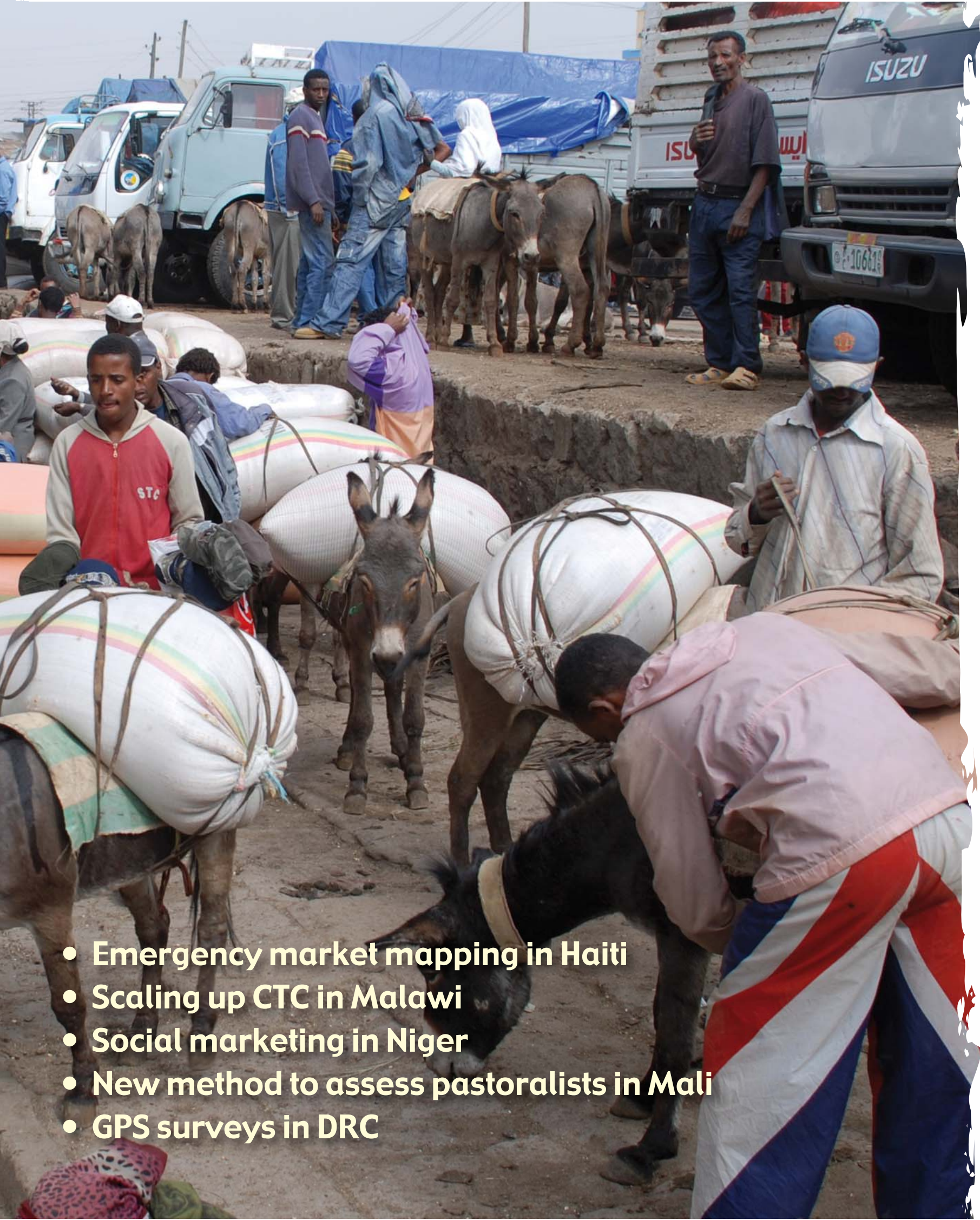


Field Exchange

Emergency Nutrition Network



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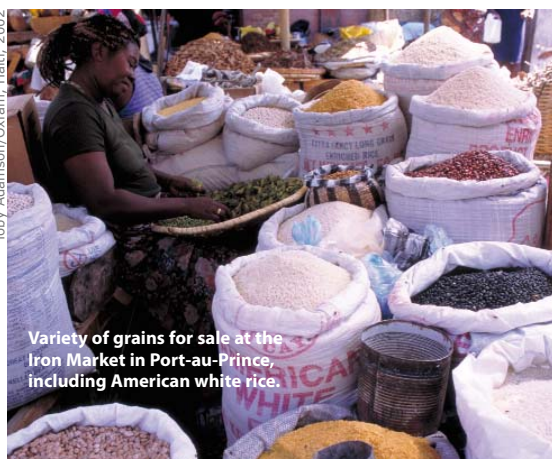
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Variety of grains for sale at the Iron Market in Port-au-Prince, including American white rice.

In this issue of Field Exchange, there are two themes which previous editorials have not addressed – sustainability of interventions and how markets can create, as well as be used to respond, to emergencies. We also revisit one 'old chestnut' – namely the rich vein of innovation that runs through our sector.

Use of the word 'sustainability' in an emergency context always needs qualification and nuancing. Are we talking about sustainability of capacity, resources, demand for services, a product or institutional sustainability? In the most acute crisis, where high levels of external international support are needed immediately, it may be really difficult to think about and implement activities that can be sustained post-emergency. In slower onset crisis or chronic emergencies, it should be more feasible. However, the donor environment may be such that with all the will in the world, implementing agencies can only undertake activities and projects within predefined time lines and budget cycles. Not only does this mean that projects are implemented over too short a period to achieve sustainable outcomes, but there is little understanding or knowledge of how long these outcomes or achievements can be maintained once the 'externally' implemented intervention is over.

A number of pieces in this issue relate to sustainability of interventions. The 2008 Humanitarian Response Index (HRI) report recently published by DARA (see research section) confirms a perennial challenge in the humanitarian sector – how better to link relief to recovery and long term development, and strengthen the resilience of populations affected by crises. The report states that humanitarian agencies often struggle to find appropriate means to achieve a balance between meeting short term needs and laying the foundation for recovery and development. The HRI findings show that some donor policies and procedures can accentuate the gap between relief, recovery and development, rather than facilitating more integrated and harmonised efforts. Similarly, donor procedures can facilitate or impede efforts effectively to engage local communities in defining and implementing programmes that meet their needs.

The field article written by Gwyneth Hogley Cotes describes efforts to scale up and integrate community therapeutic care (CTC) services within existing health services in Malawi. The authors describe numerous challenges and the key role played by the CTC advisory service that, once established, provided the institutional support and constancy necessary to ensure a degree of success. A Food and Agricultural Organisation (FAO) evaluation of the Food Security Assessment Unit and Nutrition Information Project in Somalia found that sustainability of the project (that is now in its fifth phase) is vulnerable, given the substantial resources required to maintain the systems. The evaluation concluded that an exit strategy is needed that foresees the handover of at least some of the activities to local stakeholders in the mid to long term. Recommendations for achieving this include giving more voice to the different Somali actors in the project steering committee, giving preference to partnership with Somali national or sub-national entities even if these are weak compared to international non-governmental organisations, and reducing costs as much as possible so that eventual transfer is eased.

Sustainability is also an important issue for the private sector. A field article by Nutriset explores their experience of 'social marketing' of a ready to use micronutrient supplement in Niamey, Niger. Sale price must cover direct and

indirect costs if the product is to be manufactured locally. Nutriset has financed the setting up of the distribution network, training and the large awareness communication campaign. This expenditure has been vital for kick-starting the process – however it is not known whether demand can be sustained without this type of expenditure and whether private producers can absorb these costs or will need to pass them onto the urban poor who are the main target group.

A news piece on the recent World Health Organisation expert collaboration on management of moderate malnutrition in children under five years of age highlights the fundamental issue of the affordability of new products coming onto the market. While many of these new products may have considerable nutritional advantages compared to the types of fortified blended foods used in the past, their cost and therefore the sustainability of their provision, is an unknown – especially in relation to government spending capacity and priorities. Similar issues apply to the role of ready to use therapeutic foods in community-based management of acute malnutrition and scaling up these programmes. It is notable that there has been no modelling of least developed countries government capacities to support provision of these types of product on a large scale over the long term, or discussion of whether the international aid community would be prepared to subsidise such interventions indefinitely.

While previous editorials have highlighted the importance of understanding market behaviour from an early warning perspective, we have never turned the spotlight on the role of the market in creating nutritional crises and how markets may be used to respond to crisis. This issue of Field Exchange carries a number of pieces about the cause and effect of the current food price crisis, as well as possible responses.

According to a recently published ALNAP paper, summarised in this issue, food prices have increased by an average of 52% between 2007 and 2008. The ALNAP paper aims to assist those agencies undertaking operational relief and recovery work in the context of high food prices. It provides a framework for analysing the problem and designing a response. The Centre for Strategic and International Studies (CSIS) launched a task force on the current food crisis. Its report cites a number of root causes of the crisis. These include soaring global energy prices, rise in the production of bio-fuels based on food grains, demand for cereal grains outstripping supply, bad weather, and gross under-investment in agricultural production and technology in the developing world. Other factors singled out for blame are the agricultural and trading subsidies and tariffs that create grave distortions, disadvantaging producers in poor developing countries, and an antiquated international system of mobilising and deploying food relief that slows the response to emergencies and imposes unacceptable costs and inefficiencies. The report contains a number of recommendations to address the crisis, including a modernisation of emergency assistance and a re-focusing of US trade policy on promoting developing country agriculture.

A paper by FANTA deals with the under-served area of humanitarian interventions amongst urban populations. The authors examine the growing trend in urban crisis – which is often mediated through market distortion and hyper-inflation and the various urban specific interventions to address food and nutritional crisis. Two key highlighted interventions involve market channels – market assistance programmes and support to national strategic grain reserves.

A field article written by Lili Mohiddin from Oxfam and Mike Abu from Practical Action describes a newly developed emergency market mapping and analysis tool and the experience of applying the tool following tropical storms in Haiti. The tool allowed for sophisticated analysis of market conditions leading to highly nuanced recommendations regarding interventions in timber and bean markets. The tool can be used by non-specialists and can help determine the appropriateness and optimal design for a broad range of response options including cash transfers.

This issue of Field Exchange has its usual fair share of new and cutting edge programming initiatives. At a time of deepening gloom over the global economic downturn and our sleepwalking into environmental catastrophe, successful innovation and problem solving in our sector serves to maintain some degree of optimism and sense of progress.

A field article by Action Contre la Faim (ACF) describes their experience of implementing a new survey method for assessing acute malnutrition in nomadic pastoralist populations. The sampling method can be used for collecting information on many different variables in addition to malnutrition. In particular, it gets around problems of selecting a sample in an area with a mobile, low density population for whom there are few reliable data on population size at the community level.

The Italian NGO COOPI (Cooperazione Internazionale) has contributed a field article from the Democratic Republic of the Congo (DRC), which describes another take on estimating coverage of CTC programmes. Having found the centric systematic area sampling (CSAS) approach to be too time consuming and biased when there is poor mapping detail available and recent population movement – both problems they encountered – COOPI developed a modified approach involving GPS, which they employed in Goma. This approach appears to be quicker and more accurate as the first ‘mapping’ phase freed up the survey team, allowing them to focus their energies on actually collecting the data.

A paper by the Alchemy project summarises lessons learnt in implementing micro-credit and other loan programmes for long term refugee and displaced populations. Such interventions have not been widely applied but may have an important role in certain refugee contexts.

Finally, a word on our own piece of innovation. We would like to announce the launch of the ENNs online forum, en-net, funded by USAID/OFDA. It will enable field practitioners to pose urgent and challenging questions they face on emergency nutrition/food security programming, and so access a wide range of experience-based and expert advice that is not reflected in standard guidelines – a sort of interactive Field Exchange. As we launch this initiative, we welcome feedback on the facility and look forward to the questions and debate that materialise and that may well feature in future issues of Field Exchange.

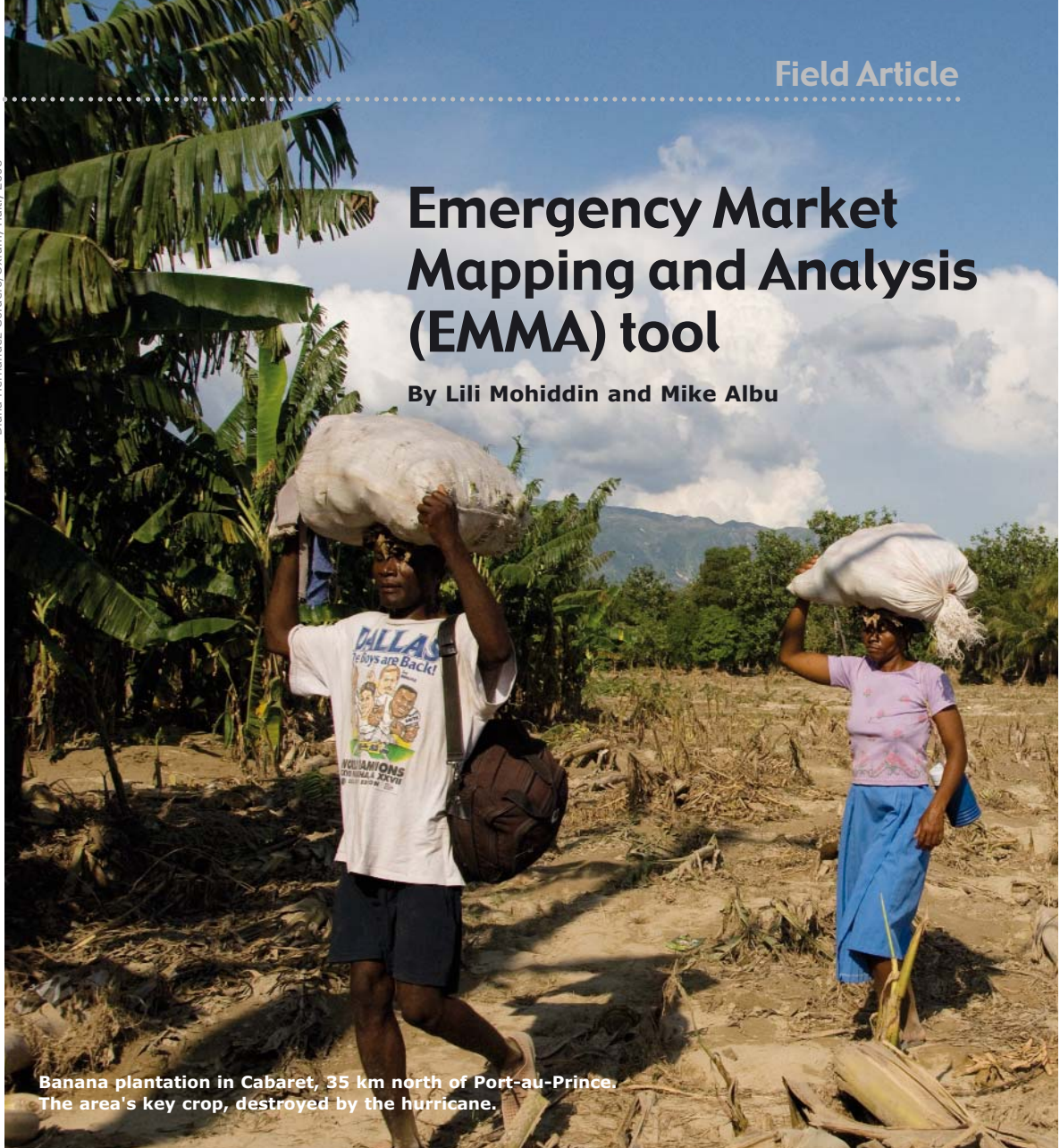
Jeremy Shoham
Editor

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

¹ Development Assistance Research Associates

² Food and Nutrition Technical Assistance

Diana Hernandez Cordero/Oxfam, Haiti, 2008



Banana plantation in Cabaret, 35 km north of Port-au-Prince. The area's key crop, destroyed by the hurricane.



Lili Mohiddin has been an Emergency Food Security and Livelihoods Advisor with OXFAM GB since September 2005, based in the UK.



Mike Abu is an international projects manager with the Markets & Livelihoods programme of Practical Action since 1999, based in the UK

Many thanks to the agencies, especially IRC-UK, that have made this work possible in Haiti, Myanmar, Kenya and in UK and via USA-based discussions and forums. In Haiti, the collaboration of Red Cross (Haiti and Canada), Oxfam (GB, Intermon and Quebec) and ACDI/VOCA was vital. Our gratitude goes to Emmet Murphy and Anita Auerbach who contributed hugely to both the development of EMMA and the pilot in Haiti. Thanks also to the project donors that include OFDA, Waterloo Foundation and Oxfam GB.

This article describes a work in progress by Oxfam GB in developing a new tool to enable emergency practitioners to map and analyse markets in emergencies

Good practice standards¹, guidelines and evaluations, all emphasise the importance of including markets in emergency situation and response analysis. However, in practice, emergency practitioners have often overlooked the potential and actual role of markets in emergency and early recovery responses. This is mainly due to uncertainty of how to understand or work with traders and other market actors in an emergency setting, and unfamiliarity with the private sector. Commonly cited challenges include not knowing what data to gather and from where (macro versus micro levels), how to interpret basic information collected, such as prices, or how to translate analysis into programme decisions.

Recent trends in humanitarian responses indicate an increase in agency use of cash-based initiatives alongside or in place of conventional relief distributions of food and non-food items and local procurement. Some of these cash interventions are also implemented without proper assessment of market actors' capacity to respond to households increased purchasing power, or analysis of the risks of abuse of market-power (uncompetitive behaviour).

These analytical challenges and implementation trends indicate the need for better market analysis capacity. The EMMA (Emergency Market Mapping and Analysis) tool has been developed for Oxfam GB and International Rescue Committee UK (IRC) by Practical Action Consulting to enable more appropriate emergency and early recovery responses by enabling agencies to undertake essential market analysis.

¹ Sphere Project 2004 edition

Prior to initiating the development of EMMA, a review was undertaken better to understand the need for such a tool in rapid onset emergency settings². The review sought to better understand market analysis needs, decision maker information requirements, identify existing market analysis tools, and get a better understanding of the capacity of field level staff who would undertake such analysis. Conclusions underlined the need for a user-friendly non-specialist analytical tool, as many existing market analysis tools were too specialist or development orientated and therefore not suitable to emergency settings where specialists are hard to locate.

Why is market analysis in emergencies important?

During the early phase of a rapid onset disaster, humanitarian priorities are essentially concerned with ensuring survival and protecting livelihoods rather than the assessment of market-systems³, even if the need for this kind of analysis is increasingly recognised.

Why market-systems matter in designing early responses		
For ensuring survival	For protecting livelihoods	
Market-systems could supply food and essential items or services related to basic survival needs	Market-systems could supply or replace urgent non-food items, agricultural inputs, fuel, tools and vital services	Market-systems could maintain demand for labour, employment or production that restores incomes

The rationale for EMMA is that better understanding of the key market-systems in any given situation could enable humanitarian agencies to consider a broader range of responses. These responses might include cash-based interventions, local procurement and other innovative forms of support to market actors (e.g. traders) that enable programmes to make better use of existing market-system capabilities. This could lead to more efficient use of humanitarian resources, as well as encouraging recovery and reducing dependency on outside assistance.

With few exceptions, crisis-affected households use markets or other forms of exchange

for acquiring food, hygienic items and services, or for selling products and labour to others. There is a growing realisation that unless our responses are designed with a good understanding of key market-systems, they may inadvertently damage livelihoods, jobs and businesses; thus undermine recovery and prolong dependence on outside assistance.

EMMA – What is it?

The EMMA toolkit is a set of tools and guidance notes, designed to encourage and assist front-line humanitarian staff in sudden-onset emergencies to better understand and make use of market-systems.

EMMA aims to provide accessible, relevant guidance to staff who are not already specialists in market analysis. The EMMA toolkit is intended to complement established humanitarian practices in diverse contexts, so that the EMMA process can be integrated flexibly into different organisations’ emergency assessments and response planning. Above all, the EMMA tools are adaptable, ‘rough-and-ready’, speed-orientated processes, designed to reflect the information constraints and urgency of decision-making required in the first few weeks of a sudden-onset emergency.

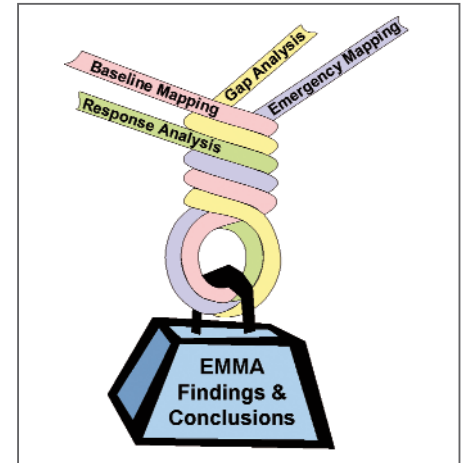
EMMA’s Scope

- **Sudden-Onset Emergencies:** where fast-moving events mean agencies have little advance knowledge of markets and limited resources to investigate.
- **A Broad Range of Needs:** any market system that may be critical in addressing priority needs, including food, non-food items and supporting services.
- **Rapid Assessment and Decision-making:** supporting humanitarian teams to take urgent response decisions faced in the first few weeks.

Four ‘strands’ run throughout EMMA. At the start, they may be relatively separate, but like the strands of a rope, as EMMA proceeds they (should) come together to provide a strong and coherent rationale for the final recommendations to hang upon (see diagram). The four strands are:

1. **Gap Analysis:** to understand the needs, livelihood strategies, emergency situation and preferences of the target population.

2. **Baseline Mapping:** to develop a profile of the ‘normal’ pre-crisis market-system. Seasonal analysis is included.
3. **Emergency Mapping:** to understand the crisis situation, the impacts on market-system, its constraints and capabilities to play a role in humanitarian response.
4. **Response Analysis:** to explore different opportunities for humanitarian assistance: their respective feasibility, likely outcomes, benefits and risks.



EMMA helps humanitarian agencies to *understand* the important market aspects of an emergency situation and *communicate* this knowledge promptly and effectively into programme decision-making processes.

Understanding market-related aspects of an emergency situation means knowing:

- How did affected populations engage with and use markets as part of their livelihoods before the crisis, and how they are doing so now?
- What has been the impact of the emergency on the most critical market-systems that people depended upon before the crisis?
- What capacity do these market-systems now have to supply priority goods and services to people if the affected population had purchasing power (i.e. cash to spend)?
- What would be the impact on these market systems if essential services were brought in from outside the market area (i.e. in-kind assistance)?
- How might key market-systems be quickly assisted to recover or function better so they contribute more effectively to meeting affected population’s emergency needs?

Answers to these questions are relevant to agencies considering the use of cash-based interventions or prolonged in-kind responses. They are also important for thinking about how any response might either encourage subsequent recovery or prolong dependence on outside assistance.

Communicating this knowledge means ensuring analysis results feed into the key decision-making processes of the organisation. The toolkit emphasizes succinct, accessible, non-technical formats targeted at the analysis users: programme managers responsible for planning initial and early responses to crisis.



Two men stand on the roof of their flooded home in Gonaïves, the fourth largest city in Haiti, following tropical storm Hanna.

Oxfam GB, Haiti, 2008

² Market Analysis Tools in Rapid-Onset Emergencies – Phase 1 report. Albu and Murphy. July 2007 Practical Action Consulting

³ Market-systems involve a web of people, structures and rules. Their interactions together determine how any given item, product or service is produced, exchanged and accessed by different people. The market-system concept includes aspects (infrastructure, services, policy, rules and institutions) that are not always emphasized in value-chain analysis.

Market-System Map

A main tool in EMMA is the Market-System Map (examples given in case studies). The maps and other data make comparisons between the baseline and emergency situation. As they give a brief visual representation of the impact of a shock on a market system, the maps are a key communication tool for busy decision-makers.

As market-systems are different and particular to every good, crop, non-food item or service, EMMA has to independently analyse the market-systems for different items (e.g. sorghum, clothing, transport services). Prior to using EMMA and using their needs and gap analysis, practitioners select which market-systems (i.e. which item, crops, product) are critical from the humanitarian emergency perspective.

Mapping requires research and interviews with different market actors and other informants. The aim is to rapidly draw up comprehensive baseline and emergency-affected pictures of the system, which capture the most relevant available information about the situation before and since crisis onset.

