curve compared with the height group < 85cm. For the group of \geq 85 cm and \geq 80cm, the MUAC generally underestimated malnutrition compared to WH and in both groups, 10/12 surveys this difference was statistically significant.

These findings led us to consider whether assessment tools should be adapted to height, to achieve better sensitivity. Accordingly, malnutrition prevalence in different height groups was compared to different MUAC cut-offs to find the cut-off point that lies closest to the WHM, with results as follows:

- In areas of very high prevalence, e.g. Denan, (23.3 - 40.7 % WHM), the best cut-off was 125 or 126mm for children \leq 80 or 85cm, respectively, and 133 or 136mm for children > 80 or 85cm, respectively.
- In areas of high prevalence, e.g. Tine (18.1%), the closest cut-off was 127mm for height \leq 80cm and 137mm for height > 80cm.
- In areas of moderate prevalence, e.g. Iriba and Darfur (11-13%), the best cut off was 125-127mm for height \leq 80cm, 125-128 mm for \leq 85cm and 133-137mm for height > 80 or 133-138mm for height > 85cm.
- In areas of lower prevalence, e.g. Korma (8.3%), the best cut-off was 127mm for height \leq 80cm or 128mm for height \leq 85cm and 137mm for height > 80cm or 138mm for height > 85cm.

Thus there is an inverse relationship between MUAC cut-offs and prevalence of global acute malnutrition, with lower MUAC values in high prevalence areas.

However, the variation inside the same height group is small (125 to 128 mm for shorter children and 133 to 138 mm for taller ones). Therefore, in practice, we could use a single cut-off per height group.

Effect of chronic malnutrition

During the analysis of the 80 and 85 cm height groups, we explored the role of chronic malnutrition. The prevalence of chronic malnutrition (as defined by HAZ) was found to be high in all the surveys (for example, between 30 and 40% in the Denan series), with the highest overall (45.4%) in the second survey in Serif Umra.

In the Denan surveys, we examined H/A by height group and noticed that the prevalence of chronic malnutrition was higher in the group of children < 80cm (from 64.8 % to 80.2%) than in the group \geq 80cm (16.6% to 28%). This is in contrast to more common findings of increased prevalence with increasing age (highest in 24-36 months group) and may be linked to the measles outbreak that occurred in 2000.

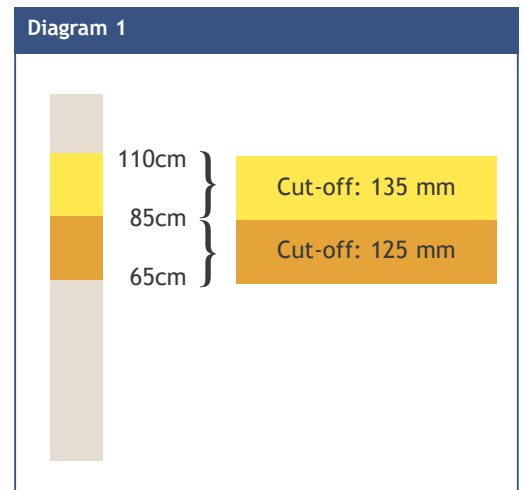
Conclusions and recommendations

It is clear that the use of a single MUAC cut-off, for all children 65 to 110 cm in height, may produce prevalence data in some contexts that correlates poorly with the prevalence of global acute malnutrition found using other anthropometric indices.

Using the MUAC with different cut-offs (see Diagram 1) represents one solution. However, deeper analysis of the context for each situation is also required. Since one cut-off point is not enough for the entire age range, we propose a 'simplified quack-stick', with different cut-offs for children \leq 85 cm and those > 85 cm. This cut-off should be shifted to 80 cm in areas where chronic malnutrition is high. Since we are often confronted by situations of moderate/high prevalence of malnutrition, the cut-offs of 125 mm and 135 mm were chosen.

The choice of cut-off point for MUAC will be determined by the objective of the enquiry: **assessment** versus **screening**.

In some contexts, before carrying out MUAC **assessment**, an estimate of prevalence by W/H measurement must be obtained. If this is not available from past surveys, a preliminary survey would be worthwhile to determine population adapted cut-offs. Lot Quality Assurance



⁷ A quack stick is an instrument currently available for measuring MUAC for height.

