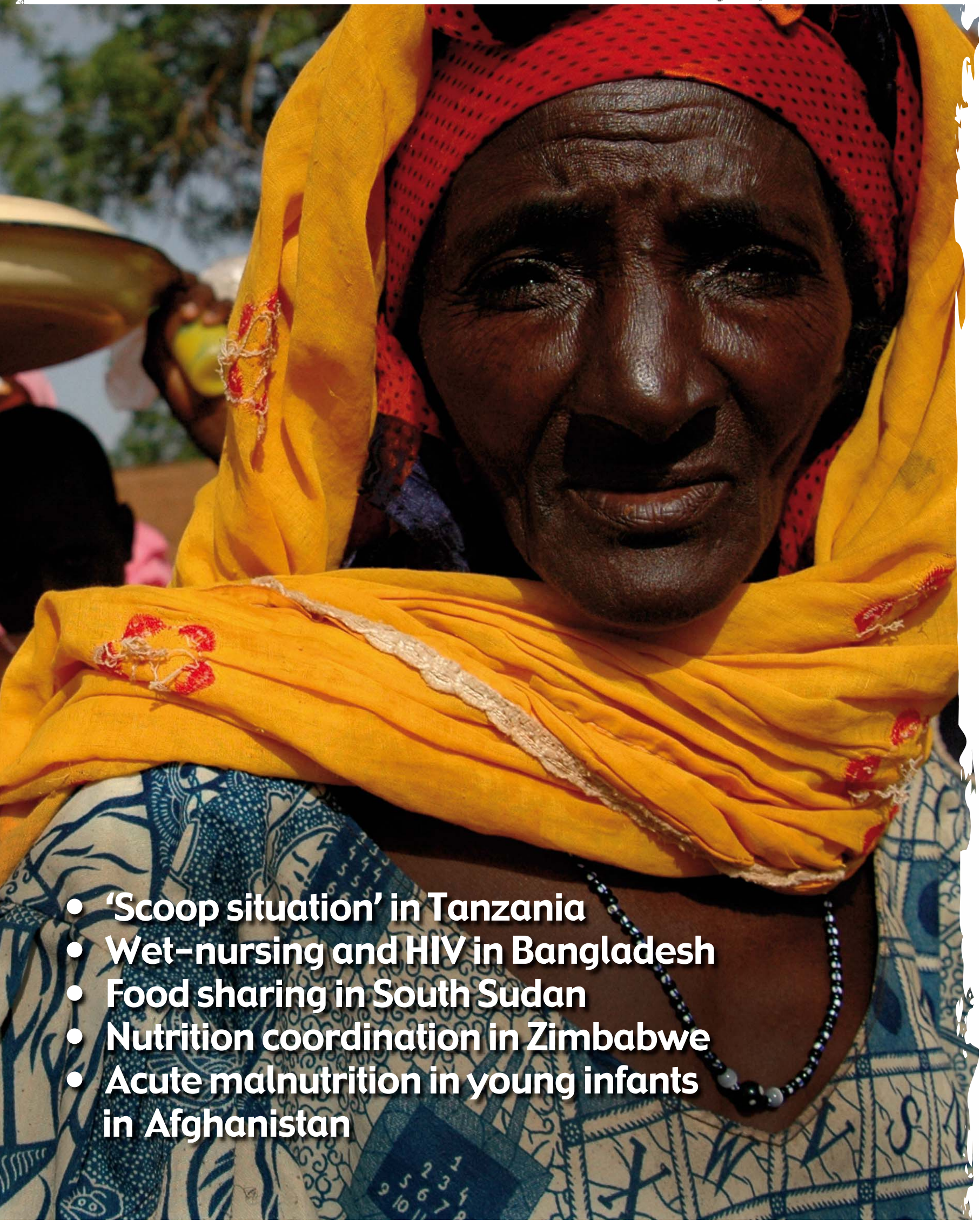


Field Exchange

Emergency Nutrition Network



- **‘Scoop situation’ in Tanzania**
- **Wet-nursing and HIV in Bangladesh**
- **Food sharing in South Sudan**
- **Nutrition coordination in Zimbabwe**
- **Acute malnutrition in young infants in Afghanistan**

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The devil is in the detail

In this edition of Field Exchange we have a number of field articles that address very detailed programming issues.

A field article by ACF deals with the experience of implementing the supplementary sucking technique (SST) for the many infants under six months presenting at therapeutic feeding units in Kabul, Afghanistan. Although the technique appears to lead to good outcomes when correctly applied, there were many instances where the SST was not well implemented. For example, many infants were considered cured when still mixed feeding and even where infants were discharged on breastmilk alone, mothers often reverted to mixed feeding at home. Unit staff found the admission criteria vague and difficult to apply, and were also confused by the treatment protocols and discharge criteria. Many of the infants presented with breastfeeding difficulties but were not severely malnourished. The author’s frank evaluation of their programming has led them to question whether the admission criteria used in the Kabul context were the best ones and whether the risks of managing young infants, who need skilled support but may not specifically need to be in these intensive care centres, outweighs the benefits.

Another field article by Yara Sfeir of UNHCR, describes the challenges of feeding a small number of infant orphans amongst Rohingya refugees in a camp in Bangladesh. Befitting the local context, it was decided to locate wet nurses for these infants. However, locating wet nurses was not straightforward, even though there were only five orphans. Eventually, wet nurses were found in the wider community, i.e. not just amongst relatives. Even then, a number of practical problems emerged, for example one husband didn’t want his wife to breastfeed another person’s child while one wet-nurse found it difficult to come to the centre to feed eight times a day as she lived some distance from there. There were also security issues about attending the centre at certain times. All these challenges were eventually met through ‘creative’ adaptation and according to the author, were well worth the effort.

An article by Chloe Angood from Southampton University describes the problems of using scoops provided with Nutriset F75/F100 therapeutic milk formula. Through her work in a paediatric ward in Tanzania where mortality rates amongst severely malnourished children were very high, she observed a number of difficulties in using the Nutriset scoops. These included over-feeding children, nurses finding it difficult to calculate the correct recipe for different feed volumes, miscounting of scoops and the difficulty of making up individual feeds for each child. A number of practical recommendations are made by the author to address these problems. Nutriset have written a post-script addressing some of these issues.

These articles remind us that although we may think our programme approaches and implementation tools are the right ones,

reality on the ground may, at times, cause us to re-assess how we do things.

Approaches cannot just be devised and implemented from ‘on-high’. We need to hold the old mantra about ‘bottoms-up’ programming at the forefront of our thinking. In other words, not only is the devil in the detail, but so is the answer. We also have our usual ‘bigger picture’ material in this issue of Field Exchange. There is a particularly interesting field article about nutrition sector coordination in the current Zimbabwe crisis, written by Dianne Stevens from UNICEF Zimbabwe. The article describes how UNICEF and partners have gradually plugged the coordination vacuum in Zimbabwe through establishing a Nutrition Technical Consultative Group (NTCG) that nominally focuses on consultation and best practice, but in effect has become a coordination mechanism that is accepted by government. Achievements of the NTCG to date, especially given the challenging programming environment, are considerable. These include greatly expanding reliable data to inform programming and mapping activities in the nutrition, water and health sector thereby strengthening inter-sectoral coordination.

We know from recent history how important it is to get humanitarian co-ordination right and what happens when we don’t. Coordination is essential for strategic planning, gathering data and managing information, mobilising resources, ensuring accountability, having a clear division of labour and providing leadership. The work of the IASC global cluster (see Field Exchange issue 31 news section) is making striking headway in strengthening country level coordination across a range of sectors including nutrition. As highlighted by Dianne Stevens, while the cluster approach has not yet been officially activated in Zimbabwe, the approach has been collectively endorsed at a Workshop on Humanitarian Reform in June 2007, and endorsed by the IASC Country Team.

This issue of Field Exchange also contains a wide range of research, evaluation and news pieces. Research topics include summaries of papers on the development of the WHO growth reference for school-aged children and adolescents, and on livelihoods-based drought responses in pastoralist areas of Ethiopia. There are also summaries of a real-time evaluation of the response to the Pakistan floods in 2007 and of a retrospective evaluation of the targeted supplementary feeding component of WFPs protracted relief and rehabilitation programme (PRRO) in Ethiopia from 2005 onwards.

We hope you enjoy this issue of Field Exchange and, as always, please feel free to write in with contributions and opinions.

Jeremy Shoham
Editor

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



A health centre in Zimbabwe

Nutrition coordination in Zimbabwe: Achievements and Challenges



**By Dianne Stevens,
UNICEF Zimbabwe**

Dianne Stevens is the Nutrition Manager with UNICEF in Zimbabwe. She chairs the Nutrition Technical Consultative Group responsible for nutrition coordination in Zimbabwe. Dianne has 10 years experience in working in emergencies both with NGOs and the UN and has been with UNICEF in Zimbabwe since 2004.

Over the past several years, Zimbabwe has experienced political and economic upheaval resulting in rampant inflation, drought, unemployment, food shortages and general deterioration across multiple sectors. Combined they have the potential to create a nutritional crisis.

In 2004 there was a vacuum in the coordination of nutrition activities in Zimbabwe. However, through a process of negotiation, UNICEF was given permission to establish the Nutrition Technical Consultative Group (NTCG) with a focus on consultation and sharing of best practice rather than coordination. Since August 2004 the NTCG, chaired by UNICEF, has been meeting monthly and is increasingly accepted by Government as the United Nations (UN) nutrition coordination mechanism. Over the past year there has been wide consultation in Zimbabwe on moving towards cluster coordination. The cluster approach has not yet been officially activated in Zimbabwe. However, the approach has been collectively endorsed at a Workshop on Humanitarian Reform in June 2007 and by the IASC Country Team. The next steps are for the IASC Country Team to make a formal submission to the Emergency Relief Coordinator.

This article highlights some of the challenges and successes to date of the UN-led nutrition coordination mechanism in Zimbabwe.

Challenges

Coordination and Leadership

There are differing perspectives on the human-

itarian situation, particularly between Government and the international community, leading to debates about whether Zimbabwe's situation is an emergency. As a result, the UN has had to be flexible in its humanitarian programming in order to address needs. Furthermore, although Government has nominally been in charge of coordinating emergency nutrition interventions, it has not played an active role in this. The NTCG was formed initially with an information-sharing mandate but also took on a 'low profile' coordination role. Through advocacy, negotiation and diplomacy, the benefits of having a coordination mechanism are now recognised by Government (although it is technically not a member, it does now send a representative to some meetings.)

Since 2004, UNICEF in its role of chair of the NTCG has effectively acted as a broker between the Government and the non-governmental organisation (NGO) nutrition community. NGOs had not been permitted to conduct nutrition surveys or establish therapeutic feeding programmes in isolation of government. Through this role, more NGOs are becoming involved in support to both nutrition surveillance and Community Therapeutic Care (CTC).

Thresholds and Supplementary Feeding

Government has its own established protocols for the treatment of acute malnutrition that are not entirely in accordance with international protocols. For example, the Government has a threshold of responding when acute malnutrition is above 7% - the national policy on supplementary feeding dictates that all supplementary feeding is blanket wet feeding of all children under five years, in geographical areas identified with high acute malnutrition. With global thinking on emergency thresholds shifting, and with trend analysis indicating a deteriorating situation with regard to acute malnutrition, partners are willing to intervene using the national threshold of 7%. However, international agencies are generally not supportive of the delivery mechanisms in the national

supplementary feeding policy. Evaluation of the large-scale, blanket wet supplementary feeding programme (SFP) in 2003 was not positive in terms of resources and opportunity cost. Zimbabwe has therefore been facing a dilemma in 2007 as acute malnutrition levels are approaching 7% and in some districts are above national thresholds and may deteriorate further. The NTCG is coming together on developing a common position on supplementary feeding and working towards solutions that can be negotiated with Government.

Capacity and data

Due to the limited capacity of the Government health system, their ability to monitor the impact of emergency nutrition programmes is challenging, especially as there are more than 60 Ministry of Health and Child Welfare (MoHCW) hospital based therapeutic feeding sites across the country. It is therefore difficult to establish the actual numbers of admissions, performance of therapeutic feeding sites, types of support required, commodity needs and sites that require external support. Much of the contingency planning is therefore based on weak data.



Mothers and children at a health centre in Zimbabwe

The economy

Hyperinflation of more than 15,000% makes the logistics of programming very difficult. The unavailability of cash and fuel is particularly problematic. Local NGOs often find it difficult to get into the field and staff salaries are eroded affecting morale and turnover. Through the coordination mechanisms, the UN is supporting NGOs through payment in USD (United States dollar) or USD equivalent, providing fuel to implementing partners and disbursing funds in ZWD (Zimbabwe dollar) based on timing of the activity rather than in large lump sums.

Donors

There is a difficult donor and funding environment in Zimbabwe involving restrictive conditions on funding. Support is provided mainly to humanitarian interventions and there is restriction on support to government interventions. This poses challenges when emergency nutrition interventions are primarily the domain of the government. It has therefore been very difficult to attract support to treat malnutrition in the context of HIV/AIDS although donor advocacy and linking malnutrition to HIV proposals has resulted in some success in attracting funding.

Brain drain

Zimbabwe has a strong nutrition infrastructure with tertiary training in nutrition and also provincial and district level nutritionist positions within the MoHCW. However, the 'brain drain' over the past several years has meant that many of these positions are now vacant or are filled by new graduates with limited experience. Because of this there is a diminishing capacity to implement quality nutrition programmes, including the treatment of severe malnutrition. UNICEF has been providing support to the National Nutrition Unit in the establishment of community based nutrition programming, including CTC, to alleviate the strain on the health services. Some NGOs provide nutrition support to health clinics. However, since historically the MoHCW has had good capacity, few NGOs have been involved. UNICEF through the NTCG has been working to improve government and NGO collaboration.

Addressing chronic nutritional problems

Nutrition trend analysis in Zimbabwe has shown increasing levels of chronic malnutrition and the Demographic and Health Survey (DHS) of 2005/6 found national levels of stunting of 29%. Addressing chronic malnutrition requires an integrated response including food

security, care practices, health aspects of malnutrition and water and sanitation. However, Zimbabwe does not have a National Nutrition Policy in which to frame these interventions. A 2005/6 nutrition intervention mapping exercise found that the focus of NGO nutritional activities is on food security with few working on the health and care components of malnutrition. In 2007 the NTCG emphasised capacity development of its members and a number of trainings were conducted to broaden nutrition skills. Plans are in place to develop a National Nutrition Policy and the NTCG will be included in the consultation process.

Key Achievements

Greatly expanded reliable data

Given the reluctance of the MoHCW to allow nutrition surveys, few have been conducted since 2003 to inform programming. In 2004, UNICEF started supporting the Food and Nutrition Council to establish a National Food and Nutrition Sentinel Site Surveillance System (FNSSS). The system now collects data biannually in 23 sites but is flexible and can be expanded to respond to worrying trends. This occurred following the June 2007 assessment and has resulted in the October assessment covering 60 rural districts and selected urban sites. Through the FNSSS the country now has access to timely nutrition data to inform programming. The NTCG has facilitated NGO involvement in the FNSSS in their areas of operation and NGOs are encouraged to participate in the FNSSS rather than conduct their own surveys.

The NTCG has undertaken an intervention mapping exercise for the Nutrition Sector. The 2005/6 Who-What-Where Atlas has been developed to serve as a planning tool for improved coordination in nutrition. Continued mapping is planned on an annual basis to determine the response capacity of the sector and identify key players for specific activities. In June 2007 the second Nutrition Atlas was published which is part of a broader initiative that includes intervention mapping for child protection (Orphans and Vulnerable Children (OVC)) and water and sanitation. Mapping exercises include already implemented activities as well as planned activities, in order to further strengthen coordination. Data collection tools are standardised to promote recognition and participation among partners.

Creation of the NTCG

The NTCG has acted as a forum for presenting,

sharing and discussing best practice in nutrition and HIV – an emerging area where new findings and guidelines regularly enter the public domain. The NTCG has opened its membership to include agencies working in HIV.

The NTCG has maintained a degree of emergency preparedness for Zimbabwe with coordination mechanisms in place for a scaled up response if needed. The Group meets monthly and is active in emergency preparedness activities including contingency planning and capacity development.

Currently, many non-specialists are working in the nutrition sector as well as members of the NTCG. Based on findings from the Nutrition Atlas and from a training needs assessment done with members of the NTCG, a training programme was conducted in 2007 with an emphasis on nutrition education for people living with HIV/AIDS (PLWHA).

Cluster approach

There has been considerable consultation around Zimbabwe becoming a global cluster. Several workshops on UN humanitarian reform, and specifically on cluster coordination and what it means for Zimbabwe, have been conducted. Deliberations from these meetings and workshops are always fed back to the NTCG. The Group is in the process of discussing possible implications for nutrition coordination so that all members are fully aware and have participated in the process.

Coordination

The 'Atlas' intervention mapping exercise, which describes who is doing what and where in the nutrition, water and sanitation and OVC sectors, has been a successful initiative to link coordination between the sectors. There is strong representation of different sectors in each of the coordination meetings along with strong informal linkages.

Conclusions

Zimbabwe's complex and colliding problems present enormous challenges to the nutrition sector. However, greatly improved coordination and reliable and current data have created the foundation for effective interventions. As the need in Zimbabwe grows, it is vital this coordination is maintained and donor support is broadened.

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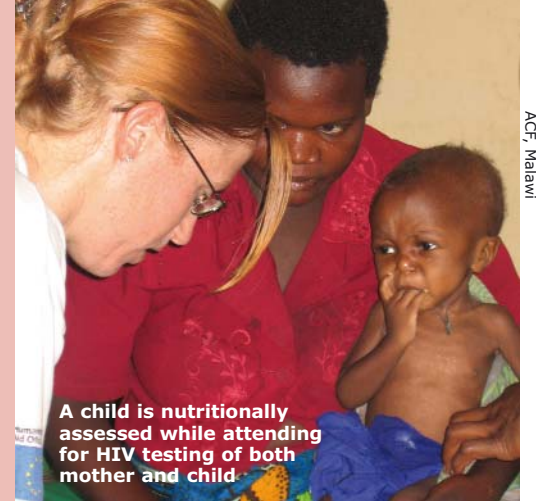
A focus group discussion in Zimbabwe

Review of targeting methods in HIV programmes

By Josh Colston



Josh Colston studies demography and public health at the London School of Hygiene and Tropical Medicine. In the past he has worked as lecturer in British culture at the China University of Geosciences in Beijing, for a health and development NGO in India and as operations intern at Action Against Hunger UK.



A child is nutritionally assessed while attending for HIV testing of both mother and child.

Action Against Hunger (ACF) recently conducted a review of methods of targeting within HIV programmes. The review is intended to facilitate wider discussion. It is based on the premise that there is currently little agreement regarding criteria to be used to determine a person's eligibility for assistance when mainstreaming HIV/AIDS into food security programming. Four types of targeting approach are identified and discussed.

Targeting based on HIV status (Direct targeting)

Arguments against this approach include the fact that HIV positive status does not automatically denote food insecurity or vulnerability. Conversely, many who are vulnerable or food insecure are not HIV positive. Also, many who are HIV positive are unaware of their status and when testing services are available, refuse these services for fear of the stigma attached. Furthermore, in societies where stigma prevails, singling people out for assistance may cancel out the benefits of inclusion in a programme or lead to increased social disharmony.

There are, however, some advantages to such an approach. It is relatively unambiguous with little room for misinterpretation or exploitation by beneficiaries. Furthermore, it may encourage people to find out and be open about their status and therefore help tackle stigma head on.

From ACF's perspective, the main problem with the approach is that by the time a person is diagnosed with HIV, it's likely to be fairly late on in the disease's progression. An effective targeting tool should be able to select households which are vulnerable to the effects of the pandemic before they get to this late stage. Ideally, targeting should be 'predictive' so as to include households of people who may have been infected with HIV but are as yet unaware, and those of people who are not yet infected but whose circumstances put them at high risk of infection.

Targeting based on proxy indicators and livelihoods (Indirect targeting)

The rationale here is that, because of the strong interconnection between food insecurity and the disease, certain types of household are vulnerable to the effects of both (e.g. households affected by death due to chronic illness, child-, female-, or older person-headed households, etc). This realisation has led many organisations to move their focus away from HIV sero-status towards broader vulnerabilities. This leads to selection of a large section of the population. Agencies like the World Food Programme (WFP) target their HIV/AIDS assistance on the basis of food security status, although they will select geographic areas where prevalence of HIV/AIDS is high. WFP

targeting aims to catch families before they become destitute and thus even more vulnerable to the risk of infection.

Proxy indicators can, however, be misunderstood or manipulated. One study found that in Malawi, households described as female-headed had an active male of about the same age as the household head. In addition, many people described as orphans were in fact the children of broken marriages rather than the children of dead parents.

Participatory approaches to targeting

This approach involves the community in targeting and may be implemented to create greater transparency and accountability to beneficiaries. One ACF project used this approach in Kasungu district in Malawi in 2005/6. Here, existing health committees were recruited with other community members to form a selection committee and to make a list of households that fitted certain selection criteria. They were told to include households that found it hard to undertake casual labour as they did not have an adult male fit enough to work. The explicit aim was to assist those households that were vulnerable with respect to food security, not solely those affected by HIV/AIDS. Evaluation of the project found that only 14.5% of non-beneficiaries thought the selection process was unfair.

One problem with the community based approach is that committees could be tempted to discriminate against those who they suspect of being HIV positive or there may be other vested interests in other regards where some are favoured over others.

There may also be cultural resistance to ideas like gradations of poverty and asking people to distinguish between the poor and very poor might meet opposition.

Poverty, dependency and resilience

HIV affects productive members of households more than dependents. ACF Malawi devised a discriminating version of the dependency ratio, the 'food-labour ratio' in order to target resources (see Field Exchange issue 25¹). The theoretical daily food energy requirements were summed for all members of the household and divided by its labour force with sliding contribution from older family members. This method required extensive interviewing to determine the age and sex of each member of a household. Assets also determine resilience to shocks like HIV/AIDS so in Malawi households were given asset scores, which represented the total value of their assets divided by the number of members. For each household, this second score was subtracted from the food labour score plus ten. Households were then targeted based on their final score.

Evaluation of the method concluded that while the methodology did succeed in selecting a higher proportion of highly dependent and poor families than present in the baseline population, this extra precision was not enough to justify the considerable effort in interviewing and data processing.

Conclusions

It is necessary to distinguish between responding to HIV/AIDS (the clinical symptoms that affect an individual) and responding to the effects of HIV/AIDS at household or community level (e.g. money spent on household health care, decrease in household income, etc). In the case of the former, HIV status would be the appropriate targeting criteria with the intervention geared towards nutritional support of individuals, while for the latter, targeting criteria should make reference to the households resilience as outlined above. In other words, if a household were to suffer the effects of HIV/AIDS, how resilient would they be to these effects? The intervention would be more food security than nutrition focussed.

There is a need to take into account the changing level of vulnerability of the HIV-infected and affected. Vulnerabilities increase as the disease progresses but the rate at which it increases depends on various other factors. Where standards of HIV services and access to a holistic package of care are high, the level of vulnerability will be more stable. Where this is not the case, it becomes even more important to identify vulnerable people as early as possible, before the subsequent sudden increase in vulnerability.

The distinction between those who are HIV positive, aware of their status and showing symptoms of the disease and those who are just at risk, whether actually infected or not, is useful because the needs of the two groups are different and the former group can, in principle be targeted (using sero-status with all the problems entailed). To reach people as early as possible in the disease progression, then the targeting tool needs to have some concept of level of risk built into it, i.e. an individual's vulnerability to HIV infection (based on a questionnaire about lifestyle, work, sexual health awareness, etc) and assign to them a score based on this. This score could then be totalled for the household in which they live and balanced against that household's level of resilience to the potential effects of HIV/AIDS. This approach would, however, be extremely labour intensive and rely rather too heavily on the veracity of individual testimony.