Why use EMMA?

- To make early decisions about which form/s and/or combinations of different direct response (such as cash-based and/or in-kind response) options is the most appropriate in meeting immediate needs. EMMA helps you compare the likely outcomes and relative risks of different interventions.
- To assess opportunities for complementary 'indirect' actions. EMMA explores opportunities for alternative forms of market-system support that could rehabilitate or assist recovery of critical market-systems, i.e. those that are most critical for ensuring survival and protecting livelihoods. In doing so, interventions ensure more long-term stability and supply within the affected area or region.

An **indirect response** is any action working with other actors – traders, officials, suppliers – to indirectly help target households, such as:

- Rehabilitation of key infrastructure, transport links.
- Grants (or loan guarantees) for local businesses to restore stocks, rehabilitate premises or transport assets.
- Provision of technical expertise, business services.

- To track the continuing impact of the crisis – and of our own humanitarian responses – thereby reducing the risk of 'doing harm'. As EMMA increases awareness of the potential for harm to businesses and households in critical market-systems, it contributes to reduce aid dependency, promote long-term recovery and increase the stability of key local markets.

Emergencies often cause temporary damage to market functions and trade networks. These problems can be made worse by inappropriate humanitarian responses, for example:

- The depression of a local economy due to loss of income may be aggravated by prolonged in-kind relief.
- Inflationary price rises due to local shortages of essential goods can be intensified by ill-considered cash-transfers.

- To assist in monitoring performance and accessibility of market-systems, aiding changes in programme implementation

decisions. EMMA includes a monitoring tool that can help agencies track both the continuing impact of a crisis, and the outcomes of humanitarian actions, on critical marketsystems.

- To reveal and define the requirements for more detailed market analysis. Where information is poor, time is short or skills to interpret market data are lacking, EMMA can help define Terms of Reference for more thorough research.
- To improve the quality of disaster preparedness and planning. In contexts of frequent shock, EMMA market mapping and profiles can provide necessary knowledge of how critical market-systems work, their potential and vulnerabilities.
- Advocacy and influencing NGOs and donors. EMMA can provide agencies with information needed to influence donor funding decisions and agency implementation choices, improving intra-agency coordination and consistency.

When can EMMA be used?

EMMA has been conceived to help address the limited capacity and confidence for doing rapid 'rough-and-ready' market-system analysis during the first few weeks of a sudden onset emergency situation, when staff time is precious and expert market analysis capabilities are not yet available to agencies.

In principle, EMMA can be used as soon as an emergency situation has stabilised sufficiently that the findings are not in danger of becoming immediately out-of-date due to further changes. Typically, this means that absolute priority needs are being addressed, any displaced people will have settled, and market-system actors (producers, retailers, traders) will have had a chance to assess their own situation and begin devising coping strategies. This could be within two weeks of an emergency, if staff and resources are available.

Equally, EMMA may continue to be useful for many weeks (or even months) into a crisis, if for whatever reasons humanitarian agencies' understanding of key market-systems that relate to emergency needs remains sketchy.

Who is EMMA for?

EMMA is intended for humanitarian staff doing early assessments on the frontline during sudden-onset emergencies, and by extension, for their managers and decision-makers responsible for planning initial and early responses to crisis.

EMMA is designed for generalists, as well as staff working in food security, shelter, water and sanitation, who have little or no previous experience of economic or market analysis specifically. For this reason, EMMA tries to avoid technical language, or tools which require detailed quantitative skills.

Time and human resources needed

It is difficult to predict how long EMMA takes to implement. There are many variables, such as context, scale of the emergency and travel distances. Two scenarios are envisaged:

- **Single-handed EMMA process**
EMMA is conducted by an experienced lone EMMA practitioner, with assistance from one or two colleagues with local knowledge of the crisis area. This is quicker (estimated at 9-16 days including background reading, field work, travel, analysis and report writ-



Selling sugar on Carrefour-Feuilles Market – with prices rising, these traders are selling 3 sacks a week compared to 2 per day previously.

ing), but the amount of territory that can be covered is limited.

Team-based EMMA process

EMMA is conducted by a team, led by an experienced EMMA leader who is responsible for training a small team of local interviewers/assessors. This takes longer, and is more uncertain (quality of team) but potentially can cover a lot more territory (depending on the size of the team). The time required for this process is estimated at an additional 8-10 days to include staff recruitment and training, etc. A guide, 'Training an EMMA Team in Emergencies', is included in the EMMA reference manual.

Work in progress – EMMA to date and next steps

Following the development of a draft toolkit and manual, EMMA has been piloted in three locations, (Haiti, Myanmar and Kenya), with the last and fourth pilot planned for Pakistan in January/February 2009. To ensure toolkit suitability and effectiveness, modifications are made after each pilot using lessons learned and reflections from pilot teams and the pilot consultant.

To facilitate tool relevance and adoption once completed, from inception the development of EMMA has aimed to involve as many international agencies as possible. This has included the establishment of a common information and discussion website (details below) and multi agency piloting and updates.

With the toolkit and technical manual planned for completion in early 2009, EMMA training materials will be developed and piloted over the next 6-9 months. All EMMA outputs (toolkit, manual and training materials) will be made available to agencies for their own/ combined coordinated use in rapid onset disasters.

Haiti case study

The case study below outlines a recent use of EMMA in a post emergency situation and response analysis⁴. More information and details are available on request.

EMMA was piloted in Haiti in September/October 2008 by three agencies, the Red Cross⁵ (Haitian, Canadian), ACDI/VOCA⁶ and Oxfam (GB, Intermon, Quebec) responding to the tropical storms (Fay, Gustav, Hanna and Ike)⁷ that struck last summer. Each organisation was involved in emergency response activities to address basic needs or protect livelihoods and in the phase of designing future programme activities based on assessments. EMMA was used to understand the market systems as part of a process of ascertaining appropriate response modalities. Two market systems – timber for construction and beans – were analysed.

The timber market system

The Red Cross identified shelter as a priority need in their implementation areas of St. Marc, Desdunes and Grande Saline. As the majority of households use timber for construction, they decided to analyse the timber market. EMMA was used to identify the most appropriate intervention modality. Some specific programme questions that needed answering included:

- What is the market capacity to supply timber (for reconstruction) to the affected population?
- Can cash be used or direct purchase?

EMMA analysis enabled the teams to answer these questions but also consider the timing and organisation of a potential response.

Findings included:

- Imported timber market system had to be analysed in detail as target households previously relied on locally grown timber, thus contributing to unacceptably high levels of environmental degradation.
- The timber supply chain is normally stable and was functioning well in both the non-affected and affected areas (see market map in Figure 1).
- As traders were importing more than double the whole target population timber needs in one week, the market system had the capacity to respond to

the predicted population household timber demand at every level of the chain.

- Timber suppliers would only require one month notification.
- Recommendations included:
- Using basic seasonal calendar analysis in the target area, the reconstruction period was planned not to coincide with peak labour/agricultural activities.
 - As weak competition was identified in one implementation area (Saint Marc), additional care and attention to agreements and contracts was warranted.
 - The intervention should try, where possible, to source timber from the nearest available supplier to inject cash into the local economy and affected area.
 - Although most cash preconditions were favourable and traders would have been compliant, households expressed a preference for an in-kind response. This was due to concerns regarding trader corruption and their financial and logistical inability to transport the timber to their household. These constraints could be overcome and cash/vouchers used, with further investigation and discussion with communities, traders and transport agencies and through establishing a monitoring and accountability system.
 - Additional analysis is required to ascertain other factors, including the availability of other shelter materials, the willingness of communities to participate, local labour skill levels to guarantee minimum standards in construction and land tenure agreements.

The beans (haricots) market system

This market system was analysed by ACDI/VOCA and Oxfam teams because it was considered an essential component of the Haitian diet and a good indicator of the overall functioning of the national food market. EMMA analysis was undertaken in two areas – Artibonite (Gonaives) and the South East (SE) (Jacmel, La Vallee and Bainet).

At the time of analysis, imported food aid was being delivered to most affected house-

holds and many non-governmental organisations (NGOs) were curious as to how the hurricanes had affected bean farmers and traders. EMMA was used to understand better the implementation context and investigate potential response decisions. The following questions were of particular interest:

- How the crisis has affected farmers' access to bean markets (to sell produce)?
- What is the availability of bean supplies (for purchase/consumption)?
- How has the crisis affected bean market chain actors and how are they coping?
- When should food aid be stopped, and how?

Findings included:

- Due to the timing and impact locations of the hurricanes and storms, bean prices varied significantly across Haiti.
- With the hurricane season being more destructive than usual, bean crop losses were high (50-90%), which heavily affected the local economy and diet. Agricultural land was damaged and varying levels of rehabilitation required.
- The relationships between principal market system actors (see market map) were affected, especially in the case of wholesalers and small farmers.
- The local markets and economy seemed robust enough to respond to an increased bean demand with advance notification. Local and preferred varieties may have to be replaced by cheaper less popular imported varieties.
- Traders were able to access further supplies and many said they only needed consumer demand to initiate this.
- Although rural market sellers were fewer than seasonally expected, they mentioned higher than normal surpluses. This could have been due to food aid and lower local purchasing power.
- The conditions of secondary and tertiary roads were improving gradually, facilitating transportation of commodities to and from markets.
- Destruction of trader stocks and storage facilities and the breakdown of the informal credit systems would affect the early

Figure 1: Timber Market System after the cyclones in 2008

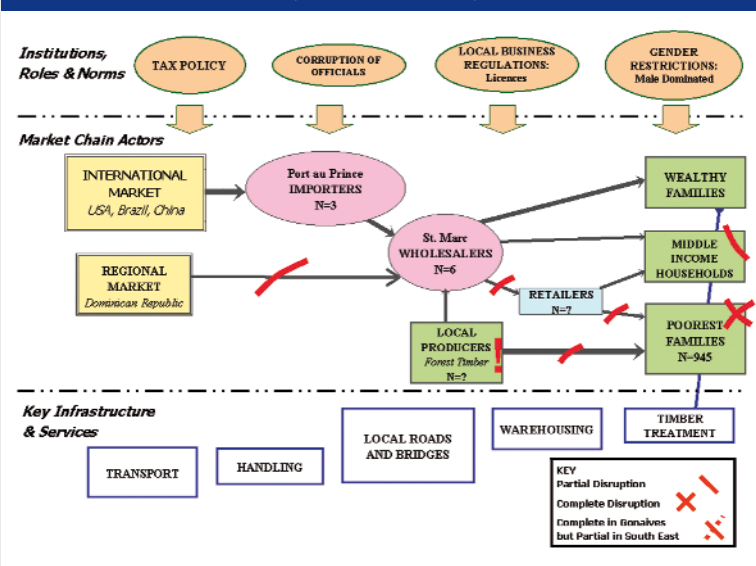
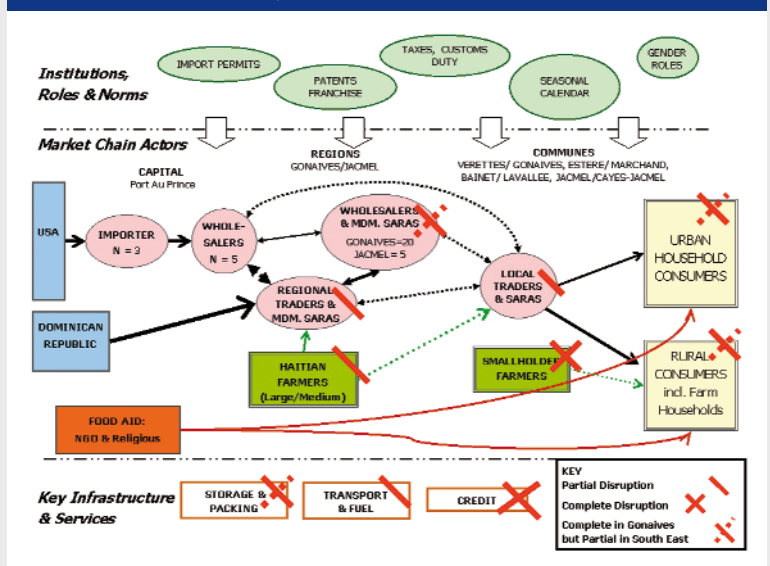


Figure 2: Bean market system in Haiti after 2008 hurricane



Challenging the accuracy of 'hungry' figures

Summary of published research¹

recovery of market system actors in the affected areas. Therefore it was likely that prices would take time to decrease to pre-crisis levels as traders tried to compensate for their losses.

- The decrease in bean demand due to lack of cash or food aid reduced trader incentive to rehabilitate and recover their activities. This was especially worrying in Gonaives, where the rehabilitation process would take longer due to enormous amounts of mud clogging the streets and a large number of poorly coordinated responses between agencies.
- Poor households (including producers) rely heavily on cash to purchase more than half of the food consumed. Higher prices mean that many are forced to consume less and risk nutritional deterioration. Although food aid filled the gap for some households, targeting was difficult and many were not included.

Recommendations included:

- Increase the purchasing power of target beneficiaries by injecting cash into the local economy via cash transfer programmes.
- Provide support to some traders that may need access to credit in order to re-stock (particularly in Gonaives) or to rebuild storage facilities (wholesalers in Gonaives).
- Provide bean seeds and agricultural inputs to farmers to ensure planting of the subsequent crop.
- Stopping food aid by the time the next harvest begins.
- Food for Work and Cash for Work activity timing should consider seasonal livelihood activities/opportunities to ensure labour availability.
- Stagger implementation periods based on recovery capacities. In La Vallee and Baine, targeted distributions may only be necessary until the next harvest if farmers are assisted to recover through targeted agricultural inputs.
- As households frequent markets 3 – 5 times/week, buying in small quantities (due to lack of cash, storage facilities and refrigeration), organisations should consider these aspects and security risks for those receiving large amounts of assistance.
- During harvest months, agencies should complement the local availability of food by implementing interventions that harness local production.

How to get involved or access more information

For more information and access to EMMA outputs please sign on to D groups site: www.dgroups.org/groups/RMAT or email Mike Albu, email: mike.albu@practicalaction.org.uk

⁴ Key Findings and Recommendations EMMA Pilot Test 3 – Haiti Sept 29 – October 14th. Anita Auerbach Practical Action Consulting

⁵ International Federation of the Red Cross and Red Crescent Societies

⁶ www.acdivoca.org

⁷ Tropical Storm Fay was the first to hit, on 15 and 16 August, followed by Hurricane Gustav on 26 August. Tropical storms Hanna and Ike brought with them more high winds and rain on 1 and 6 September. The storms struck all 10 of Haiti's regions.

A figure of 850 million hungry people on the planet was cited at the G8 summit in Tokyo in July 2008. However, the accuracy of such public statements is rarely scrutinised. A recent article in the Lancet challenges the technical basis of such claims.

The above figure and indicator most frequently cited for the magnitude and severity of hunger is the Food and Agriculture Organisation's (FAO) proportion of the population undernourished. The indicator is also used to monitor the progress towards Millennium Development Goal 1 (MDG1). The figure has been questioned in terms of inadequacy of adjustments for calorie requirements. However, the Lancet article levels more serious criticisms at the estimate. The fact that the data are derived from food availability data is the main problem. This is a macro-economic indicator based on national food balance sheet analysis and therefore tells us nothing about the hungry, e.g. who they are, where they are and how they look.

Another frequently cited indicator is the prevalence of underweight children under 5 years of age, which is also used for monitoring the progress towards MDG1. The author acknowledges that this is more meaningful in that it is derived from actual measurements of individuals. However, there are still three types of limitation. First, malnutrition is not caused exclusively by household food security but also by other factors, e.g. disease, inappropriate feeding practices. Therefore, there may be false

positives, i.e. those underweight but not hungry or food insecure. Second, since there is an obvious lag between becoming hungry and then becoming underweight, the indicator lacks time-sensitivity. Third, the indicator overlooks a parental behaviour common across countries: parents tend to ensure food for their children by reducing their own portions. The prevalence of underweight children cannot be extrapolated to an estimation of hunger in older age groups because of this risk of underestimation.

According to the author, the proportion of the population below the national poverty line for food can also be used as a proxy indicator for hungry people. This is generally defined as the expenditure needed to purchase the food basket that meets the country-specific minimum calorie requirements for an individual. However, the indicator is not readily available across countries, probably because of the lack of standardisation in defining the food basket.

The author also points out weaknesses in definitions of food security and the lack of a threshold and concludes that hunger will continue to be relevant after 2015 (the target year of the MDGs) and that appropriate indicators for hunger need urgent reconsideration. As the author puts it "the moment this is being read, someone, somewhere in the world is becoming hungry and that person must be counted."

¹ Aiga, H (2008). How many people are really hungry? www.thelancet.com, vol 372, October 18th, 2008

UNMIS/Tim McKulca, Sudan, 2008
Emergency food distribution in Agok, Sudan.





US Government vessel offloading in the port of Djibouti 42,000 MT of donated food aid in Ethiopia in 2002. The food will reach Ethiopia after a three day journey.

Call for strategic US approach to the global food crisis Summary of report¹

In May 2008, in response to the growing global food crisis, the Centre for Strategic and International Studies (CSIS) launched a task force to assess the rising humanitarian, security, developmental, and market impacts of rising food costs and shortages. The task force convened two high level meetings with members of the United States (US) government and experts in the fields of food supply, energy, bio-fuels, trade, relief efforts and agriculture. The resulting report reflected a strong majority consensus on ways forward.

The authors of the report assert that the crisis poses three fundamental threats: a moral and humanitarian threat, a developmental threat that is endangering the economic gains of the past decades, and a strategic threat resulting in food-related riots and unrest with heavily urbanised nations most at risk.

The report cites a number of root causes of the crisis:

- Soaring global energy prices contributing to cost increases in agricultural production and transportation.
- Rise in the production of bio-fuels based on food grains.
- Demand for cereal grains has outstripped supply over the past several years.
- Bad weather, linked possibly to global climate change.
- In past decades, a gross under investment in agricultural production and technology in the developing world.
- The present global agricultural production and trading system, built on subsidies and tariffs, creates grave distortions, disadvantaging producers in poor developing countries.
- An antiquated international system of mobilising and deploying food relief slows the response to emergencies and imposes unacceptable costs and inefficiencies. Under the current US system, US-procured commodities (mandated by law, and accounting for over 40 percent of the World Food Programme's (WFP) supplies) can take up to six months to reach intended beneficiaries. Shipping, handling, and other management costs were consuming 65 percent of budgets as of early 2007, with the percentage continuing to rise. US-origin grain often arrives late and dampens rural grain prices.

The CSIS Task Force argued that urgent action is needed on two fronts – emergency relief and related safety net programmes, and longer-term efforts to reduce poverty and hunger. The following recommendations were made:

- **Modernise emergency assistance.**
 - Increase the scale of US commitment and significantly improve the speed, agility, liquidity, and flexibility of the US response.
 - Double the US level of annual commitment to emergency food relief from \$1.6 billion to \$3.2 billion.
 - Require that no less than 25 percent and as much as 50 percent of these expanded emergency funds be available for local and regional purchases. The targets for local and regional purchases should be raised over a five-year period, so that ultimately at least 50 percent and as much as 75 percent of emergency funds are available for local and regional purchases.
 - Pursue a robust multilateral approach: reconstitute the Food Aid Convention to reflect better current tonnage and nutritional needs and reinvigorate donor commitments. Renew regular international consultations on emergency food relief response and actively test the feasibility of emergency regional food stocks and the capacity for rapid regional purchases.
 - Intensify US food security diplomacy: encourage major oil-producing countries to contribute more to food relief. Press for more stable and predictable international financing mechanisms for supporting the WFP and its implementing partners.
 - Enlarge, bilaterally and multilaterally, emergency social safety net programmes such as budget support, school feeding, and food for work. Pursue innovative financial and risk management tools such



Bagging donated US aid on dock in Ethiopia.

- as vouchers and insurance schemes.
- Expand nutritional assistance programmes to pregnant and lactating women.
- **Make rural development and agricultural productivity US foreign policy priorities.** For example, elevate agriculture to be a top priority of US foreign assistance strategy. Set an official target to increase significantly productivity in the developing world in the next decade, support the doubling of agricultural programming by multilateral institutions such as the World Bank, and better coordinate and integrate US foreign assistance programmes.

- **Revise the US approach to bio-fuels.** For example, issue an official policy statement that outlines the steps the US will take to expand food crops for consumption purposes and to decouple food and energy issues so that the debate progresses from one of fuel versus food to fuel and food security.
- **Focus US trade policy on promoting developing country agriculture.** For example, press on an urgent basis for a successful conclusion on the Doha Development Round that promotes investment and trade in developing country agriculture and reduces long-standing subsidy and tariff barriers. Also, take deliberate and bilateral and multilateral diplomatic action to ease export bans and restrictions that have contributed to higher food prices including strengthening World Trade Organisation rules on export restrictions.
- **Strengthen US organisational capacities.** For example, create a White House-led standing interagency mechanism on global food security and a Food, Agriculture and Nutrition Bureau at the US Agency for International Development (USAID).

The report concludes that the current crisis is unlike any food emergency the world has faced in the past. It is caused by a web of interconnected forces involving agriculture, energy, climate change, trade, and new market demands from emerging markets. The authors caution that time is of the essence in formulating a response and that the Bush administration, the presidential campaigns, the congressional leadership and the next administration all have a responsibility to move US leadership forward.

Following the CSIS Task Force report, US Senators introduced a bill (S3529) to the US Senate for a Global Food Security Act of 2008. The five year appropriation is asking for over US\$ 7.5 billion for actions to address food insecurity, \$2 billion for the CGIAR (Consultative Group on International Agricultural Research) system for research and \$1.5 billion for a permanent Board for agricultural education. There is also a \$500 million fund for an Emergency Food Assistance Account which can make local and regional purchases of food where appropriate. The legislation would provide USAID with the flexibility to respond to emergencies more quickly, without supplanting other food programmes.

The legislation still requires approval and financing. It will complement the existing US support for food and nutrition programmes from the Farm Bill (Title 11 food aid), PEPFAR (President's Emergency Plan for AIDS Relief) and the Foreign Assistance Bill.

¹ CSIS (2008). A call for a strategic US approach to the global food crisis. Centre for Strategic International Studies, July 2008

Global food price crisis: lessons and ideas for relief planners and managers

Summary of published research¹

Food prices have increased by an average of 52% between 2007 and 2008. ALNAP² has recently published a paper which aims to assist those agencies undertaking operational relief and recovery work in the context of high food prices.

The key areas affected by the food price crisis are said to be Asia, sub-Saharan Africa and Central America. Experts do not agree on how long the price crisis will continue. However, most analyses suggest that within 15 months, most of the price spike will disappear. The possible exception is maize prices where the impact of United States (US) ethanol production may still keep prices high. In the medium term, staple food prices are expected to be 20-40% higher in 10 years than they were in 2002 in real terms, owing largely to increased real costs of oil and bio-fuel production. The impact of rising food prices can be seen in places like Kenya. Here the Kenya Food Security Steering Group (KFSSG) has identified a number of effects. These included increased population below the poverty line, diet changes and reduction in meal frequency, informal wage rates declining due to increased demand for casual jobs, rise in school drop outs, civil unrest, distress livestock sales amongst pastoralists, and livelihood crises in urban slums and amongst pastoral, agro-pastoral and marginal agricultural farmers.

A detailed set of policy prescriptions has been laid out in the Comprehensive Framework for Action, developed by the High Level Task Force on the Global Food Crisis³. A number of stakeholders have already begun to address the consequences of the crisis. Actions include reallocation of resources, mobilisation of new funds, nutritional care and support, supporting social safety nets for the most vulnerable, and supply of seeds, fertilisers and other basic inputs to small-holders. In addition, major pledges of support for agriculture have been made by the African, Asian, Islamic and Inter-American Development Banks, as well as bilateral donors and non-governmental organisations (NGOs). Given all the above, relief managers and planners are faced with a range of challenges, problems and questions and will need to adapt and/or expand humanitarian aid programming to food insecure people. There has already been some evidence of action, in Kenya for example (see Box 1).

Ideas and lessons

The ALNAP paper suggests a number of ideas and lessons:

Food price rises call for stronger analysis and monitoring of food and other basic commodity prices and markets and their impact on the needs and vulnerabilities of different livelihood groups. Such analysis is necessary to understand what type of assistance is appropriate in which context – food, seeds or cash, for example. However, analysis alone is not sufficient. It is also important to anticipate how the situation might change over time and to build in contingency measures to ensure that a programme can be adapted in response, to undertake evidence-based advocacy and to coordinate efforts. The livelihoods framework provides a tool for analysing people’s livelihoods and the impact of specific threats or shocks on livelihood vulnerability.