Sampling (LQAS)⁸ surveys with these MUAC cut-offs could ensue for further assessments or follow-up. In a case where only rapid MUAC assessment information is available, consideration should be given to basing operational decisions on the prevalence in shorter children (< 80-85cm) instead of up to 110 cm, as our studies suggest better correlation with other indices in this age group.

For **screening** purposes, a nutritional survey should be performed first, and adapted MUAC cut-offs then chosen, for use in subsequent screening. This choice should be based on the need to have sufficient sensitivity to capture the majority of malnourished children, while minimizing false positives (children who fail W/H entry criteria for nutrition programmes). Unnecessary referrals exact a high social cost for families (travel, family disruption etc) and discredit the screening team. Where we believe that social cost may be important, implementation of W/H measurement on the spot following MUAC screening, for selected children, will differentiate between those who do and those who do not meet admission criteria, and hence reduce this social cost.

For selection criteria to a Supplementary Feeding Programme (SFP), consideration should be given to utilising both MUAC and W/H (as they detect different physiopathological situations in a child) and to adapt entry criteria to MUAC < 125mm or WHM < 80%.

Considerations for future studies

In nutritional survey analysis:

- Consider stratifying analysis on the basis of height rather than reported age.
- Consider presenting graph of height distribution as well as age distribution. Age rounding may bias age distribution.
- MUAC measurements may be influenced by quality of technique. MUAC is quick and easy to measure but needs training and supervision to be precise. Presenting a graph of the MUAC distribution may help assess the quality of measurements, influencing the validity of findings.
- Calculate and present prevalence of chronic malnutrition (H/A).
- Interpretation of results should consider the role of context: mortality rates, past and present epidemics, population characteristics (nomads, refugees, internally displaced persons (IDPs)), seasonal variations or practices (hunger gap, Ramadan) etc.

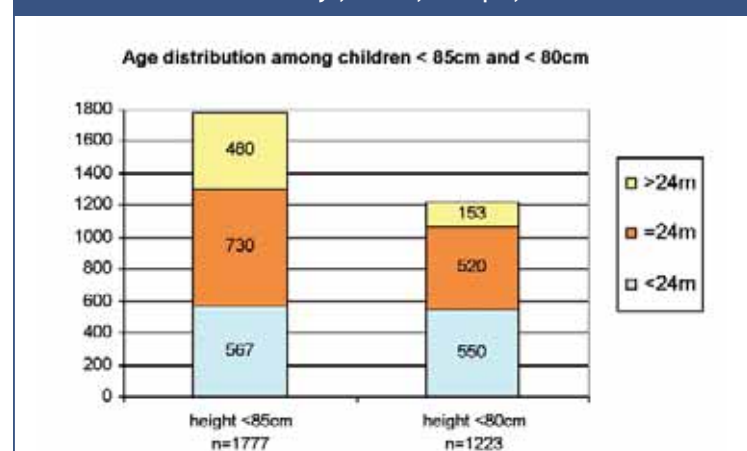
Further studies to explore these factors and their influence on malnutrition indices would be worthwhile. These investigations were done with the NCHS growth references. It would be interesting to repeat a similar analysis of the dataset with the new WHO growth standards to see if similar results are obtained. However, as the growth standards are only presented as Z-scores, they will need to be expressed as % of the median in order to allow comparison.

For further information, contact:

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⁸ Lot quality assurance sampling (LQAS) is a methodology that originated in the manufacturing industry and has been applied to health contexts, such as immunisation coverage. Sub-populations are divided into 'lots' and the sample size is the number of units that are selected from each lot. Before sampling, a decision must be made on the number of 'defective' items, e.g. children not immunised, that will deem a 'lot' unacceptable, which in turn will influence sample size. Since the response for each sample is binary, i.e. acceptable or non-acceptable, smaller samples are required compared to other survey methods. By combining information from different 'lots', the LQAS method offers a less conventional means of stratified sampling. (WHO/V&B/0126(2001))

Figure 3 Discordance between reported age and height in MSF-B nutritional surveys, Denan, Ethiopia, 2000-2001.