For further information, contact: Josh Colston, ACF, email: joshcolston@googlemail.com

¹ Field Exchange 25. May 2005. Targeting vulnerable households within the context of HIV/AIDS in Malawi. p46-p47



ACF Malawi

MUAC measurement in Malawi

An investigation of anthropometric training by NGOs

By Naomi Tilley



Naomi has just completed her MSc in Public Health Nutrition at the LSHTM. A qualified nurse, she has previously worked with MSF in Ethiopia and Sudan.

A recent cross-sectional study reported in *Field Exchange*¹ investigated weighing scales used in emergency nutrition programmes specifically for infants less than six months old. The purpose of the study was to see which type of scale was used in emergency nutrition programmes and the type of scale that would be most appropriate. In response to the deficiencies identified, the University of Southampton is developing weighing scales for field conditions suitable for children 0-5 years. While this will improve capacity to assess young infants accurately and precisely, this outcome will also depend on the competency of the measurer. If the staff that are undertaking the anthropometric measurements have limited training and standardization, the measurement error could continue to be significant.

The aim of this project² was to investigate anthropometric measurement training in nutrition programmes. The main objectives were:

- To investigate the level, depth and frequency of training provided by a sample of non-governmental organizations (NGOs) in weight, height and mid upper arm circumference (MUAC) measurement for staff in emergency nutrition programmes.
- To analyse and evaluate the anthropometric measurement training guides and methods used by a sample of NGOs.
- To explore methods of standardising training for field staff in emergency nutrition programmes.

Methodology

A literature review was undertaken to look at anthropometric measurement error, training and standardisation methods that have been employed in emergency nutrition programmes. Staff and students at LSHTM who had previously worked for a NGO in a nutritional intervention capacity were solicited to be involved in the study and recruitment emails were targeted at international NGOs and to contacts supplied by the Emergency Nutrition Network (ENN). Both self-administered and interview-administered questionnaires were used.

Research

Participants were split into three categories:

- National nursing or nutritional staff working within a nutrition programme.
- Nursing or nutritional supervisors (national or expatriate) working within a nutritional programme.
- Nutritional or medical coordinators or advisors to the nutrition programmes

One questionnaire was devised for each of the three categories of interviewee. The questionnaire was pilot tested by five individuals with experience in nutritional interventions.

Fourteen nutrition and anthropometric measurement manuals were tested for:

- Readability
- Clarity of instructions/explanation
- Clarity and depth of diagrams

The Flesch/Flesch-Kincaid Readability Tests were used to measure how difficult a passage of text was to read and what level of education would be needed to comprehend the text (American grading converted to age in years) Clarity of instruction was assessed according to defined criteria and scored (1-3). Diagrams were also scored 1 (clear diagram present), 2 (diagram present) and 3 (no diagram).

Participants

Thirty-two individuals participated in the study (91% response rate). Countries represented included Somalia, Ethiopia, Niger, Malawi, Zimbabwe, and Uganda. The participants worked for a variety of NGOs including Samaritans' Purses, Medecins sans Frontieres (MSF) Holland, MSF UK, MSF France and MSF Spain, Concern Worldwide, Valid International, Action Contre la Faim (Spain, UK and USA offices), Save the Children UK and Medecins du Monde.

The limitations of the study included:

- Small sample size
- High proportion of the nursing and nutritional staff having a good level of English and computer skills
- Some of the participants required translation of the questionnaire. This process introduces an element of error.
- There were discrepancies between the two readability scores used to measure the manuals.

Results

Questionnaires

Of the 32 study participants, 94% had received anthropometric training. Five respondents (16%) had received only theoretical training from reading a book or listening to a lecture. One fifth (20%) of the supervisors have not received anthropometric measurement training in the last 5 years.

In general, national staff received longer anthropometric training - 87% reported training of 2 or more days, compared to 7% and 10% of coordinator/advisors and supervisors respectively. Over half (55%) of the national staff were trained by the nursing or nutritional supervisor.

Twenty two percent of the trainings received did not include infants less than 6 months and adult assessment.

Ten of the 13 medical / nutritional coordinator or advisors had been actively involved in training nursing or nutritional staff within a nutritional programme. One third (33%) of the coordinator/advisor participants described the training at the project sites as "very good".

Of the nursing and nutritional supervisors, 64% were content with the anthropometric measurement training they received. Half of the 36% of

participants who were unhappy with the training received attributed this to a lack of practical training and experience. Recurring issues regarding anthropometric measurements/training reported by nursing and nutritional supervisors included:

- Undertaking MUAC on infants under 6 months
- Staff becoming tired and bored causing sloppy measurements
- Inconsistent clothing removal and positioning of individual
- Calculation and number problems
- Problems distinguishing between calibration and zeroing of scales
- Concept of eye level for Salter scales
- Time of day the measurement is undertaken
- When to measure length or height
- Scales not accurate enough to measure infants
- Too many different MUAC tapes that can be confusing to read.

Calibration

Half (50%) of the supervisors said calibration of the weighing scales occurred every time the scales were used, 25% said calibration occurred monthly and 12.5% said calibration never occurred. A quarter of nursing / nutritional staff had never calibrated, whilst three-quarters reported calibration with each use³. However over half (63%) of the supervisors highlighted calibration as an area of concern with little consistency of calibration or zeroing in the project sites.

Perceived competency

While 88% of national nursing and nutritional staff said they felt very competent at undertaking weight measurement for children aged between 6 months and 5 years, this fell to 29% for infants less than 6 months. The majority (86%) of participants said they were 'very competent' at measuring height, while a lower proportion (71%) felt 'very competent' at measuring length.

The study identified some confusion amongst participants on when to measure height and length (75cm v 85cm cut off).

Policy on training

Two-thirds (67%) of participants said there was no agency recommendation for the frequency of training, while 17% of participants said that training depended on a number of variables, namely:

- Undertaken before every nutrition survey
- Depending on the motivation of the trainer
- Depending on the need of the project and context
- On induction for new staff members.

When asked about refresher training, 11% of the participants said it occurred prior to the surveys or randomly rather than routinely.

Evaluation of training manuals

Most of the manuals scored '1' in clarity, i.e. the anthropometric measurement instructions were clear and broken down into a step-by-step process. Overall, nearly half (46%) of the participants said the manuals were "very good", because the manuals were clear, comprehensive, user friendly and complete. One third (33%) of respondents considered the manuals were "OK", describing them as not stimulating or interactive and too focused on the 6 - 59 months age bracket. This report varied between the three groups - three quarters (75%) of the nursing and nutrition staff said the manuals provided by the NGOs were very good, compared with only one third (33%) of supervisors. One fifth (19%) of the supervisors and advisors/coordinators said the manuals were not good. For the manuals to be more engaging participants suggested the

diagrams needed to be updated and a training CD should accompany the manual.

The average readability score of those manuals assessed was rated 60, which is considered consistent with average readability. With a score of 84, the Sudan Nutrition Manual had the highest readability score, which indicated it was 'easy' to read. The World Health Organisations' The Management of Nutrition in Major Emergencies⁸ and Valid International's Community Based Therapeutic Care (CTC); A Field Manual had the lowest readability score of 34, which indicated they were 'difficult' to read.

The average number of years of education required to read the manuals was 12. This indicates that most of these manuals would not be ideal for staff that have a limited education or are reading in a second language. The Sudan Nutrition Manual required the lowest level of education, as individuals only needed 5 years of education to be able to understand the manual. The most difficult manuals required over 13 years of education to understand them.

There appeared to be no recommended frequency of calibration or clarity between the use of calibration and zeroing in the anthropometric measurement manuals.

Some of the coordinators and supervisors said interactive training tools would help reduce their burden of work. Standardising training plans would ensure that all the important topics are covered in the training.

Recommendations

The following recommendations will hopefully reduce the irregularities in anthropometric measurement in emergency programming:

- Universal anthropometric measurement training policies which standardise training frequency, calibration, cut off points for length and height measurements, standardisation strategy and population age groups which are focused on in the training.
- Availability of interactive training tools and session plans, with updated diagrams and instruction that can be adapted by the facilitator to the project context.
- Training that includes all population groups including infants under 6 months and adults.
- Standardised MUAC tape with colours.

The following issues are suggested areas to concentrate on in the anthropometric measurement training:

- Allow increased time for practical training.
- Measurement training includes all population groups.
- Guidance on clothes removal that is context specific.
- When to use lying and standing length/height measurements.
- Involving parents when measuring smaller children and infants.
- Calibration and zeroing and when they should be used.
- Standardisation sessions.
- Storage, maintenance and setting up of equipment.
- Importance of accuracy and precision.
- MUAC training.

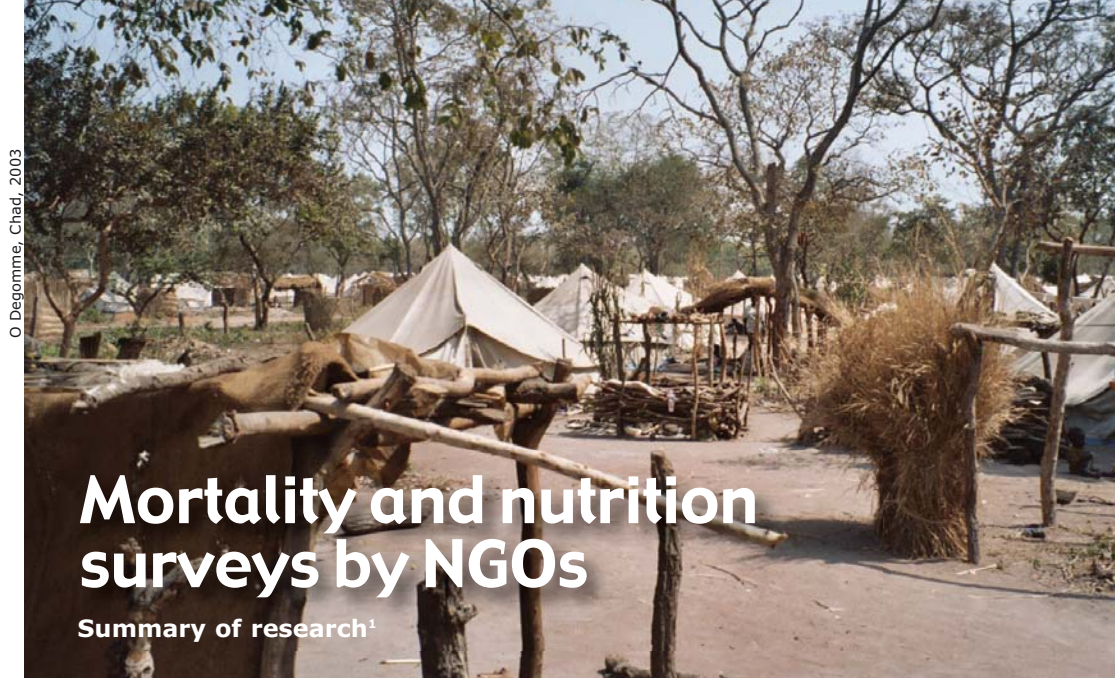
This study has highlighted some of the problems that the participants faced with regards to anthropometric measurement and training and will hopefully provoke further thought and discussion on anthropometric measurement training.

For further information or to obtain the project report, contact: Naomi Tilley, email: naomitilley@hotmail.com

¹ Field Exchange 29. Dec 2006. Angood C. Weighing scales for young infants. A survey of relief workers.

² Investigation into Anthropometric Measurement Training in Emergency Nutrition Programmes. LSHTM. Report of a project submitted in part fulfillment of the regulations for the degree of Master of Science in the Faculty of Medicine, University of London. August 2007.

³ The study findings suggested that there was confusion amongst respondents on the difference between calibration and zeroing. The high reported calibration is likely a reflection of this.



Mortality and nutrition surveys by NGOs

Summary of research¹

Between 1980 and 2000, the number of non-governmental organisations (NGOs) registered within the Organisation for Economic Co-operation and Development (OECD) industrialised countries increased from 1600 to over 4000. Nearly half are involved in crisis situations.

A recent paper has explored the strengths and gaps among the surveys conducted by NGOs and other agencies, based on an analysis of the records of the Complex Emergency Database (CE-DAT) held within the Centre for Research on the Epidemiology of Disasters (CRED) in Brussels. This database was created in 2004 in an attempt to collect surveys from complex emergency situations and to make this information available through an internet-based database. The overall objective is to improve the evidence-based policy on conflict prevention and response by providing standardised and comprehensive data on the human impact of conflict.

The surveys compiled by CE-DAT report on mortality, nutrition and vaccination indicators. As of January 1st 2007, the database contained information on 1329 nutrition and/or mortality surveys from 41 different countries conducted between 2000 and November 2006. Most surveys (over 90%) included nutritional indicators and almost two-thirds covered mortality as well.

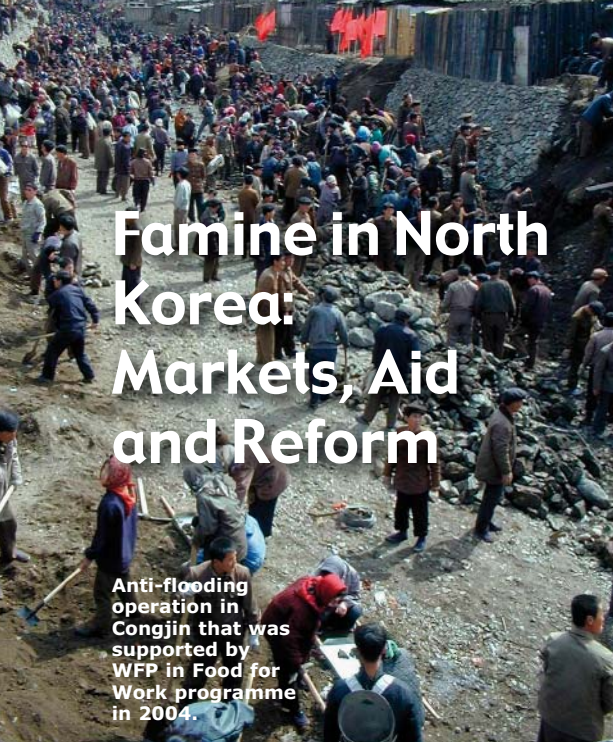
Overall, two-thirds of the surveys were undertaken by NGOs or in partnership with one. United Nations (UN) agencies were involved in 37%. Only one-fifth involved government bodies. Surveys undertaken by NGOs covered smaller geographical units than those undertaken by UN, government or academic groups. While the UN provides surveys that are nationwide or cover very large regions, NGOs are practically the main source of information at sub-national levels for internally displaced people and affected residents. NGOs have access to insecure areas that, for various reasons, are inaccessible to academics or UN organisations. Data on refugees in camps, on the other hand, are primarily available through the UNHCR Standard Indicator Reporting system, which partly draws from NGO reports and partly from their own civil registration system.

The data selection process in CE-DAT indicates that survey quality and use of standard methodology is more advanced for nutrition information than for mortality or morbidity data. There is consensus on the use of nutritional survey information to confirm the severity of a crisis and on procedures for gathering and analysing anthropometric data. In almost all nutritional surveys, the results are triangulated with morbidity and mortality rates, seasonal fluctuations, pre-emergency levels of malnutrition and the underlying causes of malnutrition.

On the other hand, there is less consensus on the optimal methods for measuring mortality and morbidity in crisis situations and their interpretation for judging the severity of the crisis or identifying the appropriate response. The quality of mortality surveys in conflicts was variable and coverage uneven compared to nutrition surveys. However, there was little difference between the levels of methodological detail in the survey reports of NGOs, UN and academic agencies.

The authors conclude that NGO are the main source of surveys from complex emergency sites and provide information at lower levels of resolution than other sources. NGO surveys also aim at assessing a local situation for needs and programming resources or for monitoring their impact. NGO surveys do, however, suffer from some weaknesses. First, consensus on appropriate thresholds and baselines to estimate excess deaths needs resolution, not just amongst NGOs but all parties involved. It is also suggested that NGO survey reports should strengthen the peer review process. Limited peer review, which is the case for most NGO surveys, affects both quality and credibility of their work. At the same time, the shelf-life of survey findings in emergency situations is extremely short and a significantly rapid peer review mechanism will need to be found so that results are not outdated for any practical decision making.

¹ Degomme, O and Guha-Sapir, D (2007). Mortality and nutrition surveys by Non-Governmental organisations. Perspectives from the CE-DAT database. Emerging themes in Epidemiology, vol 4:11 pp 1-5, 2007 Available online at <http://www.ete-online.com/content/pdf/1742-7622-4-11.pdf>



Famine in North Korea: Markets, Aid and Reform

Anti-flooding operation in Congjin that was supported by WFP in Food for Work programme in 2004.

WFP/Cerard Bourke, DPR Korea, 2003

Summary of book review¹

'Famine in North Korea: Markets, Aid, and Reform' is a newly published book² with a foreword by Nobel prize winning economist, Amartya Sen. It provides a pithy analysis of the mass starvation that began in North Korea in the early 1990s leading to an estimated 600,000 – 1 million deaths out of a population of 22 million people. This is a summary of a book review appearing in a recent edition of the *Lancet*.

Although North Korea had suffered from bad weather, external shocks and low food production, the authors suggest that the cause of famine was primarily the collapse of entitlements, notably the ability of people to command food from the public food distribution system in an authoritarian state. According to the authors, locked into a landmass of which only about 20% can be cultivated, North Korea adopted a misguided strategy of food self-reliance. Chronic difficulties in agriculture and food spiralled into a full-blown crisis in 1995 with a series of set backs: withdrawal of aid from the then Union of Soviet Socialist Republics (USSR), flooding and a succession of natural disasters, and geopolitical isolation resulting from the country's attempt to develop a nuclear arsenal.

However, it was neither the weather or shocks which caused the famine but rather state failure of denying people their food entitlement from a collapsed public food distribution system. Not all Koreans suffered equally. Hardest hit were the young and elderly, people in the north-eastern provinces and those from lower status occupational groups, such as farmers housekeepers and the jobless.

The authors place responsibility for the famine squarely with the North Korean govern-

North Korean workers packing fortified biscuits at factory in Sinuiju city, North Pyongan province supported by WFP and UNICEF in 2003.



Research

ment. They argue that the crisis was systemic, intimately related to the authoritarian structure of government, the absence of accountability to the citizenry, and the denial of political and civil liberties and property rights. "The government requested international food aid only in 1995, although food difficulties were evident as early as 1991". How much of the government's procrastination and ineptitude were due to malfeasance or lack of information is unclear, which the authors generously accept by considering a range of explanations for failure of the state. Such entitlement failures of socialist political systems are the source of some of the greatest 20th century famines: the USSR in 1921-22 and 1946-47; Ukraine in 1932-34; China in 1958-62; Cambodia in 1976; and Ethiopia in 1984-85.

The international humanitarian aid community is not let off the hook either. Between 1995-2005, North Korea received about \$2.3 billion in foreign aid, two-thirds as food aid. Government insisted upon controlling food aid by restricting the number and movement of foreign staff, blocking agencies from developing independent channels for food delivery, and forcing them to accept assigned Korean translators. Data show that as donated food volumes increased, the government reduced its purchase of imported food. Aidgivers were forced to accept North Korean "exceptionalism", tight restrictions on their oversight, and supervision of donated food. Consequently, aid-givers worried over access to people in need, monitoring and tracking, and outright leakages. The authors estimate that about 30% of food aid was diverted, mostly to the county's elite, including the military.

The routing of food aid reflected, respectively, harder line versus softer line in pushing for North Korean cooperation in security negotiations. Aid-givers thus had mixed humanitarian and political motives, with the latter heightened during political negotiations over North Korea's ambition to develop nuclear armaments.

The authors are quick to point out that these difficulties do not mean that aid was without positive benefits. The ruthless behaviour of a self-preserving regime unresponsive to the needs of its citizens was balanced by the mixed motives and poor coordination of foreign aid-givers.

The collapse of the public distribution resulted in a bottoms-up marketisation of food, changing the basic economic pattern of food distribution in North Korea and opening up space to secure food beyond the public distribution system. An expanding food market in North Korea was an unintended consequence that the regime now treats with mixed signals of tolerance. Markets in food, if sustained and expanded, could become the seeds of major reforms of North Korea's economy that are essential for sustainable food security and famine prevention.

The final conclusion of the authors is that "we see no substitute for a policy of seeking to aid the North Korean people while engaging the government and encouraging its political, as well as economic, evolution."

¹ Chen. L and Lam. D (2007). A penetrating analysis of famine in North Korea. *www.thelancet.com*. Vol 370, Dec 8th, 2007, pp 1897-1898

² Haggard. S and Noland. M (2007): *Famine in North Korea: Markets, Aid and Reform*. Columbia University Press, 2007. Pp 368, US\$35.00. ISBN 0-231-14000-2



Market analysis and humanitarian action in Niger

Summary of published research

In April 2005, a typical household in Niger depended on market purchases for 90% of its food. The large majority of Sahelian households are not self-sufficient in staple foods. This market dependence increases in years of poor agricultural production. Food security analysis in the Sahel has for some time focused on the assessment of agricultural production. A recent article in *Humanitarian Exchange* argues that it is now time to devote more resources to analysing how markets contribute to the distribution and pricing of food and that market analysis is important for food security assessment. There are three main reasons for this. First, markets have the capacity to ameliorate the negative impacts of shocks. Second, market analysis contributes to food security monitoring and third, market analysis informs the debate over cash versus food assistance.

The hike in food prices in Niger followed steep price rises in Nigeria, caused by lower agricultural production and buoyant demand. This stemmed from high consumer purchasing power and demand from the poultry and food processing sectors. Higher prices in Nigeria caused a drastic drop in exports to Niger. Meanwhile cereal flows reversed with Niger now supplying Nigeria. This trade-driven supply squeeze was compounded by lower domestic crop production because of locust attacks and some dry spells.

During 2004-5, SIMA (the national system for agricultural market information in Niger) and FEWS NET² reported relatively high price levels, although this alert was not well received by humanitarian actors and donors. The reasons advanced to explain the price increases were neither complete nor convincing. This was mainly because of a lack of shared knowledge of cereal markets and trade and the absence of reliable statistics on imports and agricultural production in Nigeria. In addition, humanitarian actors did not understand just how dependent households in Niger were on food market purchases, how households were linked to markets and how these relations had evolved. Lastly, there was no agreed alert threshold for price increases amongst humanitarian actors.

The widespread publicity given to food prices and markets during the Niger crisis encouraged greater analysis of cross-border trade and markets. FEWS NET, SIMA and the Permanent Interstate Committee for Drought Control in the Sahel (CILSS) began conducting missions to markets in northern Nigeria that helped provide an explanation of the 2005 price hike. The following lessons were learnt.

- A sub-regional or regional approach, covering all the key trade linked zones in West Africa, is preferable to a purely national approach.
- Assessments should devote more attention

Livestock Feeding Support as Drought Response

Summary of research¹



Women and children, in the village of Barmou, gather and wait to receive WFP distributed food

WFP/Martin Specht, Niger, 2005

to demand factors at the micro level, in addition to analysing the various sources of food supply, prices, markets and trade structures. Market monitoring should be conducted on the basis of an agreed understanding of the market's structure, conduct and performance. The analysis should cover flow information, as well as prices. Partnerships for market assessments should be broadened to capture the multidimensional character of markets and to agree on conclusions and recommendations.

At the end of 2005, FEWS NET and the World Food Programme (WFP) launched a study to identify knowledge gaps regarding links between markets and food security in West Africa. The study also formulated recommendations to reinforce market analysis of food security assessments. These included establishing a regional monitoring system for cross-border flows, strengthening capacities to conduct market analysis, and developing tools to analyse the links between households and markets.