In the context of livelihoods, it is especially important to develop integrated information strategies that bring together early warning, assessment, targeting and monitoring and evaluation. Here, the Integrated Phase Classification (IPC) work provides invaluable lessons, where bringing together information specialists, managers and local partners has ensured that the benefits of an integrated information strategy have been realised across regions and countries facing high food prices.

In the context of high food prices, it is especially important to analyse the specific vulnerabilities of particular household groups, e.g. agricultural, agro-pastoral, pastoralist and urban poor households.

There are also many reasons why it is valuable for humanitarian agencies to assess and understand markets rapidly in emergency situations, all of which are relevant to food-price rises:

- Markets may offer a fast, cost-effective and empowering way to respond to people’s priority needs.
- Inappropriate relief responses can do further damage to market systems.
- The way markets respond to interventions can indicate whether the response is working as intended.
- Market recovery is a necessary aspect of livelihood rehabilitation and food security.

- Crises in market systems can also be opportunities for reconstruction and addressing issues of market power, equity and access.

Market analysis by institutions such as CILSS⁷, FEWS NET⁸, SIMA⁹ and the WFP have generated important lessons, e.g. a sub-regional approach is preferable to a purely national approach and assessments should devote more attention to demand factors at the micro-level. Also, market monitoring should be conducted on the basis of an agreed understanding of market structures, conduct and performance, and the analysis should cover flow information as well as prices.

Once analysis of the current situation is complete, it is important to extend it into the future and consider different scenarios (see Table 1). There are several different methods of scenario development, e.g. best to worst approach (self-explanatory), and augmentation or step scenarios that try to set levels at which additional action and response capacity is required. A ‘time’ approach defines conditions at set points in time starting with the onset of the emergency, while the ‘operational resource’ approach is based on understanding the types of operation required under different circumstances.

Contingency planning can make a significant contribution to improving operational anticipation and flexibility (see example in Box 2). It provides an opportunity to identify constraints and focus on operational issues prior to the onset of a crisis, enables individuals, teams and organisations to establish working relationships, helps

¹ ALNAP (2008): The global food price crisis: Lessons and ideas for relief planners and managers. Available at www.alnap.org

² <http://www.alnap.org/>

³ CFA Report

⁴ Food and Agricultural Organisation, World Food Programme, United Nations Children’s Fund, United Nations Development Programme, Office for Coordination of Humanitarian Affairs

⁵ Solidarites is a humanitarian organisation which provides aid and assistance to victims of war or natural disaster.

⁶ Peste des petits ruminants (PPR), is an acute or sub acute viral disease of goats and sheep characterized by fever, stomatitis, gastro-enteritis arid pneumonia.

⁷ Permanent Interstate Committee for Drought Control in the Sahel

⁸ Famine Early Warning System, <http://www.fews.net/>

⁹ Niger government’s système d’informations sur les marchés agricoles

Box 1: United Nations (UN) priority areas in Kenya

According to the KFSSG meeting report, FAO, WFP, UNDP, UNICEF and OCHA⁴ agreed five priority areas of activity in Kenya in response to rising food prices:

1. An integrated joint programme between WFP and FAO on cash/food for work transfers where appropriate, but focusing on marginalised farmers along river valleys who can improve their productivity from small-scale irrigation projects.
2. UNICEF/WFP/WHO have agreed to consult around the issue of surveillance and management of both moderate and acute malnutrition through therapeutic and supplementary feeding, with focus on urban/peri-urban poor and pastoralists.
3. FAO is to consult with partners on urban agriculture projects, including with Solidarites⁵, on the expansion of their pilot project on vegetable production in slum areas. These activities are proposed for other towns such as Kisumu, Mombassa and Nakuru.
4. FAO is to consult with other stakeholders and develop a proposal on emergency response to the PPR⁶ outbreak among small ruminants in pastoral districts.
5. Provision of assistance to pastoralists who have already been, or are close to being, forced to drop out of pastoralism.

Table 1: Advantages and uses of different approaches to scenario development

Scenario/ approach	Advantages	Best use
Best, most likely, and worst case	<ul style="list-style-type: none"> • Provides a basis for planning for different scales of problems • Easy to understand 	<ul style="list-style-type: none"> • Planning for a single situation • When scenario development involves many actors
Augmentation	<ul style="list-style-type: none"> • Good for planning for situations which increase in magnitude over time • Easy to build plans which allow for expansion of operations 	<ul style="list-style-type: none"> • Displacement situations (internally displaced populations and refugees)
Timeline	<ul style="list-style-type: none"> • Allows planners to adapt operations over time while a crisis evolves 	<ul style="list-style-type: none"> • When rapid-onset disasters occur, response needs can change very rapidly in the initial days and weeks
Operationally representative	<ul style="list-style-type: none"> • Allows for a greater focus on operations • Can be used to develop more flexible plans • Can be used to identify preparedness actions that help in multiple situations 	<ul style="list-style-type: none"> • Situations that are

Box 2: WFP index for triggering contingency planning

The WFP has been working on an index for triggering contingency planning when an emergency is detected. This is the Livelihood Protection Cost Index (LPCI), a weather-based index aimed at providing an objective, independently verifiable and replicable indicator of livelihood loss. The index is developed by evaluating historical weather data and determining its correlation to crop yields and revenues. One possible application of the LPCI to pastoral areas is being discussed, whereby weather data could be correlated to grass cover and forage conditions using the Livestock Early Warning System methodology. Similar approaches might usefully be explored in the context of rising food prices.

reinforce coordination mechanisms by keeping them alive and allows organisations to put in place measures that enhance preparedness. Good contingency planning will include appropriate programming options and triggers for action, as well as predetermined roles and responsibilities amongst different actors. There are two broad approaches in humanitarian contingency planning:

- Needs-based planning, where planners must analyse existing operational capacity to determine how much strengthening will be needed to meet anticipated needs.
- Capacity-based planning, which uses available capacity as a basis for planning, regardless of anticipated needs. This approach can be used to plan for the initial phase of a crisis where external resources are not readily available.

Coordination and partnerships between humanitarian organisations, development organisations, national and local governments and private firms are vital to an effective response. Coordinated advocacy is especially important in the face of rising food prices, to ensure that the conditions faced by the most vulnerable are addressed in timely and effective manners.

To counteract dramatic increases in costs and demand and bring food prices back to levels that the poor can afford, agriculture needs to make big leaps in productivity. Investments are therefore needed by the private sector. Equally important are good seeds, improved crop varieties and support systems. Water harvesting and water storage systems are needed to reduce stress caused by dry spells and pastoralists need support. It is also important to ensure that financial services, such as insurance and credit, are available to poor farmers.

Careful decisions also have to be made over whether cash or food or a combination of both is

needed to support the worst affected. The decision should not be resource driven. Recent experiences with cash programmes have shown that:

- Where markets can provide enough food, and food insecurity is a result of lack of purchasing power, cash can work.
- The combination of food plus cash can provide all the benefits of both while avoiding the limitations of each.
- Cash may be more appropriate for certain groups, such as pastoralists.

Key points to consider when deliberating over a cash-based response are:

- Accurate market analysis and monitoring is crucial.
- There must be realistic assessment of the capacity to distribute cash and sufficient funds for capacity building.
- Monitoring the impact of cash distributions requires gender sensitivity.

Social protection is an umbrella term used to describe a broad range of initiatives and transfers intended to reduce the economic and social vulnerability of the poor and food insecure. Instruments that provide a seasonal safety net, coupled with other options, can offer a livelihood package that can meet immediate needs, while building a buffer for the future. Instruments to offer a safety net include employment-guarantee schemes or conditional cash transfers, micro-credit, food for work or cash for work, asset transfer or production support.

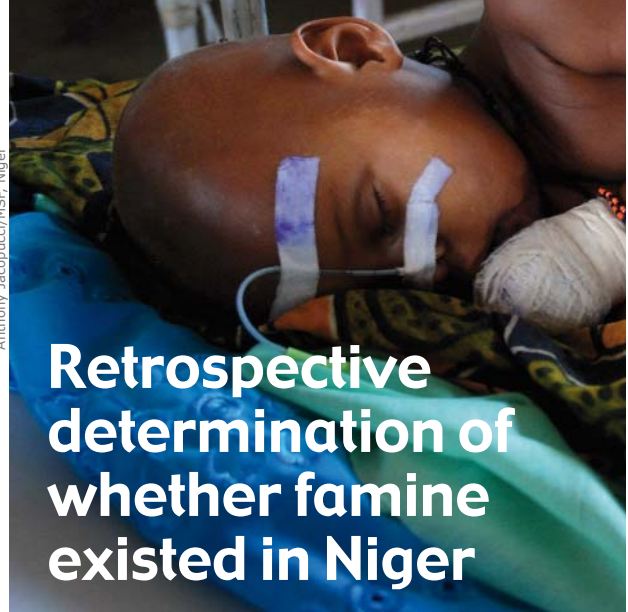
Governments, rather than the humanitarian community, should manage and implement social protection. NGO involvement should be geared towards facilitation rather than direct implementation and look to increasing their role in lobbying, advocacy, and capacity building. There is also a role for NGOs to participate in social mobilisation by engaging with civil society to hold states accountable to their social contracts and monitor the extent to which social transfers are carried out and who these are serving.

Different social protection instruments are appropriate for different sources of vulnerability. A mix of different approaches will be needed in different settings (see Table 2).

There is growing concern about the implications of rising food prices for cash-based social protection, given the eroding value of cash transfers in the face of food price inflation. Some argue that this makes the case for index-linking transfers. However, this requires governments or donors to take on the price risk that poor people face all the time and demands a degree of flexibility in planning and budgeting that governments and donors may find daunting.

Table 2: Source of vulnerability and suitability of social transfer instruments

Source of vulnerability	Benefit	Modality	Examples of types of instrument
Chronic poverty	• cash • food	Direct support Public works	• Conditional/unconditional cash/food transfers • Micro-finance
Personal shock	• cash	Direct support	• Social welfare grants • Pensions
Lack of access to key livelihood inputs	• cash • inputs • assets	Conditional transfers (e.g. must have land to utilise inputs)	• Conditional cash transfers • 'Starter Packs' (farmers) • Land reform (women) • Restocking (pastoralists)
Market failures	• cash • subsidies • food	Direct support Public works Subsidies	• Cash transfers • Food stamps/vouchers • Food price subsidies • Employment guarantees
Inadequate uptake of basic services	• food • cash • waivers	Conditional transfers, e.g. conditional on attendance	• School feeding • Conditional transfers (health) • Fee waivers (education and health)



Anthony Jacopucci/MSF, Niger

Retrospective determination of whether famine existed in Niger

Summary of published research¹

A recent study set out to apply the famine scale developed by Howe and Devereux to the situation in Niger, west Africa, in 2005, to determine retrospectively whether famine existed.

The authors assert that the absence of universal benchmarks or criteria to identify famine conditions creates uncertainty about the magnitude of the crisis, resulting in delays and inappropriate responses. In the context of the current global food crisis, with dramatic price increases and reduced accessibility to food in already food insecure populations, it may become even more critical to develop an internationally accepted definition of famine to guide humanitarian response and funding and to enforce accountability.

The famine scale proposed by Howe and Devereux is based on scales of intensity and magnitude. The intensity level in a given population is based on a combination of anthropometric and mortality indicators and on descriptors of food security. These descriptors include coping strategies and stability of the market and food prices. The intensity scale is used to assign population areas within a country to a level, from 0 (food secure conditions) to 5 (extreme famine conditions). Intensity levels of 3 (famine conditions) or above register as a famine on the magnitude scale, which ranges from minor famine to catastrophic famine. The magnitude scale is determined retrospectively by measuring excess mortality caused by the crisis.

International agencies raised concerns about the increasing admission rates of malnourished children in therapeutic feeding centres in the Maradi region between February and April 2005. Local surveys in the Maradi and Taboua regions between April and May 2005 showed that the prevalence of global acute malnutrition among children aged 6-59 months exceeded the 15% critical threshold established by the World Health Organisation (WHO). It was unclear whether these reports represented a localised event or if the crisis extended to regional and even national levels; the question of a current or imminent famine was also uncertain. Thus the scale and severity of the food crisis in Niger remained in dispute.

The researchers applied the famine scale to the situation in Niger in 2005 by assessing mortality and household coping strategies

Can anthropometry measure gender discrimination?

Summary of published research¹



A child admitted to an MSF therapeutic feeding programme in Niger.

with rates of malnutrition, to determine retrospectively whether famine existed. Surveys were carried out in eight regions, using stratified two stage cluster survey design. Pastoralists (estimated at 5%) were excluded from the survey, given the complexity of sampling this mobile population. Coping strategies for dealing with insufficient food needs since the beginning of the last hungry season in 2005 were stratified into four mutually exclusive categories: no coping strategies, reversible adaptive strategies that should not harm future livelihoods, irreversible coping strategies that threatened future livelihoods, and survival strategies involving disengagement from any normal livelihoods systems and focusing purely on survival.

Findings

The estimated national crude mortality rate was 0.4 (0.4-0.5) deaths per 10,000 per day and the under five mortality rate was 1.7 (1.4-1.9) deaths per 10,000 per day. Nationally, 22.3% (95% confidence interval 19.9%-24.8%) of caregivers of under 5 year olds did not resort to any coping strategies to deal with insufficient food needs. Reversible coping strategies were, however, used by 5.8% (4.7-7.0%) of caregivers, whereas 49.4% (46.9-51.8%) relied on irreversible coping strategies and 22.6% (20.0% to 25.4%) on survival strategies.

On the basis of the famine scale, most regions in Niger 2005 experienced food crisis conditions and some areas approached famine proportions. The absence of a universally accepted definition of famine contributed to disagreements about the magnitude and severity of the problem. This highlights the need for an internationally agreed definition of famine and for clear guidelines on the timing and magnitude of a response.

Although the utility of the famine scale by Howe and Devereux needs rigorous assessments, it does provide more objective criteria than previous approaches. It also moves from a binary concept of 'famine or no famine' to a graduated approach that captures a range of food insecurity situations.

The authors conclude that nutrition surveys such as these, with data collected on malnutrition and mortality as well as on coping strategies, improves the ability to triangulate different types of information to determine the true magnitude of a crisis.

Sex differences in life expectancy and child survival in Bangladesh have been attributed to discrimination against girls and women and to mothers' low social status and lack of power within the household. A recent study used a large data set of Bangladeshi children's heights and weights to explore whether anthropometry can be used as a tool to examine gender discrimination. In the past, anthropometric data from nutritional surveys in Bangladesh have not reflected the patterns of gender discrimination shown in mortality and demography data. This apparent discrepancy may be explained by the growth references used to calculate standardised nutritional indices.

The study analysed the linear growth of a large sample of Bangladeshi children (> 500,000) aged 6-59 months using the new World Health Organisation (WHO) growth standards and, for comparison, the National Centre for Health Statistics (NCHS) and 1990 British growth references. Height-for-age was examined on the basis that this may be the most sensitive indicator of longer-term discrimination in health care and feeding. Trends in stunting were examined from 1990-1999, a decade during which gender discrimination in Bangladesh is thought to have diminished. The focus of the analysis was on the group aged 6-23 months, as this is the age at which gender differences in health and nutrition have been shown to emerge due to an increased reliance on non-breast milk intakes and vulnerability to diseases. The data were collected by the Nutrition Surveillance Project (NSP) of the Helen Keller Institute (HKI) and the Institute of Public Health Nutrition. The NSP collected data every two months on randomly selected samples of children in rural Bangladesh.

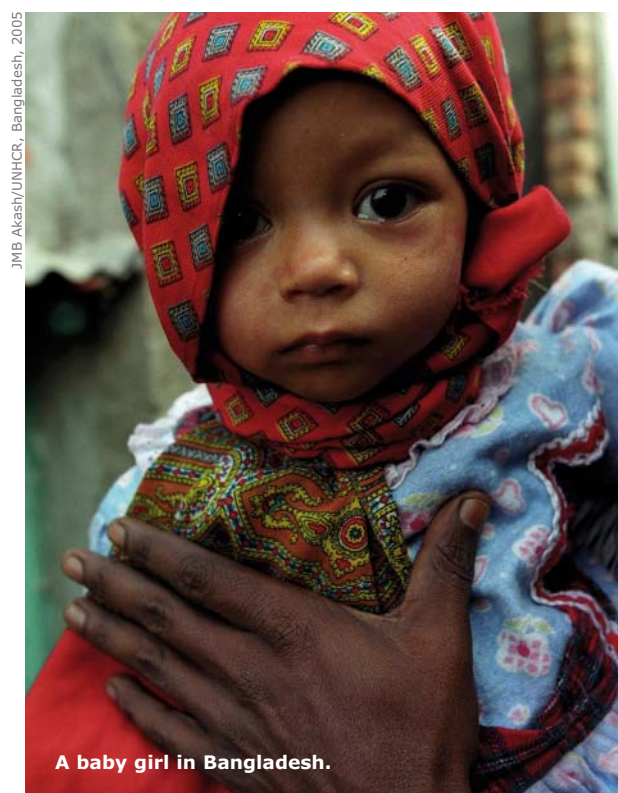
Three key findings emerge from the study. First, conclusions on sex differences in growth of Bangladeshi children depend on the norm used. The three sets of growth curves present conflicting pictures of the relative growth of girls and boys, in relation to both age and time. Second, conclusions also depend on the method of analysis used to examine the growth curves, whether in relation to their shape (i.e. an assessment of growth faltering or catch-up with age that captures cumulative and gradual sex differences) or their relative position (i.e. a simple comparison of average Z-scores or stunting prevalence at a specific age). Finally, there is value in using a large test population to explore a specific application of a growth norm. This may also serve to expose other important issues, such as the continued problem of age determination and digit preference in nutrition surveys.

The author asserts that it is encouraging to find that the WHO standards uniquely pres-

ent Bangladeshi girls as faltering faster or catching up slower than boys throughout their pre-school years, a finding consistent with the literature on gender discrimination in Bangladesh. Yet, confusion arises if Z-score averages for a specific age group are compared. For example, use of the WHO standards for children 6-23 months of age gives girls higher average Z-scores than boys. The author concludes that there a number of technical and practical implications of these findings.

There is a need for further research to examine the causes behind the differences in the growth curves produced using the three norms, bearing in mind that differences reflect variations not only in the reference populations used but also the methodologies applied to construct the growth curves. Such research should also examine sex differences in growth in infants under 6 months of age. Practical implications relate to the fact that anthropometric data are routinely collected and analysed throughout the world and that this affords the opportunity to ensure that gender discrimination is monitored and reported upon as a matter of course. Further research and debate are needed to determine whether and how this can be achieved.

Finally, the ongoing global process of implementing the new WHO international growth standards presents an opportunity to explore the role of anthropometry for gender analysis. At the same time, research is needed to corroborate or dispute the study findings and to help establish whether and how the WHO international standards can most meaningfully be used to measure and monitor gender discrimination.



A baby girl in Bangladesh.

¹ Reza.A (2008). Retrospective determination of whether famine existed in Niger, 2005: two stage cluster survey. *BMJ* 2008;337:a1622doi:10.1136/bmj.a1622 Download full article at: http://www.bmj.com/cgi/content/full/337/oct02_1/a1622

¹ Moestue. H (2008). Can anthropometry measure gender discrimination? An analysis using WHO standards to assess the growth of Bangladeshi children. *Public Health Nutrition*, September 2008, pages 1-7

Micro-credit in refugee situations

Summary of published research¹

Micro-credit and other types of loan programmes have not been widely attempted within refugee and internally displaced population (IDP) contexts largely due to the fact that repatriation, resettlement or further displacement may prevent repayment of loans. However, an increasing number of refugees and IDPs remain 'stuck' in protracted situations, creating potential for using credit-based interventions to support their livelihoods. A recent paper based on a compilation of best practices and lessons learned from the 'Alchemy Project'² has been made available by the Feinstein International Centre.

The paper identifies the main problems affecting loan programmes in refugee situations as:

- i) The difficulties around repatriation, resettlement and onward migrations, which creates instability and problems with repayment.
- ii) Isolated camps and restrictions on movement that create market access problems and transportation constraints.

The main lessons are:

- Micro-credit is not for everyone.
- There is a need to make loan size and type appropriate for clients, markets and community.
- Do not accept low repayment rates.
- Include training, monitoring and evaluation in programme design.

Micro-credit is not for everyone

So called 'vulnerables' are seldom the most appropriate candidates for micro-credit and their presence in a programme can both undermine the programme and increase the client's vulnerability by exposing them to debt. Micro-credit should be provided only to stable, economically active refugees who have demonstrated their own initiative in starting a business. Good candidates might also be refugees with prior micro-credit experience or experience with formal credit institutions like banks.

Bad practices by unqualified agencies trying to do micro-credit include:

- accepting poor repayment rates
- doing nothing about absconders or defaulters
- charging inappropriate or unsustainable interest rates
- calling a 'grant' a 'loan'
- allowing loans to be used for consumption purposes
- targeting micro-credit at vulnerable populations.

There are often contradictions between the target group that a non-governmental organisation (NGO) is mandated to support in a refugee camp context, and whether that group can be supported with credit. Donors and UNHCR often require that assistance programmes are targeted at the most vulnerable in the refugee population.

The authors argue that livestock and in-kind loans should be used to support those not ready for micro-credit. Refugees who are not appropriate candidates can best be helped with traditional relief, or less onerous in-kind loans or small livestock programmes. In-kind loan programmes have less demanding repayment

requirements, and can be more easily managed by a relief agency. Livestock and in-kind loans can support a variety of people, including new arrivals or so-called 'vulnerables' such as child-headed households and the disabled.

The provision of small stocks (goats, sheep, chickens, ducks, etc) either for breeding or trading purposes can help launch livelihoods and are good starter programmes. Successful completion of an in-kind loan programme can prepare the client for participation in a micro-credit programme.

In refugee settings it is best to be conservative about using micro-credit and to wait until the agency is familiar with the displaced community, and is working productively with relief organisations, groups and leaders.

Good programme design

Before designing and implementing a credit programme, NGOs should conduct a market study, identifying market constraints and possibilities for clients as well as risk. Good loan appraisal or well designed group loan methodology will prevent problems arising from repossession, and is a first step in identifying clients who might eventually be unable to make repayments. In refugee situations, various loan conditions, including legal documentation and collateral are missing or compromised. But this need not necessarily prevent the loan, if appropriate alternatives can be identified. It might be possible to waive documentation requirements once the implementing agency is familiar with the community and has the cooperation of key members and leaders who can help detect loan risks. Alternative forms of collateral can be identified. For example, where refugees have access to farmland, collateral can take the form of vegetables produced by the refugees that are assessed for their market value.

In certain situations, refugees may lack any form of collateral and other ways to ensure repayment, such as group pressure, are absent. Under these circumstances, some agencies have provided micro-credit using controversial repayment strategies. These include working with the government so that refugees who did not repay their loans were not permitted to renew their documents.

Given the existence of a grant mentality amongst many refugee populations, it is best not to associate micro-credit programmes with UNHCR or relief organisations that have traditionally handed out grants. Furthermore, micro-credit programmes should never be attempted by untrained relief agencies. The skills and mindset needed to manage and administer micro-credit programmes are rarely found in traditional relief programmes.

Loan size, interest rates and repayment frequency

Loan size should be appropriate for the client's enterprise. For refugees it is important that loan amounts are appropriately sized to meet the special marketing needs of refugees which may include transport and marketing costs. These should be based on institutional cost assessment, inflation, market rates, risk and client capacity. Interest is the way in which a

programme is made sustainable by creating additional income beyond repayments that cover administrative costs. In Islamic areas, where interest cannot be charged, service charges on the loan can be imposed instead. Interest rates can be problematic amongst poor refugees. Some experts have suggested that since refugee programmes are not meant to be sustainable, charging nominal interest can be a way to create a good credit culture.

Provision of a mix of services

For refugees with no in-country business experience, marketing assistance can help businesses. Refugees often cannot access markets and cash economies either because they live in isolated and remote border areas, or because the government's policy requires refugees to stay in camps or restricts freedom of movement.