	Mortality		All children							
	CMR *	U5MR*	N ^c	W/H<-2 Z score or oedema	W/H < 80% or oedema	Muac <125	MUAC<125/WH<80% sens %	spec %	PPV	r _c MUAC/WHM
Denan			5286	42.4	32.6	19.6	46	93	0.76	0.47
05/00	27.5	8.9	765	52.9	40.7	37.0	73	87	0.79	0.58
08/00	1,2**	0,4**	897	43.7	33.8	23.1	51	91	0.75	0.49
10/00	0,27**	0,13**	914	40.8	31.3	15.5	36	94	0.72	0.43
02/01	0,25**	0,15**	906	37.2	27.2	13.0	31	94	0.64	0.29
04/01	0,25**	0,12**	902	51.2	40.5	20.7	43	94	0.84	0.41
09/01	0,27**	0,1**	902	30.0	23.3	10.8	34	96	0.74	0.55
Korma			1835	16.6	10.7	4.4	32	99	0.80	0.46
04/05	2.2	1.3	923	19.6	13.1	6.4	40	99	0.81	0.48
12/05	2.2	0.8	912	13.5	8.3	2.4	22	89	0.32	0.19
Serif Umra	1.8	0.8	1741	17.5	13.0	7.3	33	97	0.61	0.31
10/04	1.2	0.8	865	14.7	11.2	8.0	41	96	0.58	0.28
06/05	0.2	3	876	13.5	10.7	6.6	34	97	0.55	0.34
Tine	2.2	1.3	536	29.5	18.1	6.5	28	98	0.77	0.37
Iriba			828	19.6	12.2	7.7	40	97	0.63	0.38

* .. / 10.000 / day
 ** mortality data collected prospectively by Community Health Workers (CHWs) during a specific period

Figure 1 Comparison of malnutrition prevalence expressed in MUAC or W/H, MSF-B nutritional surveys, Denan, Ethiopia, 2000-2001

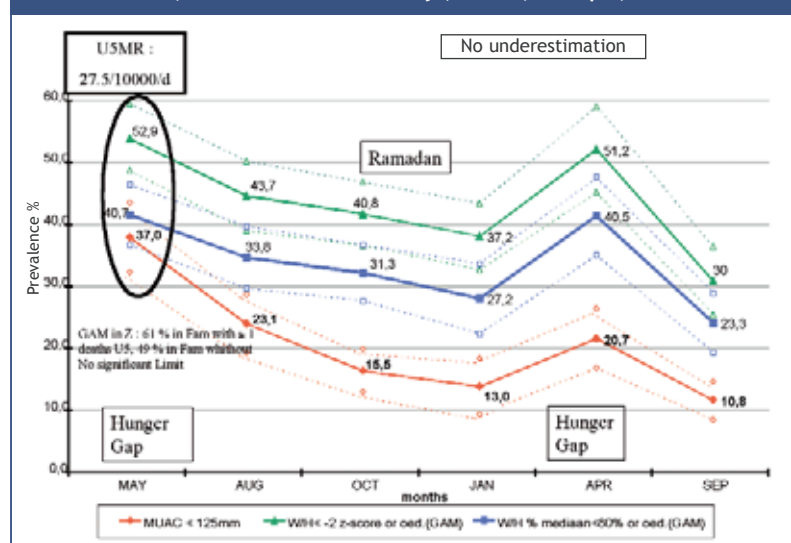
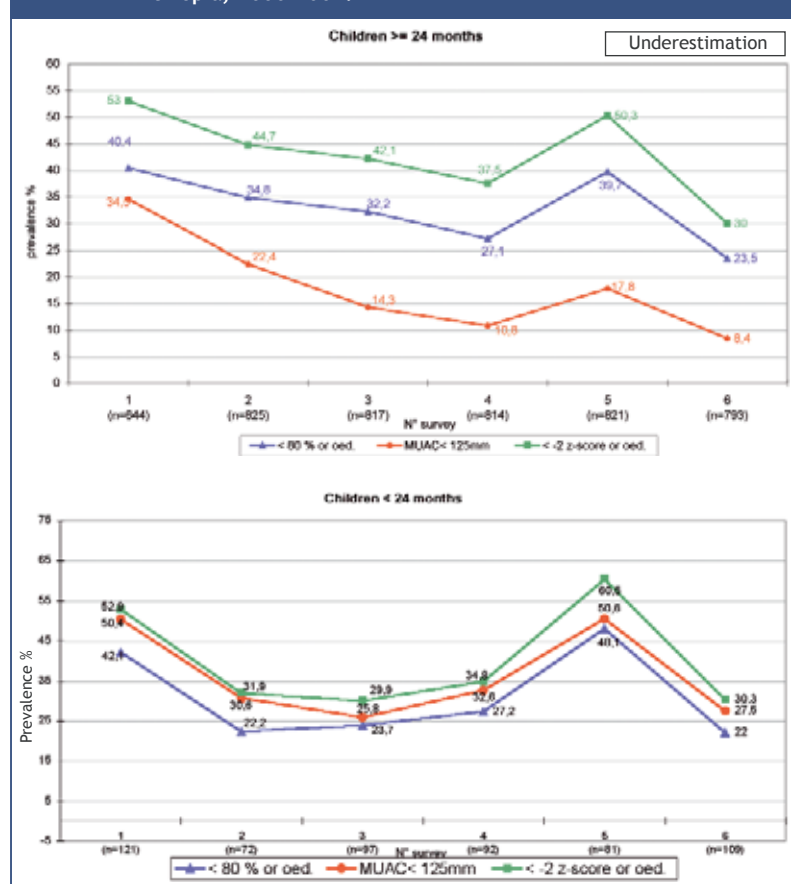