In the context of making CILSS the regional centre of excellence for market analysis in West Africa, two high-priority challenges have been identified. First, CILSS and its sister organisation, the 'Reseau des Systemes d'Information sur les Marchés en Afrique de l'Ouest (RESIMO), must be supported to establish a strong regional market monitoring system and to become a technical assistance provider to national market information systems.

The second challenge concerns the interaction between households and markets. Characterising these relationships would assist in identifying when price changes could jeopardise food access. Pilot testing of qualitative and quantitative methods to analyse these interactions has been conducted in Mauritania, but further work is necessary. As the influence of markets on household food security varies for each livelihood group, a livelihood approach is essential. In addition, due to intra- and inter-annual variations, longitudinal data is necessary to enable a meaningful characterisation of households' interaction with markets. FEWS NET and WFP are ready to support CILSS in tackling this priority challenge – an initial stock-taking of experiences in other regions of the world, which might be adapted to the West African context, has been initiated by FEWS NET, in collaboration with its partners.

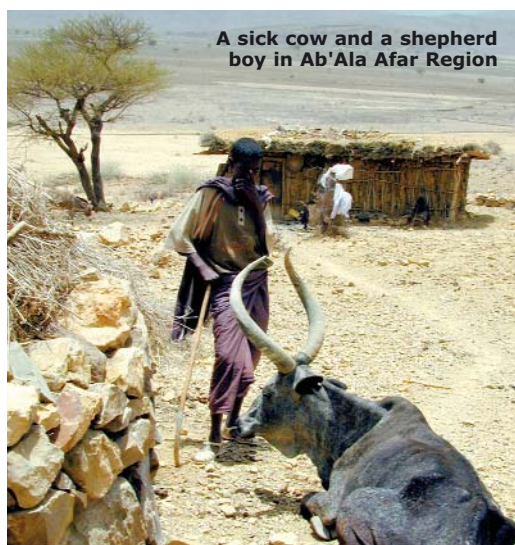
¹ Beekhuis, G and Laouali, I (2007). Cross-border trade and food markets in Niger: why market analysis is important for humanitarian action. Humanitarian Exchange, No 38, pp 25-27, 2007

² Famine Early Warning System. See <http://www.fews.net/>

A livelihoods-based drought response in pastoralist areas could aim to protect key livestock assets and support rapid rebuilding of herds after drought. One aspect of developing such a response requires decision makers to understand the relative importance of different causes of livestock mortality during drought.

Research conducted by the Pastoralist Livelihoods Initiative in Afar, Borana and Somali areas of Ethiopia aimed to quantify different causes of livestock mortality during 'normal' and 'drought' years (see Table 1). These figures show that:

- Most of the excess livestock mortality recorded in drought years is caused by starvation.
- Disease is an important cause of mortality in both normal years and drought years, indicating weaknesses in veterinary services in both situations (disease-related mortality does not always increase during drought).



A sick cow and a shepherd boy in Ab'Ala Afar Region

WFP/Magdi Othman, Ethiopia, 2002

Evidence from Pastoralist Livelihood Initiative (PLI) impact assessments in southern Ethiopia showed that when some livestock were de-stocked, pastoralists chose to use part of the resulting income on both animal feed support (up to 31% of income) and veterinary care (6% of income). This pattern of investment contrasted with a typical aid response for livestock during drought, which focuses heavily on veterinary treatments or vaccinations.

An analysis of supplementary livestock feeding programmes in northern Kenya in 2001 assumed that feed was provided for 8000 sheep and goats for three months during drought. Each animal was fed 250g concentrate/day. The cost was compared with the cost of replacing these animals by restocking after the drought. Whereas the feed

programme cost US\$82,353, the restocking would have cost US\$258,065 – it was around three times more expensive to restock than to keep sheep and goats alive during the drought through feed supplementation.

A theoretical analysis of feed, transport, operational and administration costs for delivering feed in Afar region found that restocking sheep and goats cost around 6.5 times more than supplementary feeding. Restocking cattle costs 14 times more than supplementary feeding.

The PLI research highlighted a number of key policy and programming issues:

- The livelihoods objective of supplementary feeding is to protect a core herd of breeding animals, and encourage post-drought recovery. This requires participatory assessment with pastoralists to agree on the composition and size of core breeding herds before drought occurs.
- Supplementary feeding is not a stand-alone intervention – it should be part of an overall drought cycle management approach that combines early de-stocking and preventive veterinary care. However, in terms of proportional investments in different types of livestock intervention, far more investment should be made in supplementary feeding and this investment should probably exceed expenditure on veterinary care.
- Feeding can start during the alarm phase of a drought with high energy, high fat and high protein concentrates – this is very cost-effective compared to restocking after drought. Some roughage, such as hay, may also be needed.
- Maintaining drought-stricken herds on roughage alone may not be very effective as weakened animals cannot regain body weight and strength in a short time to cope with the situation. Hay is also relatively expensive to transport due to its physical bulk.
- Optimal feed provision in pastoral areas should be planned for a maximum of three months at a time, as most droughts (or the need for additional feed from outside) do not last longer than that.
- In normal periods, agencies need to assume that livestock feed purchase and distribution will be required in the next drought. Procurement and transport costs need to be anticipated, and reliable sources of feed identified. This type of planning will assist rapid buying and distribution of feed.

¹ Pastoralist Livelihoods Initiative (2007). Food for Thought: Livestock Feeding Support during Drought. Policy Brief, Number 2, November 2007

Table 1 Livestock leaving pastoralist herds in normal and drought years

Reason for off-take or loss from herd	Afar herds		Borana herds		Somali herds	
	Normal year	Drought year	Normal year	Drought year	Normal year	Drought year
Starvation	0%	19.5%	0.7%	13.1%	0%	15.5%
Disease	10.1%	16.7%	12.5%	11.9%	12.6%	7.3%
Sale	6.0%	6.5%	8.4%	8.5%	7.0%	5.1%
Slaughter	0.6%	0.4%	1.7%	1.8%	4.1%	3.1%
Predation	4.7%	5.1%	6.8%	6.1%	6.1%	4.6%
Other	6.1%	5.3%	7.0%	6.2%	2.9%	1.2%
Total	27.5%	53.5%	37.1%	47.6%	32.7%	39.8%

Assessing micronutrient deficiencies in emergencies

Summary of review¹

Micronutrient deficiencies have been reported for years in emergency settings, especially in refugee camps where they were most frequently assessed. However, assessments have remained scarce, with less than 10% of anthropometric nutrition surveys reported in the Nutrition Information in Crisis Situations (NICS)² bulletin in 2005-6 having a micronutrient assessment component. Anaemia, measured by blood haemoglobin concentration, and clinical vitamin A deficiency were the main deficiencies investigated.

A recent review published by the Standing Committee on Nutrition (SCN) explores options available for investigating micronutrient deficiencies. It draws attention to best practices and includes references to practical tools and guidelines. It begins with the premise that when investigating micronutrient deficiency disease (MNDD), it should be remembered that clinical signs will usually only be the tip of the iceberg. Beneath this a much greater burden of sub-clinical deficiency will almost always be found. Two main approaches to investigate micronutrient deficiency disease are used:

- i) *Indirect* assessment that involves estimation of nutrient intakes at population level and extrapolating risk of deficiency and likely prevalence and public health seriousness of MNDD.
- ii) *Direct* assessment involving measurement of clinical or sub-clinical deficiency in individuals and using information to estimate population prevalence of MNDD.

The review highlights a number of recent initiatives and resources to improve field practice, e.g. World Health Organisation (WHO) reviews, field manuals by the Centre for Disease Classification (CDC) and the Micronutrient Initiative (MI) and SPHERE project manuals. However the reviewers argue that many gaps exist in our knowledge of how to assess micronutrient deficiencies and how to react to the information collected.

The main conclusions of the SCN review are as follows;

Further improvements in field friendly techniques for assessment are needed. Using direct collection and storage of liquid serum and urine remain a more reliable method of sample collection than blood spots, but more work on sample collection and storage is needed to make field surveys easier to conduct in remote locations.

The increasing introduction of micronutrient-fortified foods in food rations (especially blended food) since the mid-nineties, has probably helped to prevent a number of major micronutrient outbreaks. However, outbreaks have continued to arise. The review suggests that a combination of responses may be appropriate, namely increasing access to fresh food, improving livelihoods and access to markets, enhanced fortification of food items of the general food distribution, distribution of pills, and home-based fortification with micronutrient powders or fortified condiments are some of the alternatives³.

For the rapid design of nutritionally adequate rations at minimum cost, linear programming and other mathematical optimisation techniques can be important tools. They can take into account constraints like dietary practices and food costs in developing diets that meet nutrient recommendations and can be used to model the worst and best case scenarios to more reliably determine risk of deficiency. They can also be used to assess the economic value of fortified food supplements. Implementation of these approaches in easy-to-use software tools could lead to dramatic improvements in the nutritional quality of rations and a reduction in costs. However, they have seldom been used in emergency contexts to date.

In the absence of fortification or supplementation, diets need to be diversified and balanced. However, it has proven difficult to distribute fresh, perishable foods on a large scale due to logistic constraints. Some small-scale successful

home gardening programmes have been reported, but their impact on nutrient intake was not investigated.

Fortification of food aid commodities may be achieved at different stages of the logistic pathway. Guidelines on food fortification have been recently released by WHO and initiatives to increase the fortification of foods within developing countries continue to expand.

While pill distribution has been useful in preventing/treating MNDD in the short-term, longterm supplementation might be less sustainable. Maintaining a distribution network to serve the whole population and ensuring adherence and safe use by different population sub-groups would also be a major challenge for health and nutrition agencies.

Home based fortification using a micronutrient powder, highly fortified paste or sauce has been increasingly used in programmes. However, published evidence on its use in emergencies is still scarce. A large-scale distribution of a micronutrient powder to children aged 6 months to 12 years in families displaced by the Tsunami was successfully implemented in Aceh and Nias provinces of Indonesia in 2005-6, but no data on nutritional impact has been reported.

A number of issues related to supplementation persist, e.g. the potential toxicity of supplementing children with iron in malarious areas if supplementation is targeted at the whole population rather than those known to be iron deficient. There is also uncertainty, and therefore the need for caution regarding the use of micronutrient powders in home fortification.

The authors conclude that efforts to improve the micronutrient status of populations in emergency situations should continue and be given priority as a major public health issue.

¹ SCN (2007). Assessing micronutrient deficiencies in emergencies: Current practice and future directions. Supplement by Andrew Seal and Claudine Prudhon October 2007. Standing Committee on Nutrition (SCN), Geneva, Switzerland.

² See online at <http://www.unsystem.org/SCN/Publications/html/rnis.html>

³ Exclusive breastfeeding for infants under six months and continued breastfeeding is another significant and recognised means to protect micronutrient status of infants and young children. See news piece this issue of Field Exchange on WHO/UNICEF Joint Statement on micronutrient deficiencies in emergencies (p18). (eds)



Field haemoglobin testing using a hemacue machine

Filippo Dihar/Andy Seal, Ethiopia, 2004



Premixing fortified food in Zambia

Filippo Dihar/Andy Seal, Zambia, 2004



A case of Casals necklace (pellagra) in Angola

Filippo Dihar/Andy Seal, Ethiopia, 2004

Triggers, Early Warning and Response in FFP Assistance

Summary of research¹

The Office of Food for Peace (FFP) FY 2008 Title II Assistance Proposal Guidelines (APGs) include the incorporation of 'early warning and response mechanisms (including trigger indicators)' into Title II-supported multi-year assistance programmes (MYAPs). Prior to 2006, in order to respond to an increase in food needs due to a shock, resources were often diverted from the development programme to the emergency response. While this approach did facilitate a rapid response to acute food needs, it ran the risk of potentially undermining advances being achieved by the development interventions. The FY 2008 Title II APGs aim to improve this approach by allowing the continuation of development interventions, with appropriate modifications to respond to changing circumstances, while adding emergency resources to the programme to respond to food needs over and above those that are being addressed by the adjusted development interventions.

A recent paper set out to review briefly cooperating sponsor experiences with operationalising trigger indicators² and early warning and response systems to date, outline the key characteristics of early warning and response systems and trigger indicators within the MYAP context, and provide suggestions on how cooperating sponsors can operationalise the FFP guidance on trigger indicators. Cooperating sponsor experiences reviewed within a MYAP context were Africare, CARE, Catholic Relief Services, Food for the Hungry and World Vision. The main findings of this review include the following:

Trigger indicators differ from other monitoring and evaluation requirements for Title II MYAPs in several important ways. First, trigger indicators are strongly encouraged, but not mandatory for cooperating sponsors to include in MYAP proposals. Second, trigger indicators aim to enhance programme flexibility rather than monitor or evaluate programme impact, unlike most other reporting requirements. Third, trigger indicators are not standardised by FFP – the cooperating sponsors have a great deal of flexibility to define trigger indicators. Finally, trigger indicator information is to be reported to FFP principally via ongoing dialogue with Missions, rather than via existing annual reporting requirements.

Many cooperating sponsor programmes will be developing trigger indicators in the absence of full food security early warning systems in their programme area. Cooperating sponsors should remember that the purpose of the trigger indicators is to identify when a shock may undermine food security sufficiently to warrant either adjustments in programming of Title II resources or additional emergency food resources.

Cooperating Sponsors that aim to operationalise the FFP guidance on trigger indicators should consider the following:

- Trigger indicators should be selected to provide advance notice (typically one to six months) of a potentially serious deteriora-

tion in food security conditions. To identify trigger indicators, it is necessary to first identify the shocks of greatest local concern – including slow-onset sub-national/local shocks. A brief justification for the trigger indicators in a proposal should draw from the national vulnerability analysis that the cooperating sponsor conducted as a basis for the proposal.

- Given the function of trigger indicators, the thresholds of trigger indicators should be set conservatively.
- Trigger indicator monitoring plans can encompass data collection from primary and secondary sources, and should identify triangulation/validation strategies when data indicate that trigger indicator thresholds have been reached. Trigger indicator levels at the start of the programme should be documented, and triangulation/validation strategies for trigger indicator data identified.
- Trigger indicators should be linked to a series of actions, with an emphasis on partnering with national and community food security, early warning and/or disaster preparedness institutions wherever possible.
- Trigger indicator monitoring and analysis should be integrated into ongoing monitoring and evaluation of the cooperating sponsor, rather than carried out as a discrete and parallel activity.

Recommendations to operationalise guidelines on trigger indicators

i) FFP strongly encourages cooperating sponsors to include trigger indicators in the MYAP proposals, and where they are not included, the proposal should explain why these mechanisms are not necessary. Where cooperating sponsors decide to include trigger indicators in their MYAP proposals, the following guidance is given. The proposal should identify the shocks of greatest concern to food insecurity in the population concerned. Nutritional and

dietary impact indicators are not in themselves sufficient as trigger indicators in a MYAP proposal. Cooperating sponsors that do not have a well-established early warning presence in a given country should start by taking stock of what is already being done in the country in early warning.

ii) The proposal should indicate the trigger thresholds or indicate how and when they will be established. The thresholds should be justified briefly, unless they are to be determined via the baseline or other research at the start up of the MYAP.

iii) The MYAP proposal should identify the strategies to be used to obtain the primary and/or secondary trigger indicator data. Proposals should describe how the trigger indicator information would be integrated into the agency's broader monitoring and evaluation.

iv) The proposal should briefly note plans for keeping the Mission and FFP up to date, including where evidence of a problem is seen, information on which populations may be affected and why, the potential severity and assumptions underlying the scenario.

v) The proposal should briefly present a plan for how the cooperating sponsor will engage with national or sub-national early warning and disaster preparedness and response institutions and networks, at least at the level of information sharing.

vi) Cooperating sponsors should include plans for at least one situational and needs assessment to follow up where trigger indicator thresholds are reached

¹ Mathys, E (2007). Trigger Indicators and Early Warning and Response Systems in Multi-Year Title II Assistance Programs. Washington, DC: Food and Nutrition Technical Assistance Project, Academy for Educational Development, 2007.

² Indicator used to determine the threshold at which MYAPs need to shift activities and/or require additional resources for new activities in response to a slow-onset shock.



Villagers in Mali appraising Months of Adequate Household Food Provisioning (MAHFP).

O Aouabacine/GFSI, Mali, 2007

WHO growth reference for children and adolescents

Summary of published research¹



The need for a widely applicable growth reference for older children and adolescents has increasingly been recognised by countries attempting to assess the magnitude of the growing public health problem of childhood obesity. This need has been reaffirmed by the recent release of the new under-five growth standards by the World Health Organisation (WHO) (see Field Exchange issues 28 and 30).

A paper has just been published which reports on a reconstruction of the 1977 National Centre for Health Statistics (NCHS)/WHO growth reference for older children. It compares the resulting new curves (the 2007 WHO reference) with the 1977 NCHS/WHO charts, and describes the transition at 5 years of age from the WHO references for under-fives to these new curves for school-aged children and adolescents.

The approach used in constructing the 2007 WHO reference addressed the limitations of the 1977 NCHS curves, recognised by the 1993 expert committee that recommended their provisional use for older children. The height-for-age median curves of the 1977 and 2007 references overlap almost completely with only a slight

difference in shape. This is probably due to the different modelling techniques used. When compared to the 1977 NCHS/WHO curves, the differences in the newly reconstructed weight-for-age curves are significant in all centiles apart from the median and the -1 standard deviation (SD) curves. This reflects the important difference in curve construction methodology. The fact that the median curves of the two references overlap almost completely is reassuring in that the two samples used for fitting the models are the same within the healthy range (i.e. middle range of the distribution).

The reference data for Body Mass Index (BMI)-for-age recommended by WHO are limited in that they begin only at 9 years of age and cover a restricted distribution range (5th–95th percentiles). The 2007 reconstruction permits the extension of the BMI reference to 5 years, where the curves match WHO under-five curves almost perfectly (see table 1 for reference values). Furthermore, at 19 years of age, the 2007 BMI values for both sexes at +1 SD (25.4 kg/m² for boys and 25.0 kg/m² for girls) are equivalent to the overweight cut-off used for adults (25.0 kg/m²). The +2 SD value (29.7

kg/m² for both sexes) compares closely with the cut-off for obesity (30.0 kg/m²).

The 2007 height-for-age and BMI-for-age charts extend to 19 years, which is the upper age limit of adolescence as defined by WHO. The weight-for-age charts extend to 10 years for the benefit of countries that routinely measure only weight and would like to monitor growth throughout childhood. Weight-for-age is inadequate for monitoring growth beyond childhood due to its inability to distinguish between relative height and body mass. Hence, the provision of BMI-for-age complements height-for-age in the assessment of thinness (low BMI-for-age), overweight and obesity (high BMI-for-age) and stunting (low height-for-age) in school-aged children and adolescents.

Growth reference data for children and adolescents aged 5-19 years (or 61-228 months) is available on the WHO website, <http://www.who.int/growthref/en/>

¹ Onis de M et al (2007). Development of a WHO growth reference for school-aged children and adolescents. Bulletin of the World Health Organisation, volume 85, No 9, pp 649-732, September 2007. Available at <http://www.who.int/bulletin/volumes/85/9/07-043497/en/print.html#R18#R18>

Table 1 Reference values for height-for-age, weight-for-age and body mass index-for-age at 5 years by sex for the 1977 and 2007 references, and the WHO Child Growth Standards

Z-scores	Boys			Girls		
	1977 reference	2007 reference	WHO standards*	1977 reference	2007 reference	WHO standards*
Height-for-age (cm)						
-3 SD	96.1	96.0	96.1	95.1	94.9	95.2
-2 SD	100.7	100.6	100.7	99.5	99.6	99.9
-1 SD	105.3	105.2	105.3	104.0	104.3	104.7
Median	109.9	109.7	110.0	108.4	109.1	109.4
+1 SD	114.5	114.3	114.6	112.8	113.8	114.2
+2 SD	119.1	118.8	119.2	117.2	118.6	118.9
+3 SD	123.7	123.4	123.9	121.6	123.3	123.7
Weight-for-age (kg)						
-3 SD	12.3	12.6	12.4	11.9	12.2	12.1
-2 SD	14.4	14.2	14.1	13.8	13.8	13.7
-1 SD	16.6	16.1	16.0	15.7	15.8	15.8
Median	18.7	18.3	18.3	17.7	18.1	18.2
+1 SD	21.1	20.9	21.0	20.4	21.0	21.2
+2 SD	23.5	23.9	24.2	23.2	24.5	24.9
+3 SD	25.9	27.5	27.9	26.0	29.1	29.5
Body mass index-for-age (kg/m ²)**						
-3 SD	-	12.1	12.0	-	11.8	11.6
-2 SD	-	13.0	12.9	-	12.8	12.7
-1 SD	-	14.1	14.0	-	13.9	13.9
Median	-	15.3	15.2	-	15.2	15.3
+1 SD	-	16.6	16.6	-	16.9	16.9
+2 SD	-	18.2	18.3	-	18.8	18.8
+3 SD	-	20.1	20.3	-	21.3	21.1

*WHO Child Growth Standards for 0–5 years of age.

**For BMI, the 1991 reference data start at 9 years of age.

A group of nurses learning how to make F75 and F100

C Angood, Tanzania, 2007



Treatment of severe malnutrition in Tanzania – a problem with ‘scoops’

By Chloe Angood



Chloe Angood has an MSc in Public Health Nutrition and a BA and MA in International Development Studies. She works for the International Malnutrition Task Force, at the Institute of Human Nutrition at the University of Southampton. In the past she has worked for various NGOs, including Viva Network, with whom she spent several years working in Sub-Saharan Africa. Chloe has also worked for ENN on the Infant Feeding in Emergencies programme.

The author would like to acknowledge the hard work of local staff at Muhimbili National Hospital, Morogoro Regional Hospital and Amana District Hospital reflected here. In particular, the author would like to mention Dr Mary Azayo, Dr Jesse Kitundu and the nurses at Makuti B, Makuti A and the general paediatric complex at Muhimbili National Hospital. The author would like to acknowledge the Tanzania Food and Nutrition Centre and WHO Tanzania Child Health Team who are spearheading the work in Tanzania. The author would also like to acknowledge the supervision and support of Professor Ann Ashworth, of the London School of Hygiene and Tropical Medicine and Professor Alan Jackson and Dr Penny Nestel, of the Institute of Human Nutrition at the University of Southampton.

This article describes practical problems in preparing therapeutic milk in a hospital-based setting and makes some suggestions to resolve them.

It is estimated that 3% of children under 5 years are severely wasted in Tanzania¹. Severe malnutrition with complications requires inpatient management². As adequate structures do not yet exist in Tanzania to provide community-based care, uncomplicated cases are also currently treated as inpatients. Significant efforts have been made in recent years by UNICEF, the World Health Organisation (WHO), the Tanzania Food and Nutrition Centre (TFNC) and the Paediatric Association of Tanzania (PAT) to build the capacity of inpatient facilities in Tanzania to manage severe malnutrition. These efforts have included training of selected health staff by WHO and UNICEF and the supply of F75, F100, Plumpy'nut®, weighing scales and length boards to 11 inpatient facilities by UNICEF since October 2006.

In April 2007, a follow-up visit was made on behalf of the International Malnutrition Task Force (IMTF), in association with WHO/UNICEF and the Royal College of Paediatrics and Child Health, to assess progress, particularly at Muhimbili National Hospital (MNH). It was found that although the WHO and UNICEF training had improved doctors' knowledge and prescribing practices at MNH, training had not been adequately transferred to nurses delivering care and the quality of care remained unsatisfactory. The case fatality rate at MNH for October 2006 to April 2007 was 33%.