Training of individuals, loan groups and loan committees before loan disbursement is highly valued by group members, and increases the success of programmes. The existence of organised groups in the community is an asset in loan programmes, as these create strong pressures to repay, groups can combine funds to finance larger businesses and groups are self-monitoring. Group loan schemes only work in environments of trust. Group lending is inappropriate if clients are unwilling or unable to take responsibility for each other's debts. In many refugee and urban contexts, there is a lack of trust and it may be preferable to work with individuals, and put in place other safeguards to reduce the risk of absconding and non-payment. In some camps, traditional rotating credit schemes familiar from the home country are re-started by the refugees themselves. It is best to work with existing groups.

Resettlement and repatriation

All parties involved with the refugees, including the host government, refugee leaders, resettlement organisations and UNHCR, must build an understanding about how repatriation or resettlement will be managed in the loan programme. When UNHCR initiates voluntary repatriation or resettlement, agencies can plan repayment schedules accordingly. It might be necessary to make loan periods shorter to reduce repatriation risk in general. Loan cycles should be shorter than in non-refugee situations.

Credit programmes and refugee livelihoods are supported when governments allow refugees to work outside of camps, and disabled when there are government restrictions on refugee movement. In some cases, governments impose different requirements and restrictions on different refugee nationalities. The biggest challenge remains for NGOs and UNHCR to advocate on behalf of economic freedom for refugees and the protection of their rights to pursue a livelihood as set out in the 1951 Refugee Convention.

The economic contribution of refugee entrepreneurs can be a potential win-win situation for both host countries and refugee communities. Their economic contribution can be maximised by agencies advocating for their rights to work and freedom of movement.

¹ Jacobsen, K (2004). Micro-credit and other loan programmes in protracted refugee situations: Lessons from the Alchemy Project. Feinstein International Centre. <http://nutrition.tufts.edu/>

² The Alchemy Project is an experimental project aimed at supporting displaced people's livelihoods by providing access to a variety of forms of credit.

Targeting in complex emergencies: the cases of Somalia and Columbia

Summary of case studies^{1,2}

The World Food Programme (WFP) recently commissioned research to investigate the participation of recipient communities in the targeting and management of humanitarian food assistance in complex emergencies. Four case studies were carried out involving desk reviews and field visits. The purpose of the research was to understand the ways in which participatory or community-based approaches to targeting (CBTD) have been attempted within the definition of community-based targeting suggested by WFP. This definition includes the notion of working through local or traditional leaders to target food to the most vulnerable. Two of the country case studies are summarised here.

Somalia case study

The Somalia case study looked at CBTD under the ongoing WFP Protracted Relief and Rehabilitation Operation (PRRO). The majority of food aid is targeted to the south-central part of the country where political stability has been most problematic. The largest single category of assistance has been general food distribution for food insecure rural populations as well as for internally displaced populations (IDPs). However there is now a substantial amount of food assistance going to urban populations as well.

According to the review, targeting at the geographic level of district and livelihood is well informed by analysis but less informed by adequate assessment at village and household level. Security considerations, limited staff numbers and other constraints have long meant that the actual oversight of what happens to the delivered food must be left in the hands of local leaders at the village or IDP camp level. Under these circumstances, there have been allegations of widespread diversion of food aid by militias and other powerful actors before it reaches the community level, and widespread practices of the redistribution of food aid beyond the WFP-targeted recipients at the community level. The limited access for follow up and monitoring means that the real impact of redistribution is not known.

In Somalia, the WFP relies to some extent on local leadership to oversee and target food aid within the community. However, there are large differences in the accountability and legitimacy of local leadership in different locations. These range from a reasonable degree of accountability of leadership in rural communities (where the presence of clan elders and religious leaders allowed for some checks and balances and some redress mechanisms) to populations effectively kept in check by 'gate-keepers' who control information, access, and resources. The latter type of local leadership tends to predominate in IDP camp situations. Although committees of local leaders exist in both situations, the degree to which leaders actually represent the community differs enormously and most of the evidence about diversion of assistance comes from situations in which representation is the lowest.

The practice of redistribution limits the number of people in any recipient community

who are excluded from food assistance, but also ends up ensuring that no one receives very much. Strong views were expressed virtually everywhere the study team visited that external assistance in the form of food should be shared equally within communities.

Much of the process of food aid targeting remains opaque to recipients. They are often not aware of their entitlements or the process of determining who is entitled. Redistribution rarely takes place in an organised or supervised way, and is often so ad hoc and disorganised that it results in fighting or even loss to looting.

The authors of the Somalia case study conclude that improved targeting would be promoted by an improved analysis of context, increasing the capacity of staff and partners to target at the village level, and a willingness to work with the reality of sharing and redistribution. Other means of improving the participation in targeting include identifying and bolstering appropriate checks and balances, involving all stakeholders in planning, improving transparency through informing the community of overall food aid being delivered and making better use of localised complaints mechanisms.

Columbia case study

Columbia has one of the largest displaced communities in the world – between 1.8 million to 3.7 million people. Women and children and marginalised ethnic minority groups such as the indigenous and the Afro-Columbian people are over-represented among the IDP populations. There are currently 2,000 communities assisted under nearly 3,000 projects in PRRO 10366. Approximately 499,000 beneficiaries are served by the PRRO.

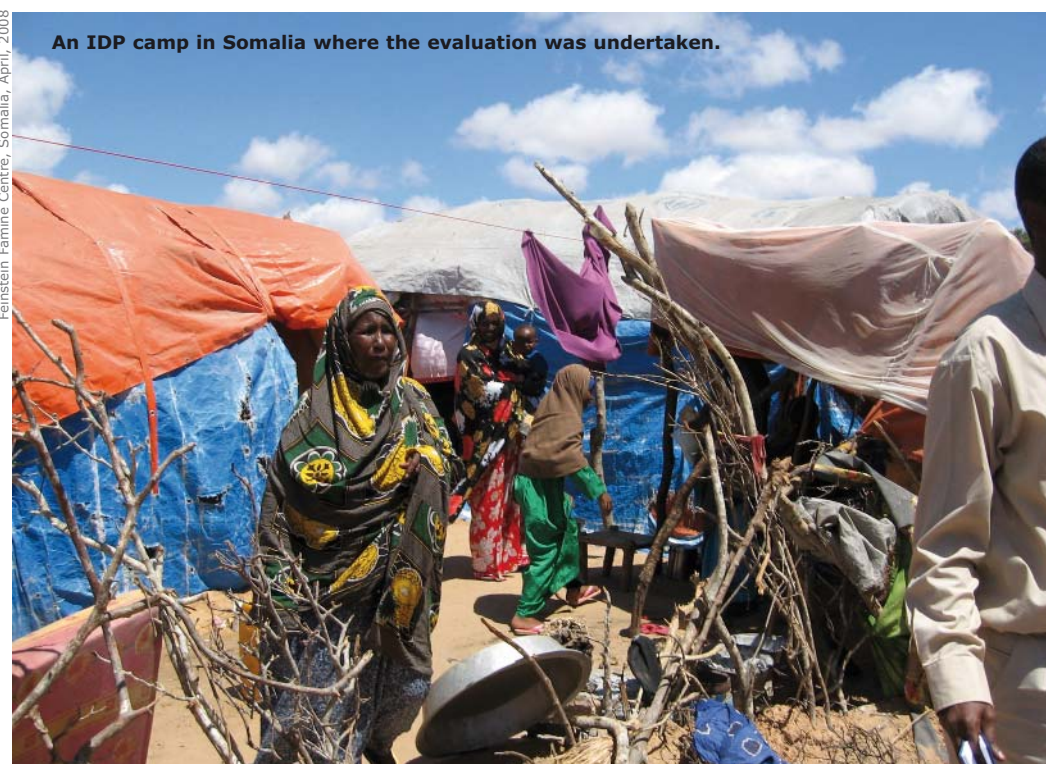
The case study involved visits to five very different geographic regions. In this case, targeting involves two distinct steps. The first step involves the use of geographical and

administrative targeting methods, based on geography, population and institutional criteria using a vast network of informal partners, as well as a formal agreement with two Government of Columbia (GoC) institutions. The second step involves choosing between seven possible food assistance modalities (relief, food for work, food for training, nutritional risk, mother and child, pre-school feeding and school feeding), each with their own specific beneficiary profile and food assistance package delivered by a chosen implementing partners. Both steps involve various decision-making processes.

There is ample scope for direct community participation in Columbia because about one third of WFP implementing partners are community based organisations. Community based participation begins after the second step of targeting and revolves more around programme implementation than programme design and setting selection criteria. The study found that some communities can influence the implementing partners' negotiation process with WFP to implement a food assistance project and hence can be said to participate successfully in the targeting strategy through advocacy. This is much more likely to happen in communities with strong cohesion and with leadership styles that encourage good working relations with outsiders wishing to support that particular community. In some cases, the beneficiary community itself approaches WFP to implement the project – this was seen to be more likely to be led by women in urban settings, where perhaps traditional leadership styles had somewhat broken down.

¹ Jaspars, S and Maxwell, D (2008). Targeting in complex emergencies. Somalia country case study. Feinstein International Centre, July 2008.

² Frize, J (2008). Targeting in complex emergencies. Columbia country case study. Feinstein International Centre, July 2008.



An IDP camp in Somalia where the evaluation was undertaken.

Feinstein Famine Centre, Somalia, April, 2008

Participative methods are encouraged by WFP for all its implementing partners and set out in the Columbia PRRO 10366 operations manual. Important examples include encouraging meetings with beneficiaries (especially women), explaining the origins of food assistance, and creating a Food Committee or equivalent. Close and regular contact with the communities and implementing partners was found to be an essential ingredient for participative and representative approaches. The WFP has successfully achieved this in many of the projects it supports. The creation of representative food committees in the community to run food assistance projects was seen to be one of the most successful ways of balancing out leadership roles and introducing checks to mitigate against corrupt leadership styles. In addition, the food committees were seen to have successfully empowered female community members to advocate for the strict adherence of the programme selection criteria and gain networking and resource mobilisation skills. Where the food committee was made up of hand-picked friends of corrupt community leaders, the scope for community participation was seen to be greatly diminished. Participative consultation techniques were also observed among representatives of IDPs who had accumulated years of experience representing their community and had gained their trust.

The main exception to this observation was the mechanism of working with targeting practices already in place through established community leadership mechanisms set up for other purposes. This proved to be the mechanism that was most prone to abuse in terms of promoting participation, especially when associated with the selection criteria under GoC food for work programmes. Corrupt leadership is something for which WFP's current targeting strategy has few checks and balances.

Main enabling factors for participatory targeting included:

- Proximity and trust between community and implementing partners.
- A targeting strategy that allows for changing needs.
- Strong community leadership.
- Urban populations that come together for collective action.

Constraining factors included:

- Inadvertent support for existing systems of selection that are unfair and benefit the elite.
- Insufficient time spent with beneficiaries and non-beneficiaries to explain targeting criteria.
- Implementing partners having a tendency to work with communities with a higher degree of cohesion.

The case study authors concluded that CBTD is an approach that needs to be judged for its contribution to more effective targeting, as well as for its contribution to more participatory programming methods. In the case of Columbia, CBTD achieves both of these objectives when it empowers community members to gain new skills and does the opposite when communities cause further exclusion through unfair systems of targeting.

Emergency food-based programming in urban settings

Summary of published research¹

The Food and Nutrition Technical Assistance 11 (FANTA-2) Project has recently published a paper to provide technical information and lessons learned to support USAID and its partners to design effectively and implement emergency food assistance programmes in urban and peri-urban settings. The USAID Office of Food for Peace (FFP) food assistance programmes have traditionally focused largely on rural areas, offering a large body of literature on best practice. Similar information on urban food assistance programming has been limited, particularly in emergencies.

The paper sets out a number of factors that may differentiate urban and rural crises resulting in a different set of response criteria and mechanisms. These include:

- Urban-rural differences in food security.
- Food consumption and access – food is generally the largest expense category in the budget of the urban poor and the main source of food insecurity amongst urban populations is food access.
- Labour market – the urban poor mostly earn cash from low-paying unstable jobs in the informal and formal sectors, with populations displaying a higher degree of economic inequality than rural areas.
- Social networks and gender – urban social networks are based on political, religious and economic, as well as ethnic, affiliations. Although ethnicity is the dominant factor in determining residence and settlement in some cities, as a general rule, groups tied together by these factors are less geographically circumscribed in urban than in rural settings.
- Public health and care practices – urban populations as a whole make greater use of health services than rural populations.
- Institutional and stakeholder environment – there is a broader range of stakeholders that can serve as partners in urban areas than in rural areas.
- Socioeconomic status – a given population's socioeconomic status is usually higher but more variable in urban areas, with remittances a critical source of income.
- Property issues – urban areas in low-income countries often include unplanned settlements or slums, whose residents are frequently at high risk of food insecurity.
- Rural-to-urban migration and connections – urban and especially peri-urban residents often retain active economic and social links with rural areas. Health care in cities may also be a draw for rural to urban migration, particularly for HIV services.

Planning food assistance in urban emergencies

The paper sets out how to plan food assistance in urban emergencies and specific issues that relate to the urban environment.

Assessment

There is no internationally accepted standard guide or instrument for urban emergency needs assessment. The authors suggest that time and

resources permitting, a rapid nutrition survey can be conducted to help provide a representative picture of groups of concern. However, urban under-nutrition prevalence estimates often mask significant variation among socio-economic groups. Assessing food security in urban contexts is also a challenge. Assessments should aim to capture impact of the crisis on expenditure on basic needs and household income because urban populations tend to access most of their food from the market. There are key contextual issues to consider. Population density and poor sanitation elevate the risk of communicable disease epidemics, including acute diarrhoeal disease. HIV is also more prevalent in urban populations, increasing nutritional requirements and morbidity risks during a crisis. Exclusive breastfeeding rates are lower in urban than rural settings, so the risk of contamination of food and water is elevated in urban emergencies.

Targeting

Deciding what targeting approach to use usually depends on the proportion of the population that needs assistance, the type of programme contemplated, trade-offs between targeting cost and targeting accuracy, and the feasibility of targeting options. Considerations include:

- Proportion of population to receive assistance – if the large majority need assistance and resources support a large scale response, then it is not cost-effective to select households and individuals.
- Type of programme – some programmes require targeting eligible institutions and providing assistance to all individuals at those institutions. Others, like targeted distribution of 'take home' rations, require identifying households that meet certain social or economic criteria.
- Targeting costs and accuracy – targeting generally entails a trade-off between costs and accuracy.
- Feasibility of targeting approach – community based targeting requires accountable and strong community structures, transparency and high community engagement.

Exit strategies

Although most urban emergency food assistance programmes will aim to address transitory food insecurity within a short (e.g. one year) time frame, exit strategies must still be identified from the outset. Many of the factors contributing to urban food insecurity – including rising food prices and climate change-related shocks – are expected to be medium to long term. This underscores the need to address underlying causes, as well as to establish ways to support these populations through national structures (e.g. social safety nets) wherever possible. An urban emergency food assistance programme's exit strategy should include

¹ Food and Nutrition Technical Assistance II Project (FANTA-2). Emergencies in Urban Settings: A Technical Review of Food-based Program Options. Washington, DC: FANTA-2, Academy for Educational Development, 2008. Available at www.fantaproject.org

components such as graduation and exit criteria, an exit timeline, benchmarks and activities required to meet those benchmarks, a monitoring and evaluation strategy, and a sustainability strategy.

Security

Population density in urban areas heightens the need for security and crowd management at sites where food is distributed.

Institutional partners and stakeholders

Urban settings offer several opportunities to partner with local institutions and stakeholders. Two types of stakeholder are more prominent in urban settings: central level public service delivery institutions (e.g. health, education, nutrition extension) and private sector actors. This is important to consider when developing an exit strategy and the handover of programme services. Urban authorities are more able to monitor and influence programme activities in urban settings, underscoring the need for an active partnership, transparency and even legal agreements to document plans, roles and responsibilities related to the programme. Unless urban food assistance programmes work solely through national systems, e.g. school feeding, MCHN (Mother, Child Health and Nutrition) clinics, they frequently require negotiating with the urban private sector. For example, access to land is required for wet or dry ration distribution sites, while access to infrastructure is required for food for work.

Urban food assistance programme options

The remainder of the FANTA-2 report describes and analyses eleven types of urban food assistance programme options. These are:

- Targeted household food distribution
- Food for work
- Food for training
- Wet feeding programmes
- Community-based management of acute malnutrition programmes
- Supplementary feeding in MCHN programmes
- Institutional feeding for street children, orphans and other vulnerable children and other vulnerable groups
- School feeding programmes
- Food support to child care facilities
- Market assistance programmes
- Support to national strategic food reserves

For each of these interventions, advantages, disadvantages and programming issues in an urban context are considered. Programming issues include targeting, long-term developmental considerations, specific programme requirements, risks and potential pitfalls, monitoring and evaluation considerations and exit strategies. Urban country examples of each type of intervention are also given.

For the purposes of this summary, we only highlight key points raised in the paper relevant to implementing these interventions in an urban context. We also select one case example for each type of intervention.

Targeted household food distribution

This involves the direct distribution of dry take-home food commodities, usually to pre-identified target groups. It typically targets a larger population than just the traditional category of vulnerable individuals, e.g. elderly or female headed households. Objectives include meeting immediate food needs of households unable to access their normal sources of food, preventing famine, protecting livelihoods and/or supporting livelihood recovery and freeing up income for other household needs. Urban targeted household food distribution poses a number of challenges, including defining target groups and identifying eligible beneficiaries (the risk of inclusion error can be high especially with urban political and social elites), exclusion of non-beneficiaries in densely populated areas, defining household in a way that encompasses the diversity of household compositions seen in urban settings and assisting a large and relatively mobile population.

ability of local staples, rather than production and the agricultural calendar as in rural settings. Finally, it is important to be aware that distribution sites can help link beneficiaries up with other social or economic services to which marginalised groups may have had poor access.

In 2008, the World Food Programme (WFP) distributed targeted household rations (wheat) to urban and semi-urban households most affected by rising wheat flour prices in Afghanistan. The programme targeted 1,147,000 chronically poor people, especially female-headed households, disabled heads of households with unreliable income, poor households with more than 9 family members and only one income earner, and some recently deported poor households from Iran. Beneficiaries were selected by non-governmental organisations (NGOs), government institutions and community councils.

Food for Work (FFW)

Urban FFW programmes are public works programmes that pay workers with food rather than cash. Given the highly monetised urban economy, such schemes naturally tend to favour the most food insecure who will self-select into them. Projects normally focus on urban infrastructure – most notably public water, sanitation and hygiene services – thus providing important public benefits.

There are numerous challenges to urban FFW. Activities usually involve issues of private property and civil planning before and after the project, requiring complex consultations and arrangements with a range of stakeholders. Speculation can follow infrastructure improvements, leading to the eviction of the very people the project aims to assist. Special attention is required to protect beneficiaries from possible effects of raised rents and property values following infrastructure improvement. Working through municipal government structures is essential to clearly delimit areas in which the project will take place, where benefits will be expected and what community support is required. Targeting residents of informal settlements and slums can be sensitive politically, especially where construction in those areas is in violation of municipal regulations.

CARE implemented an urban food for work programme in 25 urban slum communities (kabeles) of Addis Ababa from 1997-2001. The project focused on road and sanitation infrastructure and the majority of participants were women.

Food for Training (FFT)

In FFT, beneficiaries are given a food ration in exchange for their participation in an activity designed to impart knowledge or skills that can generate income. Food can be provided as take home or on-site feeding or a combination of the two. Food is used to compensate for the time spent in training and the opportunity cost of other economic activities forgone. FFT can support recovery of crisis-affected communi-



Children attending Stara School, Nairobi, that receives WFP food support.

Ration planning should consider what staple foods are most appropriate for urban populations. These populations often have diverse diets, less time to prepare distributed commodities, and may show higher rates of specific chronic illness, e.g. HIV. Urban households are also heavily cash dependent and some degree of monetisation of take-home rations should be expected to pay for other household necessities like rent and fuel. The exit strategy of an urban targeted household food distribution is particularly challenging, given the inequality and structural poverty in urban centres. Where possible, phase-out will be contingent upon the re-establishment or expansion of income and food sources among beneficiaries and afford-

ties, such as for ex-combatants newly integrated into urban and peri-urban communities. It can also promote community self-management, although government systems should not be duplicated. FFT projects in urban areas can build capacity of small-scale traders and informal entrepreneurs. However, effects of FFT on rural-to-urban migration should be assessed.

World Vision's Food Aid Supporting Transformation in Urban Population programme ended in 2008. It focused heavily on FFT with an emphasis on health, nutrition, water and sanitation in East Jakarta and Surabaya. The programme had about 4,300 FFT beneficiaries in 2007.

Wet feeding programmes

These programmes distribute prepared, cooked foods to beneficiaries for on-site consumption. They may be appropriate under very specific circumstances, such as where a distribution of take-home rations is not feasible due to physical insecurity. It will be necessary to situate wet feeding sites throughout the urban area to minimise the risks of over-crowding or violence and other antisocial behaviours, as well as to reduce the distance that programme beneficiaries have to travel for meals. As urban wet feeding is management intensive, it requires working through local partners. This can mean a longer start-up time if their capacity is not already strong. In densely populated urban areas, wet feeding can encourage overcrowding around the distribution site, requiring crowd control and management of hygiene and sanitation risks. Wet feeding can induce rural-to-urban migration if services are not in place to address acute food insecurity in surrounding rural areas. Working with highly mobile urban populations can be a challenge for monitoring and evaluation.

SAACID, a Somali NGO, worked with the Danish Refugee Council to run a WFP-supported blanket wet feeding programme in greater Mogadishu in 2008. The programme aimed to help the most marginalised and vulnerable internally displaced people within the city, as well as the urban poor who lost access to work due to conflict. The project expanded from 10 to 16 sites and from 50,000 to 80,000 meals per day in Mogadishu. Beneficiaries were self-selected.

Community-Based Management of Acute Malnutrition (CMAM)

These programmes address acute malnutrition through inpatient care (for children with severe acute malnutrition (SAM) with complications and infants below six months of age with visible SAM), outpatient care (for children with uncomplicated SAM), and community outreach.

For urban families with economically active adults, CMAM reduces the time that caregivers must spend in inpatient facilities during stabilisation and recovery. Referral for health and other services from a CMAM programme, when necessary, is generally easier in urban than rural settings due to proximity of health centres. However, CMAM requires a strong community outreach system to support timely referral and coverage that can be challenging in urban environments – especially in unplanned settlements. In order to minimise the risk of overburdening the existing system, additional nutritional centres may need to be constructed.

In urban areas, referral centres may be urban tertiary hospitals, which are frequently overwhelmed with cases of SAM. Because urban populations often seek health and nutrition related services from a large variety of sources, e.g. traditional healers, private and public sector, it is especially important to establish collaboration with these providers and ensure that core messages related to nutrition are consistent among these actors. Since income insecurity in urban areas is more related to economic volatility than agro-climatic seasonality, predicting and planning for increases in case load can be more challenging. Another potential issue is that because paid outreach workers and community volunteers are more likely to come from the same community in urban settings and may be social peers, it might be more problematic to have both categories of workers within the same programme (one of which is paid and the other unpaid).

Valid International (with Concern support) implemented the scale-up of CMAM in Lusaka, Zambia in partnership with the Ministry of Health.

Supplementary Feeding in Maternal and Child Health and Nutrition Programmes (MCHN)

Food can be distributed through MCHN programmes to meet a number of objectives: prevention of malnutrition in at-risk groups, recuperation from malnutrition of beneficiaries determined to be malnourished, and as an incentive to participate in programme services. Targeting of beneficiaries for food support through MCHN programmes in an urban emergency would include preventive models targeting pregnant and lactating women and children 0-24 months of age. A risk factor may be that if rural areas are underserved, urban programmes could become a magnet.

A 2006-9 WFP programme in Angola includes supplementary feeding for about 15,000 pregnant and lactating women through health centres in food-insecure areas.

Institutional Feeding for Street Children, Orphans and Vulnerable Children (OVC) and other Vulnerable Groups

This refers to a broad range of interventions all characterised by provision of food resources to urban institutions that provide services to street children, OVCs and other vulnerable groups. Facilities may include orphanages, drop-in centres for street children where they receive basic services, hospitals, long-term care facilities/hospices. Food can be given to support food security and vocational and life-skill training.