Figure 2 Comparison of MUAC < 125 mm, W/H < -2 Z score and W/H < 80% prevalence by age group, MSF-B nutritional surveys, Denan, Ethiopia, 2000-2001.



Agency Profile

Name:Save the Children Federation Incorporated (SC - USA)
Head office:54 Wilton Road Westport, CT 06880
Sub Head office:2000 M Street NW, Suite 500, Washington DC 20036
Telephone:Head office: (203) 221-4000 Sub Head office: (202) 293-4170
Internet site:www.savethechildren.org
Year formed:1932
President:Charles MacCormack
Overseas staff (no.):4950 national staff, 210 expatriate staff and 78 US programme staff (supporting programming based in the US)
HQ staff (no):393 (268 Westport based and 125 DC based)
Annual budget (2006): ..\$332,420,000 USD



Save the Children trained assistant of the commune health centre in Proi Village, Dr. Tran Thi Kim Lien, teaches Ho Thi Em how to wash her daughter Ho Van Chen's hands before eating.



Save the Children®

By Jeremy Shoham

The ENN interviewed Tobias Stillman from Save the Children USA (SC USA) for this issues agency profile slot. Tobias is a Nutrition Advisor within the Children in Emergencies and Crisis Hunger and Malnutrition team. Tobias started in this 'business' as a solidarity worker in Nicaragua and then took a degree in international health, focussing on medical and nutritional anthropology. This was followed by a Masters in Public Health at Johns Hopkins School of Public Health in Humanitarian Assistance. Overseas experiences include long-term assignments in Nicaragua, Mozambique, Zimbabwe, Western Tanzania, and Ghana, and shorter term assignments in places like Iraq and Haiti. Tobias joined SC USA in 2003.

The Children in Emergencies and Crisis Hunger and Malnutrition team consists of five health and nutrition experts, three livelihoods experts, and several commodity experts. Apart from Tobias, there are Food Security/Nutrition Advisors based in Uganda, Guatemala, and Mozambique (although they are still considered part of headquarters), one emergency health advisor, one emergency nutrition advisor, one livelihoods advisor and one agriculture advisor. There are also nutrition focussed technical staff in other SC USA departments who play a considerable role in both development and emergency nutrition programming.

Although Tobias hasn't been with SC USA that long, he provided a brief potted history of the organisation. SC USA was set up in 1932, thirteen years after the Save the Children Fund was set up in the UK (1919). SC USA initially focussed on domestic issues, with international work only really starting in 1940. Relationships between the different national Save the Children (SC) organisations became formalised in 1977 with the formation of the SC Alliance. Initial members of the Alliance were Canada, Denmark, UK and the US. This has expanded to 28 members, including some developing countries. Within the Alliance, members of all size collectively support the work of one another to achieve the common goal of helping children in need, in both development and emergency contexts.