Programme to improve the inpatient treatment of severe malnutrition in Tanzania

The author, working with University of Southampton and IMTF, was subsequently invited to Tanzania for 6 months to help

improve the treatment of severe malnutrition and to support MNH staff through a programme of task-oriented training and supervised practice. This activity was conducted in collaboration with the Child Health Team of WHO Tanzania. Working closely with a paediatrician from MNH, a four-phase programme was developed, described in Figure 1. Input and advice was also received by other staff members of MNH, PAT, WHO, the IMTF and University of Southampton. Parts of the programme were subsequently tested at the regional level, at Morogoro Regional Hospital, where the case fatality rate for February to March 2007 was 50%, and at the district level at Amana District Hospital, with an estimated case-fatality rate of 36%. The knowledge and skills of nurses greatly improved following the training and there were many positive changes in practice at each of the three hospitals.

Preparation of F75 and F100 on the wards

In all three hospitals, UNICEF Tanzania provides boxes of Nutriset-produced F75 and F100 sachets. The sachets are a considerable advantage to staff, as they make feeds easy to prepare and provide children with micronutrients that are otherwise difficult to obtain in Tanzania. To make up one sachet of either F75 or F100, 2 litres of water should be added, to make 2.4 litres of feed. However, in most wards visited, only a few cases of severe malnutrition are treated at any one time, usually two to four children. Furthermore, there is usually no refrigerator, so fresh feeds must be made up every 3 to 4 hours. Therefore making up one whole sachet of F75/F100 (2.4 litres) each time

¹ United Republic of Tanzania, Ministry of Health and Social Welfare (2006). National Nutrition Strategic Plan 2006/7 – 2009/10. Dar es Salaam: MoH.

² WHO (2003). Guidelines for the inpatient treatment of severely malnourished children. Geneva: World Health Organisation.

Figure 1 Four-phase programme to improve the inpatient treatment of severe malnutrition in Tanzania

Phase one: Assessment (of each ward where severely malnourished children are treated)

- Detailed assessment of 10 child records.
- Observations of staff actions and procedures over several days.
- Findings discussed with ward staff and hospital managers and action plan and time-lines put together.

Phase two: Training

A 10-hour training course was developed for all ward nurses and nursing assistants, based on the WHO guidelines (WHO, 2003*). The course is highly participatory and practical and focuses on nursing tasks. This course was run for 22 nurses at Muhimbili (the course was subsequently run for 12 nurses at Morogoro and 12 nurses at Amana).

Phase Three: Implementation of new procedures

- Practical training sessions on each ward to teach correct feeding procedures to nurses and doctors; problems were identified and solutions discussed with staff.
- Provision of missing necessary equipment e.g. measuring jugs, feeding cups.
- Provision of wall charts detailing important information (e.g. feed recipes, discharge procedures); nurses were taught how to use the wall charts as job aids.
- Provision of charts to help nurses and doctors record 24-hour food intake for each child, and to calculate how much feed to prepare daily for the ward.

Phase Four: Supportive supervision (implementation of systems to ensure ongoing supportive supervision and quality improvement on each ward)

- Institution of a weekly meeting to review deaths occurring (using a special form) and to create weekly action plans.
- Set up of data collection systems to help staff to record important patient data and calculate monthly case fatality rates.
- Institution of 'nurse-of-the-month' to reward good work amongst nurses and provide motivation.
- Provision of a checklist to help train new staff coming onto the ward in good practice.

* Guidelines for the inpatient treatment of severely malnourished children. Geneva. WHO 2003.



Training in Action



C Angood, Tanzania, 2007

leads to considerable wastage. With a limited country supply of F75 and F100 sachets available, this system is unsustainable.

To avoid wastage, nurses prefer to make up only the volume of feed required on the ward every 3 hours. In the absence of dietary weighing scales, scoops are a practical way of measuring the right amount of F75/ F100 powder to make up feeds. Nutriset provides a packet of small red scoops inside each box of F75 and F100 to help with exactly this problem. These scoops measure approximately 4g of F100/ F75 powder. The instructions that come with the scoops instruct users to add 20ml water to one scoop of F75 and 18ml water to one scoop of F100. This is potentially a very helpful solution for nurses. However, in practice, the use of these scoops throws up problems.

Problems with the Nutriset 'red scoop'

The following problems were observed in the application of these instructions in Tanzania:

1. Children are commonly overfed F75. The final volume of 'made up' F75 or F100 is not stated. Nurses commonly assume that the final volume is the same as the volume of water added (e.g. 20ml when making F75, when, in fact, the final volume is 20% higher, i.e. 24ml). If a child is prescribed 100ml F75, nurses using this system will
2. Nurses find it difficult to calculate the number of scoops to use for different feed volumes. For example, if a child requires 80ml of F75, the nurse must divide 80ml by 24ml to find the number of scoops of powder to use. The answer is 3.3, which must be rounded to 4 scoops. The nurse must then calculate how much water to add by multiplying 4 by 20ml (which is 80ml water). The maths skills of the nurses encountered were generally quite low and all found this calculation to be very complex. Calculations were frequently wrong, leading to risk of either fluid overload (if too much F75 is given) or hypoglycaemia (if too little F75 is given). To avoid this calculation, a table is needed showing the volume of water to add to 1, 2, 3 scoops etc., and the final volume of reconstituted F75 or F100. But Nutriset does not indicate this final volume per scoop, and so the table is difficult to create.
3. Miscalculation of scoops: When making up feeds, it is very easy to miscount the number of scoops when the number required is above 5. This happens when feed volumes are in excess of 100ml, which is very common. This means that it is all too easy to reconstitute feeds incorrectly.

4. Difficulties of making up feed for several children: The red scoop is too small when there are more than 10 severely malnourished children, all feeding 2 or 3 hourly. Larger quantities need to be prepared which requires a larger scoop. The big challenge with this method is finding an accurate measure of one quarter/one half of a sachet.

Possible solution to the problem of 'scoops'

A meeting of the partners was held in October 2007, including representatives from Muhimbili National Hospital, Morogoro Regional Hospital, Amana District Hospital, TFNC, WHO Tanzania, Muhimbili National Hospital, the IMTF and University of Southampton. The above issue of scoops was discussed. It is very difficult to source ready-made, calibrated scoops in Tanzania. Much research was done during the 6 months and no satisfactory solution was found. The possibility of sourcing or making better scoops in Tanzania was considered by the partners, but quickly dismissed due to technical and resource constraints. Instead it was felt by the group that Nutriset should consider adapting the existing red scoop to something more useful that could have international applicability. Specifically, the group would like to request the following from Nutriset:

Postscript

Response on F-75 and use of measuring scoops

By Mamane Zeilani, Nutriset

Mamane Zeilani is Director for International Development and Nutritional Strategies at Nutriset, including product Research and Development. Before joining the team in August 2006, he implemented and oversaw emergency nutrition and food security programmes in west and southern Africa (Malawi, Burundi, Eritrea, Zimbabwe, Niger), and Asia (DPRK, Afghanistan and Tajikistan) for several international NGOs.

Since 1986, Nutriset has been very involved in seeking practical solutions for the development of quality nutritional products. These products are today widely used by humanitarian actors in the developing countries. Among them are two formulae utilised in the dietetic treatment of severe malnutrition, mostly in children aged under 5 years of age. These therapeutic milks, named F-75 and F-100, are used for the initial treatment (or stabilisation phase) and for nutritional rehabilitation of severely acutely malnourished children, under medical supervision and according to internationally recognised guidelines and protocols.

From large scale to individual solutions (using scoops)

The F-100 formula was designed in 1993 and F-75 in 1994. They were first used in large emergencies. As is the case for the majority of prod-

ucts developed by Nutriset, packaging and instructions were initially created to reflect the situation on the ground. The need of the international community was to rapidly treat hundreds of children in any given therapeutic feeding centre (TFC). Thus, at the request of non-governmental organisations (NGOs), each sachet contained the quantity of milk powder required to make up 2.4 litres of formula. This was considered to be the most pragmatic solution. The sachet had to be manufactured in such a way so as to withstand tough transport and storage conditions. The quantity of F-75 and F-100 added to 2 litres of boiled water is 410g and 456g, respectively. NGOs did not request any measuring instrument for smaller quantities.

With the progressive and extensive implementation of the WHO manual for the management of severe malnutrition, Nutriset adapted

its supply in terms of products and packaging. Smaller size TFCs were set up in countries facing nutrition emergencies. However, the lack of refrigeration facility and the resulting wastage of therapeutic milk then became a serious issue. To satisfy a special request from one of its partner working in such a context (treating small number of children at any one time in a TFC), Nutriset developed red measuring scoops. This enabled field workers, and particularly local staff, to easily measure the exact quantity of milk powder needed to prepare small quantities of F-75, as well as F-100. These red scoops are also used to make up ReSoMal (Rehydration Solution for the Severely Malnourished).

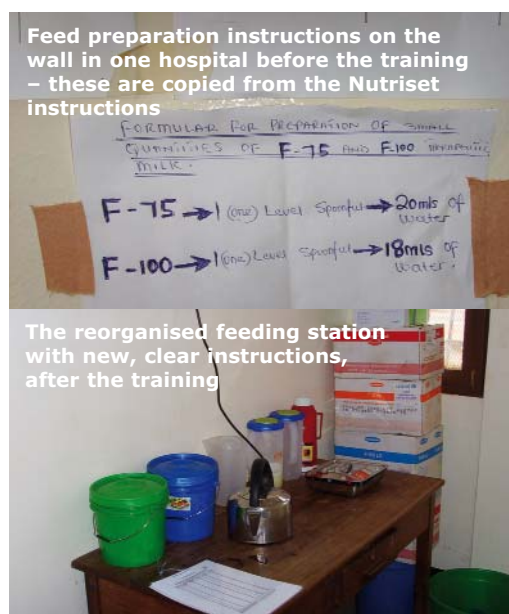
Ongoing research and development

These red scoops are currently packed in every box of F-75 therapeutic milk manufactured by Nutriset in Malaunay, France. Further technical solutions, including the development of smaller sachets, have been sought and are reaching final technical validation stages. Moreover, sachets that contain the equivalent of either a quarter or a half of the original F-75 sachet have successfully passed the final validation process in 2006.

As can be seen, Nutriset is constantly seeking to develop products and related packaging solu-

- a) Much clearer instructions that avoid confusion and miscalculations and that explain how much water to add to each red scoop **and the resulting volume of feed.** Instructions could include a chart of pre-calculations for 1, 2, 3 scoops, etc.
- b) A scoop that accurately measures one quarter of a sachet (perhaps a blue scoop for F100 sachets and an orange scoop for F75 sachets to co-ordinate with respective box and sachet colours) with clear instructions that explain how many scoops to use, how much water to add **and the resulting volume of feed** (instructions should detail how to make one quarter and one half of a sachet).

For more information, contact:
Chloe Angood, Institute of Human Nutrition,
University of Southampton,
email:c.angood@soton.ac.uk



tions best adapted to the context of humanitarian nutrition interventions. Having read Chloe Angood's article in this issue of Field Exchange it is clear that further work needs to be done in order to facilitate the use of F-75 and F-100 therapeutic milk by nutritionists in the field. Nutriset would like to acknowledge the great value of the work done by this research group.

Nutriset would like to invite organisations and individuals that train and/or manage therapeutic feeding programmes within health structures in the developing world to contact us, as we would be very pleased to explore new means of improvement. Nutriset will welcome solutions to improve packaging of F-75 and F-100, as well as its other products for the treatment/prevention of malnutrition. Our team will work to clarify instructions accompanying red scoops to enable everyone to comprehend the quantities of scoops needed per quantity of water to make up the different volumes of feed.

For more information, contact:
Mamane Zeilani, Nutriset,
email:mzeilani@nutriset.fr or
nutriset@nutriset.fr

Regional workshop on IFE in Bali 2008



A three day strategy workshop/one day training on Infant and Young Child Feeding in Emergencies (IFE) is scheduled to be held in Bali, Indonesia on 10-13th March, 2008. This workshop is being organised under the auspices of the Inter Agency Standing Committee (IASC) Global Nutrition Cluster¹ that is led by UNICEF. Within the cluster, the main organiser is the IFE Core Group², in cooperation with UNICEF East Asia and Pacific Regional Office, UNICEF South Asia Regional Office and the Ministry of Health, Indonesia. The Emergency Nutrition Network (ENN) as co-ordinator and representative³ of the IFE Core Group is co-facilitating this workshop. The workshop is funded by the Global Nutrition Cluster and by contributions and in-kind support of IFE Core Group members.

This strategy workshop on IFE has been identified as a key step to help improve coordination, policy guidance, implementation and response capacity in the region. The focus of the workshop is on emergency preparedness and improving the early response to protect and support IFE. Indonesia was chosen as the hosting country in order to learn from their IFE experiences in the recent tsunami and earthquake responses.

The workshop will bring together participants from a mixture of key government, UN, donor, international and local NGO representatives from 16 countries – Afghanistan, Bangladesh, Cambodia, China, India, Indonesia, Maldives, Myanmar, Nepal, Pakistan, Papua New Guinea, Philippines, Sri

Lanka, Thailand, Timor-Leste and Viet Nam.

The objectives of the meeting are to:

- Increase awareness of the importance of IFE in the region, including orientation on relevant policy, guidance and key issues in IFE
- Identify key constraints to providing early support and protection for appropriate infant feeding practices in emergencies, and
- Identify strategic directions and practical steps to address these at country and regional levels.

Further information and an agenda are available on the ENN website and from the key meeting contact (below). A summary of the meeting report and of experiences shared at the workshop will feature in future issues of Field Exchange.

For further information, contact:
Ali Maclaine, tel (UK): +44 (0)20 8989 5735
fax: +44(0) 1865 324997
email: alimaclaine@btinternet.com
or Marie McGrath, ENN,
email: marie@ennonline.net

The Operational Guidance on Infant and Young Child Feeding in Emergencies (v2.1, Feb 2007) is now available in Bahasa (Indonesia), Japanese and Chinese, online at <http://www.ennonline.net/ife>

¹ <http://www.humanitarianreform.org/>

² The IFE Core Group is an inter-agency collaboration that comprises UNICEF, UNHCR, WFP, WHO, Emergency Nutrition Network (ENN), Action Contre la Faim and CARE USA. It is co-ordinated by the ENN.

³ The ENN/IFE Core Group is a member of the UNICEF-led IASC Global Nutrition Cluster on behalf of the IFE Core Group and highlights IFE issues in global cluster activities.

The Humanitarian Response Index

Summary of published news¹

A recent news piece in the Lancet covered the launch by Kofi Annan, former UN Secretary General, of an index that ranks 23 countries in the Organisation for Economic Co-operation (OECD) according to their effectiveness in humanitarian donorship. The Humanitarian Response Index aims to make donors more accountable by ranking them according to 57 indicators that reflect the principles and good practices that govern humanitarian action. The Indicators are focused around five themes – responding to humanitarian needs, integrating relief and development, working with humanitarian partners, implementing international guiding principles, and promoting learning and accountability. The outcomes are based on hard data and the views of various humanitarian agencies working on the ground in eight countries.

According to the index, Sweden is the most effective donor and Greece is the least effective. The wide-ranging indicators also high-

light where donors could 'do a lot better'. For example, the UK is ranked ninth and although it scores well in the amount of money given and its speedy response to humanitarian crises, it is let down by having a poor human rights record.

The authors conclude that this new index is a useful "report card on donor activity" but it will only be truly effective if it inspires donors to improve their humanitarian donorship record. Individual citizens, civil society, non-governmental organisations, and politicians should use this new tool to hold their governments to account.

For more on the Humanitarian Response Index, visit the website of Development Assistance Research Associates (DARA) who have devised the index, <http://www.daraint.org/>

¹ The Humanitarian Response Index. The Lancet - Vol. 370, Issue 9603, 8 December 2007, Page 1880. Register for access to full text at <http://www.thelancet.com>

New Red Cross Guidelines for Cash Transfer Programming



The International Red Cross and Red Crescent Movement have just published Guidelines for Cash Transfer Programming. The guidelines are designed for field practitioners with experience of humanitarian programmes, including generalists such as programme managers or relief coordinators, as well as specialists on food security, economic security, livelihoods or shelter. They are designed for use at national or international level, for headquarters, branch or field offices.

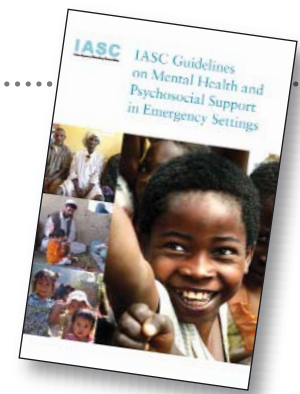
There is a growing body of evidence that cash-based programming can be a very appropriate and effective form of response, alone or in combination with other in-kind programmes. Building on the broad range of cash experiences within the Movement and in the humanitarian sector, these guidelines help programme managers identify those situations where cash is appropriate, and provide practical, step-by-step support to the design and implementation of cash programmes. They can be used following a rapid assessment and also to support programmes at any point of the disaster cycle – disaster risk reduction, preparedness, response or recovery – or in a situation of conflict or political instability.

The first section of the guidelines follows the programme cycle with detailed information on whether, when and how to design and implement cash-transfer programmes. The second section gives step-by-step guidance on particular forms of cash transfers. The last section provides some practical tools that can be used in any cash transfer programme, such as market assessment, community-based targeting, or how to assess financial institutions.

A revised edition of the guidelines is planned for 2009 and a feedback form is included at the end of the document in order to allow field practitioners to contribute to the improvement of the document.

For further information, contact: Charles-Antoine Hofmann, Humanitarian Policy Adviser at the British Red Cross, email: cahofmann@redcross.org.uk, Mija-tesse Ververs, Senior Advisor Food Security, Nutrition, Livelihoods, International Federation of Red Cross and Red Crescent Societies, email: mija.ververs@ifrc.org, tel: +41 22 730 4449

IASC Guidance on Mental Health and Psychosocial Support in emergencies



The Inter Agency Standing Committee (IASC) has issued Guidelines on Mental Health and Psychosocial Support in Emergency Settings: Minimum Responses in the Midst of Emergencies. The guidelines have been developed by 27 agencies, with input of hundreds of experts worldwide.

The aim of these guidelines is to enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses. These guidelines are responding to the absence, until now, of a multi-sectoral, interagency framework to enable effective coordination, identify useful practices, highlight potential harmful practices and clarify how different approaches to support mental health and psychosocial support in emergencies complement each other.

The guidelines specify 25 minimum responses in emergencies in three areas:

Area A. Common functions – coordination, assessment, monitoring and evaluation, protection and human rights standards, and human resources.

Area B. Core mental health and psychosocial supports – community mobilisation and support, health services, education and dissemination of information.

Area C. Social considerations in sectors – food security and nutrition, shelter and site planning, water and sanitation.

The guidelines include 25 Action Sheets that explain how to implement each of the minimum responses.

For further information, visit <http://www.humanitarianinfo.org/iasc/content/products/default.asp> or email: IASCmhps@who.int or IASCmhps@interaction.org

Health and Nutrition evaluation guidelines

The Inter-agency Health and Nutrition (IHE) Initiative, comprised of a broad range of NGOs, UN agencies, CDC, donors and academic institutions, has produced their first version of IHE Evaluation Guidelines. The guidelines outline a process for commissioning and managing inter-agency health and nutrition evaluations, as well as provide an evaluative framework for these types of evaluations. The aim of these evaluations is to analyse the overall performance of the health and nutrition sector, and the impact of interventions on the health of crisis affected populations.

This is the first version of these guidelines, based on experience gained during the six IHE evaluations done so far and feedback received on earlier draft versions. It is hoped that these guidelines will stimulate more inter-agency evaluations in the health sector. Ongoing discussions are planned within the health cluster, to see how such evaluations can complement assessment and monitoring processes.

For more information, please contact Olga Bornemisza at olga.bornemisza@lshtm.ac.uk

To see copies of the evaluations done so far, see <http://www.unhcr.org/doclist/research/3b8a2e3de.html> and search for IHE.

FAO Livelihoods Assessment and Analysis e-learning course



The EC-FAO Food Security Programme has produced an e-learning course on 'Livelihoods Assessment and Analysis'.

The Livelihoods course introduces the concept of livelihoods and the components of the livelihoods framework. It also provides guidance on assessing livelihoods in different food security contexts and on selecting and interpreting livelihoods indicators.

Previous e-learning courses include Food Security Information Systems and Networks, Reporting Food Security Information, and

Nutritional Status Assessment and Analysis. All of these are available in English and French.

The new course is available for free online at: http://www.foodsec.org/dl/dlcourselist_en.asp or on CD-Rom, email: information-for-action@fao.org, tel: +39 06 570 54003. Related resources for trainers, which can be customized for face-to-face training, are also available.

EC-FAO Programme website: www.foodsec.org FAO website: www.fao.org

WHO Technical Consultation and Update on HIV and Infant Feeding

The Report of a Technical Consultation on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants and Infant Feeding and an Update of recommendations¹ is now available.

At a Consultation (held in Geneva on 25–27 October 2006), researchers, programme implementers, infant feeding experts and a broad cross-section of agencies reviewed the substantial body of new evidence and experience regarding HIV and infant feeding. The aim was to further clarify and refine the existing United Nations (UN) guidance, which was based on the recommendations from a previous consultation in 2000.

The group endorsed the general principles underpinning most of the October 2000 recommendations and reached consensus on a range of new issues and their implications. New data that were not available in 2000 were reviewed. These included recent trial data on 18-month and 24-month HIV-free survival based on different infant feeding practices, and morbidity and mortality reported among HIV-exposed but uninfected infants enrolled in several ongoing trials where mothers ceased breastfeeding by six months.

The Technical Consultation Report presents a summary of the new findings, conclusions and recommendations and Annex 1 provides details of the discussions that took place.

Based on the Technical Consultation, 'HIV and infant feeding: Update' has just been produced by WHO to provide the full list of update



recommendations and an explanation of key points². It is aimed at programme managers and decision makers, and those who will be in charge of revising national guidelines on prevention of mother-to-child transmission and infant and young child feeding. Guidance will continue to be refined and clarified as new evidence becomes available.

For further information, contact:
World Health Organisation, 20 Avenue Appia,
1211 Geneva 27, Switzerland
email: cah@who.int or hiv-aids@who.int or
nutrition@who.int
<http://www.who.int>

The updated guidance is available at
<http://www.who.int/child-adolescent-health/documents/en/>
The Consultation Report and other WHO documents on HIV and infant feeding can be found at:
http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm

¹ HIV and Infant Feeding. New evidence and programmatic experience. Report of a Technical Consultation. Geneva, Switzerland, 25–27 October 2006, held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants. WHO, UNICEF, UNAIDS, UNFPA. WHO 2007.

² WHO, UNICEF, UNAIDS, UNFPA. HIV and Infant Feeding: Update. Geneva, WHO, 2007.

Launch of The Lancet's Series on Maternal and Child Undernutrition

The Lancet's Series on Maternal and Child Undernutrition has just been launched. (January 16, 2008). The Series aims to increase awareness around maternal and child undernutrition and serve as a catalyst for national-level governments, non-governmental organisations and the international nutrition community to spur action and stimulate national interest, leadership, and commitment.

Series launches have been held in Washington, D.C. and London, and will continue in Ethiopia, India, Peru, Vietnam, and West Africa to help raise awareness of and deepen support for maternal and child nutrition at the donor, policy and programmatic levels in countries that face the most serious nutrition challenges. Many health and development agencies including Johns Hopkins Bloomberg School of Public Health, UNICEF, USAID, the World Bank, the



World Health Organisation, and the Bill & Melinda Gates Foundation contributed to the production of the series. It includes contributions from leading academics and nutrition experts from the UK, USA, Asia, Africa, and Latin America.

There are five papers in the series with one being published in the print edition of The Lancet each week. All five papers, the web appendices, and a 12-page Executive Summary of The Lancet's Series, are available online (free) at: <http://www.globalnutritionseries.org/> The website also includes details of global events, a media centre and resources centre.