In emergency situations, these sites can be used to expand rapidly food support to vulnerable groups and also offer the opportunity to link beneficiaries with other services. However, programmes can become quickly overwhelmed by rapid increases in demand and like all wet feeding, appropriate sources of cooking fuel and safe water must be found. Long-term development impacts are few unless the support is linked to other capacity strengthening initiatives. A potential undesirable consequence of programmes is to act as incentive for poor or food insecure families to place children who are not orphans in orphanages. It also risks undermining traditional community based mechanisms for supporting OVCs. Also, in low-income countries, these facilities frequently receive no government funding so alternative

funding is required. This is a key issue to consider at the outset of the programme to avoid building institutional dependency on food assistance.

CRS has provided food to orphanages and other OVC facilities in Haiti. CRS provides the dry commodities which are then prepared for wet feeding by facility staff.

School feeding programmes

These programmes distribute food to schools for on-site wet feeding. They aim principally to support food access and prevent deterioration of nutritional status in children of primary school age, and also to boost school attendance and attainment.

School selection in urban areas is challenging because the schools are frequently in close proximity. Selection must be justified in a clear and transparent manner to minimise conflict with neighbouring schools that are not covered.

From 2004-8, WFP implemented a school feeding programme in the peri-urban slums around Nairobi to provide a dietary support for all children attending school to combat short term hunger, improve attention span and cognitive ability and provide an incentive to girls and orphans to enrol in, attend and remain at school. The daily food basket consists of 150g of maize, 40g of pulses and 5g of vegetable oil per child.

Food support to child care centres

These programmes aim to alleviate poverty by providing working parents with low-cost child care to facilitate the development of their young children and to promote community participation in the overall development of children. As with school feeding programmes in urban emergencies, child care feeding may be implemented where there is an existing and well established institution already in place and where additional support in the form of food provision for the crisis-affected community has been determined to be feasible and appropriate. Lack of child care options may represent a major obstacle to achieving household livelihood and food security among urban women, especially women heads of households. The cost per child is relatively low, ranging from US\$ 0.58 per child per day in Columbia to US\$2.15 in Bolivia. Disadvantages include the fact that each child care centre can only serve a limited number of children to be effective, so that many centres are needed to reach scale increasing logistical complexity. Another difficulty may be that women who often spend very long hours away from home between commuting and work may have difficulty complying with programme participation requirements.

In Guatemala, the Hogares Comunitarios began with donated food (including Title 11 food aid through Catholic Relief Services). Positive results were obtained on household income, child nutrition and psychosocial development. The value of the programme and its popularity among the urban poor has motivated subsequent governments to maintain the programme since its inception in 1998.

Market Assistance Programmes (MAP)

This programme provides food to food insecure households through targeted market sales at subsidised prices. MAPs distribute food through retail outlets and existing traders and use less preferred commodities to assist in self-targeting. Subsidised staple commodities can also be sold through a set of programme vendors to benefi-

ary households identified to be eligible, i.e. where the programme is not self-targeted.

There are many advantages of these programmes. They can stabilise volatile food prices by infusing cheaper foods into the urban markets. If food insecure households tend to use identifiable vendors, these types of vendors can be specifically enrolled in the programme. Because MAPs work through existing markets, they are easier to undertake than direct distribution which usually requires setting up a separate distribution system. Furthermore, MAPs are usually self-targeting and may be more cost-effective than FFW or targeted household distribution because of the reduced cost of distribution and the possibility of earning revenue that can help cover costs.

MAPs do pose a number of potential risks and pitfalls. Subsidies may stimulate rent seeking behaviours among politically and economically advantaged groups, such as traders and government employees. Existing market stocks, purchased earlier at higher prices by retailers, will dampen the initial effect of the subsidy as traders will want to reduce their loss by passing it progressively to consumers.

Subsidies require market monitoring to detect market distortion, while the implementing agency must have the capacity to monitor the target population to determine if the target beneficiaries are being reached. There are also exit strategy issues. The main obstacle to phasing out food subsidies are political resistance as people begin to feel entitled, particularly where there is concern that the poor will not be able to purchase the staple food at free market prices.

Since 2003, the C-Safe Market Assistance Programme has provided milled sorghum to the working poor via subsidised sale through small retailers in targeted neighbourhoods in selected urban areas in Zimbabwe. It has used 'desirability' and geography as the means to target beneficiaries, e.g. self-selection, as those with sufficient income prefer milled corn where available.

Support to National Strategic Food Reserves

These programmes typically entail the transfer of grain by donors to a national strategic grain reserve or food security reserve. The main objectives of increasing national strategic grain reserves are to ensure stocks are sufficient for large-scale direct distribution in the event of an acute food crisis. This includes lending to humanitarian agencies to expedite response, and enabling the government to manipulate food markets by injecting food commodities into those markets.

This type of intervention is suited to an urban population that still has access to income to purchase food. This intervention works through national grain storage and distributions systems, thereby building capacity rather than setting up a parallel system.

Ethiopia's Emergency Food Security Reserve (EFSR) holds more than 400,000 MT of food as a reserve for distribution by the Government or to lend to humanitarian agencies in case of crisis. Via a parastatal organisation, the Government of Ethiopia began urban distributions of grain in 2008 as price inflation outstripped the capacity of poor urban dwellers to purchase staple grains.

² A fully or partially state-owned corporation or government agency.

Impact of WHO Growth Standards on SAM response to treatment

Summary of published research¹

A recent study set out to assess the impact of adopting the World Health Organisation (WHO) growth standards and weight-for-height z-score (WHZ) criterion on the response to treatment of severe acute malnutrition in children compared with the use of the National Centre for Health Statistics (NCHS) growth reference.

The study used data from children aged 6-59 months with acute malnutrition who were admitted to the Medecins sans Frontieres (MSF) nutrition programme in Maradi, Niger, during 2006 (N= 56,216). Differences in weight gain, duration of treatment, recovery from malnutrition, mortality, loss to follow-up and need for inpatient care were compared for severely malnourished children identified according to the NCHS reference and weight-for-height <70% of the median (WHM) criterion versus the WHO standards and the WHZ <-3 criterion.

A total of eight times more children (n=25,754) were classified as severely malnourished according to the WHO standards compared to the NCHS reference (n=2,989). Children included according to the WHO standards had shorter durations of treatment, greater rates of recovery, fewer deaths, and less loss to follow-up or need for inpatient care. Previous estimates of the change in the prevalence of severe acute malnutrition range from increases of 1.5 to 2.5 times and 1.7 to 4.2 times, when applying the same WHZ of <-3 to both the NCHS reference and the WHO standards.

Differences among estimates are likely because of the criterion used for comparison and will depend on the age, weight, and height profiles of the population.

The authors concluded that the introduction of the WHO standards with the z-score criterion to identify children for admission into severe acute malnutrition treatment programmes would imply the inclusion of children who are younger but have relatively higher weight for height on admission compared with the NCHS reference. These children have fewer medical complications requiring inpatient care and are more likely to experience shorter durations of treatment and lower mortality rates.

The WHO standards with the z-score criterion might become a useful tool for the early detection of acute malnutrition in children, although additional research on the resource implications of this transition is required. The implications of the introduction of the WHO standards should also be evaluated in the context of new community-based programmes for the management of severe acute malnutrition, because fewer children would require inpatient care according to the WHO standards and z-score criterion compared with the NCHS reference and percent of the median criterion.

¹ Isanaka, S et al (2008). Assessing the impact of the introduction of the WHO growth standards and weight for height z-scores criterion on the response to treatment of severe acute malnutrition in children: Secondary data analysis. Accessed at www.pediatrics.org on December 30, 2008. Preliminary findings of this research featured in issue 34 of Field Exchange, Impact of WHO Growth Standards on admissions in Niger. P6. Field Exchange 34. October 2008.



More younger admissions to therapeutic feeding programmes are one of the implications of moving to the new WHO Growth Standards.

Humanitarian Response Index (HRI) Summary of report¹

Eight billion dollars was invested in humanitarian relief in 2007. The 2008 Humanitarian Response Index (HRI) Report has been released by DARA (Development Assistance Research Associates)². The top five ranked donors (of good practice, based on Good Humanitarian Donorship) were Sweden, Norway, Denmark, Ireland and the European Commission (EC). The US, which is the largest provider of aid by volume, ranked 15 out of 23. The US was only above average in terms of learning and accountability.

The findings from the HRI 2008 point to five key inter-related areas where wealthy countries can work to improve the quality, effectiveness and impact of humanitarian action:

1) *Wealthy countries could do more to strengthen their commitments to provide aid in an impartial, neutral and independent manner, not based on other priorities or objectives.*

The HRI 2008 findings show that donors are not always providing aid in an impartial, neutral and independent manner, or where it is most needed. Many donors are still biased and influenced by other factors when it comes to allocating resources. Too many crises around the world continue to be a showcase for poor practice, despite all of the lessons from the past. In many places, humanitarian assistance continues to be compromised by wealthy countries' political, economic, or security agendas, while elsewhere other crises are forgotten and neglected.

2) *Wealthy countries should contribute to efforts to improve the quality and use of needs assessments to determine who needs assistance, where, and of what kind.*

The HRI 2008 findings also suggest that there are gaps in the area of needs assessments that should be addressed to ensure that humanitarian assistance is provided in accordance with needs. The findings show that there are disparities in the quality and consistent use of needs assessments. If humanitarian donorship is truly to be needs based, donors could contribute to improving global needs assessments tools with clear transparent criteria on how to allocate resources at global level for a more equitable response between crises. Donors could support their humanitarian partners in funding and improving harmonised needs assessments at the country level. Promoting a continual process of monitoring the evolving context and assessing how needs change, as well as making available the necessary flexible funding to adapt responses accordingly, are also suggested. Donors could therefore help promote a more nuanced position that balances the need for rapid assessments with the time needed to engage affected populations in identifying their evolving needs.

3) *Wealthy countries could do much more to harmonise and link relief efforts to early recovery and longer term development strategies.*

The HRI 2008 findings confirm a perennial challenge in the humanitarian sector – how better to link relief to recovery and long term development, and strengthen the resilience of popula-

tions affected by crises. Humanitarian agencies often struggle to find appropriate means to achieve a balance between meeting short term needs and laying the foundation for recovery and development. The HRI findings show that some donor policies and procedures can accentuate the gap between relief, recovery and development, rather than facilitating more integrated and harmonised efforts. Similarly donor procedures can facilitate or impede efforts to engage effectively local communities in defining and implementing programmes that meet their needs.

4) *Wealthy countries should invest more resources to strengthen the humanitarian system's capacity at all levels.*

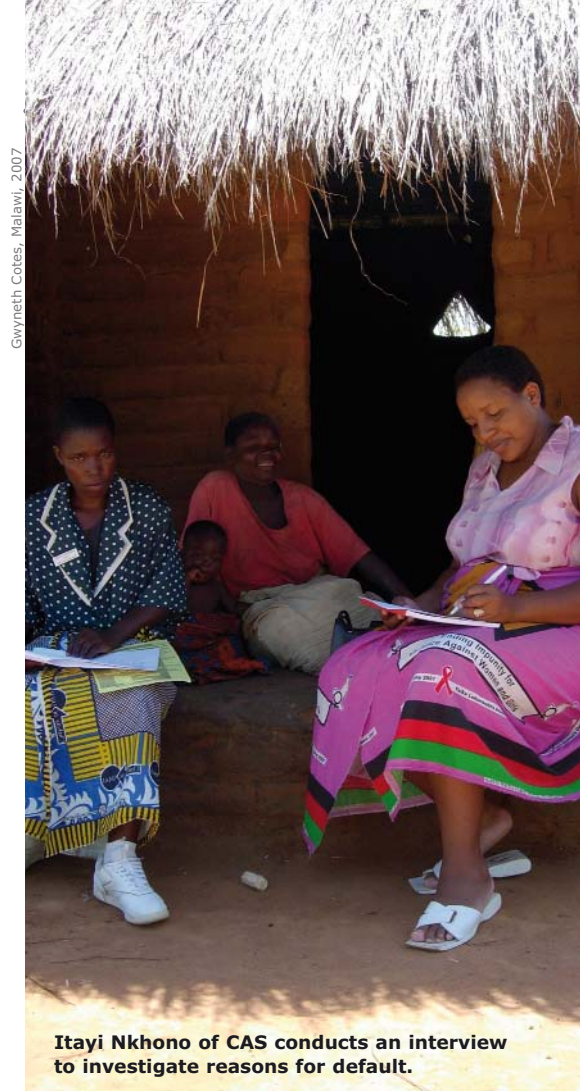
The HRI 2008 findings indicate that in general, donors could do much more to prioritise capacity building in the humanitarian system as an integral part of their assistance. For example, donors can do more to fund and prioritise efforts to strengthen community level and government capacity to reduce risks, and prepare for and respond to a crisis. At the same time, there is a deficit in donor support for strengthening the capacity of humanitarian organisations that make up the system. Without investing in areas such as contingency planning and standing operational capacity, the system will be hard pressed to deal with the increasing demands placed on it. Donors need to approach this issue strategically, and consider the benefits of investing in building the capacity of the whole system – not just parts of it – and do so in a holistic way that encourages harmonisation and coordination among different levels. This might include increased support for the United Nations (UN) humanitarian reform process to ensure that it is strengthened and expanded to include other components of the humanitarian system – including means to integrate more closely with existing capacities at the national and local level.

5) *Wealthy countries should assume more responsibility for ensuring implementation of international standards and good practice, and for improving accountability and performance in humanitarian action.*

Donors could take a more active leadership role in promoting a shared understanding of good practice in humanitarian action. The HRI findings show that there is inconsistent application of the international laws, principles and standards that guide and inform effective humanitarian action, especially those that attempt to ensure that people affected by crisis receive the support, protection and assistance they require. Collectively donors need to renew efforts to ensure these tools are used consistently, particularly in conflict situations, where such laws are often needed most, but most frequently ignored by some donors themselves.



¹ http://www.hri.daraint.org/what_is_hri/hri_2008_overall
² <http://www.daraint.org>



Itayi Nkhono of CAS conducts an interview to investigate reasons for default.

The CTC Advisory Service: Supporting the Countrywide Scale-up of CTC in Malawi

By Gwyneth Hogley Cotes

Gwyneth Hogley Cotes holds an MPH from Tulane University, with a focus on child health and nutrition. She has worked with the CTC Advisory Service in Malawi as a Health and Nutrition Advisor for the last two years. Previous assignments include coordinating nutrition programmes in Darfur and supporting immunisation programmes in Ghana.

The author would like to thank Kate Golden of Concern Worldwide, Tapiwa Ngulube of the Malawi Ministry of Health, and Roger Mathisen of UNICEF for reviewing and contributing to this article.

In response to a food shortage in 2002, Concern Worldwide and Valid International piloted a Community-based Therapeutic Care (CTC) project in two districts in Malawi. The two pilot projects were largely considered a success based on coverage, community acceptance, and treatment outcomes. In 2004, the Malawi Ministry of Health (MoH) agreed to expand CTC to additional districts in order to assess different approaches to implementing the programme.

When a second food shortage occurred in 2005, the MoH encouraged other organisations wanting to contribute to the emergency response to use the CTC approach. Four organisations responded, setting up CTC programmes in 10 additional districts.

At the beginning of 2006, a national stakeholder workshop was held to share experiences from all CTC programmes in Malawi and to review the evidence in support of scaling up CTC in a non-emergency context. The review found that CTC programmes achieved rates for cure, death, and default that were within Sphere standards and that CTC had the potential to reach more children than the traditional inpatient therapeutic feeding approach. Although CTC programmes had been solely implemented by non-governmental organisations (NGOs) up to that point, the review found that there were favourable conditions for scaling up CTC nationally, including local production of Ready to Use Therapeutic Food (RUTF) and existing community outreach structures.

As a result of this workshop, in April 2006 the MoH publicly confirmed its intention to scale up CTC to all 28 districts in Malawi, and to integrate CTC into the Malawi health system to make it more sustainable.

The Challenge: National Scale-Up

Although the MoH had endorsed the scale-up of CTC, a number of challenges were evident. Key among those was the wide variety of approaches being used by different organisations, poor communication among stakeholders, and a lack of involvement of government staff at the district level. Stakeholders and donors also had serious concerns about the sustainability of the programme, given the high cost of RUTF.

It became clear that a number of things had to happen for CTC to be effectively scaled up in Malawi:

1. A standardised approach, including clear protocols, national guidelines and a monitoring and evaluation system, was needed across all districts.
2. Extensive technical support and capacity building was needed at the national and district levels to support government staff to take up CTC services and maintain quality.
3. A national system for monitoring and evaluating nutrition programmes was needed for planning and to ensure the quality of CTC.
4. Coordination and communication among all stakeholders needed to be improved to promote learning and programme effectiveness.
5. Strategic planning and advocacy within the MoH and among partners was required to integrate CTC into the health system functionally, in order to ensure future funding and improve cost-effectiveness, and thereby make CTC more sustainable for the government to manage.

The Approach: CTC Advisory Service

A recent article on how to achieve wide-spread change in global health emphasised that simply spreading information on the success of a new approach is not enough to ensure it is scaled-up effectively. The authors noted that "Even when health care systems leaders or clinicians become aware of a promising innovation, their ability to introduce it is often severely constrained by limitations of time, resources, and skill." The authors concluded that "most innovative technologies...must be actively, not passively, spread, or they may not spread at all."¹

This was certainly the case in Malawi – although the MoH took on primary responsibility for scaling up CTC, it was obvious that limited resources, time, staff and expertise within the MoH would be a major barrier. Recognizing these limitations, the MoH chose to take an active approach to scaling up CTC and in 2006, formed the CTC Advisory Service (CAS) in partnership with Concern Worldwide.

CAS was conceived as a 5-year project, with a team of experienced nutrition and monitoring and evaluation (M&E) officers who act as a technical arm of the Ministry of Health's Nutrition Unit to facilitate the scale-up of CTC, while building the capacity of the government to take on CTC management.

Under a simple Memorandum of Understanding (MOU) with the government, CAS was given the mandate to coordinate, monitor, and evaluate CTC activities, provide technical support and capacity building for CTC at the national and district level, standardise tools and materials used for CTC in the country, and continuously advocate for the scale-up and integration of CTC into the health system.

The MoH provides leadership and direction for CAS activities, while Concern Worldwide is responsible for the day-to-day management and administration of activities. The project has been funded by several donors, including USAID, UNICEF, and Irish Aid.

Main achievements

In the last two years, CTC has spread more rapidly than was originally expected. Since CAS began operating, it has provided support to 25 districts to initiate and carry out CTC. As of November 2008, 21 districts, out of 28 in the country, have started CTC and six more are in the stages of training or planning.

CAS has been instrumental in facilitating the development of national CTC guidelines, along with standardised reporting forms and job aids, which have been printed and disseminated to all districts by UNICEF. These tools are now being used by all districts.

CAS has also taken the lead on developing a national monitoring and evaluation system. District HMIS (Health Management Information System) officers have been trained to compile monthly health centre data using a national database that incorporates reports from Outpatient Therapeutic Programmes (OTP), Nutritional Rehabilitation Units (NRU), and supplementary feeding programmes. The

MoH has taken on responsibility for collecting CTC programme data, but CAS still supports with analysis and reporting. Districts that show poor performance are prioritised for CAS support.

Another achievement is the development of a team of national CTC trainers, along with a draft training manual for CTC. A total of 46 health staff from throughout the country has been trained to provide training and technical support on CTC. This is an important step in ensuring that the work of CAS can be continued by the government once the project ends. While CAS continues to monitor training quality and mentor the national trainers, all district-level trainings are now conducted by MoH staff.

Finally, CAS has played an important role in coordinating CTC activities and facilitating better communication among stakeholders. The CTC Learning Forum, which brings together people involved in CTC several times a year, has been an effective tool for sharing and replicating best practices and lessons learned.



Attendees of the 7th CTC Learning Forum practice conducting supervision at an OTP session.

Challenges

Although a great deal of progress has been made over the last two years, there is still much work to be done before CTC is fully scaled up and integrated into the health system.

There was no initial strategy developed to guide the scale-up process, and as a result scale-up has occurred rapidly and haphazardly. Scale-up and support from CAS has been reactive, driven largely by demand from district health offices and supporting NGOs. CAS recently developed criteria for prioritising districts for support visits, but no such criteria were used to guide the scale-up process. CAS is currently facilitating the development of a national plan of action for carrying out the work that is remaining, focusing on integrating CTC into the Malawi health system. The plan will include specific actions for achieving the plan, and will specify the roles and responsibilities of all stakeholders.

From the outset, there has been confusion over the role of CAS. CAS's mandate was not clearly communicated to districts, and initially some NGOs did not welcome CAS involvement

¹ McCannon, C.J., Berwick, D.M., Massoud, M.R. "The Science of Large-Scale Change in Global Health" *Journal of the American Medical Association*, October 24/31, 2007. Vol 298, No 16.

in the CTC programmes that they supported. The MOU developed with the Ministry lists general areas where CAS is supposed to take the lead, but does not specify how roles and responsibilities should be divided between MoH and CAS. Also, CAS is not the only agency providing technical support on nutrition programmes in Malawi and roles sometimes overlap. In particular, there is a need for better coordination of programme monitoring and support by CAS, WFP and UNICEF.

Supervision of nutrition activities has been a particular challenge due to a lack of time and staff at the national level, and a consequent lack of accountability at the district level. Although Malawi now has a team of national CTC trainers, these trainers need ongoing support and mentoring to ensure that they are ready to take over training and technical support activities.

As a result of poor supervision, the quality of service provision remains a problem in many districts. Although cure, default, and death rates have stayed within Sphere standards in most districts, there are issues with children being admitted even though they do not meet criteria, or not being discharged properly. The shortage of nurses and clinicians in the country mean that children are frequently not assessed by a clinically trained health worker.

Finally, there remain significant obstacles to direct management by the MoH. Among those are the cost of RUTF and other supplies and the availability of human resources. In 2007, about 400 MT of RUTF was used for CTC programmes in Malawi, costing about 1.6 million dollars. This covered 35,724 children treated in OTPs and NRUs. However, the price of locally produced RUTF increased in 2008, and the CTC caseload is expected to rise by about 30%, once CTC is fully scaled up. Then, the projected cost of RUTF provision alone will be about 2.6 million dollars a year. There will likely be a need for external support for the purchase of RUTF for some time. CTC services need to be better streamlined and incorporated into existing health services – such as drug

procurement systems and pre-service training for health staff – to make it affordable for the government to manage. CAS is currently working with the MoH to advocate for inclusion of RUTF funding into the national SWAp funding system (Sector-Wide Approach).

Lessons Learned

Having a separate support unit within the MoH to focus on issues of scale-up has been essential to the rapid progress achieved in Malawi, as the demands of scaling up generally exceed existing resources. However, there are several things that could be improved on if the approach were replicated in another country.

A clear strategic plan for scaling up and integrating CTC into the health system is needed right from the beginning. This plan should prioritise districts in order of when they should start CTC, determine how resources will be procured, and should clarify roles and responsibilities of all stakeholders.

The terms of reference for the support unit need to be very clear and specific. They should lay out how the responsibilities of CTC management will be divided between the MoH and the support unit. Once the agreement is finalised, the MoH should disseminate the agreement to all district health officers and supporting NGOs so that they are familiar with the support unit and know how to access support. In the second year of the project, the CAS unit was provided office space by the MoH, which has led to greater acceptance of CAS support.

It is important that the support unit emphasises capacity building of local and national partners in all its activities. Although it is often easier and quicker to use NGO resources to manage and coordinate CTC activities, it is critical that the government is involved in all aspects of the programme right from the beginning, to ensure a sustainable handover of the programme.

District health offices have also expressed a need for better tools and support on planning and budgeting CTC activities. Capacity building needs to focus on issues of logistics, budgeting, and monitoring and evaluation, not just training and technical support. Tools such as a standard budget template and guidance on estimating costs and caseloads for CTC would be very valuable.

The CAS approach has been working well in Malawi, despite the challenges, and continues to refine and improve its approach. The approach could be appropriate for other countries wanting to scale up and integrate CTC, but will need to be adapted. In emergencies, for example, the rate of scale up may need to be accelerated and more logistical and staffing support provided.

In about half of all districts in Malawi, CTC is now managed entirely by the district health office, using the existing health systems. While some issues of quality remain, these districts have shown that they are capable of managing CTC activities largely on their own, provided they have initial technical support and training, good ongoing supervision from the national level, and funding support for RUTF and other supplies.