There has been enormous effort in recent years to increase connectedness between the different Alliance members and to create a 'unified presence' within established programme countries. The Alliance is committed to having one Save the Children office per country, although it will take some time before this is achieved. The model is currently being rolled out in several 'learning' countries, including Myanmar,

Angola, and Tajikistan. Lessons learned in those countries will be applied to a broader roll out in the future.

Aligning different programme approaches, philosophies, and constituencies between Alliance members, however, has not always been easy. In recent years there has been a great deal of effort put into aligning emergency food security and nutrition programming – evolving collaboration between the US and the UK, in particular, has led to productive outcomes on all sides. Food security and nutrition advisors from SC USA and SC UK now meet regularly to discuss programme directions – and the organisations have developed joint position papers on areas of particular interest, including school feeding and food aid. All major emergency response activities are now conducted in a coordinated fashion as an Alliance.

Large scale emergency food programming was only episodically a element of SC USA's work up until the 2001 Ethiopian drought in Gode. In the past 4-5 years, SC USA continued expanding its work in emergency nutrition and food programmes, following the crisis in Darfur and emergencies in Aceh and Pakistan. SC USA's emergency nutrition portfolio has expanded considerably in recent years and their work now includes cash based programmes as a complement to general food distributions, the treatment of severe acute malnutrition (SAM) (through community therapeutic care (CTC)), infant and young child feeding in emergencies (IFE), and Supplementary Feeding Programmes (SFPs) that are usually part of CTC programming.

Resources available to the Hunger and Malnutrition Unit within Children and Emergencies and Crisis have increased by almost 1000 percent over the past seven years, with concomitant increase in emergency programming. SC USA is fully committed to emergency nutrition and food security responses carried out within the context of the Alliance. SC USA will respond to a major emergency, whether there is already a programme on the ground or not, if local coping capacity is insufficient to handle the need. However, many of the agencies' response activities take place in countries with established programme portfolios - SC USA has an extensive portfolio of developmentally oriented nutrition programmes in the most food insecure countries in the world. Tobias reflected that the considerable developmental portfolio and experience of SC USA in the nutrition sector serves them well for emergency programmes like CTC, where transitioning from emergency to longer-term programming is critical.

Tobias identified numerous lessons that have been learned through this recent rapid expansion in emergency nutrition programming. Key amongst these has been the difficulty of ensuring quality programming when moving into new

programme areas and/or scaling up. In particular, some of the work with severe acute malnutrition has been challenging.

The experience of shifting from TFC to CTC in Ethiopia in 2002/03 has been very influential. In particular, there was a lot of learning in transitioning from centre-based to community-based care, and then in identifying appropriate mechanisms for transitioning out following the crisis. Their early CTC work in Sudan also provided lessons where, with hindsight, Tobias believes SC USA could have been more open to collaboration with other agencies in addressing the various facets of CTC. As the agencies portfolio continues to expand, they have become more adept at both implementation and at saying no: "In some cases it may be better for the agency to let go, say no and let other agencies take responsibility. While General Food Distributions are pretty straightforward for SC USA and we are set up institutionally to implement such programmes rapidly, we have become more careful about rushing in to do more direct nutrition interventions like CTC".

SC USA has ongoing emergency CTC programmes in eight districts in Ethiopia, in West Darfur Sudan, and in two Districts in Malawi. The agency has pilot programmes looking at Community-based Management of Acute Malnutrition in developmental and transitional contexts in Malawi and Ethiopia (targeting those who are HIV+), in Bangladesh and Pakistan, and will have additional pilots in Haiti and Mozambique within the next few months.

In terms of the future, SC USA is in the midst of a strategic planning process that will guide further investments and programme directions. Strategies that are taking shape are the need to be as good at emergency work as development work, increasing focus on newborn and child health in emergencies, and the treatment of acute malnutrition – in particular establishing strong infrastructure for moving from development to emergency treatment of SAM.

Our last topic of discussion was about SC USA funding. With regard to nutrition, most development resources come from USAID's Office of Food For Peace, while emergency resources come largely from USAID's Office for Disaster Assistance (OFDA) and WFP. However, this is slowly changing and there is a growing private funding base including private foundations. Tobias concluded that diversification of funding sources can only be a good thing for SC USA in terms of giving them greater programming flexibility.