Sphere Project celebrates 10th anniversary



The Sphere Project celebrated its 10th anniversary in 2007. To mark the occasion, a special report has been published, '10 years of Sphere in Action, enhancing the quality and accountability of humanitarian action'. This report aims to provide a degree of insight into the first ten years of the Sphere Project. It includes examples both from those who 'govern' the Project and those who 'use' the Humanitarian Charter and the Minimum Standards, citing first-hand experiences and case studies from diverse contexts.

The report is available for download in PDF format and as a Flash presentation at: <http://www.sphereproject.org/content/view/301/32/lang,English/>

A Memorandum of Agreement has been signed with 'Books for Change' in India to print a low cost, English language edition of 'The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response' handbook, 2004 edition. The handbook is available for 210 Indian Rupees (discounts for bulk orders) in the following countries only: India, Bangladesh, Pakistan, Afghanistan, Bhutan, Nepal, Sri Lanka and the Maldives (Sales Territories).

Requests should be addressed directly to: Shoba Ramachandran, Publisher and Chief Editor at Books for Change, 139 Richmond Road, Bangalore 560 025, Karnataka, India Ph: +91-80-25580346 Fax: +91-80-25586284 Email: shoba.ram@actionaid.org

The Sphere Project team also invite registered Sphere Project members to update their contact details online, to send news articles on the Sphere related activities and to include any 'Sphere event' in the events calendar on the Sphere Project website.

For further information, contact: Laura Lopez-Bech, The Sphere Project, <http://www.sphereproject.org> Tel.: +41 (0) 22 730 4482 Fax: +41 (0) 22 730 4905 email: laura.lopez@ifrc.org

Nutriset and Valid Nutrition sign licence agreement

In 1996, Nutriset patented an innovative concept of ready to use therapeutic food (RUTF) products sold under the brand name Plumpy'nut® and used in the treatment of severe acute malnutrition. In 2000, Valid International developed the Community Based Therapeutic Care (CTC) model to deliver care to people with severe acute malnutrition.

Nutriset and Valid Nutrition (VN) have just announced (December 2007) that they have formally signed a Licence Agreement. This agreement enables Valid Nutrition to independently manufacture peanut based Ready to Use Foods covered by the Nutriset patent in developing countries and to market these products under the VN brand name.

This significant development should increase competition and improve availability of RUTFs for the treatment of malnutrition, as well as encourage innovation and stimulate new product development of cheap and cost effective formulations.

Valid Nutrition (VN) is a not-for-profit company established in 2005 to make and market highly-fortified nutritional pastes to treat and prevent malnutrition in a number of developing countries. The aim of Valid Nutrition is to set the benchmark for the quality, effectiveness and cost of Ready-to-Use Foods (RUFs). All profits are channelled back into expanding local production and funding the provision of Community-based Therapeutic Care (CTC). For more information, visit <http://www.validinternational.org>



Local production of RUTF in VN Kanengo factory in Lilongwe, Malawi



WHO/UNICEF Joint Statement on Optimal Iodine Nutrition

WHO/UNICEF have released a joint statement on Reaching Optimal Iodine Nutrition in Pregnant and Lactating Women and Young Children. This statement presents the conclusions of a technical consultation and subsequent follow up meeting in 2005, on the prevention and control of iodine deficiency in pregnant and lactating women and in children less than two years of age.

The primary strategy for sustainable elimination of iodine deficiency remains Universal Salt Iodisation (USI). However new evidence and lessons learned in the last decade show that implementation of salt iodisation programmes may not be feasible in all areas of all countries, thus resulting in insufficient access to iodised salt for some groups within the population. In these cases, as well as strengthening USI programmes, additional complementary strategies are suggested.

As a first step, countries need to assess and categorise the level of implementation of salt iodisation programmes and based on this analysis, revisit the strategy for the control of Iodine Deficiency Disorders (IDD), as necessary. The statement includes guidance on categorisation and the subsequent planning process for additional iodine intake in pregnant and lactating women and young children. Guidelines for decision-making are also given for these population groups in specific situations such as emergencies, amongst displaced people, and in geographically remote areas, where additional iodine intake should be considered. If iodised salt is not accessible in these specific situations, increasing iodine intake is required in the form of iodine supplements for pregnant and lactating women, and a supplement or a complementary food fortified with iodine for children 7-24 months of age. In cases where it is difficult to reach pregnant women, supplementation to all women of reproductive age is advised.

Recommended dosages are included for daily or annual supplementation for pregnant women, lactating women, women of reproductive age (15-49y), and for children under 2 years (7 – 24 months). For infants 0-6 months of age, iodine supplementation should be received by the infant through breastmilk, assuming that the infant is exclusively breastfed and that the lactating mother received iodine supplementation.

Monitoring of IDD prevention and control programmes is crucial – whether they are based on fortification or supplementation – to ensure that additional iodine intake is effective in reducing the deficiency, while preventing excessive intake that may lead to adverse health consequences. The monitoring process should include the assessment of coverage and iodine nutrition status.

The joint statement is available at: https://www.who.int/entity/nutrition/publications/WHOSTatement_IDD_pregnancy.pdf

For further information, contact: Dept. of Nutrition for Health and Development, WHO, 20, Avenue Appia, 1211 Geneva, Switzerland, email: micronutrients@who.int Or Nutrition Section, Programme Division, UNICEF, 3 United Nations Plaza, New York, NY 10017, USA, email: nutrition@unicef.org



Filippo Dibari/Andy Seal, Ethiopia, 2004

Revival of 'New & Noteworthy in Nutrition'

The new publication *New & Noteworthy in Nutrition* (as a reincarnation of the earlier World Bank publication) is now available (Issue 1, December 2007). Originally a World Bank Publication, it was taken over by the International Food Policy Research Institute (IFPRI) in 2000 where it continued until 2003. The Population Reference Bureau (PRB) has now relaunched it.

The aim of reviving the publication is to enhance learning opportunities in nutrition and to complement the SCN News¹ and other relevant materials. For the moment it will be published every four months. Content will be based on a review of recent literature, news articles, and outcomes of important events and conferences related to nutrition. Each issue will close with a section entitled

'Whatever Happened to . . .?' that takes a look back at the ideas that were supposed to help save the world nutritionally but didn't, based on readers suggestions.

The publication is available at: <http://www.prb.org/NewandNoteworthy.aspx>

Subscribe to NNN by visiting <http://www.prb.org/NewandNoteworthy.aspx>

To give feedback or make suggestions, contact: Population Reference Bureau, 1875 Connecticut Ave., NW, Suite 520, Washington, DC 20009 USA.

tel: 202-483-1100 fax: 202-328-3937

email: nnn@prb.org

<http://www.prb.org>

¹ <http://www.unsystem.org/scn/publications/html/scnnews.html>

Joint Statement on micronutrient deficiencies in emergencies

A Joint Statement has been issued by WHO, WFP and UNICEF on preventing and controlling micronutrient deficiencies in populations affected by an emergency. It focuses on pregnant and lactating women and children aged 6 to 59 months, as the groups most vulnerable to micronutrient deficiencies and their consequences. For a pregnant woman these include a greater risk of dying during childbirth, or of giving birth to an underweight or mentally impaired baby. For a lactating mother, her micronutrient status determines the health and development of her breastfed infant, especially during the first 6 months of life. For a young child, micronutrient deficiencies increase the risk of dying due to infectious disease and contribute to impaired physical and mental development.

Micronutrient deficiencies can easily develop during an emergency or be made worse if they are already present. So the micronutrient needs of people affected by a disaster must be adequately met. One way of achieving this is the regular provision of adequate amounts of foods fortified with micronutrients as part of food rations during emergencies.

Fortified foods include corn soya blend, biscuits, vegetable oil enriched with vitamin A, and iodised salt.

However, foods fortified with micronutrients may not fully meet the needs of certain nutritionally vulnerable sub-groups. Two daily multiple micronutrient formulae have been developed by UNICEF and WHO to meet the recommended nutrient intake (RNI) of pregnant and lactating women and children aged 6-59 months in emergencies (see table 1). Pregnant and lactating women should be given their supplement (1 RNI/day) whether they receive fortified rations or not. Dosages and schedule for administration of the children's supplement are included for situations where there is or there is not provision of fortified rations. Recommendations are made

regarding continuation of iron and folic acid supplementation in pregnant and lactating women, and vitamin A supplementation to young children and mothers post-partum. Breastfeeding and appropriate complementary feeding should be promoted actively.

The Joint Statement recommends that multiple micronutrient supplements should be given until the emergency is over and access to nutrient rich foods is restored. At this time the micronutrient status of the population should be assessed to decide whether further interventions to prevent and control micronutrient deficiencies are needed.

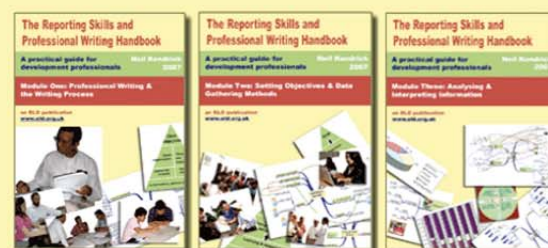
The delivery of supplements should be monitored to assess coverage, existing micronutrient programmes should continue as before the emergency, and the health of target groups monitored for deficiencies as well as excessive consumption. The continued need for supplements and fortified foods should be assessed periodically during and after the emergency. As the crisis wanes, the general distribution of supplement is likely to be reduced and then increasingly targeted to specific groups.

The Joint Statement is available at: www.who.int/nutrition/publications/WHO_WFP_UNICEFstatement.pdf

¹ WHO, WFP, UNICEF Joint Statement. Preventing and controlling micronutrient deficiencies in populations affected by an emergency. Multiple vitamin and mineral supplements for pregnant and lactating women, and for children aged 6 to 59 months. WHO, 2007

² Both supplements contain iron (27mg/day for pregnant/lactating women and 10mg/day for children 6-59 months). Risks and consequent recommendations regarding iron and folic acid supplementation in highly malarious regions are given in a WHO statement, *Iron supplementation of young children in regions where malaria transmission is intense and infectious disease highly prevalent*. (undated). Available at http://www.who.int/child-adolescent-health/New_Publications/CHILD_HEALTH/WHO_statement_iron.pdf This WHO Statement is reflected in the recommendation of the Operational Guidance on Infant and Young Child Feeding in Emergencies, v2.1, February 2007, Section 5.1.2, a position reached by consensus at the UNSCN meeting in Rome, 2007. Available at <http://www.enonline.net/ife> (Eds)

Reporting Skills and Professional Writing Handbook



To help develop writing and reporting skills, a self-study programme has been developed, designed for development professionals but also relevant to those working in the emergency sector.

The Handbook covers the entire reporting process from setting objectives, through data gathering and analysis tools, to planning, drafting, editing and designing a report. It contains examples, practical exercises, and an extended case study to fully apply all the tools presented.

Two example modules (Data Gathering Methods and Writing Clarity) are available to download from <http://www.reportingskills.org/resources.htm>

The whole Handbook comprises eight steps to 'effective reports':

- 1: Professional Writing and the Writing Process
- 2: Setting Objectives & Data Gathering Methods (entire module available for download)
- 3: Analysing & Interpreting Information
- 4: Planning the Report
- 5: Writing Skills – Clarity (entire module available for download)
- 6: Writing Skills – Organisation
- 7: Putting it all Together
- 8: Finishing Off the Report

A moderated web forum, where users can post ideas and reach the author with comments, questions and feedback, supports the Handbook.

The Handbook is only available as an electronic download and can be bought and downloaded from

<http://www.reportingskills.org> (single user edition costs £30GBP).

There are special licenses for organisations (10 users) and the Project Office Edition (50-user licence) also includes a Training Pack – Trainer Guide, Participant Notes, Supplementary Materials and over 250 slides.

The Reporting Skills and Professional Writing Handbook: a self-study programme for development professionals, © Neil Kendrick 2007. Published by Education, Language and Development Training Programmes (UK Charity no. 1083385)

Table 1 Composition of multiple micronutrient supplements for pregnant women, lactating women, and children from 6 to 59 months of age

	Pregnant/lactating women	Children (6–59 months)
Vitamin A µg	800.0	400.0
Vitamin D µg	5.0	5.0
Vitamin E mg	15.0	5.0
Vitamin C mg	55.0	30.0
Thiamine (vitamin B1) mg	1.4	0.5
Riboflavin (vitamin B2) mg	1.4	0.5
Niacin (vitamin B3) mg	18.0	6.0
Vitamin B6 mg	1.9	0.5
Vitamin B12 µg	2.6	0.9
Folic acid µg	600.0	150.0
Iron mg	27.0	10.0
Zinc mg	10.0	4.1
Copper mg	1.15	0.56
Selenium µg	30.0	17.0
Iodine µg	250.0	90.0

Report on WFP Training Workshop in Sudan

By Theresa Loro, WFP Sudan

WFP/T Loro, Sudan, 2007



Group work presentation

WFP/T Loro, Sudan, 2007



Practical work in the community session

Theresa Loro is a Senior Nutritionist working with WFP Sudan and has been based in Khartoum since 2004 as a National Officer for Nutrition and HIV/AIDS focal person. Previously Theresa worked with UNICEF Sierra Leone as UNV Nutritionist for 18 months, and has worked with the Combined Agencies Relief Team (CART), UNICEF Sudan, and the Ministry of Agriculture in Southern Sudan since 1990.

From 6-8 May 2007, WFP Kadugli sub-office, in collaboration with the State Ministry of Health (SMOH) and UNICEF, conducted a three-day Health, Nutrition and HIV/AIDS Messages Promotion Training Workshop in Kadugli locality, Sudan.

The aim of the workshop was to promote appropriate diets, healthy lifestyle measures and protection against HIV that would help in reducing malnutrition and inappropriate feeding practices in children, promote good hygiene and sanitation, and contribute towards the eradication of HIV/AIDS disease. This would complement the work of health workers from MOH, UNICEF and collaborative partners in Kadugli area.

Workshop objectives

- To build up capacities of WFP staff and cooperating partners (CPs) to impart key health, nutrition and HIV awareness messages to beneficiaries at general food distribution (GFD) sites, using a community approach.
- To develop and establish a joint health promotion educational strategy between WFP, MOH, UNICEF and CPs to raise communities' awareness of key issues through community women training. This community based training would take place in pilot project selected locations of GFD areas.

Thirty-two participants (18 men and 14 women) attended the workshop, representing eighteen

organisations, the Government of Sudan (GOS), United Nations (UN) and non-governmental organisations (NGOs), including WFP staff selected from Kadugli, Kauda and Abyei. Additional representatives from the Federal Ministry of Health (FMOH) and SMOH attended the workshop.

Professionals from the FMOH, SMOH, UNICEF and WFP nutrition unit were the main facilitators of fourteen training sessions. Field sessions in selected community villages were used to practice application of the Training of Trainers (TOT). Participants also practiced formulating training plans to train community-based women in the delivery of health promotion messages.

Opportunities

Most of the partners' organisations' participants had an adequate background in health, nutrition, HIV/AIDS and health promotion educational messages. This will strengthen the community women training in the pilot project's locations.

Collaborative partners involved in the pilot project (SMOH and UNICEF) have mandated strategies and policies that encourage involvement of communities in health, nutrition, and HIV/AIDS and health promotion messages delivery.

Challenges

An evaluation of the training workshop was undertaken. The short time allotted to training sessions limited discussion and interaction between trainers and facilitators, which led to some dissatisfaction amongst participants (19.6%).

The administration of the training budget to cover expenses needed good planning. A per diem/transportation allowance has not been considered/allowed in the training budget planning. This negatively influenced GOS

training participants' motivation as they are used to receiving payment in similar organisations' training exercises.

The provision of one meal during the day was insufficient where participants were expected to work for long hours.

Follow up

WFP field monitors and representatives from CPs who participated in health promotion training are now engaged in a pilot project, responsible for the training of community women, selected from 5-6 locations in the GFD targeted areas. Awareness programmes shall be advocated in these communities to disseminate key health messages within the programme planned activities, including nutritional values and preparation of food aid, HIV awareness, hygiene promotion, and diarrhoea management.

Recommendations

- SMOH, UNICEF and WFP should develop clear strategies for community women training programmes.
- SMOH, UNICEF and WFP should set out plans for community women training in the designated pilot project's locations.
- WFP-Khartoum should make sure that training equipments and materials are ready before a community training plan commences.
- Collaborative partners should ensure that more guidance in planning and communication skills and on follow-up of community women training are developed before pilot project community training commences.
- Literacy education partnering projects should be encouraged at project locations, as high illiteracy among the women is a major contributing factor to poor nutritional status.

For more information, contact: Theresa Loro, WFP Sudan, email:Theresa.Loro@wfp.org

Changes in eligibility for specialised food for HIV positive adults

The US government HIV/AIDS office on the use of food in programming with PEPFAR (President's Emergency Plan for AIDS Relief) has changed policy with regard to food and nutrition programming.

This policy change relates to adult patients who are enrolled in Anti-Retroviral Therapy (ART) and care programmes. Effective immediately, U.S. Government Emergency Plan country teams may provide food support to patients in ART and care programmes with a Body Mass

Index (BMI) less than 18.5 (previously the criteria was <16.0). Supplementary feeding support should cease once the patient's BMI stabilises above 18.5 (e.g. two consecutive months greater than 18.5).

Policy guidance recommends that U.S. Government Emergency Plan country teams need to determine funding allocated for this relative to other priorities. These include food and livelihoods support to orphans and vulnerable children and to HIV-positive pregnant and

lactating women. The guidance also recommends involving other resources and linkages with longer-term food-security activities.

U.S. Government Emergency Plan country teams that choose to elevate the BMI entry criterion for programme intervention should consider current models, such as the Kenya National Food by Prescription Programme, in their programme design.

The new authorisation is likely to increase substantially overall resource levels with increases expected for the use of therapeutic food in special cases.

For further information, contact Tim Quick, email: tquick@usaid.gov and Dana DeRuiter, email: deruiterdm@state.gov from the Food and Nutrition Technical Working Group, USAID.

Workshop on the Integration of Community-based Management of Acute Malnutrition (CMAM)

Date: April 28-April 30, 2008

The Food and Nutrition Technical Assistance (FANTA) Project is hosting a Community-based Management of Acute Malnutrition (CMAM) international workshop in Washington DC, sponsored by USAID's Office of Foreign Disaster Assistance and Office of Health, Infectious Diseases and Nutrition. The workshop will be organised jointly with United Nations (UN) and non-governmental organisation (NGO) partners.

In recent years, CMAM has moved into mainstream programmes. Practices once confined to humanitarian emergency programming are now being implemented in standard clinic settings. National Ministries of Health, not only NGOs, now implement CMAM. With the recent UN

Joint Statement on Community-based Management of Severe Acute Malnutrition¹, this trend is expected to accelerate rapidly, putting extra strain on existing capacity for training and dissemination. Within the humanitarian sphere there has been a discernable evolution of CMAM programming to address sustainability concerns, and to enable more effective integration into existing national health services. However, there remain a number of challenges.

The April 2008 workshop is expected to provide an opportunity to share current practices in the integration and scale-up of CMAM. Organisers hope to attract presenters from Ministries of Health in countries implementing CMAM, as well as NGOs and other partners.

Interested agencies and individuals should visit the FANTA website (see below) for a list of workshop themes and sessions, and instructions for registering and for submitting presentations for consideration.

Food and Nutrition Technical Assistance (FANTA) Project Academy for Educational Development, 1825 Connecticut Avenue., NW, Washington, DC 20009-5721
Tel: +1 202 884-8000 fax: +1 202 884-8432
e-mail: fanta@aed.org
<http://www.fantaproject.org>

¹ See news piece, Field Exchange 31. p15. The Joint Statement is available at: http://www.who.int/entity/nutrition/topics/statement_community_based_malnutrition/en/

ENN led Management of Acute Malnutrition in Infants (MAMI) Project

Funded by the UNICEF led Interagency Standing Committee (IASC) Nutrition Cluster, the ENN is planning a review in 2008 of the field management of acutely malnourished infants under six months of age.

The management of malnutrition in infants under six months of age has been severely hampered by a poor evidence base upon which to base guidance materials¹, and consequently how best to support these infants in practice. Efforts have been made to 'stop-gap' the lack of guidance to support field practitioners² and agencies have evolved guidance to meet the needs of infants as they present. A body of experience in the management of this age-group has been accumulating over the past 5 years amongst agencies. However in many instances, programme data are collected but not analysed, or internal reports written but not routinely shared with outside agencies. The ENN believe that reviewing and possibly re-analysing 'hidden field evidence' is a critical first step to gain some understanding of key issues around management of malnutrition in this age-group, e.g. overall admission numbers, programme coverage, agency guidance material, management practices and treatment outcomes.

The Management of Acute Malnutrition in Infants (MAMI) Project will endeavour to establish what is currently advised or recommended regarding the management of acute malnutrition in infants under six months in the form of guidelines, policies and strategies, by different organisations and then determine what is carried out in practice.

The review will involve an inter-agency collaboration, with the formation of a steering committee involving those agencies wishing to contribute information and data. There will

also be a research advisory committee of 'experts'. The Centre for International Health and Development, University College London (CIHD), will provide academic leadership and support while Action Contre la Faim (ACF) will be the lead for operational agencies.

This review will engage with the current review process of severe malnutrition management undertaken by WHO and the International Malnutrition Taskforce.

Findings of the MAMI study will be shared through the ENN regular publication, Field Exchange. Updates and the findings will be shared at the Global Nutrition Cluster meetings and at international fora, such as the UN Standing Committee on Nutrition meeting in 2009.

A framework and detailed scope of the review will be developed in consultation with the steering committee and research advisory group. Any individuals or agencies, including government bodies, local and international NGOs and UN agencies, who would like to participate in this project should contact Marko Kerac, email: m.kerac@ich.ucl.ac.uk or Marie McGrath, ENN, email: marie@enonline.net, tel: +44 (0)1865 249745

For more information, including a questionnaire to gauge interest and data potential, visit: <http://www.ucl.ac.uk/cihd/research/nutrition/mami>
Or <http://www.enonline.net/research>

¹ Severe Malnutrition: Report of a Consultation to Review Current Literature (WHO, 2005)

² A chapter on managing severe malnutrition in infants under six months was included in the Module 2 training resource (available at <http://www.enonline.net/ife>) developed by the IFE Core Group, with input from external experts and guided by expert technical opinion and review.



A mother with her infants enrolled in Tahoua feeding centre in Niger, run by CONCERN and supported by WFP

WFP/T. Loro, Sudan, 2007



N Dent, S Sudan

Socio-Cultural Determinants of Food Sharing in Southern Sudan

Local Dinka volunteers

By Emmanuel Mandalazi and Saul Guerrero, Valid International Ltd



Emmanuel Mandalazi is a Social & Community Development Advisor working for Valid International. Over the last three years, he has worked on community-related issues in a number of CTC programmes in Ethiopia, Malawi, Southern Sudan, Zambia, and Uganda.

The authors would like to thank Concern Worldwide for funding the research and publication of this paper.



Saul Guerrero is also a Social & Community Development Advisor working for Valid International. Over the last four and a half years, he has assisted in the design, implementation and evaluation of community mobilisation strategies for CTC programmes. He has also been involved in a wide range of operational research projects. He has worked in Ethiopia, Malawi, South and North Sudan, the Democratic Republic of the Congo (DRC), Zambia, Niger, Chad, Sierra Leone and Indonesia.

ing, as a primary pillar of Dinka identity, cannot be ignored because it ultimately determines the degree of success of humanitarian interventions.