For more information, contact Gwyneth Hogley Cotes, email: gwyneth.cotes@concern.net

Improving Training in Nutrition in Emergencies

Summary of workshop report¹

IASC
Inter-Agency Standing Committee

Nutrition Works

An international workshop on improving training in emergency nutrition was held in Nairobi on November 6th and 7th 2008². The workshop brought together universities, training institutions, humanitarian agencies and government staff with the common goal of improving training in emergency nutrition in developing countries. The main objectives of the workshop were to:

- Create awareness of the new nutrition in emergencies Harmonised Training Package (HTP), developed by NutritionWorks³ under the auspices of the Global Nutrition Cluster (see Box 1).
- Identify opportunities for the academic accreditation of nutrition in emergencies training courses.
- Explore approaches for better integrating academic training courses with field and on-the-job training and other types of sustainable training initiatives through partnerships.

A background paper was presented, as well as country and agency experiences of nutrition in emergencies training⁴. A key output of the workshop was a consensus statement for future nutrition in emergencies training (see Box 2).

In addition, nine core principles upon which future training in nutrition in emergencies is based were also agreed:

1. Prioritising national and regional capacity

Emergency nutrition training is required by a number of target groups. The priority group is 'national' staff so that in emergency contexts, there are a sufficient number of adequately trained staff with emergency nutrition skills who can be quickly and easily deployed.

2. Focus on nutrition literacy

'Nutrition literacy' refers to an understanding of nutrition concepts and issues. 'Nutrition literacy' is required by a broad range of actors involved in emergencies, and not confined to nutritionists alone. 'Nutrition literacy' needs to be raised at all levels, from field staff to senior managers.

3. Range of training

These will include training, for example, for graduate and undergraduate students, humanitarian agency staff and government staff.

4. Institutionalisation and accreditation/certification

It is important to embed training within existing institutions and structures in order



Participants of a CAS-supported training give their feedback after a practical field session.

Elizabeth Jordan-Bell, Malawi, 2008

The focus needs to be on improving 'nutrition literacy' in a broad range of professions from nutrition to food security specialists, and agricultural staff social sector workers.

to sustain initiatives. A system of certification for nutrition in emergency training courses recognised by both academic institutions and operational agencies would help to keep the quality of training high.

5. Practical experience and internships

Linking classroom-based learning with practical experience was agreed to be essential in emergency nutrition training.

6. Trainers

A cadre of good trainers in nutrition in emergencies is essential. Trainers may not necessarily be technical experts. However, it will be hugely advantageous if trainers have some level of practical experience and understand the realities of emergency contexts.

7. Sustainability

Many training initiatives have failed in the past because they were not sustained. In some cases this was due to lack of funding but more commonly, it was due to a lack of appropriate trainers on hand to do the training and a lack of commitment by participating agencies. One way of ensuring financial and political sustainability will be through developing business models that are able to ensure adequate income from funding and/or student fees, while maintaining commitment from within the training institution.

8. Advocacy

Good advocacy was viewed as the essential element to successful nutrition in emergencies training. Advocacy is needed at global level, regional and national level. A series of steps should be followed to develop a successful advocacy plan, the first of which is documenting the evidence. For example, there is a common view that there are not enough people with emergency nutrition and related skills available, especially 'national' staff, but there has been no attempt to document and analyse this gap. An 'audit' of staff that could be deployed in an emergency with nutrition-related skills would be useful. In addition to this quantitative evidence, qualitative information, such as case studies of particular emergencies and real-time evaluations, would be useful in understanding where the gaps in capacity are.

An urgent need was identified for the creation of a web based searchable register of staff with relevant skills. Creation of this register would also contribute to the audit of the 'capacity gap'. This type of analysis fits within the Global Nutrition Cluster capacity development strategy objectives.

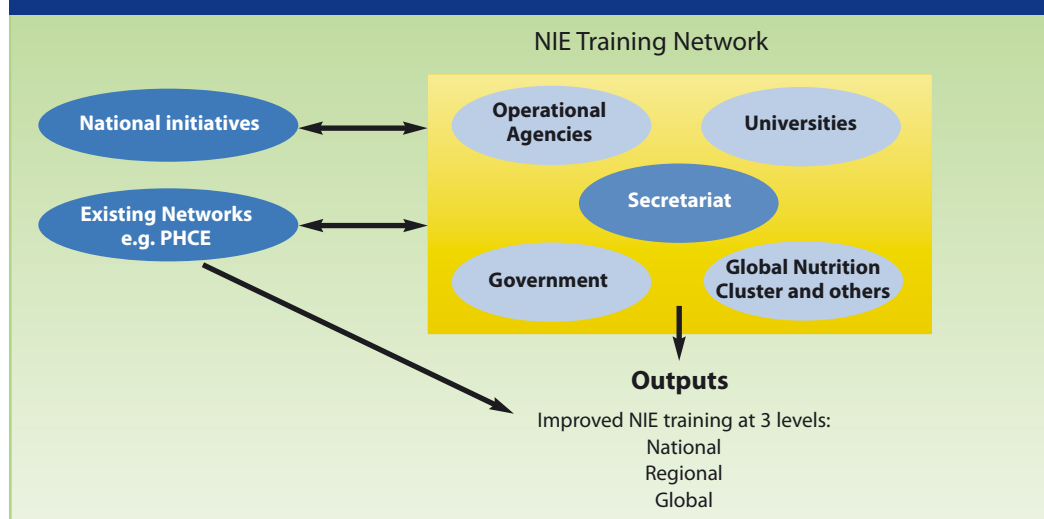
9. Evaluation/quality control

Evaluating the process and outputs achieved by training initiatives will be very important in order to ensure that the quality achieved is good enough to meet the needs for professional competence identified by employers and others.

"We're finding it increasingly difficult to recruit good quality emergency food security and livelihoods people and I'm not sure if there are less people with a public nutrition background out there or whether they don't want to work for our organisation!"

Humanitarian agency staff member, November 2008

Figure 1: Proposed structure for the Nutrition in Emergencies Training Network (NIETN)



The way forward

Global Nutrition Cluster is currently looking at the appropriate institution for hosting an interactive website for the HTP. Once established, this will provide an ideal opportunity to expand and obtain feedback on the HTP and institutionalise monitoring of the HTP. Specific recommendations were made by the workshop participants in relation to dissemination of the HTP as follows:

1. There is a need to translate the HTP if wide spread use is to be achieved. The Global Nutrition Cluster Capacity Development Working Group (CDWG) has committed to translating the HTP into French and Arabic. Portuguese was identified as another priority language.
2. To help ensure widespread use, the HTP needs graphic layout to be completed for all modules.
3. Some paper copies of the HTP may be needed because of difficulties with internet access and downloading large files.

Proposal for a Nutrition in Emergencies Training Network

There was discussion around the concept of a Nutrition in Emergencies Training Network (NIETN) and how it would look (See Figure 1). It was suggested that the network was an affiliation of four key partners encompassing universities and training institutions, humanitarian agencies, government bodies and other interested agencies, including the Global Nutrition Cluster and donors. The overall goal of the network would be to improve training in nutrition in emergencies. The network would be managed by a coordinating group that would initially be tasked with developing funding proposals to carry out key activities. A proposal for the Network has been written by NutritionWorks. It is envisaged that in early 2009, a first meeting of the network will be held and proposals will be produced for network activities.

¹ The full report is available from:

<http://www.humanitarianreform.org>, click Nutrition

² The workshop was the initiative of the UNICEF-led Global Nutrition Cluster and was organised on their behalf by NutritionWorks, in association with the Centre for International Health and Development, University College London. The workshop is part of a broader emergency nutrition capacity development strategy being implemented by the Global Nutrition Cluster Capacity Development Working Group.

³ NutritionWorks is a UK based partnership of international nutritionists with expertise in emergency nutrition and capacity building.

⁴ These can be obtained from Carmel Dolan or Fiona Watson: see end of document for contact details.

Box 1: The Harmonised Training Package (HTP)

The HTP was produced over a 1.5 year period by NutritionWorks and a number of authors and is a unique and comprehensive set of materials on nutrition in emergencies comprising 21 modules, which cover different technical areas. The HTP is a package of training materials but is not a ready to use course. Adaptation is required to create courses targeted at different audiences in different countries. The modules are designed to be used to develop stand alone, focused short courses and comprehensive nutrition in emergencies training courses and can also be used for advocacy.

The HTP has been piloted and evaluated by Valid International and is now in the public domain. It can be used by any agency or institution. To download the HTP, go to: <http://www.humanitarianreform.org>, click on Nutrition, and see under 'Nutrition Cluster Products'.

Box 2: Consensus statement

The participants of this workshop agree that:

1. Capacity to respond to nutrition problems arising in emergencies is currently inadequate.
2. There are very few nutrition in emergencies training opportunities, notably in developing countries.
3. There is an imperative to improve nutrition in emergencies training in order to fill the gap in capacity to respond effectively to nutrition problems that arise in emergencies.
4. The harmonised training package (HTP), developed by NutritionWorks under the auspices of the IASC Global Nutrition Cluster, represents a significant step forward in facilitating improved training. The workshop participants encourage its widespread use.
5. There are immediate opportunities to improve nutrition in emergency training at international, regional and national level, using the materials of the HTP, through:
 - a. training networks (such as the Public Health in Complex Emergency network) that can introduce emergency nutrition training short courses.
 - b. university nutrition and public health degree courses
 - c. diploma level training run by technical colleges
 - d. in-service training.
6. A new Nutrition in Emergencies Training Network should be formed with the objective of increasing capacity to provide effective response to the nutritional problems arising in emergencies.
7. The Secretariat (contingent on seed funding) will develop a number of concept notes focusing on advocacy, and developing and implementing courses in emergency nutrition training.

ENN launches en-net



An online forum (en-net) for urgent technical questions on emergency nutrition and food security has just been launched by the ENN, funded by the OFDA.

The aim of the forum is to enable field practitioners to have access to prompt technical advice for operational challenges for which answers are not readily accessible in current guidelines. en-net has been developed at the request of many agencies and individuals and hopes to build on the experiences of earlier fora such as NGONut and NutritionNet.

A simple online interface has been developed where users can submit questions or contribute to the answers to questions posed by others. Questions and answers have been organised into seven thematic areas:

- prevention and treatment of severe acute malnutrition
- prevention and treatment of moderate acute malnutrition
- assessment
- infant and young child feeding interventions
- general food distribution
- livelihood interventions (including cash)
- humanitarian systems

A panel of technical moderators has been created, each assigned to their expert 'theme'. They will be called upon by the ENN coordinator to contribute to particularly challenging questions. The ENNs online resource library is being expanded to support the forum.

Visit and bookmark the forum at www.en-net.org.uk or via the link at the ENNs website www.ennonline.net. The ENN Resource Library is at www.ennonline.net/resources. Any feedback can be submitted via en-net or to the ENN en-net coordinator, Tamsin Walters, email: tamsin@ennonline.net



en-net

National training on IFE in Sri Lanka



By Moazem Hossain

Dr. Moazem Hossain is the Chief of the Health and Nutrition Section of UNICEF Sri Lanka, and Nutrition Cluster Coordinator in Sri Lanka.

The author would like to acknowledge the contribution of the delegates (Drs Renuka, Sudharshini and Lalith) for facilitating the workshop and Ms. Chayatri for notes taking and compilation.

This piece summarises an IFE training led by country delegates as an action arising from the regional IFE workshop held in Bali 10-13th March 2008.

The National Workshop on Infant Feeding in Emergencies (IFE) was held on the 16th and 17th of June 2008 in Colombo, under the auspices of the Nutrition Cluster in Sri Lanka in collaboration with the Family Health Bureau (FHB). The two day workshop consisted of a series of presentations, each with questions and answers opportunities and panel discussions. The workshop focused on developing an understanding of the importance of IFE. The specific objectives were to understand why IFE is important in emergencies, appreciate the advantages of breastfeeding and the risks of artificial feeding and how best to protect and support safe and appropriate IFE.

The workshop was attended by 35 participants from United Nations (UN) agencies, project coordinators from international non-governmental organisations (NGOs), District Medical Officers and Medical officers from the Maternal and Child Health (MCH) Unit.

The workshop started with a welcome address from the Director of MCH, the FHB and UNICEF. The first day consisted of four presentations and group work. Dr. SM Hossain (UNICEF Sri Lanka) opened the workshop and introduced the importance of IFE, the Operational Guidance on IFE and the International Code of Marketing of Breastmilk Substitutes. Dr. Anoma Jayatilake gave a very comprehensive account on breastfeeding and appropriate counselling skills and Dr. Renuka Jayatissa gave a brief overview on rapid assessments. After each presentation, workshop participants were given practice exercises to test their grasp of the topic just covered – all showed a good understanding.

The emphasis on the second day of the workshop was sharing the experiences of the Bali IFE workshop, presented by Dr. Renuka Jayatissa. She concluded her report by sharing the pledge for action issued by the workshop participants to promote, protect and support breastfeeding during emergencies, to prevent the inappropriate use of breast-milk substitutes and to support infant and young child feeding in general.

Dr. Lalith Chadradasa followed with a presentation on IFE media exposure in emergencies. He explained that the media can play a major role in emergencies – not only in highlighting problems but also providing an opportunity for intervention through communication. However, often the media delivers the wrong messages during emergencies, either because the media writer/source is ignorant of the issues or the receiver misunderstands the information or has misconceptions around IFE.

The final presentation of the workshop was on preventing and controlling micronutrient defi-

ciencies in populations affected by emergencies, by Ms. Vishaka Thilakeratne. The major deficiencies include Vitamin A, Iron, Zinc and Iodine. She emphasised that in order to meet the micronutrient requirements during emergencies, foods fortified with micronutrients should be provided, e.g. corn-soya blend, biscuits, vegetable oil enriched with vitamin A, and iodised salt. It was pointed out that these foods must be appropriately fortified, taking into account that other unfortified foods will meet a share of micronutrient needs. It was also highlighted that fortified foods may not meet the requirements of pregnant women, lactating women and young children. In these cases, supplementation is warranted and UNICEF and the World Health Organisation (WHO) have developed a daily multiple micronutrient formula to meet the recommended nutrient intake (RNI).

Ms. Thilakeratne elaborated on micronutrient supplementation programmes in the context of Sri Lanka, where a supplementation programme is already in place for mothers and young children. She considered the current increase in food prices would have an impact on nutritional status and considered it timely to intervene with supplementation. She concluded by emphasising that supplementation should not be a long term intervention strategy.

The participants then broke up into groups and were asked to consider two scenarios: Aftermath of the Pakistan earthquake and Refugees in Tanzania. The four groups were tasked to select the criteria they would use to identify best practices and then select best practice interventions.

The final item of the workshop was the drafting of a national policy on IFE (modelled on a process used at the Bali workshop to generate a Joint Statement), which was facilitated by Drs Shudharshini Fernandopulle and S.M Hossain. Inputs were received from participants and it was agreed that during emergencies, the key areas to concentrate on are to protect, promote and support breastfeeding, to prevent donations of breastmilk substitutes and powdered milks, to ensure availability of age appropriate complementary foods and supplements and in only exceptional circumstances, support replacement/artificial feeding. Following the workshop, the national policy directive to Support and Ensure Appropriate and Adequate Infant Feeding during Emergencies was finalised and is pending approval by the Director General of Health Services, Ministry of Health Care and Nutrition, Government of Sri Lanka. The whole workshop was facilitated and coordinated by Dr. Sudharshini Fernandopulle from MoH FHB, who attended the regional IFE workshop in Bali to represent the Government of Sri Lanka.

For more information, including copies of workshop presentations and the policy directive, contact: Dr SM Hossain, UNICEF, email: smhossain@unicef.org

Toolkit for Addressing Nutrition in Emergency Situations

A Toolkit for Addressing Nutrition in Emergency Situations is now available. The toolkit was developed by the Capacity Development Working Group of the IASC Nutrition Cluster with the participation of a wide range of humanitarian nutrition actors.

The toolkit describes tools and approaches for 12 different nutrition interventions:

- Infant and Young Child Feeding in Emergencies
- Treatment of diarrhoea with Oral Rehydration Therapy/Zinc
- Prevention and Treatment of Vitamin A Deficiency
- Prevention and Treatment of Micronutrient Deficiencies
- Management of Moderate Acute Malnutrition
- Management of Severe Acute Malnutrition
- Nutrition, HIV and AIDS
- The Psychosocial Components of Nutrition

- Nutritional care for Groups with Special Needs
- The Use and Role of Food Assistance
- Food Handling, Storage and Preparation
- Household Food Security and Livelihoods

The toolkit offers guidance and support for nutritionists and humanitarian workers to ensure that basic guidelines are followed and the basic nutritional needs of populations in emergencies are met. It is not intended to be an exhaustive resource for each intervention presented, but rather an overview of potential interventions. The toolkit contains key references and links to more detailed technical guidance.

The document can be downloaded from the Nutrition Cluster website:

<http://www.humanitarianreform.org/humanitarianreform/Default.aspx?tabid=74>

A limited number of copies are available on mini-CD, contact Josephine Rajasegera, email: jragasegera@unicef.org

FANTA training guide for CMAM

The Food and Nutrition Technical Assistance (FANTA) Project have released a Training Guide for Community-based Management of Acute Malnutrition (CMAM).

It aims to increase capacity for management of severe acute malnutrition (SAM) in children by increasing the knowledge of, and building practical skills to implement, CMAM in both emergency and non-emergency contexts.

The training guide is designed for health care managers and health care providers, who manage, supervise and implement CMAM. This includes health care providers who are involved in health outreach activities, as well as Ministry of Health officials at the national, regional and district levels, health and nutrition programme managers of non-governmental organisations (NGOs) and United Nations technical staff.

The training guide was produced in collaboration with Concern Worldwide, Valid International and UNICEF, with technical input and review from USAID, the World Health

Organisation and numerous NGOs. Support for the development of the guide was provided by USAID's Bureau for Democracy, Conflict and Humanitarian Assistance's Office of Foreign Disaster Assistance and Bureau for Global Health's Office of Health, Infectious Disease and Nutrition.

The guide can be downloaded from FANTA-2's website at www.fanta-2.org



New online Field Exchange search facility

In order to improve access to the wealth of experiences covered in Field Exchange over the past 12 years, the entire archive has been catalogued and is available in a new online search facility. This development was funded by the UNICEF-led Inter-Agency Standing Committee Nutrition Cluster.

This facility means it is now much easier to access single articles on your chosen topic. You can search using a simple or advanced search and explore content by category, issue number, country, article title or type. Individual

articles can be downloaded, bookmarked or links/articles emailed to others. Citations are available at the touch of a button.

A CD version and a printed catalogue will also be available online and limited copies from the ENN. Send your request and details to Rupert Gill, ENN, email: office@enonline.net, tel: +44(0)1865 324996 or mail requests to the usual ENN office address.

As you use this facility, we welcome your feedback so that we can improve and develop it. Email any comments to: office@enonline.net

Food Security E-learning Courses and Training Materials from FAO

The EC-FAO Programme (www.foodsec.org) has developed a series of free Food Security e-learning courses and related training materials, designed to support capacity building and on-the-job training. The courses are available in English and French and are being translated into Spanish. The courses are currently being used by over 15,000 registered learners all over the world. Both CD and web-based versions are available.

Courses include:

- Food Security Information Systems and Networks
- Reporting Food Security Information
- Availability Assessment and Analysis
- Baseline Food Security Assessments
- Food Security Concepts and Frameworks
- Collaboration and Advocacy Techniques
- Livelihoods Assessment and Analysis
- Markets Assessment and Analysis
- Nutritional Status Assessment and Analysis
- Food Security Policies – Formulation and Implementation
- Targeting
- Vulnerability Assessment and Analysis

On-line Access:

1. Register on-line at: http://www.foodsec.org/DL/dlregistration_en.asp
2. Log-in with your User Name and Password. This will take you to the My Courses page.
3. Choose a course by clicking the 'Select a New Course' button on the My Courses page.

CD-Rom:

1. Go to the Courses page: http://www.foodsec.org/DL/dlcourselist_en.asp
2. Click 'Request a free copy' of a specific course and complete the form.

Resources for trainers

To support trainers, the EC-FAO programme has created training resources based on the e-learning courses. Each course includes a training guide complete with a set of presentation slides, student notes and class activities that can be adapted by trainers to meet their own needs. If you would like to develop your own courses based on the EC-FAO e-learning materials, you can access the Resources for Trainers section at: http://www.foodsec.org/tr_res.htm

For more information, please write to: information-for-action@fao.org

WHO/UNICEF/WFP/UNHCR informal consultation on moderate malnutrition management in U5's

Summary of meeting^a

The World Health Organisation (WHO) convened a meeting in Geneva (September 30th - October 3rd, 2008) with the overall aim of answering the question, 'What diets should be recommended to feed moderately malnourished children?'^b. The general objectives of the meeting were: i) to identify areas of consensus on the nutrient needs and dietary management of moderate malnutrition (MM) in children that can be translated into evidence-based global guidelines and ii) to identify knowledge gaps that should be addressed by research, both in the area of dietary management and the modalities for providing that diet.

Moderate malnutrition (or moderate wasting) includes all children with a weight-for-height between -3 and -2 z-scores^c. Moderate stunting is defined by a height-for-age between -3 and -2 z-scores. Most of these children will be moderately underweight (weight-for-age between -3 and -2 z-scores).

Four background papers were commissioned by the WHO in advance of the meeting and circulated among participants. Presentations of these and other papers were followed by discussions and working group sessions to develop consensus statements and identify areas for research on the improved dietary management of MM.

Nutrient requirements of moderately malnourished children

A background paper (prepared by Prof Mike Golden, Emeritus Professor, Aberdeen University) provided tentative recommendations for diets suitable for feeding MM children. Nigel Rollins's (WHO) presentation on managing the needs of HIV-infected children emphasised how little is known about the relationship between HIV and MM in infected children and how there is currently no basis for recommending different nutritional management, apart from increased energy intake, compared to non-HIV infected children. A presentation by Mark Manary (St. Louis Children's Hospital) on recent attempts to supplement the diet of MM children to prevent kwashiorkor in Malawi, highlighted the lack of an evidence base to make specific recommendations for the dietary management of MM children in areas of high kwashiorkor prevalence.

Consensus statements

- The nutritional requirements of moderately malnourished children probably fall somewhere between the nutritional requirements for healthy children and those of children with severe acute malnutrition during the catch up growth phase.
- The nutrient intakes of moderately malnourished children need to be adequate to allow wasted children to synthesise the lean tissue deficits and to allow stunted children to achieve both accelerated linear growth and associated accrual of lean tissue.
- Diets with a nutrient density equivalent to F100 and a low anti-nutrient content, provided at an energy intake to support the desired rate of weight gain, are adequate to promote height and weight gain. Such diets may also be effective at restoring functional outcomes, including physiological and immunological function towards normal, in moderately wasted children.
- There is evidence that growth deficits can be treated (i.e. that catch up growth for height can occur) in children far beyond two years of age, and even in adolescents, provided that a high quality diet is sustained. Though there is no evidence of similar recovery of other deficits associated with stunting, such as cognitive deficits. However, the prevention of stunting should always be directed at the 'window of opportunity' from conception to the first 24 months of life, when most growth faltering occurs and impacts on health and brain development are greatest.
- Proteins used to feed moderately malnourished children should have a PDCAAS of at least 70%. Giving lower amounts of proteins with higher PDCAAS^d may be advantageous.
- The diets of children recovering from moderate wasting should provide at least 30% of their energy as fat. A higher percentage of energy derived from fat (35 to 45 %) might have advantages provided the density of nutrients is adequate.
- It is recommended that diets for moderately malnourished children contain at least 4.5%

of their total energy content from n-6 polyunsaturated fatty acids (PUFA) and 0.5% of their total energy content from n-3 PUFA. It is advised that the ratio of linoleic/_linolenic acid remains in the range of 5-15. A ratio within the range of 5-9, however, may be preferable.

- When large quantities of nutrients known to have an effect on acid-base metabolism are added to foods, their potential effect on the acid-base balance of the body after being absorbed and metabolised should be estimated. Their overall effect should remain neutral.
- Energy needs of moderately malnourished HIV-infected children are increased by 20-30% compared to non HIV-infected children who are growing well. There is no evidence for an increased protein requirement in relation to energy, i.e. 10-15% of the total energy intake is sufficient.

Research needs

It is unclear whether a diet adequate for treating a moderately wasted child will also be adequate to treat a stunted child. The length of time required for catch up growth is also not known. Further studies are needed to clarify the effect of the diet on the timing of linear growth in relation to weight gain.