It is impossible for the ENN not to reflect on the fact that there have been very few agencies out of the 30 interviewed as part of the Field Exchange agency profile slot over the past ten years that have not raised the issue of independence of action and constraints faced through the pursuit of funding.

People in aid



ENN, 2007

Oleg O Bilukha (CDC), Flora Sibanda Mulder (UNICEF), Carmel Dolan (NutritionWorks)



ENN, 2007

Tina Van Den Briel (WFP) with Mesfin Teklu and Colleen Emary (World Vision)



ENN, 2007

Swewangazaw Lule(left), his brother and his brothers' two children. Shewangazaw was Jeremy Shoham's WFP counterpart during a mid term evaluation of the PRRO in Ethiopia. He is now working with Sc Indonesia.



ENN, 2007

Lida Lhotska (IBFAN-GIFA), Ali Macclaine (Ind/ENN), David Clark (UNICEF), attending the UNSCN meeting in Rome, February, 2007.



ENN, 2007

Carol Williams (CIHD, London) and Rebecca Norton (Fondation Tdh), attending the UNSCN meeting in Rome, February, 2007.

People in aid



J Shoham/ENN, Ethiopia, 2006

Villagers gathering for group photo in highland area of Arbe Menche in SNNPR

Breakfast at lake Arwassa



J Shoham/ENN, Ethiopia, 2006



J Shoham/ENN, Ethiopia, 2006

Productive Safety Net Programme beneficiary, being interviewed in WFP vehicle near Harar in Dire Dawa.



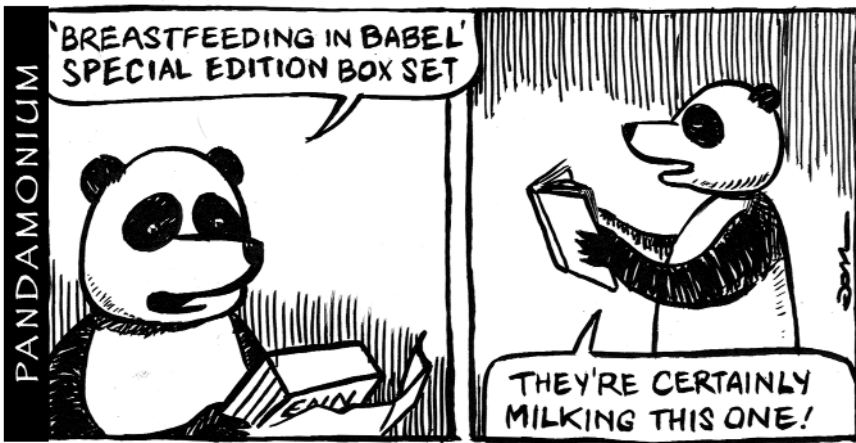
J Shoham/ENN, Ethiopia, 2006

Engineering workshop for apprentices at Salem orphanage in Addis Ababa

Shawangazaw Lule and WFP driver at Lake Arwassa with Malibou stork in background



J Shoham/ENN, Ethiopia, 2006



Field Exchange

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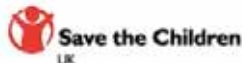
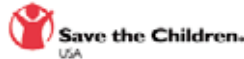
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On the cover

Refugee children in East Chad,
Dafur.
Dafur, MSF, 2005



Field Exchange
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Correction

In the field article on infant feeding experiences from Lebanon and Indonesia in Field Exchange 29, two of the Code violation articles cited are incorrect. The corrected articles are highlighted in the extract below:

P3, Box 1
By NGOs:

- In Lebanon, one INGO distributed 'baby kits' including formula and bottles to hospitals, municipalities and directly to IDP households....(Untargeted distribution is a violation of Code Article 6.6 and Ops Guidance 6.4.1 and 6.4.3).
- Many health workers distributed single tins or samples of formula milk to mothers (Violation of Code Article 7.4).

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 tri-annual publication, 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 publication are food and nutrition workers involved in emergencies and those researching this area. The reporting and exchange of field level experiences is central to ENN activities.

The Team



Jeremy Shoham (Field Exchange technical editor) and Marie McGrath (Field Exchange production/assistant editor) are both ENN directors.



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