Methodology

The writing of this article was prompted by what was perceived as a deficit of information on food sharing practices amongst the Dinka of Southern Sudan, and the impact that such practices and obligations had on humanitarian programming. The main bulk of the data were collected in 2004 as part of a month-long research study, funded and supported by Concern Worldwide in Aweil West and North, Bahr-el-Ghazal (Southern Sudan). Further field visits to Aweil West and North in 2005 and to Tonj County in 2007 provided additional research opportunities. During these visits, information was gathered using qualitative research methods including Focus Group Discussions (FGDs), in-depth interviews and informal discussions with key stakeholders.

Background

The Dinkas, or Moinjaang, are the largest ethnic tribe in Southern Sudan, inhabiting the swamplands of the Bahr el Ghazal region of the Nile basin, Jonglei and parts of southern Kordofan and Upper Nile regions. The group has an estimated population of around 2 million, constituting about 5% of the population of the entire country¹. The numerical strength of the Dinka's has historically made them a force to be reckoned with in the political and economic direc-

tion of Southern Sudan². Their involvement in the Civil War was particularly prominent, with Dinkas filling the ranks and providing much of the strategic direction of the Sudan People's Liberation Army/Movement (SPLA/M). The interaction between Dinka socio-political identities and the Civil War has been multifaceted and has been extensively explored elsewhere³. For the purpose of this discussion, however, two elements are worth exploring. First, the impact of the conflict on the Dinka's traditional source of livelihood (pastoralism), and second, the war-induced changes in traditional marriage practices and polygamous households in particular.

The Dinkas have traditionally considered themselves pastoralists. Recently, however, environmental factors such as flooding and erratic rains have led to the emergence of agro-pastoralism as the primary livelihood in much of the Upper Nile region⁴. Livelihood changes aside, cattle continue to play a central social, political, cultural and economic role in the Dinka traditional identity. Cattle have been the historical measure of a family's wealth, and the means by which further wealth is sought. Cattle are the primary means by which households and clans are expanded, as it represents the main form of dowry (known locally as arueth) used in marriages. The Dinka are polygamous, and the number of wives taken by a man has been closely linked to the number of cattle that each man (and his clan) possesses. The cattle given by a man to his wife's family, is then redistributed between the man and his close relatives, thus expanding their communal wealth.

Given the proximity to the border between North-South Sudan, Dinka communities experienced some of the heaviest attacks and raiding by murahaleen (northern militia groups) coming from the Kordofan and South Darfur regions in the north. The socio-economic costs of these attacks were immense. For example, in areas such as Paliau, the decline in cattle number was so significant that it led to agriculture entirely replacing pastoralism as the primary source of livelihoods⁵. From an economic perspective, raiding and looting precipitated a decrease in the socio-economic status of most Dinka families in the affected areas (particularly in Bahr-el-Ghazal and Upper Nile regions). This impacted not only on the overall vulnerability of households, but also has led to the loss (almost overnight) of significant wealth amongst the richest families and clans. Polygamous men (often married to tens of women) became unable to sustain and support the individual female-headed households linked to them through marriage. Individual Dinka family units, and in particular female-headed households, have had to become increasingly self-sufficient. In this context, food aid has proved useful in support-

This field article explores the socio-cultural determinants of food sharing amongst the Dinka of Southern Sudan and explores the implications for humanitarian programming.

In 2004 the Concern Worldwide Southern Sudan Supplementary Feeding Programme (SFP) faced sub-standard recovery rates (vis-à-vis Sphere standards), long lengths of stay, and children becoming severely malnourished in spite of the supplementary rations provided. Anecdotal reports pointed to food sharing as the primary underlying cause. A field study was commissioned by Concern Worldwide to explore food sharing as a cultural phenomenon, to determine its roots and its implications for the Community Therapeutic Care (CTC) programme, as well as possible responses. Much of this article is based on the findings of this study.

Food sharing has been, and continues to be, an important feature of the identity of the Dinka of Southern Sudan. Kinship structures play an important role in how food is utilised in the Dinka society. The Civil War that engulfed North and South Sudan for over two decades has led to an increased reliance by Dinka (and other) communities on these kinship structures for their survival. These important features have gone largely unacknowledged by humanitarian practitioners working with communities, such as the Dinka, in which sharing plays a prominent role. This article argues that shar-

¹ FAO/WFP (2006). FAO/WFP Crop and food supply assessment mission to Sudan (Special report).

² Jok, Jok Madut and Hutchinson, S. E. (1999). Sudan's Prolonged Second Civil War and the Militarisation of Nuer and Dinka Ethnic Identities.

³ See reference 1. p126

⁴ Johnson, D. H. (1989). Political Ecology in the Upper Nile: The Twentieth Century Expansion of the Pastoral 'Common Economy'. The Journal of African History, Vol. 30, No. 3. p463

⁵ Harrigan, S and Changath, C. (1998). The Sudan Vulnerability Study, (Save the Children Fund- UK, Nairobi)

⁶ Ntata, P. R.T (1999). Participation by the Affected Population in Relief Operations: A Review of the Experience of DEC Agencies during the Response to the 1998 Famine in South Sudan. (Chancellor College, University of Malawi, unpublished report). p21

ing households – but it has been kinship support networks and obligations that have proved essential in safeguarding the most vulnerable⁶.

Dinka Kinship Structures: a brief overview

For the Dinkas of Southern Sudan, kinship structures have been and still remain an important mechanism that dictates their lives. There are three kinship structures in the Dinka society that regularly influence people's lives - from marriage, to allegiance in local conflicts to food sharing. First, there is dieth or 'clan' - the largest kinship structure that an individual belongs to which an individual belongs, membership being inherited patrilineally (from one's father). Clans tend to comprise a large number of families in a given area. For example, there are five dieth (panchol, panayuel, panrec, panayik and panakuol) amongst the Bor Dinkas of Paliau⁷. The second significant group is the paruaidie or 'in-law', which generally includes the clan and close relatives of one's spouse. Thirdly, is the mac thok - the smallest and closest group in the lineage with which a person identifies. It generally comprises members of the nuclear family, parents, siblings and their nuclear families. The boundaries of the mac thok are individually determined, and do not seem to follow rigid kinship or social lines. It is from the mac thok that the dowry (or bride wealth) generally derives – and to which the dowry for a married woman is in turn distributed.

Food sharing mechanisms

Food and asset sharing is a multilayered process; essential to everyday life amongst the Dinkas, and equally central as a coping mechanism in times of food insecurity. Not only is food sharing widely recognised as a social norm but it has also been firmly imprinted on the traditional legal system of the Dinka. Broadly speaking, food sharing relies on two regular mechanisms; informal but regular 'meal' sharing, and the more formalised sharing of foodstuff and assets.

Informal Meal Sharing

Informal meal sharing is a regular practice that takes place between different households but mostly (though not exclusively) amongst members of a mac thok. This communal sharing of meals is widely referred to as buro and has traditionally been used as an informal forum to discuss community issues, retell stories and share advice from one generation (older) to another (younger). Our own field observations showed that buro is conducted along very strict gender lines. Men over the age of eight come together in one central place (usually in one of the participants' households) while women and children have a separate and usually distant location⁸. Another subdivision is made where women have their own buro whereby young children are given their own dish to eat from. The Dinka often explain this arrangement by pointing to the difficulties for children to eat their fill if they had to 'compete' for food with older siblings or adults. The civil war, and the resulting loss of resources and displacement of entire communities, has weakened this practice – but it remains an active and relevant institution for the Dinka. From a food sharing point of view, buro relies on individual contributions of food according to individual capacity – it is not imperative to contribute, thus allowing for food insecure individuals to rely on the more food secure. Although the

practice of buro is reportedly decreasing, there is evidence to suggest that it is still part and parcel of the Dinka culture and everyday community interaction.

The introduction of humanitarian food rations into Dinka society has had mixed effects on buro. The use of Corn Soya Blend (CSB) in SFPs has introduced quantities of flour, which even though may not be considered sufficiently 'large' to be shared as an asset (see below), have certainly entered into the communal meals in cooked form (e.g. porridge). Our research indicates that the porridge prepared by mothers of targeted households, is openly and systematically shared amongst the children of all households participating in buro⁹. Whilst CSB may be shared during buro, our research found little evidence to suggest that Ready-to-Use Therapeutic Foods (RUTFs) such as Plumpynut® undergo a similar sharing process. The exclusion of RUTFs from the systematic means of food sharing such as buro are, arguably, the result of two factors; first, the individually packaged RUTF rations are more difficult to add to a communal meal on a regular basis. Secondly, nutrition programmes have consistently presented RUTF as a 'medicinal food' – a hybrid between medicine for the child's condition, and food to fulfil its daily nutritional requirements. As such, mothers may be less willing (at least during the initial stages of treatment) to allow other seemingly healthy children to consume the product.

Formal Sharing

The more formalised type of sharing takes place in times of need or shortage and mainly involves borrowing foodstuff and livestock during food insecure periods or when individuals are entitled to request assistance from members of their mac thok. During these periods, individuals may request items such as grains, pulses and livestock from close relatives such as nephews, uncles, in-laws and siblings in order to meet their food needs. During marriage, an individual is also entitled to ask the members of their mac thok for assistance to raise the required dowry (mostly in the form of cattle). In turn, the bride wealth that the bride's family receives from her husband is shared amongst members of her mac thok so that it is

also used as dowry contribution during marriages of their male children. When the dowry is to be collected, a bull is slaughtered and a meal prepared for all people from both sides except for the groom who waits for *lok thok*¹⁰ to be performed. Repayment mainly depends on the quantities shared; no immediate or future repayment is generally expected when very small quantities – such as 1 tin of sorghum – are exchanged. Only when the quantities are large (over 3 tins of sorghum for example) – is repayment generally expected. There is evidence that food aid sharing is also part and parcel of the formal sharing. For example as Ntata reports, "during the 1998 emergency, food, after being distributed to women, was subsequently taken to a secondary distribution point where it was redistributed by the leadership structure based on its own definitions of vulnerability"¹¹. Our own evidence supports Ntata's findings of 'secondary sharing' at household (or *mac thok*) level.

Enforcing and formalising food sharing options

Amongst the Dinka there are a few general rules, such as legal action, social exclusion and shaming, that govern the way sharing is conducted.

Shaming

As Harrigan (1998)¹² reports, the Dinkas use shaming as a mechanism to advocate for a fair distribution of resources amongst a larger majority of people – especially one's mac thok. People who do not share food with members of their mac thok (i.e. who do not engage in prac-

⁷ See footnote 3, p33.

⁸ See footnote 3, p21.

⁹ Guerrero, S. (2004). Socio-Cultural Assessment of Food Sourcing and Sharing in the Communities of Aweil West & Aweil North, Bar-El- Ghazal, South Sudan (Valid International & Concern Worldwide, unpublished report)

¹⁰ The *lok thok* is a traditional Dinka ritual amongst the Dinkas that is performed when dowry is paid for and is collected by the bride's family. It literally means 'cleansing one's face with water' a necessary step to allow the groom to eat together with his in-laws. Prior to the performance of *lok thok*, the groom is traditionally considered 'dirty', 'impure' and too immature to eat together with his in-laws. For the ceremony, a bull is slaughtered for the groom and he eats it with his peers as a way of bidding farewell to them and graduating into adult life.

¹¹ See footnote 4, p14.

¹² See footnote 3

¹³ See footnote 3



A group of Dinka elders

N Dent, S Sudan

tices such as buro) are often branded as kor (lit. 'lion'). This has elsewhere been attributed to the notion that like lions, people who eat alone give nothing to others, and should expect nothing from other members of the group¹³. Sometimes if one refuses to share food with those in need it could lead to death - through spear masters who may invoke the wrath of the ancestral spirits. Whilst selfishness is socially shunned, sharing is socially rewarded. A wife who is generous to the children of her in-laws, for example, will be highly esteemed by the members of her husband's family. Shaming, traditional beliefs and appreciation are the socially constructed and powerful enforcement mechanisms that promote food sharing.

Legal action in traditional courts

The ability of households to rely on members of their mac thok in times of food insecurity is also firmly protected by traditional Dinka law. Traditional law allows individuals to bring to court members of one's mac thok who are unwilling to assist in times of need. In exceptional cases, in-laws can also be brought to court if they fail to complete dowry payment. These courts, known locally as luke, are run by village elders and socio-political leaders (e.g. Executive Chiefs). The courts are responsible for cases ranging from adultery (luke ting ci kor) to stealing (luke cur) and murder (luke tier). During the pre-harvest months, the courts also witness a significant increase in food/hunger related cases (luke ecok). These cases are mostly founded on refusals to share food, or failure to pay for cattle given or promised during marriage. The system allows people to 'file' cases against any member of the mac thok for failure to honour a debt or promise. The system also ensures that sharing of food and assets such as livestock eventually takes place, especially in situations where the accused does not sympathise with his/her relative's plight and/or needs. This makes sharing food with one's disadvantaged relatives not only an issue of social or moral responsibility, but also a legally founded obligation.

Implications of food sharing practices for humanitarian programming

Much of this article has focused on the social, economic and cultural roots of food sharing - as an integral feature of local livelihoods, and social norms, as well as a legal obligation in Dinka society. In doing so, it has highlighted the importance of the system for the Dinkas themselves. Food sharing is not merely a characteristic or feature of Dinka society and humanitarian programmes should recognise it as an operational variable and a factor to be acknowledged and accounted for in order to maximise humanitarian programme performance. Doing so would ensure two of the most fundamental principles of humanitarian programming -

minimising the negative impact on local support networks, and maximising the impact of proposed interventions.

A clear understanding and recognition of the Dinkas as a social group with a social and cultural structure that leans towards a collective way of life would help minimise any potential negative impact on local support networks of humanitarian programming. Members of the community and, in particular, from the mac thok, may try to help those in need and overlook their own individual requirements in order to conform to societal obligations. Food sharing may play an essential role in humanitarian programming in that food sharing mechanisms and obligations will ensure that all families benefit from the food that is available, especially when some families have surplus food reserves. However, it must be recognised that in situations where the majority of families have limited food, food aid will still be shared out in the wider community. For example, the humanitarian food rations such as CSB in SFPs have been part and parcel of communal meals (buro). The rations effectively become diluted so that the nutritional requirements of the most vulnerable, e.g. the malnourished, are least likely to be met.

In order to maximise humanitarian programme performance, food aid meant to benefit the vulnerable directly may need to be marked as medicinal food as it will be less exposed to sharing. However, even where food is 'medicinalised' this may not be enough since in Dinka culture, a person is regarded as vulnerable mainly on the grounds of the kinship structures that an individual has around them to support them. Local people often say that rather than targeting, it is better to get a handful for everyone as it makes them all equal. In these and in other instances when food aid might not be easily medicinalised, programmes may be more effective if they are accompanied by 'civic education' through community sensitisation, to highlight the importance of only making the food available to the most vulnerable. Key people, including leaders of clans, community and traditional courts, directly involved in the decision making around food and asset sharing, should be targeted.

All in all, food and asset sharing is deeply rooted in the Dinka culture. It is therefore imperative for the humanitarian practitioners operating in Southern Sudan to invest adequate resources in exploring and recognising cultural traits that will ultimately enable programmes to become more culturally amenable.

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WFP Targeted Supplementary Feeding in Ethiopia

Summary of evaluation¹

In October 2004, the Executive Board of the United Nations (UN) World Food Programme (WFP) approved Protracted Relief and Recovery Operation (PRRO) 10362.0 for Ethiopia. This intervention aimed to address the food needs of 3.8 million beneficiaries (relief 1.7 million, recovery 2.1 million) over the period 1 Jan 2005 to 31 December 2007.

PRRO 10362.0 comprises four main programme components including targeted supplementary feeding (TSF) for vulnerable children and women, working within the Government of Ethiopia's framework of Enhanced Outreach Strategy (EOS).

The EOS/TSF programme delivers a combination of key child and maternal health interventions including Vitamin A supplementation, measles vaccination, provision of insecticide treated bed nets and de-worming on a six-monthly basis. Screening of pregnant women, women with infants under six months of age and children under five years of age² using mid-upper arm circumference (MUAC)³ also takes place, in conjunction with delivery of the health inputs. Those women and children who are found to have a MUAC below the cut-off point of 21.0cm and 12.0cm respectively are given a ration card and referred to the TSF programme. Those with a MUAC below 11.0cm and/or with oedema are referred for treatment of severe malnutrition where available. The TSF beneficiaries receive two 3 monthly food supplements that comprises 25 kg of micronutrient fortified Corn or Wheat Soya Blend (CSB/WSB) and 3 litres of fortified vegetable oil. This provides 1,690 kilocalories, 55g of protein and 15g of fat per day. At the end of 6 months, beneficiaries automatically leave the programme.

The MUAC screening and TSF referral takes place every six months at designated EOS sites. The TSF distribution takes place every three months at TSF designated sites. The FMOH/UNICEF are responsible for the EOS component while the Disaster Preparedness and Prevention Bureau (DPPB)/WFP are responsible for the TSF component.

The overall aim of the combined components of the EOS/TSF is to "reduce morbidity and mortality in children under five". The TSF objectives are nutritional and are as follows:



A homestead in South Sudan

N Dent, S Sudan



- To prevent the nutritional deterioration of children under five and pregnant and lactating women.
- To prevent those moderately malnourished becoming severely malnourished.
- To rehabilitate moderately malnourished children and pregnant and lactating women through the provision of fortified supplementary food.
- To promote key nutrition messages.

It should be noted that while the objectives of the TSF are typical of traditional supplementary feeding (SFP) programmes, the TSF is not a standard SFP. The TSF operates on the basis of a three-monthly food distribution without a general ration, absence of facilities for treatment of severe acute malnutrition (SAM) and no follow up of a child or women's weight gain during their enrolment in the programme. (Ed).

In December 2006, WFP conducted an evaluation⁴ of the TSF/EOS component of the PRRO as part of a larger evaluation of the whole programme. Interviews were conducted with key stakeholders in Addis Ababa and the evaluation team visited five regions of Ethiopia where the TSF was being implemented. Interviews were conducted in regional capitals and at field level. The following were the main findings of the evaluation team.

- The achievements of the TSF in a relatively short space of time have been impressive.
- Over a one and a half year period, the TSF has expanded from just one region and 10 woredas in April 2005 to 264 woredas in 10 regions by the end of 2006.
- In 2005, only 62.2% of planned TSF beneficiaries were reached. This was due to start up problems related to capacity constraints in government, including a lack of training and coordination, under-achievement in terms of nutritional screening targets and delays in secondary transport of food delivery. By November 2006, approximately 400,000 children and 190,000 pregnant and lactating women received two distributions of the food supplement i.e. a total of six months of supplementary food. Furthermore, 4,000 food distribution agents had been trained.
- Considerable resources have been invested in TSF staff training at all levels. In addition, the programme provided a 'minimum package' for the regions that included cars, motorbikes and computers. In 2006, an estimated 54% of all TSF woredas received the minimum package.
- Another significant achievement has been the substantial network of highly capable

trained local women (Food Distribution Agents (FDAs)) created for overseeing all aspects of the food distribution and for providing nutrition education. In addition, WFP has made considerable efforts to strengthen programme implementation – largely through operational research/pilot studies. WFP have also developed a monitoring system especially for the TSF.

Challenges

Currently, there is insufficient evidence that the TSF is having a positive impact on nutritional status of children enrolled in the programme. This is a critical gap given the unusual design of this programme and lack of precedent for implementing this type of programme. There are also no population level data (baseline and post-intervention) on prevalence of acute malnutrition in children under five and women or infants and under five mortality rates that could be used to demonstrate an impact of the programme at population level. However, the scale of the food transfer, the coverage and the integration with EOS health inputs would suggest that the programme must have some nutritional and health benefit even though the magnitude of this has as yet to be measured.

There is also a lack of clarity and policy guidance with regard to how the TSF should be adapted where acute nutritional crises occur. This has reportedly led to situations where the EOS/TSF has been viewed as a replacement for traditional SFPs in situations where child wasting levels have substantially increased.

Another challenge is that there are no formal linkages between the TSF and relief/Productive Safety Net Programme (PSNP) components of the PRRO. Although, according to the PRRO document, the TSF programme was meant to serve a subset of the relief/PSNP beneficiary population, no operational linkages have been established. A high proportion of TSF beneficiaries may therefore not be in receipt of an adequate general ration. This will lead to sharing (small scale studies conducted by WFP suggest that over 50% of TSF beneficiaries may be sharing rations with other family members) and consequent dilution of impact of the TSF ration. However, as a significant proportion of those identified as mild and moderately malnourished may not be food insecure but affected by poor health and/or caring practices, it may not be appropriate to formalise a linkage between the TSF and relief/PSNP components of the PRRO. This issue requires follow up study to determine whether a formal linkage between the programmes should be established.

Another issue is that there is no clearly articulated exit strategy for the TSF component, although the overall EOS/TSF programme is expected to phase out as the national Health Extension Programme (HEP) expands. It is unclear how long the planned HEP expansion will take although considerable progress is being made in training Health Extension Workers (HEW) and in constructing health posts. In addition, there is currently no stated role for supplementary food in the HEP documentation. It is therefore unclear how the programme will continue if WFP withdraws from programming in the future.

The evaluation made a number of recommendations that include the following.

In order to demonstrate impact of this novel type of programming, WFP should:

- Conduct a robust nutritional impact and efficacy assessment of the TSF as a priority, with all parties and donors involved in the study design to ensure shared objectives and ownership of the results.
- Ensure the study involves representative samples of cohorts of children to assess nutritional outcome and also include programme coverage indicators to understand what levels of exclusion and inclusion error are occurring.
- Ensure that if impact and efficacy are demonstrated, there are discussions with key stakeholders to determine clear programme targets for the future, including exit criteria.

To strengthen linkages between EOS and create opportunities for FDAs to become a bridge to the HEP, WFP should formalise the role of FDAs in EOS screening.

To ensure that the TSF does not inhibit an appropriate response to acute nutritional crises, WFP should develop clear guidance material on the role of the TSF in acute crisis, especially with regard to emergency targeted SFPs implemented by international non-governmental organisations.

¹ Summary Evaluation Report Ethiopia PRRO 0362.0. 10 October 2007. Available at <http://www.wfp.org/eb/docs/2007/wfp137560~2.pdf>

² The screening actually includes older children who are stunted as the entry to the EOS programme is based on a height less than 110.0cm

³ Up until March 2006, MUAC screening was followed by weight for height measurements but this was stopped after agreement among all stakeholders to simplify the system and use only MUAC as a good predictor of mortality risk.

⁴ WFP (2007): Summary Evaluation Report Ethiopia 10362.0: Enabling livelihoods protection and promotion. Executive Board 2nd Regular Session, Rome 22nd-26th of October. Agenda Item 6

Real time evaluation of Pakistan Flood Response

Summary of evaluation¹

The Pakistan floods of 2007 devastated large swathes of rural Sindh and Balochistan Provinces in southern Pakistan, destroying homes, crops and roads, and caused the temporary displacement of over 2.5 million people. The Government of Pakistan (GoP), through its newly created National Disaster Management Authority (NDMA) and with the help of the Army, launched a major relief operation. The United Nations (UN), with other members of the international humanitarian community and local non-governmental organisations (NGOs), mobilised resources to help. The decision was taken by the Inter Agency Standing Committee Country Team (IASC CT)² to launch a full-scale humanitarian response. An application was made to the Central Emergency Response Fund (CERF). Clusters were set up and started work, a joint rapid assessment was carried out with NDMA, and a Flash Appeal was announced and promoted.

For a variety of reasons, the GoP did not fully support the IASC CTs decision and approach. In addition, the assessment was delayed, the Flash Appeal was issued three weeks after the onset of the emergency and raised only 26%³ of its target, and the Clusters failed to achieve their full potential as coordinating mechanisms. As a result and despite substantial efforts, the humanitarian community did not succeed – to the extent it considered appropriate – in delivering humanitarian relief to the already-impooverished people of Sindh and Balochistan. A Real Time Evaluation (RTE) was set up over a two week period, staffed and operating independently of the UN, to help understand the reasons and suggest improvements for the future.