Research is also needed on safe upper limits of different nutrients at different ages, as well as the requirements and importance of specific and often 'forgotten' nutrients like potassium, sulfur, phosphorus and selenium.

More field friendly techniques (like blood spot technology) for assessing deficiency of certain Type I nutrients are needed.

Research is required to understand better the pathophysiology of how HIV causes undernutrition, how HIV-related undernutrition differs from undernutrition due to other causes and how to distinguish between the different aetiologies.

Fundamental research is needed to obtain a better understanding of the pathophysiology of kwashiorkor. Currently, none of the proposed mechanisms for how kwashiorkor develops are supported by strong evidence that can be translated into preventive programming.

Foods and ingredients suitable for use in moderately malnourished children

A background paper (prepared by Prof Kim Michaelsen and colleagues from the University of Copenhagen, and Prof Tsinel Girma, from the University of Jimma, Ethiopia) provided an

Examples of different RUTF formulations developed by Prof Jeya Henry, Oxford Brookes University 2005



J Henry, Oxford, 2005

¹ WHO (2008). Proceedings of the WHO UNICEF WFP UNHCR informal consultation on the management of moderate malnutrition in under-5 children

² Another WHO consultation is planned to review the evidence on strategies and programmatic approaches to managing moderate malnutrition, which aims to answer questions not addressed in this meeting.

³ WHO. Management of severe malnutrition: a manual for physicians and other senior health workers. Geneva, 1999. Available at: http://www.who.int/nutrition/publications/severemalnutrition/en/manage_severe_malnutrition_eng.pdf

⁴ PDCAAS (Protein Digestibility Corrected Amino Acid Score) is a method of evaluating the protein quality based on the amino acid requirements of humans

extensive description of foods and ingredients most commonly used to feed MM children. Elaine Ferguson (London School of Hygiene and Tropical Medicine) presented a short paper explaining how linear programming can be used to check the nutritional adequacy (and assess the cost) of diets recommended for MM children.

Consensus statements

- The addition of animal source foods to a plant-based diet promotes the recovery of moderately malnourished children.
- Diets based exclusively on plant foods need to be fortified and processed in such a way to remove anti-nutrients.
- Diets with low anti-nutrient and fibre content are beneficial for promoting the recovery of malnourished children.
- Phytate may seriously limit the efficacy of plant based foods. The possibility of safely reducing its content by the use of phytase and/or food processing should be explored.
- Highly refined cereal flours (those with low extraction rates) have lower levels of anti-nutrients and dietary fibre than less refined flours. Highly refined flours cost more and have lower vitamin and mineral levels – although these vitamins and minerals are more bioavailable.
- Blended flours prepared with de-hulled legumes are preferable to those prepared with whole legume flour.
- Food processing techniques, including home-based processing techniques such as fermentation and soaking, can improve food quality, specifically nutrient bioavailability. The effect of anti-nutrients in complementary foods based on the family diet can be decreased by various traditional food processing methods such as malting or soaking. The feasibility and efficacy of these processing techniques for the management of moderate malnutrition should be assessed.
- The energy density of semi-solid foods can be increased by reducing the water content or by adding fat or sugar. Adding fat and sugar, however, decreases the nutrient density in relation to energy and is acceptable only if the overall density of each and every essential nutrient is sustained at a level that supports normal balanced tissue synthesis.
- The increase in viscosity resulting from the reduced water content can be limited by using amylase or amylase rich flours.
- Foods with a high energy density often have a high renal solute load and may not provide enough water for recovering children.
- Children fed diets with a high solute load in relation to their water content may need additional water during and between meals. Breastfeeding provides large quantities of water in addition to a full range of nutrients. It has a low solute load and should always be encouraged before potable water when energy dense foods are provided.
- As most diets in poor countries have a low level of n-3 (omega-3) fatty acids and an inappropriately high ratio of n-6 fatty acids in relation to the n-3 fatty acids, foods with high n-3 fatty acid content should be promoted. These include soybean and rape seed oil, and fatty fish or its products. This

is especially important for non breastfed children.

Research needs

There is uncertainty about the minimum quantity or type of animal source foods that are needed in the diets of MM children. Milk, and potentially eggs, seem to have advantages over meat and fish in terms of growth, but not in terms of improving micronutrient status. It is unclear whether children who are stunted but not wasted may benefit from different proportions of animal v plant protein in their diets, as compared to diets designed to treat wasting.

Research is also needed to assess whether dairy/ whey stimulates linear growth and / or reverses wasting in comparison to plant based foods (e.g. soy) with a high PDCAAS, low levels of anti-nutrients and low fibre content in malnourished children. The extent to which cooking/heat treatment denatures bioactive components of dairy products should also be investigated.

Saskia de Pee/WFP



Local production of fortified blended food

Data are needed on the maximum acceptable levels of intake of the most important anti-nutrients and of different types of fibres for MM children. There is also a need to establish upper acceptable limits for sodium and iron content of foods for MM children.

Dietary counselling for moderately malnourished children

This background paper (prepared by Prof Ann Ashworth, London School of Hygiene and Tropical Medicine) concluded that mothers of MM children are usually given the same general dietary advice as mothers of well-nourished children. The paper suggests that generic dietary recommendations developed by the WHO and Food and Agricultural Organisation (FAO) for well-nourished children may meet requirements of MM children if the recommendations are made more specific and context appropriate.

To date, there have been few studies of the efficacy of dietary counselling in treating MM. Studies looking at dietary counselling for MM report very different weight gains. Little information is available on other outcomes. Even

height gains are rarely reported. Differences in reported weight gain are probably due to differences in initial nutritional status (stunted vs wasted). It was noted that one of the most effective pilot nutrition counselling programmes implemented in Bangladesh provided micronutrient supplements that may have increased its efficacy. Save the Children US presented data showing that large scale positive deviance programmes in Vietnam and other countries have not had a significant impact on reducing MM.

Consensus Statements

- Dietary counselling for the prevention and management of malnutrition in general is often weak or absent and should be strengthened for all caregivers, especially those of children aged less than 24 months.
- Dietary counselling, breastfeeding counselling and improving feeding practices should always be part of the management of MM. This is essential even when food supplements are given.
- Formative research should always be carried out before formulating dietary recommendations. Only foods and feeding practices that are affordable, feasible and acceptable to families should be recommended.
- Where prior assessment indicates that it is not possible to provide all nutrients needed by the child using the accessible family foods, other approaches, (including the use of fortified foods, food supplements, or micronutrient supplements) should be recommended.

Research needs

One of the key research questions is whether to always aim to maximise the rate of catch-up in wasted children and what the most appropriate delivery channels for dietary counselling are. Research into the effectiveness of a combination of approaches for addressing MM is also needed, e.g. infection control and nutritional support and the combined and separate impact of food supplements and dietary counselling.

In order to inform this research agenda, researchers need to report weight gain as g/kg/d (as well as % moving between different weight-for-height and height-for-age categories), disaggregate weight gain among wasted and non-wasted children and broaden the number of outcomes (e.g. body composition, height gain, immune function, morbidity). Overall, we need a better understanding of how to provide and deliver effective dietary counselling.

Food supplements used to treat moderate malnutrition in children

This background paper (prepared by Dr Saskia de Pee and Dr Martin Bloem, WFP) reviewed specialised food supplements that are currently used to treat MM children in different contexts. This includes fortified blended foods prepared with cereals and legumes as major ingredients, complementary food supplements providing nutrients and energy missing in the family diet, and micronutrient powders.

Dr de Pee and Dr Bloem reiterated that most supplementary feeding programmes (SFPs) for moderately malnourished children supply fortified blended foods (FBFs), such as corn soy blend (CSB) and wheat soy blend (WSB), in

combination with oil and sugar. However, there are a number of shortcomings with FBFs such that they are not optimal for feeding moderately malnourished children and need to be improved and/or replaced by foods that better meet their nutritional needs.

Presentations from WFP, UNICEF and USAID described the various improvements the agencies all plan to make to their fortified blended flour products, e.g. increasing the energy density, adding dairy products, dehulling soybeans, possibly removing cereal germ, changing the proportion of energy from fat, improving the EFA and micronutrient profiles.

Improvements and adaptations to lipid-based nutrient supplements (LNS) and ready-to-use foods (RUFs) are also being made by the members of the LNS Research Network (supported by grants from the Bill and Melinda Gates Foundation and with support of the USAID-funded FANTA-2 Project) and Valid International.

Papers on field research from Malawi (Prof Ken Maleta, Blantyre College of Medicine), China (Prof Chen Chunming, International Life Science Institute), Niger and Sierra Leone (Dr Susan Shepherd, MSF-Nutrition Working Group) and Ghana (Prof Kathryn Dewey, University of California, Davis) presented data on the impact and outcomes of using specialised products to treat and prevent MM in different contexts. For example, in Malawi, supplementary feeding of milk/peanut and soy/peanut fortified spreads to treat moderately wasted children resulted in slightly higher recovery rates than feeding with CSB. In Niger, a targeted MSF supplementary feeding programme for moderately wasted children using RUF had a 95% recovery rate. In Sierra Leone, soy peanut fortified spread resulted in higher weight gain and shorter treatment than premix CSB-oil.

Consensus statements

- There is an urgent need to develop clear terminology for the different specialised foods used to treat moderate malnutrition.
- When it is expected that a new food product will have at least equal impact on growth, morbidity and micronutrient status compared to an existing product (often a FBF such as CSB or WSB), then it is permissible to use this product in programmes for feeding moderately malnourished children provided that the product is acceptable to the beneficiaries. In that case, it is important to collect programme data to monitor the impact of this new product on the time needed for recovery of MM children, when the product is used for treatment, or on the occurrence of new cases of malnutrition if it is used for prevention. Concurrently, the efficacy of the new product should also be assessed under carefully controlled circumstances in the same or another area or country, depending on local possibilities. Such efficacy testing should include measures of physiological, immunological, cognitive and body compositional recovery as well as simple weight gain.
- It is very likely that different types of specialised foods and programme formats (e.g. blanket or targeted, dietary counselling) will be used to treat, or prevent,

moderate malnutrition in the future, depending on the context (security, prevalence of malnutrition, general food security conditions, etc). The next WHO meeting on moderate malnutrition, which will focus on programming issues, should endeavour to develop algorithms for determining what programme type and product to use in different situations.

Research needs

Areas of uncertainty still exist with respect to improving FBFs. These include: the impact of dehulling and degerming of soy, maize and wheat, addition of phytase and/or amylase to improve nutrient availability and food acceptability, maximum tolerable fibre content, the minimal quantity of energy provided by fat to ensure adequate energy intake, the amount/proportion of milk required in the formula, the possibility and efficacy of using plant protein isolates, especially soy protein isolates, as a possible substitute for dairy products. There is also a question regarding whether the anti-nutrient content of FBFs can be significantly reduced by encouraging farmers to produce crop types that have naturally lower concentrations of anti-nutrients.

Agencies urgently need to collect impact assessment data from the different products (FBF, RUF, LNS, micronutrient powders) being used to treat and prevent MM in different contexts so that field agencies/governments know which product to use in a given context.

The impact and outcome data for new products need to be comparable across studies and programme evaluation. Information on non-food context factors should also be collected (e.g. programme incentives). The operational advantages of some products/programme types should be recorded (e.g. blanket distributions may be easier in food insecure areas).

It is essential to collect information on the costs of providing different types of specialised products, complementary interventions, and the means of distribution.

Recommendations of the meeting – Next steps

The meeting made a number of recommendations to move forward and to continue to improve current programmes in the next few years.

Establishment of a process to develop specifications for food categories for moderately malnourished children and validation of new products for prevention and treatment of moderate malnutrition in children.

Dr. Carlos Navarro-Colorado (Emergency Nutrition Network) presented a description of a generic approach to validate the efficacy of new foods for moderate malnutrition. This would need to be based upon clear classification of different types of food supplements required and the nutrient specifications for each category of food supplement. Four stages of validation were proposed: (i) analysis of composition and processing, (ii) small scale clinical pilot, (iii) field efficacy trial, and (iv) post-validation monitoring. It would not be necessary to conduct all four stages for all products.

The design of studies and validation of products will face a number of challenges. These include lack of baseline dietary information, accounting for differences in the quality of programme implementation, the need to

broaden and define outcome indicators beyond anthropometry, and accounting for the fact that an unknown proportion of moderately malnourished children will recover spontaneously. Another significant challenge will be how to establish an institutional mechanism and identify a lead agency for ensuring coordinated validation of products.

A working group then examined how to move forward and to set up a process of improving existing food supplements and ensure their efficacy is adequately evaluated.

Consensus statements

- A standing task force should be established and led by WHO with appropriate UN agencies and other technical experts to develop specifications for specialised products, in particular for moderately wasted children, in a first step.
- A separate expert group should be established to examine different endogenous food components that have potential negative effects and develop upper limits for these anti-nutrients and toxins. One of the tasks of this group would be to determine the maximum acceptable level of different types of dietary fibres and other potentially deleterious natural constituents that can be present in food supplements.
- There is a need for an independent standing working group to assist national governments and agencies to determine if newly available products that are put onto the market are appropriate and whether (a) particular type(s) of product testing are required before granting approval for their use among specific target groups.
- The meeting recommended that this set of activities should be initiated within the next six months.

Research Needs

In the discussions, the meeting also identified the need to estimate the level at which recovery from moderate malnutrition occurs in absence of supplementation so that this can be accounted for in trials involving new products. This can be achieved either by examining data from previous studies where some children did not receive any supplement or by taking as the control group in intervention studies a group receiving adequate dietary counselling but no food supplement.

There is also a need to elaborate specific non-anthropometric measures that can be used to compare outcomes and product efficacy. This will involve developing and strengthening field friendly techniques for measuring outcomes such as body composition, immunocompetence, micronutrient status, renal concentrating ability, physical activity level, sodium pump function, intellectual development, etc.

Organisation of a second meeting on improving programmes addressing the management of moderate malnutrition

The focus of this technical meeting was dietary requirements of MM children, so that programmatic issues were not substantively addressed. The WHO is planning a further technical meeting on programming for MM children.

For more information, contact: Zita Weise-Prinzo, WHO, email: weiseprinzo@who.int

Sphere revision underway

The Sphere project was launched in 1997 as a joint initiative of non-governmental organisations (NGOs) to improve quality and accountability in humanitarian response. The Sphere handbook forms a key tool of the project and has become one of the most recognised tools for improving humanitarian response for NGOs, United Nations (UN) agencies, donor governments and other actors.

The first edition of the handbook was published in 2000, and then following a revision was republished in 2004. Since the last revision, significant changes have taken place in the humanitarian sector – especially with regard to technical and cross cutting issues and humanitarian reform. There have been considerable developments and change in the field of nutrition in terms of the prevention and treatment of malnutrition and how it is defined.

For this reason, the handbook is now undergoing revision to produce an updated version by 2010. The revision process will be led by a project coordinator appointed through the Sphere project and involve a team of 11 focal points. Funded by the UNICEF-led Nutrition Cluster, Save the Children UK (SC UK) will act as a focal point to revise and update the minimum standards in the nutrition component of Chapter 3, as well as contributing to revisions in cross cutting issues.

Wide reaching formal consultations will be arranged for later in the year, however if you have ideas as to what should be included in the next version or would like to be included within the consultation process, please send your feedback to the contact below or through the Sphere project website.

SC UK focal point for review: Susan Thurstans, email: s.thurstans@savethechildren.org

Management of Humanitarian Emergencies: Focus on Children and Families

Case Western Reserve University, Ohio, USA
June 15-19, 2009

Now in its 13th year, this five day course examines the key problems and priorities in disaster situations as they relate to children and their families.

This programme is designed for paediatricians, primary care providers, nurses, public health workers, mental health providers and other professionals interested in training for the care of children and families in disaster situations.

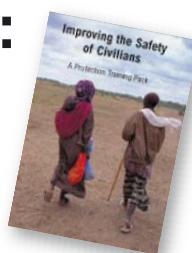
The learning objectives for the programme include the following:

- Develop critical thinking and problem solving skills through problem based learning exercises.
- Identify organisations most frequently involved in providing assistance in disasters and define their roles and strengths.
- Rapidly formulate a plan for epidemiologic assessment and describe the role of training in prioritising relief efforts.
- Recognise malnutrition and its consequences and plan interventions.
- Define developmental variations of stress reactions in children and age appropriate interventions.
- List basic points of international humanitarian law as they apply to women and children.
- Provide a framework for addressing ethical dilemmas in resource-poor settings.

The course is held at Case Western Reserve University, Cleveland, Ohio, presented by the Rainbow Centre for Global Child Health. The course is supported by the Master of Public Health Programme, Department of Epidemiology & Biostatistics, The Centre for Global Child Health and Diseases, Case Western Reserve University.

For more information, including costs, and to register on-line, visit <http://cme.case.edu> or contact the Registrar, CME Programme, 10524 Euclid Avenue, Cleveland, OH 44106-6026, USA, tel: +1 (216) 983-1239

Improving the Safety of Civilians: A Protection Training Pack



A training pack has been developed by OXFAM to help humanitarian workers to improve the safety of civilians being subjected to violence, coercion, or deliberate deprivation. The pack includes modules on 'what is protection', planning a programme and mainstreaming programming for protection.

The activity sessions within the modules cover a range of topics, including international standards for civilian protection, objective setting, indicators and monitoring, humanitarian negotiation, co-ordination and alliance building, reducing the risk of sexual violence and advocacy for humanitarian protection. A selection of core exercises at the end of the book is designed to encourage interaction and create debate.

Entitled 'Improving the Safety of Civilians', the pack outlines all activities, with detailed trainers' notes, timings, resources needed, and handouts, feedback, and evaluation sheets. Colour cards and posters are included at the back of the book.

An accompanying CD contains the full text of the manual, including the cards and posters for users to print.

The materials are designed for use by experienced facilitators, who have some knowledge of protection issues, to train emergency-response teams. Activities can be adapted for participants with different levels of knowledge.

The print version with CD-ROM costs £19.95 (inc. VAT) or the entire content is available on line (PDF, 1.34MB) at <http://publications.oxfam.org.uk/oxfam/display.asp?K=9780855986162>

Print copies can be ordered online or contact BEBC Distribution, PO Box 1496 Parkstone, Dorset BH12 3YD, UK Tel: +44 (0) 1202 712933 Fax: +44 (0) 1202 712930 www.bebcdistribution.co.uk email: oxfam@bebc.co.uk

Call for abstracts for MSF Scientific Day

The Médecins Sans Frontières (MSF) Scientific Day is an international forum showcasing MSF's research to the outside world and across the organisation. It also presents the opportunity for several presentations from external NGOs or academics that are relevant to MSFs operations.

This year's MSF Scientific Day will be held on Thursday, 11th of June, 2009 at Glaziers Hall in London. The deadline for abstracts is 27th February 2009.

MSF are interested in all types of analysis, from surveys, descriptive programme evaluations to drug/device trials.

For more details, contact: Tejshri Shah, Head of Manson Unit, tel: +44 (0)20 70674218 email: tejshri.shah@london.msf.org or Liane Cerminara, Scientific Day Coordinator, tel: +44 (0) 20 7404 6600 email: liane.cerminara@london.msf.org

Nutriset, Niamey, Mali, 2006



Participants in the organoleptic study.

Social marketing of a nutritional supplement in Niger

By Alejandra Beltran Fernandez, Isabelle Sauguet, Florence Da Costa, Virginie Claeysens, Adeline Lescanne, Michel Lescanne.

This article shares some experiences of the company, Nutriset, in applying a social marketing approach to assess the affordability of a micronutrient supplement for 1-5 year olds to low income mothers in Niamey, Niger.

This article presents the first results of a feasibility study (part of ongoing research) conducted by Nutriset¹ and its partner STA², in Niamey, Niger, since May 2006. Niger was chosen as the pilot country since it is one of the poorest and least developed countries in the world³. Here, 1,120,000 children between the ages of 1 and 5 years are at risk of malnutrition⁴ and 50,000 of these children live in Niamey. Moreover, Niger presented favourable political, economic, social, technological, environmental and legal (PESTEL) conditions for setting up the project.

The objective of this study was to determine if the distribution of a nutritional supplement for vulnerable low-income populations in urban Niger was viable. Social marketing techniques were applied throughout the project to gather qualitative and quantitative data and to evaluate the sustainability of such an approach to prevent malnutrition among at-risk populations. The nutritional supplement is manufactured locally by STA. It is hoped that through local production, nutritional capacity development will increase. If Nutriset's social marketing experience in Niger is positive, the methodology may be used to develop similar projects in other developing countries.



Methodology

The research methodology was based on social marketing techniques⁵, i.e. using commercial marketing techniques to address social or public health challenges. According to the literature⁶, there are important differences between social and commercial marketing approaches.

Commercial marketing seeks to persuade people to purchase specific goods or services, whereas social marketing prioritises and seeks the well being of individuals and of society. In the latter case, needs are not artificially created. The research methodology was validated by marketing specialists from Ferrero⁷, France.

Qualitative and quantitative questionnaires were administered to mothers and children in low-income urban neighbourhoods and in Niamey's suburban rural villages. A random sample of 80 people participated in the questionnaire surveys and a total of 144 adults and 382 children participated in the organoleptic tests held in Niamey and one rural village.

The study comprised four phases, with each phase lasting 6-8 months. An assessment was made at the end of each phase before moving on to the next one. The four were:

- Phase 1: Market study and evaluation of need and feasibility.
- Phase 2: Establishing the marketing mix (product, price, distribution and communication mechanisms).
- Phase 3: Optimising the marketing mix and validation (this includes industrial production).



Alejandra Beltran Fernandez was the Nutriset's Deputy Project Manager, Social Marketing for Niger from the beginning of the research in 2006 to mid 2007.



Isabelle Sauguet is Nutriset's General Manager.



Florence Da Costa is the Nutriset's Deputy General Manager and Marketing Director.



Virginie Claeysens is the Nutriset's Deputy project Manager, Social Marketing for Niger.



Adeline Lescanne is the Nutriset's Deputy General Manager and director of International Department.



Michel Lescanne is the Nutriset's President and Chief Executive Officer.

Phase 4: Pre-launch in selected areas followed by the actual launch (this includes the start of a public information campaign).

The four phase feasibility study started following authorisation from the Ministry of Health in Niger.

Main findings influencing the marketing-mix

The type of product, its price and packaging were established simultaneously, as the economic constraints of the target households allowed for little elasticity. The product chosen was a ready-to-use micronutrient supplement, suitable for children between 1 and 5 years of age. It does not require dilution and can be eaten at any time of the day. Daily consumption is set at 5g, which provides a minimum of 50% of the main recommended vitamins and minerals for this age group as well as essential fatty acids, but only a small quantity of energy. It is therefore not intended to replace a balanced meal.

The name 'Grandibien' was chosen after interviews with 78 people. 'Grandibien' is easy to understand and emphasises the product's perceived benefits. Due to the high level of illit-

¹ Nutriset is a French company that designs and produces specialised products for the treatment of different forms of malnutrition (e.g., Plumpy'nut, Plumpy'doz).

² STA: Société de Transformation Alimentaire, partner of Nutriset and member of the PlumpyField network.

³ In 2007, Niger's rank in the United Nations Human Development index was 174, out of 177 countries. Source: <http://www.unicef.org>

⁴ A national survey, carried out in October 2007.

⁵ Kotler P and Zaltman G (1971). Social Marketing: an approach to planned social change. *Journal of Marketing*, volume 35 (July), p. 3-12.

⁶ Rothschild Michael (1979), Manoff Richard (1985), Kotler and Roberto (1989), Alcalay and Bell (2000).

⁷ Ferrero is one of the leaders in the food industry. They market products for the mass market.

eracy, simple graphic messages are used to advertise and promote the product. The graphics were designed by ZigZag⁸ and tested by a selection of mothers.

Table 1: Example of the cost of a daily menu in the target population (per person)

	Purchased food	Paid price
Morning	Local flat cakes made of puff pastry, or doughnuts.	50 CFA franc (0.075€)
Noon	Rice with plain sauce	100 CFA franc (0.15€)
Evening	Millet balls with sauce	100 CFA franc (0.15€)

Price setting was the most challenging part of the marketing mix. The product had to be affordable and at the same time not displace other foods normally consumed in the diet. The calculation was based on the fact that on average the daily dietary expenses of low income families are about 250 CFA franc⁹ per person.