The main findings of the evaluation go some way to explaining the disappointing overall response and include:

- When the floods struck, the UN reforms (being piloted in Pakistan), the Humanitarian Response reforms, and the NDMA set up were all still in their transition phases. They needed more time to take root and for all parties to understand new mandates, roles and modes of operating.
- There were huge expectations within the UN that the success of its own Pakistan earthquake operation, mounted jointly with the GoP and fully supported by the international humanitarian community, could be repeated. However the contexts were very different and expectations were disappointed.
- Balochistan, in particular, is a highly politically sensitive part of Pakistan, and there have been restrictions on access for non-Pakistan nationals for some time on safety grounds.
- The GoP, and specifically the NDMA, was uneasy about launching a full scale international humanitarian response, including the Flash Appeal.
- The UN did not really grasp the implications of this GoP unease. Decisions were made by the IASC CT (to establish 12 Clusters, for example) with the best of intentions that, with hindsight,

were over-ambitious and over-complex in all the circumstances.

- Lessons from the 2005 Pakistan earthquake, particularly in relation to the operation of the Clusters, had not been learned or implemented, and many of the issues that were identified in the earthquake RTE re-emerged this time.

Main recommendations of the RTE may be summarised as follows:

- The UN, the GoP and indeed the international humanitarian community as a whole, must continue to invest in the new structures so that they achieve their objectives. Greater efforts must be made to understand each others' mandates, roles and operating procedures and develop a real sense of partnership in working towards common humanitarian goals.
- Common assessment tools, an effective management information strategy and systems, and shared operating procedures, contingency plans, standards and principles are needed.
- The Resident Coordinator/Humanitarian Coordinator (RC/HC) needs, in some circumstances, a special budget for immediate emergency response, or fast-track access to the CERF. Also, the capacity for a 'quick Flash Appeal', followed by a later full assessment-based appeal update, could achieve greater response from donors while media attention is still focused on the emergency.
- The RC/HC role is extremely testing, and the management and decision-making structures at country level are labyrinthine, particularly during a humanitarian response. A constructive development would be the separation of both roles by appointing a HC, as deputy to the RC, with Disaster Management (DM) and leadership skills and experience. The RC should be empowered during the period of the response to exercise overriding authority over the country heads in exceptional circumstances, and if necessary for the purposes of the response.
- The decision-making structures should be simplified by creating a senior level Disaster Management Team (DMT) jointly with the GoP/NDMA and representative(s) of other agencies as appropriate. The DMT should be empowered to make all the key strategic response decisions quickly and effectively.
- The Office for Coordination of Humanitarian Assistance (OCHA) needs to be adequately and quickly resourced for a humanitarian response in country, if it is to do its job effectively. The general view is that this was not the case in Pakistan.
- The lessons of the 2006 earthquake RTE particularly relating to clusters, and reinforced by the floods RTE, should be learnt and implemented.

The issue at the heart of the findings from the RTE relates to the role of the UN in a sovereign state with a strong government, and a humanitarian crisis to which the humanitarian community feels impelled to respond, but where the government does not wish to seek or receive international assistance at the level which the humanitarian community believes is appropriate.

This fundamental issue is a delicate and sensitive one and raises essential issues of international law in a situation where passions run deep on both sides of the argument. One person's imperative can easily become another's imperialism. Careful negotiation and discussion are required as well as patient advocacy based on good quality information.

¹ IASC Inter-agency real time evaluation of the Pakistan floods/cyclone – October 2007. FINAL Version: 31st October 2007

² Inter Agency Standing Committee. See

<http://www.humanitarianreform.org>

³ Correct on 30th September 2007

Wet nursing for refugee orphans in Bangladesh

By Yara Sfeir, UNHCR Bangladesh



Yara Sfeir is an International United Nations Volunteer posted as a Nutrition Coordinator for the two Rohingya refugee camps of Nayapara and Kutupalong on the border of Myanmar in Bangladesh.

The opinions expressed are those of the author and cannot be attributed to UNHCR.

In Nayapara TFC, the first wet nurse was the baby's aunt



This article shares the practical realities of identifying wet nurses for young orphans where artificial feeding was not considered an acceptable, feasible, affordable, sustainable and safe option.

UNHCR started working in Bangladesh in 1992 upon the invitation of the Government of Bangladesh to assist in the repatriation of more than 250,000 Rohingya refugees. These people had fled from Myanmar during the same year due to socio-economic and political reasons. UNHCR has since assisted in the repatriation of around 230,000 refugees, equivalent to 95% of the original registered refugee caseload.

As of end December 2007, there were some 27,400 refugees residing in the two camps of Kutupalong and Nayapara situated along the Bangladesh-Myanmar border. UNHCR provides care and maintenance while actively pursuing durable solutions for the remaining refugees¹. The Ministry of Health along with one local non-governmental organisation (NGO), Technical Assistant Inc (TAI), were the only two UNHCR implementing partners until recently. In November 2007, Research Training Management International and Handicap International began working in the two camps. In both camps², Medecins Sans Frontieres-Holland has been present and is planning to close down its operation in 2008.

In the Rohingya refugee camps of Nayapara and Kutupalong in Bangladesh, three types of nutrition programmes are operating, in addition to the World Food Programme (WFP) general food distribution.

- A Blanket Feeding Programme (BFP) for all children between 6 and 24 months residing in the camps
- A Supplementary Feeding Programme (SFP) for pregnant or lactating mothers and moderately malnourished children between 6 to 59 months. A total of three SFPs are operating between the two camps.
- A Therapeutic Feeding Centre (TFC) for severely malnourished children from 6 to 59 months. One TFC is present in each camp, run by the MOH.

The challenge

In October 2007, Ministry of Health staff working in the TFC alerted the UNHCR team managing the camps that five orphans below six months of age had been brought by caretakers to the TFC but were sent home again since no guidelines were set for their care. No infant formula is provided in the camps and the caretakers were feeding the infants with cereals. At first the UNHCR team thought about providing infant formula for the orphans. However, after consulting the 'UNHCR Policy Related to the Acceptance, Distribution and Use of Milk products in Refugee settings (2006)³, and discussions with the UNHCR Headquarters Nutrition Unit, the challenges of introducing infant formula to such an unhygienic setting were recognised. Furthermore, the caretakers were illiterate and unable to read written guidelines. Another fear was that all mothers would start requesting infant formula for their infants, as it was common practice for distributed food to be sold in the camps.

The options

We therefore opted to find a 'wet nurse' – a woman who is not the mother who would breastfeed the infant. This strategy is included in the options outlined in the Operational Guidance on Infant and Young Child Feeding in Emergencies (2007)⁴ produced by the IFE Core Group, of which UNHCR is a member. We realised that the HIV status of the wet nurse should be considered. However, in the Nayapara and Kutupalong camps the risk of HIV was considered to be low⁵, therefore the wet nurses were not offered Voluntary and Confidential Counselling and Testing for HIV⁶.

In the Nayapara camp there was a mother who was already breastfeeding one orphan who was not a relative. She was also breastfeeding her one year old child at the same time. Since this seemed to be an accepted practice in the community, we asked the Community Health Worker (CHW) and the TFC and SFP staff, as well as the caretaker, to actively look for wet nurses amongst the relatives of orphans. In the event that no relative was lactating, we urged them to extend their search to the wider community. As an incentive, we agreed to offer the wet nurses food from the SFP. After a few days, one wet nurse was found for one orphan: she was the orphan's aunt. It had not occurred to her that she could also breastfeed her orphan nephew. "It is an honour to breastfeed my nephew" said the aunt smiling, hugging the baby and cuddling him. This positive experience encouraged us further.

The CHW and selective feeding programme staff informed us that no other wet nurse could be found so we decided to reach out to the community. One of the ways in which we did this was to talk with groups of pregnant and lactating women when they came to the SFP for food. We told them, "We are the team responsible for nutrition in the camps. We are facing a problem. We need your help. We have orphans in our camps that are too small to be given food. They should only be breastfed. We don't want to give them powdered formula because if the water in the formula is not clean, they will be sick and have diarrhoea. Would you or someone you know be able to breastfeed the orphan?" We explained that the baby already has a caretaker and that their role would only be to breastfeed the baby several times a day. We also explained that the wet nurse would receive an extra food ration from the SFP (an egg, a banana and some porridge) every day. Two lactating mothers agreed on the spot. One of them was hesitant but when we took her to see the orphan her doubts disappeared. We asked the wet nurses to come to the centre every day. The TFC staff and the caretaker would make sure the wet nurse was breastfeeding the infant 8 times a day and that she also received her extra ration. In the Kutupalong camp, a wet nurse was easily located for one orphan and she breastfed him more than 6 times a day, in the morning and the afternoon. This was also a very encouraging outcome.

However, a number of difficulties did arise. One wet nurse was not allowed by her husband to breastfeed an unknown child, so we had to actively locate and recruit another

woman for this child. Luckily, we were able to find another willing wet nurse, although she found it difficult to breastfeed 8 times a day since she lived far from the centre. Since the TFC closes at 2pm, we asked the caretaker to take the infant to the wet nurse every afternoon. This seemed to work well for all the orphans. However, another problem soon arose. As refugee women do not feel safe travelling at night, the caretakers were asking for infant formula for night-feeds. During a training on breastfeeding organised by UNHCR, a solution was found through discussion and brainstorming led by a trainer from the Bangladesh Breastfeeding Foundation. The wet nurse would hand over expressed breastmilk to the caretaker who would keep it in a container. If the milk needed to be kept for more than 6 to 8 hours, then a box of ice would be given to the caretaker for storing the expressed milk. The milk could then be heated and given to the infant by cup. This practice is now adopted in the camps.

Of course, a number of challenges remain. For example, there was an occasion when a caretaker decided that when her orphan had a bout of diarrhoea that this was due to the wet nurse's breastmilk. She therefore bought powdered milk. On showing it to us it was clear that she was unable to read the warning that clearly stated "not suitable for infants below 1 year"! We discussed the issues around this with her and offered advice. However, she seemed uninterested and never came back to the TFC. Challenges like these are, of course, to be expected but in my opinion, the advantages of wet nursing outweigh the problems faced. The best results for malnourished orphans have so far consistently been when the caretaker is also the wet nurse.

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An UNHCR Guidance on Infant feeding and HIV in Emergencies for Refugees and Displaced populations is being finalised. The purpose of the guidance is to assist UNHCR, its implementing and operational partners and governments on policies and decision-making strategies on infant feeding and HIV in emergency situations. For further information, contact: Fathia Abdallah, UNHCR, email: Abdallah@unhcr.org

¹ As per the memorandum of understanding between the Government of Bangladesh and UNHCR, a third camp (Tal), present on the banks of the Naf river, is not supported by UNHCR.

² MSF-H is also operating in Tal camp where UNHCR is not present.

³ Policy on the acceptance, distribution and use of milk products in refugee settings (2006). Available in English and French. Download from <http://www.unhcr.org> or <http://www.enonline.net> Contact: ABDALLAF@unhcr.org or HQTS01@unhcr.org

⁴ Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies. Version 2.1. February 2007. Available at <http://www.enonline.net>

⁵ Bangladesh is deemed a low HIV/AIDS prevalent country - it is estimated that the HIV prevalence in the adult population is less than 0.01%. However vulnerability is considered high for reasons that include low awareness of HIV/AIDS and low condom use. (http://www.whoban.org/hiv_aids.html Updated 7 Jan 2008. Accessed 7 Jan 2008). When dealing with refugee populations, the HIV prevalence of the country of origin and associated knowledge and practices, should also be considered for more recent arrivals (eds).

⁶ In the context of wet nursing where the risk of HIV transmission is considered very low because of an overall low prevalence and incidence, and voluntary and confidential HIV counselling and testing is thus deemed unnecessary, a potential wet nurse should still be counselled about how to avoid HIV exposure during breastfeeding. The refugee women in the TFCs are counselled regularly on HIV as a group and individually on a number of health related topics. A major campaign on HIV was ongoing in the camps in November and December 2007.

UNHCR Comment

Ann Burton, Senior HIV Asian Regional Officer, Bangkok, UNHCR.
 Marian Schilperoord, Senior HIV Technical Officer, Geneva, UNHCR.
 Paul Spiegel, Chief of Public Health and HIV Section, Geneva, UNHCR.

Bangladesh is experiencing a low level HIV epidemic. In particular, the level of HIV infection in southern Bangladesh where the refugees are located is extremely low. Notably, the 7th and latest round of sentinel surveillance in the first half of 2006 did not detect any HIV infection in sex workers (an most-at-risk population) in southern Bangladesh bordering Myanmar where the camps are located¹. Though Myanmar is experiencing a generalised epidemic, the geographical pattern is heterogeneous and available evidence indicates that northern Rakhine State (the area of origin of the refugees) is experiencing a low level epidemic. Moreover, this is a long-term refugee situation and HIV prevalence in the refugees is more likely to approximate that of the host community. Thus, in the Nayapara and Kutupalong camps, the risk of HIV is considered to be very low.

UNHCR's policy, following international guidelines, is that the first option should be replacement feeding where this is acceptable, feasible, affordable, sustainable and safe (AFASS). Where this is not available, wet nursing should only be considered in women known to be HIV negative and include HIV awareness and counselling support to the breastfeeding women (and her partner) to stay HIV negative. Thus, voluntary and confidential counseling and testing (VCCT) is required before wet nursing begins and thereafter on a periodic basis to ensure that the wet nurse remains negative.

HIV services in the surrounding host community are in the early stages of implementation; the nearest HIV VCCT centre is in Chittagong, a 4-5 hour journey one way. Though far from ideal, due to the extremely low risk and the considerable operational constraints, it was determined at the country level that the risks of not breastfeeding in this context were far greater than those posed by the risks of not offering HIV testing. However, after consultation within and outside of UNHCR, UNHCR will work with its implementing and operational partners to ensure that before potential wet nurses begin to breastfeed infants, they are HIV negative. This will require the provision of VCCT.

¹ <http://www.icddrb.org/activity.htm> Accessed 20th January 2008



Zita on a WHO field trip

Z Weise Prinzo, WHO.



World Health Organization

By Jeremy Shoham, ENN

The ENN interviewed Zita Weise Prinzo, who works in the Nutrition in Emergencies (NIE) programme of the WHO's Nutrition for Health and Development Department (NHD), for this issue's agency profile slot. Zita has been a focal point for WHO's emergency nutrition work for many years now. Her first work for WHO was in Nepal between 1992-5, where she worked as an APO, effectively seconded to the Ministry of Health (MoH) nutrition unit. In 1995 she took on the first of a series of short term assignments in the nutrition department of WHO in Geneva and has remained at head office since then. Zita's professional background includes a Masters in Science and Food Technology and a further Masters in Nutrition at LSHTM (1990-1).

WHO's interest and involvement in nutrition emerged at the First Health Assembly in 1948, where nutrition was included as one of six WHO priorities. In the early years, WHO nutrition work was mainly focussed on nutrition in development contexts. Early emergency related work included provision of technical support to WFP through the food aid programme (FAP) situated in WHO. FAP provided technical appraisals of WFP programmes and participated in joint inter-agency evaluation missions. However, the programme was mostly involved in 'developmental' programming, like school feeding and food aid for Maternal and Child Health (MCH) programmes, and had a limited emergency role. During the 1990s, WHO always had at least one nutritionist working at headquarters on NIE issues. However, it was not until 2005 that the WHO nutrition department formally instituted a nutrition in emergencies programme. The NIE programme was one of seven programmes being implemented within the Nutrition for Health and Development Department in WHO. The other programmes were growth assessment and surveillance, micronutrients, nutrition policies and programmes, infant and young child nutrition, obesity, and HIV and nutrition.

During the 1970s and 80s, WHO's nutrition department produced a number of key guidelines and management tools, some of which were specifically for the NIE sector, e.g. Seaman and Goyet's Nutrition in Emergencies handbook. However, more recently, the scope of WHO involvement in NIE has increased substantially. In addition to development of guidelines and tools for managing nutrition programmes, capacity development at national level, as a component of preparedness and recovery and operational support during emergencies, is now a key element of the NIE programme.

The capacity development work has mainly focussed upon regional and in-country training for the management of severe malnutrition. WHO have worked, and continue to work closely with, UNICEF in this area. In the 1990s, WHO undertook a series of regional trainings in the management of severe malnutrition. Capacity development involving the training of national staff has included curricula on infant and young child feeding and Nutrition and HIV. The NIE programme works closely with the HAC department in WHO by, for example, feeding into the HAC pre-deployment training of staff.

Provision of operational support in acute emergencies is perhaps the newest element of NIE work. Zita feels that, in some ways, WHO are not currently well set up to undertake this kind of work in nutrition. In the past, WHO sent out HQ staff to assist government or WHO country offices when requested to do so following the onset of an emergency. However, this did not have a sustainable impact at the country level. Zita explained "there was not a great deal of sense in suddenly getting involved in nutrition when there had been no previous involvement or presence on the ground". It was recognised that WHO needed to build up a network of nutritionists at country and regional level in advance of an emergency, in order to be able to provide operational support adequately. This would allow more appropriate responses as in situ staff "would be building upon ongoing partnerships when an emergency struck". The NIE programme has now put together a proposal that would fund nutritionists at country level. This was completed at the end of 2007 but there has, so far, been little interest from donors. Zita fears that this may partly be due to competing demands of the UNICEF-led Interagency Standing Committee (IASC)



Zita on a WHO drought survey

Z Weise Prinzo, WHO.



Zita on a WHO field trip

Z Weise Prinzo, WHO.

Name of organisation:	Department of Nutrition for Health and Development (NHD), World Health Organisation	Year formed:	2005 (with Nutrition in Emergencies as a programme area)
Address of head office:	20, Avenue Appia, CH-1211 Geneva 27, Switzerland	Director:	Dr Jørgen Schlundt, Acting Director, Department of Nutrition for Health and Development
Tel:	+41 22 7914440 (direct) +41 22 7914156 (operator)	No of Nutrition Staff (HQ):	50 (48 nutrition and support staff plus 2 nutrition staff that fall under the Health Action in Crisis (HAC) umbrella). <i>Additional small number of national programme officers at country level with nutrition terms of reference.</i>
Website:	http://www.who.int/nutrition/en	Approx annual budget for 2007:	USD 500,000 (HQ Nutrition in Emergencies programme only).

Nutrition Cluster and the perception amongst donors that this should be a Nutrition Cluster rather than a WHO role – thus failing to see the complementary role of the agencies.

Zita reflected that, in the past, WHO have put out guidelines and management tools as WHO documents but have learnt that they need to work more inclusively with other agencies in order to get comprehensive buy in. The current development of tools on the integrated management of severe malnutrition (community-based and hospital based approaches) follows this model, with other non-governmental organisations being involved in developing the guidelines. Zita and her colleagues are also aware that in the past some guidelines and tools have simply gathered dust as dissemination and roll out has been poorly planned. “To be effectively used, these finely honed documents need to be disseminated through mechanisms based on long-term relationships between WHO and governments and other local agencies”.

Zita sounded a little downbeat in response to my question about NIE funding. In short she said that it was a continual struggle. Certainly, the advent of the Nutrition Cluster with UNICEF as the lead has not helped the NIE programme cause. There are also battles to be won in house, as some NIE funding traditionally comes through HAC, and there are staff at the country-level that in turn have questioned whether certain NIE activities fall more within the domain of UNICEF. At the moment there are 25 staff in the WHO nutrition department, three of who work in the NIE programme (Zita and Chantal Gegout on the technical side and one support staff).

Zita was far more upbeat about NIE plans for the future. Work in a number of key areas is planned including;

- Updating the WHO training for hospital based management of malnutrition
- Reviewing the implications of new growth standards for operational practice
- Producing policy guidance on integrated management of malnutrition
- Reviewing and providing guidance on management of moderate malnutrition through supplementary feeding programmes and dietary counselling
- Reaching greater clarity on preventing and controlling micronutrient deficiencies in emergencies, e.g. use of iron in malaria endemic countries
- Infant and Young Child Feeding in Emergencies (IFE)
- Improving maternal nutrition in emergencies.

I left the most controversial questions until the end. I couldn't finish the interview without asking about WHO and UNICEF's relationship and any problems therein. Zita was surprisingly frank in stating that things can get a “little competitive,” especially at country level, and that the outcome (good or bad) depends very much on personalities involved and level of resources available. I also asked her about the view that WHO take ‘forever and a day’ to produce guidelines and manuals and that by the time these eventually come out, knowledge and practice have moved on. Again Zita held her hand up on behalf of WHO, saying that the length of time it can take is unacceptable but that delays also included late inputs from stakeholders and Member States on certain standard-setting work. She did, however, say that WHO are now producing fact sheets as a way of getting information out more quickly. She observed that delays are not just due to the technical discussions but also that fact that documents have to be cleared by so many stakeholders and parties within the organisa-

tion. Apparently WHO now have guidelines on how to develop guidelines.

A final question for Zita was how she saw WHO's NIE programme fitting into the sector. She quickly identified the fact that it's location, i.e. within a health organisation, allows for integration of nutrition with health and vice versa in all activities. She also believes that the NIE programme has the potential of doing excellent work in providing an evidence base for the management of nutrition in emergencies, as well as supporting and developing the capacity of member countries to undertake this management.

An overriding and familiar impression from the interview was that, as seems to occur in so many agencies, nutrition and therefore NIE, has to continually fight its corner to survive. In Zita it is clear that WHO and the nutrition community have an individual who is more than able to go the 10 rounds.



Zita on well-earned R and R!

Z Weise Prinzo, WHO.

Evaluation of Relactation by the Supplemental Suckling Technique

By Odile Oberlin and Caroline Wilkinson, Action Contre la Faim (ACF)

Odile Oberlin is a paediatrician working in a Paris hospital and research institute. She works as a volunteer consultant with Action Contre la Faim on a regular basis in Afghanistan.

The authors would like to acknowledge the contributions of the Ministry of Public Health, Afghanistan, the ACF team in Afghanistan and Cecile Bizouerne, ACF Psychologist, to this article. Acknowledgements also to the Afghan Ministry of Public Health, the French Ministry of Foreign Affairs and UNICEF for proving the financial support for the nutrition programmes in Kabul.

This article describes ACFs experiences of managing malnourished infants under six months in an inpatient setting in a challenging environment, which leads them to raise key questions about managing this age-group.

Action Contre la Faim (ACF) supports the only structures treating severe malnutrition within three paediatric hospitals or wards in Kabul. The children treated in the nutrition centres are mainly less than 5 years old with infants less than six months comprising over one-third of the admissions (37.4% from January to May 2006). The problem of infant malnutrition in Kabul is not new. Field Exchange Issue 9, p16-17, highlighted the high mortality rates (17%) observed amongst infants less than 6 months old who had been admitted in the Therapeutic feeding Units (TFUs) in Kabul in 1999.

The 1999 WHO guidelines on the management of severe malnutrition¹ do not address the specific needs of infants under six months² and do not include breastfeeding support. Supportive care to reestablish breastfeeding is described in Integrated Management of Childhood Illness (IMCI) guidelines³. A chapter on the management of malnourished infants less than six months is included in resource materials⁴ collaboratively developed by the IFE Core Group⁵. ACF has developed their own protocols based on advice from experts, observation and evaluation of the responses of infants treated within therapeutic feeding programmes, the integration of recently developed materials regarding breastfeeding, and the experience gained through the psychosocial approach to treatment developed by ACF in recent years.

¹ Management of severe malnutrition: a manual for physicians and other senior health workers. Geneva, World Health Organisation, 1999.

² Severe malnutrition: report of a consultation to review current literature. Geneva, World Health Organization, 6-7 September 2004. <http://www.who.int/nutrition/publications/malnutrition/en/>

³ Supportive care to reestablish breastfeeding is described in IMCI Management of the child with a serious infection or severe malnutrition: guidelines for care at the first-referral level in developing countries (p99-104).

⁴ Module 2 for health and nutrition workers in emergency situations. UNICEF, UNHCR, WHO, WFP, ENN, IBFAN, TdH and collaborators. Version 1.0. November 2004. Available at <http://www.enonline.net/ife/>

⁵ The IFE Core Group is an interagency collaboration concerned with policy guidance and capacity building on infant and young child feeding in emergencies. Current members are WHO, UNHCR, UNICEF, WFP, IBFAN-GIFA, CARE USA, ACF and ENN. See <http://www.enonline.net/ife/>

A mother feeding her baby using the SST



ACF, Afghanistan, 2004

Table 1 Admission criteria

Type of beneficiaries	Admission
Infant below 6 months or Infant above 6 months & < 4 kg	<ul style="list-style-type: none"> Difficulties breastfeeding (Mother Milk Insufficiency (MMI), baby too weak to suckle, cracked nipples...) and/or <ul style="list-style-type: none"> Bilateral oedema and/or <ul style="list-style-type: none"> Weight less than 2.5 kg for length less than 49 cm and/or <ul style="list-style-type: none"> Infant is more than 6 months but less than 4 kg and/or <ul style="list-style-type: none"> Infant has a W/H < 80% and infant not gaining or is losing weight

Twins admitted to one of the TFUs



ACF, Afghanistan, 2004

This picture was adapted with permission of the authors to respect cultural sensitivity

Admission criteria

In Kabul, many mothers complain of a lack of breastmilk and believe that this is due to stress and not eating enough good food. Mothers presenting with breastmilk insufficiency raise a number of challenges for treatment of infants in feeding centres. The admission criteria and treatment of these young infants in the TFUs in Kabul has evolved over time. In 2003, the criterion of 'mothers milk insufficiency (MMI)⁶, was added to the existing admission criteria. In June 2005, the criteria were amended further to admit infants with a weight-for-length less than or equal to 80% if the mother reported she was suffering from a 'lack' of breastmilk and the infant was not gaining or was losing weight at home. Admission criteria at the time of the study in 2006 for this age-group thus comprised a combination of anthropometric criteria, weight criteria and difficulties in breastfeeding (see Table 1).

The protocols that have been developed to manage this age-group involve increasing the production of breastmilk through the supplementary suckling technique (SST) (see Box 1). The aim is that infants under six months should be discharged when gaining weight and exclusively breastfed, independent of their anthropometric status. The SST for relactation has been implemented systematically in the Kabul Therapeutic Feeding Units (TFUs) since August 2004. This article describes one of a series of studies aimed at improving the management of these young infants and their mothers.

Study Objectives

The aim of the study was to evaluate the impact of the SST during the period of management in the TFU (including the support, advice and activities proposed by the psychosocial workers). Analysis was based on data found in registration books, therapeutic cards, psychosocial forms (included family history, medical, treatment, feeding history of the infant, caregiver-infant observations), MMI forms (which focus on observed and reported infant feeding practices and health status of mother) and interviews with mothers. The indicators assessed were weight gain (g/kg/d), increase in estimated breastmilk quantity during the period in the TFU⁷ and evaluation of SST application.

The study also planned to assess progress of the infants on discharge from the TFU, including weight gain, breastfeeding status, and feeding practice. Follow-up of the patients was based on analysis of the 'dry ration books' in which infants are registered at discharge and where their weights and heights are registered during follow-up.

The target group comprised infants under 6 months of age and infants aged 6 months or over with a weight of less than 4 kg.

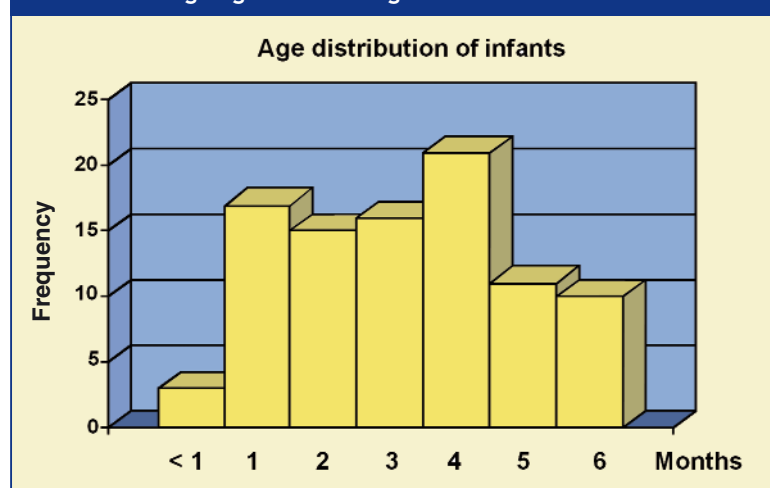
Data for each of the infants were entered into a spreadsheet and analysed using excel. Anthropometric indexes were calculated using Epinut version 5 and were exported into the excel spreadsheet.

Limitations of the study

These included;

- The size of the study was limited to infants discharged between 02/01/06 and 23/04/06.
- Some therapeutic cards (14 %) were unavailable due to poor storage and/or retrieval systems.
- The data on the therapeutic forms were often incomplete, e.g. on breastfeeding or use of the SST.
- Weight and mid upper arm circumference (MUAC) measurements were typically reported as rounded up figures. This was despite weighing scales accurate to the nearest 10g being available in all of the TFUs.

Figure 1 Age distribution of infants under six months and/or weighing less than 4kg



- The proportion of infants that were lost to follow-up after discharge hindered outcome evaluation.

Age profile

Data were analysed on the management of 94 infants aged less than 6 months old and/or less than 4kg discharged between 2/01/06 to 23/04/06 from three TFUs – Ataturk TFU (n=25), Indira Gandhi TFU (n=36), and Maiwand TFU (n=33).

The mean age of the sample was 4 months (see Figure 1). There were more boys (63%) than girls (37%). Twin births accounted for 17 % (n=16) of these admissions. According to the recorded TFU data, 18 infants had some form of disability and/or developmental problem that could affect feeding (including cleft palates, and suspected Down's Syndromes).

Admission criteria

Given the lack of consensus on admission criteria for infants under 6 months, severe and moderate acute malnutrition are referred to according to the criteria commonly applied to infants and children from 6 – 59 months of age.

Thirty-five infants met the classic criteria for severe acute malnutrition in this age-group of whom:

- 8 had oedema
- 21 had W/H < 70 % with no oedema
- 6 infants were over 6 months and weighed less than 4 kg.

Nearly one-third (31%, n=29) of infants under six months were admitted due to MMI but were not severely malnourished. Of these, 26 had moderate acute malnutrition (70 % < W/H 80 %) and three infants were not malnourished according to anthropometric criteria⁸. Reasons for admission did not vary significantly according to gender or from one TFU to another.

⁶ Maternal Milk Insufficiency (MMI) is where a mother reports a lack of breastmilk, however there is no quantifiable measure of this on admission.

⁷ This data is not presented in this field article but is available in the full study report from the authors (see contacts at the end).

⁸ An additional 3 infants had missing length data (therefore no W/H calculated).

⁹ Length data on 91/94 was available.

¹⁰ The lengths of 3 children were not measured. These children weighed 1.5, 1.5 and 1.7 kg respectively (they were aged 1 day, 2 months and 1.5 months respectively).

¹¹ One infant was classed in the category ≥ 6 months and <4 kg).

Table 2 Discharge according to admission criteria

	Total	Cured	Died	Default	Transfer	Criteria not met	Admission error
Severe malnutrition	29	20	2	3	1	1	2
Age ≥ 6 months and weight < 4 kg	6	3		1	1	1	
Length < 49 cm and age < 6 months	27	13	2	2	4	6	
Moderate malnutrition (70 % < W/H < 80 %) and Maternal Milk Insufficiency (MMI)	26	21	2	1	2		
No malnutrition but MMI	3	3					
MMI but anthropometric status unknown	3	1	1			1	
Total	94	61 (64.9%)	7 (7.4%)	7 (7.4%)	8 (8.5%)	9 (9.6%)	2 (2.1%)

Admission weights ranged from 1.2 to 4.4 kg, mean weight 2.6 kg (SD 0.6 kg). For infants <6 months old, the mean admission weight was 2.5 kg (SD 0.6 kg) and mean length⁹ was 50.7 cm (SD 4.6 cm)¹⁰.

Nearly one-third (32%, n=30) of the infants were less than 49 cm¹¹, of whom 24 infants weighed <2.5 kg and 3 infants weighed ≥2.5kg (data on 3 infants were not available).

Anthropometric indices

As weight-for-length expressed in % of the median (W/H%M) using the National Centre for Health Statistics (NCHS) references cannot be calculated for infants with a length of < 49 cm, this index is only presented for infants ≥49cm. Instead, weight-for-age z score (WAZ) and length-for-age z score (WHZ) were calculated for infants <49cm.

Infants less than 49 cm (n=30)

The mean age was 2.2 months and mean weight was 2.2 kg, ranging from 1.4 to 3.4 kg. In general, the weight of the infants <49cm increased with length (Figure 2) and the lengths of the infants generally increased with age (see Figure 3). However WAZ data in Figure 4 shows that the older infants tended to be more underweight. Figure 5 also shows a decline in HAZ with increasing age that suggests older infants are more chronically malnourished or stunted than the younger infants.

Infants ≥49 cm (n=61)

The WAZ and HAZ indexes for infants ≥ 49 cm showed the same deteriorating trend with age as in infants <49cm. The W/H%M was also determined for this group (Figure 6) although there is no clear trend with age.

Outcomes

Table 2 gives the type of discharge according to criteria for admission. Seven children died during their stay in the TFUs (7.4 %, n=7).

Causes of death were septicaemia (2), pneumonia (1), aspiration - probably due to pulmonary infection (2), and unknown (2). Out of the 35 infants who were severely malnourished, 2 died (5.7%). This is lower than in other studies for this age-group where mortality rates as high as 19 % have been reported for infants in TFUs^{12,13}.

Discharge as 'cured'

Table 3 summarises the weight gains by admission criteria for infants discharged as 'cured'.

The TFUs discharge protocol is that infants under six months are discharged when they are gaining weight on breastmilk alone (i.e. exclusively breastfed). However, data on breastfeeding status on discharge (55/61) showed that only 29% (16/55) of the infants discharged as 'cured' actually met the full criteria of 'discharge on breastmilk alone.'

The remainder (61% (37/55)) were receiving either full or partially diluted F100 milk (DF100) supplement on discharge. Discharge on supplemental milk differed by TFU, reflecting a clear-cut management difference between centres (see table 4).

Of the 26 infants admitted with MMI and with moderate acute malnutrition, only seven of the infants discharged as 'cured' were on breastmilk alone. One infant was discharged on half dose of diluted F100 and 13 infants were discharged on the full dose of diluted F100. Of the infants admitted with MMI who were not malnourished (n=3), none were discharged on breastmilk alone. One was discharged on half dose of DF100.

Failure to meet anthropometric discharge criteria

Infants who weighed < 2.9 kg at discharge or infants admitted on W/H%M criteria but had achieved only 80% W/H%M at discharge were

classified as 'criteria not reached'. In reality, however, many of these infants were gaining weight and almost half (4/9) were discharged feeding on breastmilk alone. Their mean weight gain was 12.2g/kg/day (0.7-30.3 sd 10.4). Consequently, for the purposes of analysis, this sub-group of infants were grouped together with the infants discharged as cured. Overall, only 20 out of 64 infants who were discharged as 'cured' or for whom anthropometric discharge criteria were not met, were discharged on breastmilk alone.

Evaluation of supplemental suckling technique (SST)

Information on the use of SST was taken from the therapeutic cards. Of the 94 infants, 81 cards were retrieved and studied. Since breastfeeding support or the SST was not specifically recorded on the therapeutic cards, this analysis relied on inferring how the technique was used. This was based on the recorded reduction in the amounts of diluted F100 given to the infants, according to the protocol for the SST (see Box 1). A reduction in DF100 was recorded in 25/81 infants studied (30.9%). There was no indication from the cards as to how many (failed) attempts there were or what breastfeeding support was offered to the infants.

Where details of supplemental suckling were recorded (n=25), the method worked well in most of the infants. These showed full or partial attempts at stopping the supplementary milk, in accordance with the protocol. For 20 infants, good rates of weight gain during the rehabilitation phase were maintained after reducing diluted F100 (the mean weight gain was 11 g/kg/day during these two periods). This indicates that the mothers were supplying adequate quantities of breastmilk to cover the maintenance and growth needs of their infants. These 20 infants were discharged on breastmilk alone, and showed an estimated increase in breastmilk of 384 ml/day from admission in the TFU to discharge, with an average estimated daily output over the 5 days prior to discharge of 747 ml/day of breastmilk¹⁴.

In the TFUs where the SST was rarely performed, staff reported that this was because mothers were not happy when they saw that the quantity of therapeutic milk given to the infant was reduced and stopped.

⁸ An additional 3 infants had missing length data (therefore no W/H calculated).

⁹ Length data on 91/94 was available.

¹⁰ The lengths of 3 children were not measured. These children weighed 1.5, 1.5 and 1.7 kg respectively (they were aged 1 day, 2 months and 1.5 months respectively).

¹¹ One infant was classed in the category ≥ 6 months and <4 kg).

¹² M. Golden, Y. Grellety. The management of acute severe malnutrition, 2002

¹³ Golden M. Comment on including infants in Nutrition Surveys: Experience of ACF in Kabul City. Field Exchange 2000; 9: 16 - 17.

¹⁴ The mean breast milk output during the five first days after admission and the five last days before discharge for the 20 infants that left the centre exclusively breastfeeding. Assuming an infant required 110 kcal/kg/day for maintenance of their body weight and 5 kcal for each gram of weight gain, it was possible to estimate the daily energy intake taken for maintenance and weight gain from daily weights measured. It was assumed that the energy content of breast milk is 70 kcal per 100 ml. The breastmilk output was estimated, on this basis, assuming that it was the balance of energy consumed when the equivalent of energy from the supplemental milk was subtracted from the energy needs, according to the weight gain of the infant.

Table 3 Weight gains for infants discharged as 'cured' by admission criteria

Admission criteria	Number 'cured'	Weight gain
Infants admitted with severe malnutrition (WH%M<70% and/or oedema)	20	17.1 g/kg/day (-1.8 - 43.8, sd 10.5)
≥ 6 months and < 4 kg	3	11.2g/kg/day (5.3 - 14.5, sd 5.1)
Infants <49cm	12*	21.5g/kg/day (3.5-50)
Infants with MMI and moderately malnourished	21	15.3g/kg/day (4.2-30, sd 6.6)
Infants with MMI but no malnutrition (WH ≥ 80%)	3	13.3g/kg/day (5.8-21.4, sd 7.8)
Total number of infants 'cured'	59	

*Another infant was discharged at < 2.9 kg (2.71 kg) with a weight gain of 6.5g/kg/day, after 30 days in the centre.

Table 4 Milks infants were receiving upon discharge by TFU

	Ataturk	Maiwand	Indira Gandhi	Total
Discharged on diluted F100 (full or partial dose)	3 (=)	14 (*=)	20	37
Discharged on breastfeeding alone	9	6	1	16
Unknown	0	0	2	2
Total	12	20	23	55

* Two infants had stopped the DF100 altogether but then returned to the milk = One infant's intake had been reduced to a half dose of DF100

Mothers therefore would want to go home. However this was not the experience of the TFUs where the SST was more successful. Also, of the seven infants who defaulted, the default does not appear to correspond to a decrease in the quantity of therapeutic milk given to the infants.

Where infants were not receiving therapeutic milk using the SST, the diluted F100 was given with a large cup and a spoon. This is a very 'passive' feeding technique for the infant and may cause aerophagia and feeling of satiety, thereby reducing appetite while increasing the risk of aspiration of the milk into the lungs. The use of a small cup allows the infant to drink actively, which is more appropriate where use of the SST is really not possible.

Staff in the TFUs did not show mothers how to bottle-feed or how to prepare artificial milks out of fear that this could encourage mother to adopt artificial feeding. Consequently, two-thirds of mothers were discharged using supplemental milk with no instruction on how to safely prepare feeds at home.

Follow-up of infants on discharge

A total of 64 of the discharged infants met the criteria for follow-up¹⁵. Transfers, defaulters, and admission errors were not followed up. Of 64 infants, only 26 were available for follow up – 67% (10/15) of discharges were from Ataturk TFU, 58% (14/24) from Maiwand TFU and only 8% (2/25) from Indira Gandhi TFU. As Indira Gandhi is the largest paediatric hospital and of national repute, it is often the first port of call for the mothers from distant provinces. The follow-up of infants discharged from Indira Gandhi Hospital was also limited by the issuance of a 'dry ration identification number' at discharge that was not linked to their TFU admission number. The follow-up of children discharged from Ataturk and Maiwand was easier, due to the notes taken in the dry ration book and the possibility of attending the dry ration days at the TFU.

Of the 26 infants:

- Fourteen of 20 infants who were discharged on breastmilk alone were followed up. These infants had an average weight gain of 113g/week during the period of follow up (range -50g to +300g).
- Twelve of 44 infants who had been discharged whilst still receiving a milk supplement were followed up. Average weight gain in this group was 120g/week (range minus 50g to +290g).

In both groups, one infant lost weight at a rate of 50g/week during the period of follow up and all of the others gained weight. Interpretation of these figures should be done with caution, given that two-thirds of infants who were receiving milk supplements on discharge were not followed up. There was also a large variation in both the number of weeks for which infants were recorded for follow up and the average weight gains per week between the infants in both groups.

Ten in-depth interviews were carried out with mothers who returned after discharge from the TFUs. Two reported a medical problem since discharge. Although all the mothers

were still breastfeeding their infants, nine mothers were also giving their infants powdered milk and two were adding biscuits to the milk (infants aged 5.5 and 7 months). Powdered milk was either infant formula or powdered milk bought from the market taken from large bags (shir e kilogaki). The latter was much less expensive than the infant formula, but both the composition and the poor storage conditions of this powdered milk meant it was inappropriate for the needs of these young infants. On the basis of interviews with mothers, it was apparent that the way they reconstituted the powdered milk meant over-dilution (1 or 2 spoons for half a glass of water). Powdered milk was usually given after breastfeeding, but sometimes before breastfeeding. All the mothers reported using a cup and spoon to give the powdered milk.

Conclusions

The TFUs in Kabul show a much higher proportion of admissions of infants under 6 months than in TFUs in other countries. The treatment of these infants is more complex than that for older children. The high presentation of infants <49cm may represent low birth weight babies due to prenatal malnutrition or preterm birth who have failed to 'catch up', as well as infants who became malnourished after birth. There are no reliable data on the rate of low birth weight babies in Kabul.

The study suggests that the SST is a feasible strategy for the management of severe malnutrition within the Afghan hospital environment. Where SST is correctly applied, there are good results up until discharge. However, the SST was not well implemented overall, with many infants being discharged on mixed feeding. In the TFUs, these infants were still considered 'cured' and even where infants are discharged on breastmilk alone, it appears that mothers often reverted to mixed feeding at home.

We found that TFUs staff often considered the admission criteria vague and difficult to apply and were also confused by the treatment protocols and discharge criteria. In addition, it was counter-intuitive for staff who are used to older children remaining on a full supplement until discharge, to decrease daily quantities of milk for infants. Furthermore, these infants demanded a very different and more intense follow-up on the part of staff.

This study begs the question as to whether the admission criteria used in the Kabul context are the best ones, given the profile of infants identified for admission within the TFU. Mothers with lactation difficulties need lactation support, but the TFU may not be the place to provide this.

Inconclusive trials have been carried out within outpatient facilities in Kabul, employing a period of observation and support to women who complained of breastfeeding difficulties. The majority of the mothers in these trial interventions did not stay in the centre very long as they did not receive the supplementary milk they wanted.

There is a weak evidence base for the protocols and selection and discharge criteria for the

identification and management of acute malnutrition in infants under six months. International guidance is unclear and sometimes contradictory. This poses significant challenges in deciding how best to treat these infants and in setting admission criteria - at which point do the benefits of the services and support offered from the therapeutic feeding unit in reducing morbidity and mortality outweigh the risks involved in maintaining infants in in-patient care and the introduction of artificial milk products? The absence of clear guidance for these infants often makes advocacy for inclusion of these young infants into care protocols more challenging when working within Ministry of Health structures or within national nutrition guideline frameworks.

Key policy and practical recommendations have emerged from this study for ACF programming, i.e. the need to prioritise improved care of young infants and in particular, the application of the SST. There is now an opportunity to develop the therapeutic protocols and tools for infants and include these in the new Afghan national protocol for the treatment of severe malnutrition. This opportunity must be grasped so that the needs of these young infants and their nursing mothers are adequately and appropriately catered for.

For further information, contact: Caroline Wilkinson,
email: cwilkinson@actioncontrelafaim.org

¹⁵ Among the 70 infants who were discharged home from the TFUs, 6 infants were discharged after the 13th April 2006, which was too late for their consideration in follow-up for the purposes of this study.



A grandmother establishing breastfeeding using the SST

ACF, Afghanistan, 2004

This picture was adapted with permission of the authors to respect cultural sensitivity



Sphere Project, 2006

Sphere training of trainers in Singapore in October 2006



Sphere Project, 2006

Sphere Audit/Review workshop with CARE Somalia, May 2006

People in aid



Ms Shafia Khatun, Ms Jolly Khanum, Ms Aklima Parvin, Bangladesh Breastfeeding Foundation (BBF)



Dr Shahed Rahman and Dr Younus, SC US Bangladesh



Ali Maclaine, Consultant, SC US



From left, Dr Isabella, Chloe Angood and Dr Mary Azayo, Muhimbili National Hospital, Dar es Salaam



Dr Jesse Kitundu (Head of Pediatrics at Muhimbili National Hospital, Dar es Salaam) presenting the 'nurse of the month' award to Sister Gabriella from the Malnutrition Ward



Sister Sangali (centre) with two nurses from the Malnutrition Ward, Muhimbili National Hospital, Dar es Salaam



Invite to submit material to Field Exchange

Many people underestimate the value of their individual field experiences and how sharing them can benefit others working in the field. At ENN, we are keen to broaden the scope of individuals and agencies that contribute material for publication and to continue to reflect current field activities and experiences in emergency nutrition.

Many of the articles you see in Field Exchange begin as a few lines in an email or an idea shared with us. Sometimes they exist as an

internal report that hasn't been shared outside an agency. The editorial team at Field Exchange can support you in write-up and help shape your article for publication.

To get started, just drop us a line. Ideally, send us (in less than 500 words) your ideas for an article for Field Exchange, and any supporting material, e.g. an agency report. Tell us why you think your field article would be of particular interest to Field Exchange readers. If you know of others who

you think should contribute, pass this on – especially to government staff and local NGOs who are underrepresented in our coverage.

Send this and your contact details to:

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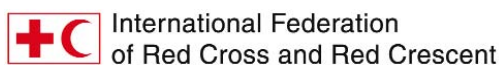
Women with their undernourished children, in the village of Barmou, gather and wait to receive food distributed by WFP at the distribution centers throughout Niger's hardest hit areas.

WFP/Martin Specht, Niger, 2005.

The opinions reflected in Field Exchange articles are those of the authors and do not necessarily reflect those of their agency (where applicable).



Field Exchange supported by:



World Vision



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, FieldExchange, 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.



Rupert Gill is ENN office manager and fundraiser, based in Oxford.



Dan George is the ENN finance assistant, working part-time in Oxford.



Matt Todd is the ENN financial manager, overseeing the ENN accounting systems, budgeting and financial reporting.



Orna O'Reilly designs and produces all of ENN's publications.

Phil Wilks manages ENN's website

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