Data gathered in the field in 2007 showed that over a two week period, the target population of Niamey (less well off) are able to spend about 200 CFA franc (0.3€) to complement the diets of their children. With this in mind, 200 CFA franc (0.3€)/70g pot and 350 CFA franc (0.52€)/140g pot of Grandibien, was considered to be affordable. Both are fixed prices and retailers are regularly checked to ensure that they are selling at these prices. These retail prices just about cover the industrial costs of production but cannot absorb the other marketing costs associated with the product launch (e.g. communication, distribution, etc.) that are currently covered by Nutriset. After launch, the costs should be covered by sales volume.

At present, Grandibien is distributed by pharmaceutical wholesalers and by 41 groceries in Niamey. The distribution channel is about to be extended to include grocery wholesalers, a network of motorcycle delivery men, women's groups recruited through health care centres and micro-credit organisations.

The public information campaign focuses on explaining the use and the benefits of Grandibien. Radio and television appear to be effective media for publicising the product. An instructive TV advertisement that had previously been tested on mothers was made by a Niger agency in the three main local languages.

Mothers, health workers, midwives, and community leaders are directly informed through meetings organised in health care centres. Mothers are also informed by retailers who have participated in training on the product.

Although a further study (to be conducted in early 2009) is needed to increase understanding of the profile of the populations currently consuming 'Grandibien', the product has been marketed and distributed mainly in poor areas of Niamey. It is stocked in shops that are located close to the health care centres (initially the product was sold at the health centres with the autho-

risation of the Ministry, but this caused confusion as treatments for children under five at health centres are free.) Also the product is sold by women in those areas (i.e. women who choose to make the distribution of Grandibien their money-making/small business activity). It is therefore expected that, in the main, those consuming Grandibien are from the poorest sections of society.

Evaluation and lessons learnt

In February 2008, 172 mothers with children in the target age range were interviewed to evaluate their views on Grandibien. Of these, 92 mothers had bought Grandibien and 80 mothers had not. Ninety eight per cent of mothers who had bought Grandibien were satisfied with the product, while the 'loyalty index' of people who had bought the product was 68%. Surprisingly, over 67 % declared that Grandibien had improved the appetite of their children. However, only 14.3% stated that Grandibien brought extra vitamins and minerals to their children, while 13.1% said that Grandibien gave energy to their children.

Positive findings included:

- The social marketing methodology used in Niger can easily be adapted to new projects.
- Ferrero considered that the survey results clearly demonstrated a successful and coherent marketing approach.
- Families appreciated participating in the survey and having the opportunity to express what they thought. The interviews and surveys provided practical and usable information.
- Mothers became increasingly aware of the benefits of nutrition supplementation.

Limitations of the study included:

- The territory covered by the feasibility

study (Niamey's urban territory) is not representative of Niger's rural society.

- Local dialects may constitute a communication barrier.
- Having the support of local health care agents and of the Niger Ministry of Health was a key factor in the development of the project. However, administrative procedures take a long time and led to delays in the project schedule.

Sustainability is a key challenge for this type of initiative. Sale price must cover direct and indirect costs if the product is to be manufactured locally. Nutriset has financed the setting up of the distribution network, training and the large awareness communication campaign. This expenditure has been vital for kick-starting the process. The product is now well known and widely distributed in Niamey. Promotion expenditures will therefore decrease significantly and distribution costs should be absorbed by sales volumes. Establishing sustainable local level production capacity will help build in-country nutritional autonomy. At the producer level, this will also help balance the financial risks of manufacturing nutritional products for humanitarian programmes.

A follow up study is being planned for the start of 2009. This study will have a number of objectives:

- To determine the proportion of the target population that is consuming the product and their socio-economic profile.
- To determine the nutritional impact of Grandibien at individual and population level.
- To determine whether and how the product displaces other family expenditures.

Nutriset plan to make the product more widely available, especially to rural people with lower purchasing power. To this end, Nutriset are exploring the potential for selling a daily quantity of Grandibien and will conduct tests in Niamey city and the suburbs with distribution partners (such as women groups and shopkeepers) over a three month period, starting from April 2009. With new packaging, the product should be more affordable for local producers. Nutriset are also planning to involve non-governmental organisations (NGOs) in distribution and training in the future, especially in rural and remoter areas.

Conclusions

Today Grandibien is well known and correctly distributed in Niamey. Mothers value the product, are aware of its beneficial effects on children and regularly purchase it. The scaling-up of distribution outside of Niamey is currently being considered and evaluated. If it goes ahead it will probably be organised through existing distribution channels and in collaboration with health centres and local organisations.

For further information, email: nutriset@nutriset.fr

⁸ Zigzag is a communication agency which works with Nutriset, particularly on social marketing projects.

⁹ Source: Niger Decree N° 2006-059/PRN/MFP/T establishing the minimum wages per professional group (8 March 2006).



A mother participates in the TV advertising qualitative survey.

Oxfam evaluation of Cyclone Sidr response

Summary of evaluation¹

A boy stands next to his makeshift home in Patarghata (Barguna District).

Kenny Rae/Oxfam America, Bangladesh, 2007

Late in the evening of 15th November 2007, Cyclone Sidr struck Bangladesh's southern coastal areas leaving around 4000 people dead and millions homeless. The cyclone also killed livestock and destroyed crops, farming equipment, and fishing boats. Planning for the emergency was already well underway before the cyclone hit land. Early warning systems and disaster preparedness measures allowed a reported 3 million people to evacuate low-lying coastal areas and local government officials and non-governmental organisations (NGOs) rapidly to move contingency stocks from neighbouring districts into the areas of anticipated impact. Following the cyclone's landfall, the government, armed forces, local civil society organisations and volunteers moved quickly to mount search and rescue operations and to distribute food, water, logging and other emergency items to survivors. The reduced death toll compared to previous cyclones is a testament to improved community preparedness measures and a credit to the 43,000 volunteers working under the government funded Cyclone Preparedness Programme.

While the immediate response to the disaster was both prompt and vigorous, Oxfam believes that some actors could and should have done more effectively to meet emergency needs. While coordination at local level was reasonably effective, gaps were visible in coordination between local and national actors, resulting in poor quality humanitarian response. Since field based staff and officials within national NGOs and institutions were rarely empowered to make programmatic and policy decisions - for example, regarding numbers of households to target or types of items to distribute - large parts of the response remained resource-driven and 'top-down', rather than needs based.

Above all, coordination at both the national and local level appears to have been hampered by a lack of strategic focus. While the informal activation of the United Nations (UN) 'cluster approach' to humanitarian coordination did allow those involved in the response to meet more regularly at Dhaka level, the clusters themselves were not utilised by either the government or UN agencies as a space for genuine policy discussions around actual needs on the ground. With regard to the UN system, the absence of a clearly identifiable, inclusive inter-agency coordination forum, as well as a dedicated Humanitarian Coordinator (HC) or other high-level UN official, also resulted in missed opportunities in terms of joint planning and preparedness.

Cross-cutting issues like gender and protection appear to have fallen through the cracks as clusters were limited to discussing the more technical and practical aspects of the response.

Many multilateral and bilateral donors gave generously during the first phase of the response but struggled to coordinate assistance

both with each other and with government. In part, this appears to be the result of the poor sharing of information and a lack of established communication channels between donors belonging to the Organisation for Economic Cooperation and Development's Development Assistance Committee (OECD-DEC) and other countries who fall outside this group. Government officials and Dhaka-based donors appear to have had little or no information on the timeframe within which substantial bilateral pledges were being spent or which activities they were funding.

Targeting the right people for relief was another major challenge in the emergency response. Relief distributions did not always benefit the most vulnerable, such as female and child-headed households or elderly and disabled people. In part this may have been the result of people's needs outstripping available resources. However, due to the information gap between national policy-makers and field staff, those leading the response did not pick up on additional needs early enough to allow donors to respond with more assistance. In light of financial and material constraints, NGOs delivering the assistance often found it difficult to select beneficiaries. This seems to have been a particular challenge for NGOs who had previously carried out development work in the same villages. A strong developmental approach meant that staff sometimes struggled to develop and explain to communities the new selection criteria required for an equitable emergency response.

Considering the fact that the vast majority of assistance programmes in Bangladesh are implemented by local actors, international donors and aid agencies have not invested adequately in strengthening these frontline responders in disaster-prone areas. More efforts are needed to build these organisations' capacity, especially in terms of beneficiary selection, the application of international quality standards such as Sphere standards and effective contingency planning.

In terms of recovery there are still two massive gaps - the repair and reconstruction of homes and the rehabilitation of people's livelihoods.

Nearly 1.5 million homes were destroyed or damaged due to the cyclone and subsequent storm surge. Damage assessments estimates are 800 million dollars. To its credit, the government of Bangladesh acted immediately after the disaster to provide families whose homes were fully destroyed in the worst affected areas with a one-off housing grant. Carried out with remarkable speed and efficiency, this distribution proved to be an innovative way of supporting extremely vulnerable families. It was clear, however, that

¹ Oxfam Briefing Note (2008). After the cyclone: lessons from a disaster. 15th February 2008. Full report at http://www.oxfam.org/en/policy/bp_bangladesh_cyclone_sidr_080214

Evaluation

the amount was insufficient to allow families to actually rebuild their homes. Most people interviewed by Oxfam reported having spent their cash on other emergency needs, such as foods or winter clothing for children, as well as to support recovery of livelihoods.

The cyclone killed over 1.2 million livestock and destroyed nearly 2.5 million acres of crops. Damage and losses were estimated at 500 million dollars, with large numbers of communities that were previously reliant on agriculture, fishing and casual labour having lost both their incomes and assets. Food security needs were significant. The World Food Programme (WFP) led the food security cluster in calling for relief distributions to continue for more than 2.2 million people until at least May 2008. However, Oxfam feel that the clusters, by not advocating for more seed distribution, missed an opportunity for improving some people's food security. Also, the fact that 95% of local markets functioned again suggested that some cash-based responses may have been appropriate.

Loans and credit are a major source of income for many rural families in Bangladesh. Most families were already carrying debt loads before the cyclone. Following the cyclone, some micro-finance institutions took decisions to temporarily suspend repayment of loans but communities expressed fears that current grace periods of 3-6 months were not long enough. These institutions must follow government advice and be more flexible, as well as write-off loans in cyclone affected areas as much as possible. There has also been unscrupulous lending at very high interest rates for new loans. Special efforts will be needed to ensure that sufficient amounts of credit are offered by micro-finance institutions and banks at low or no interest rates to facilitate recovery of those affected by the cyclone.

Considering the country's high level of vulnerability to natural disasters, the government and international donors must commit to better rebuilding and so improve future resilience to disasters. Scientists concur that the ferocity and frequency of hazard events such as cyclones, hurricanes, and earthquakes have increased. Few countries are at higher risk of climate change than Bangladesh where experts estimate that more than 50 million people could be made homeless by rising temperatures and sea levels. Climate migrants already account for at least one third of the impoverished people who are flooding from rural areas to seek work in the city of Dhaka.

Cyclone survivors have demonstrated a remarkable resilience in the face of disaster but their capacity to cope with the enormous challenge of rebuilding their lives must not be over-estimated. The government of Bangladesh and the international community have a legal and moral responsibility for ensuring that their needs do not fall off a crowded humanitarian and development agenda.



Utteran (Oxfam partner) Cash for Work programme for communities to build latrines to replace those damaged by Cyclone Sidr.

New method for assessing acute malnutrition in nomadic pastoralist populations

By Anne-Marie Mayer, Mark Myatt, Myriam Ait Aissa and Nuria Salse



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Camels at a water point in Kidal.

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This article describes a new survey method for assessing acute malnutrition in nomadic pastoralist populations, including a case study from Mali.

The work presented here was commissioned by Action Contre la Faim-International Network (ACF-IN) and took place between May 2007 and June 2008. The research aimed to identify a novel method to assess the nutrition condition of pastoralist communities in countries where ACF operates: Mauritania, Burkina Faso, Mali, Niger, Chad, Sudan, Ethiopia, Somalia, Uganda, and Kenya. Pastoralist populations are vulnerable to shocks that result in nutrition risks, e.g. drought, animal disease, market disruption and closure of borders. However, the lack of a suitable sampling method for pastoralist surveys has contributed to the omission of pastoralist populations in emergency response and development programmes.

The two main challenges in surveying pastoralist populations are:

- Case definition for wasting (the usual weight-for-height (WH) based case definition has returned higher prevalence's of malnutrition than Mid Upper Arm Circumference (MUAC) in pastoralist children over 24 months of age¹.

- Selecting a representative sample in an area with a mobile, low density population for whom there are few reliable data on population size at the community level.

Existing survey methods and their limitations in pastoralist settings

Most surveys use a two-stage cluster sampling method, e.g. 30 by 30 cluster surveys and SMART surveys². Both methods use primary sampling units (PSUs) selected using Probability Proportion to Size (PPS). This weights the sample according to community size, favouring large communities but does not ensure a geographically representative sample. In pastoralist areas, community-level population data are not available and hence the PPS method does not work. Furthermore, mobile communities (troupes) change size and composition throughout the year and may get smaller in crisis conditions as troupes disperse in search of scant grazing resources. Any official information is likely, therefore, to be out-of-date at the time of the survey.

The Centric Systematic Area Sampling (CSAS)³ approach has been used in estimating the coverage of feeding programmes⁴ and for wide-area mapping of trachoma prevalence⁵.

Trials of the use of CSAS and 'snowball' sampling in retrospective mortality surveys are currently underway. The CSAS method has been adapted for nutrition surveys in pastoralist areas, for example in Mali in the same location as this field test^{6,7}. Although addressing some of the problems of PPS methods, the main problem with CSAS is that it does not help the survey teams locate the mobile population and hence a lot of time is spent locating troupes.

Development of the new method

The new method was developed through a peer review process and designed to meet the criteria listed in Box 1. The peer review group were experts in the field of pastoralist society and

Box 1: What are the requirements for a new method?

The following requirements were considered essential to define a new method:

1. It should be a general method that can be adapted to the field situation using information gathered locally.
2. The sampling method should not require population data at the start and should not require knowledge of the location of populations ahead of the survey.
3. The method should be straightforward and efficient to conduct in the field.
4. It should be representative of the whole population – even remote communities.
5. An unbiased estimator should be used.
6. The precision should be predictable across different sample sizes and be similar to that obtained by conventional cluster sampled surveys in sedentary rural populations.
7. The case definition used should be appropriate for pastoralists and a good predictor of nutrition-associated mortality.

¹ Myatt, M, Duffield, A, Seal, A, and Pasteur, F. (2009). The effect of body shape on weight-for-height and mid upper arm circumference based case-definitions of acute malnutrition in Ethiopian children. *Annals of Human Biology*. Also see: (2008) Effect of body shape on weight-for-height and MUAC in Ethiopia. *Emergency Nutrition Network. Field Exchange* 34.

² (2005). Measuring Mortality, Nutritional Status and Food Security in Crisis Situations: SMART METHODOLOGY. Version 1 UNICEF and USAID

³ A spatial sampling method that uses a systematic spatial sample from a defined geographic area.

⁴ Myatt, M, Feleke, T, Sadler, K., and Collins, S (2005). A field trial of a survey method for estimating the coverage of

selective feeding programs. *Bulletin of the World Health Organization* 83, 20-26

⁵ Myatt, M, Mai, NP, Quynh, NQ, Nga, NH, Tai, HT, Long, NH, Minh, TH, and Limburg, H (2005). Using lot quality assurance sampling (LQAS) and area sampling to identify priority intervention areas for trachoma control activities-Experiences from Vietnam. *Bulletin of the World Health Organisation* 83, 756-763

⁶ ACF (2006). Enquete nutritionnelle et de mortalite. Commune de Kidal, Mali 16-27, Dec 2006

⁷ Vincent, E, and Salse, N (June 2008). Methodology for a nutritional survey among the nomadic population of northern Mali. *Emergency Nutrition Network. Field Exchange* 33, 14

Figure 1: Example of Organogram

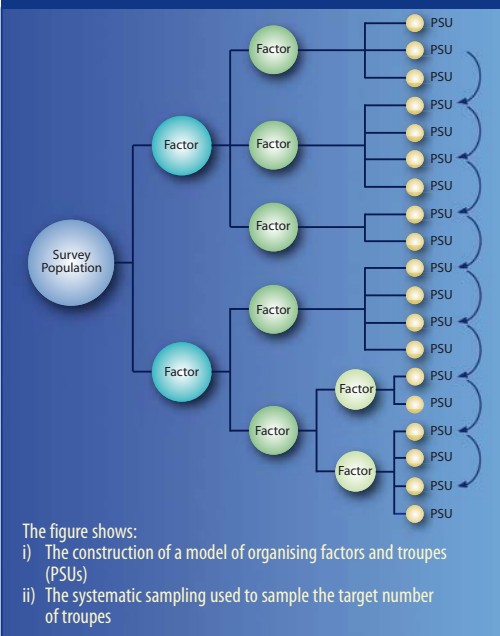
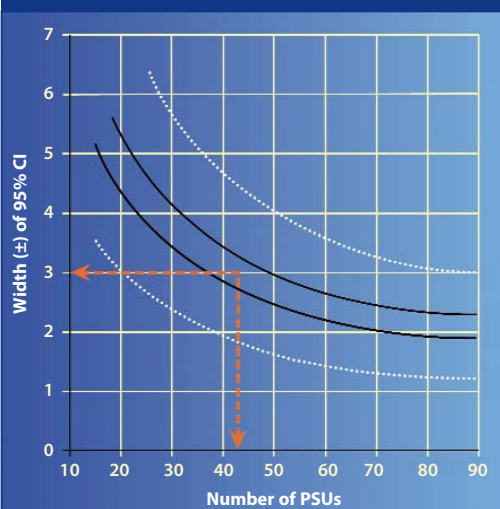


Figure 2: Precision Sampling from populations with 10% prevalence and different mean PSU sizes



The example nomogram is for an estimated 10% prevalence of malnutrition. To determine the required sample size (expressed as the required number of PSUs), it is necessary to read the number of PSUs on the x-axis for different required precision on the y-axis. Here, the example is for PSU size 15 and precision 3%. The PSU size of 15 lies half way between the lines for 10 and 20 on the graph. The arrow shows the sample size of 42 troupes is necessary with troupe size 15, prevalence 10%, and precision 3%. A margin of error should be added to this; say 15% giving sample size of 48 PSUs.

Another way of doing this is to average the sample sizes read from the nomogram for PSU size 10 (48) and PSU size 20 (38) which is 43.

At present, sample size 'calculations' are performed using a series of nomograms generated by computer-based sampling simulations. Further work will be directed towards producing a simple to use sample size calculator.

economy. Existing methods, advice from peer reviewers, nutrition assessment guidelines and the experience of the consultants were used to design the method. Computer-based simulation was used to test the design statistically. The method was then field tested in Kidal, Mali with ACH.

Description of new method (Pastoralist Survey Method - PSM)

An appropriate *case-definition* for malnutrition in pastoralists was developed based on MUAC for several reasons. Pastoralists tend to have different body shapes; compared to sedentary agrarian populations their sitting height to standing height ratio is small. The body shape of pastoralists tends to produce inflated estimates of the prevalence of wasting using a WH based case-definition⁸. MUAC gives more consistent estimates of malnutrition across different body shapes⁹ and is a better predictor of mortality than WH¹⁰, which is only weakly associated with nutrient reserves, nutrient requirements, and mortality. Compared to WH, MUAC measurement is quicker and more straightforward and requires no heavy field equipment to carry.

The *sampling* design makes use of local knowledge to construct the sampling frame using qualitative methods. This information is collected primarily from central locations in order to:

1. Define the *organising factors* (factors that define the way the population is socially and/or geographically organized) and the *troupe* (group of pastoralists who move through the territory (survey area) together).
2. Produce a detailed organisational tree (*organogram*) of the troupes for each organising factor. This organogram forms the basis of the sampling frame (Figure 1).
3. Estimate the average size of the troupe, i.e. the number of eligible children in the troupes.

The statistical design of the method was tested by computer-based simulation using simulated populations of pastoralists with data provided by peer reviewers. The simulation exercise produced *nomograms* that can be used to estimate the required sample size using the estimated size of *troupe*, precision required and estimated prevalence of malnutrition (see Figure 2).

The method uses an exhaustive sample of children from each PSU (*troupe*). This way there is no need to 'spin a bottle' to select households to be sampled; all eligible children from selected PSUs (*troupes*) are included in the sample. The use of MUAC facilitates the collection of an exhaustive sample. In the unlikely event that the troupes are too large to include all eligible children in the sample, a second level of sampling may be introduced. This eventuality has not so far occurred and hence a method has not been developed for it, although techniques such as map-segment-sample that have been used to improve the accuracy of cluster sampled survey and in community level assessments of trachoma prevalence are likely to prove suitable.

Computer-based simulations found the method, when used with a bootstrap estimator, to be accurate (i.e. unbiased) and capable of returning estimates with useful precision (i.e. comparable to conventional designs) with readily achievable sample sizes.

Particulars of the survey design

The quantitative survey is designed using information gathered in the foregoing steps (i.e. the organogram and the average troupe size).

One or more troupes are combined (for the purposes of sampling) to form a Primary Sampling Unit (PSU). This is done if the average troupe size is less than about 10 children. The number of PSUs to be sampled is then read from the nomogram and a systematic sample drawn from the sampling frame (constructed as described above using the organogram). Only when the PSUs (troupes) to be sampled have been chosen will it be necessary to locate them in the field. Qualitative methods are used to find the identified troupes. Information will come from the initial qualitative methods and by using observation and information from key informants as you get closer to the selected PSUs (troupes).

The nutrition assessment is carried out by measuring/assessing **all** eligible children in the sampled troupes. Data may be collated at the level of troupe or PSU and computerised using specially designed software. Test versions of the software are available from:
<http://www.brixtonhealth.com/psm.html>

Data may be collected using simple tally sheets and the data-entry and data-management costs are considerably lower than required for a cluster-sampled design using WH.

How these design features meet the requirements

The PSM is a general method that is adapted to the field situation when the organising factor and *troupes* can be defined. It is adaptable to different sized populations, sub-groupings and locations. This is important as these may change seasonally or in response to shocks such as drought. The method was shown to be straightforward and efficient to conduct in the field (see below).

The results should be representative of the whole population, even remote communities, if the qualitative assessments are carried out thoroughly and no sections of society are excluded. The PSM does not require population data at the start and does not require knowledge of the location of populations ahead of the survey. Only once troupes have been identified for sampling is it necessary to find them. At this stage you should already have a good idea of their location.

The sampling method has been tested statistically using computer-based simulation and has also been field tested, as reported below. Computer-based simulations showed that the estimator was unbiased and precision predictable across a range of prevalences and sample sizes. The method may also be used to measure many other parameters, such as prevalence of diarrhoea and vaccine coverage

Use-study in Mali

The survey took place in Kidal commune of Kidal district, eastern Mali in collaboration with ACH. The population is approximately 30,000 of whom about 6,000 reside in Kidal town at any one time. The area of the commune is approximately 100,000 square kilometres. The population is largely nomadic pastoralist. The survey was conducted during the cooler dry season between January-March 2008. This was not a food insecure season or a season with high risk of malnutrition.

⁸ See footnote 1.

⁹ See footnote 1.

¹⁰ Myatt, M, Khara, T, and Collins, S. (2006). A review of methods to detect cases of severely malnourished children in the community of their admission into community-based therapeutic care programmes. Food and Nutrition Bulletin: SCN Nutrition Policy Paper 21, S7



A previous nutrition survey carried out in Kidal by ACF¹¹ in December 2006 used the CSAS sampling method. This survey reported a prevalence of acute malnutrition of 5.0% (95% CI 3.8-6.2) of children 6-59 months based on the WH z-score, with 1.9% in the rural areas and 6.8% in the town. The rate of severe acute malnutrition was 0.3% (95% CI 0.1-0.7). Using MUAC, 0.8% were moderately wasted (defined as MUAC < 120 mm & > 110 mm) and no children were severely wasted (defined as MUAC < 110 mm)¹². No children in the rural areas were wasted.

Application of the design to Kidal, Mali context

Information was gathered and assembled with the help of key informants.

The *organising factor* was identified as 'water point' because most troupes were located close to water points¹³. The water points were divided into small medium and large categories by key informants (with respect to the number of troupes using the water point at that time).

Troupe was identified as 'campement'; a group of pastoralists moving together. The average (mean) number of eligible children in each troupe was estimated to be seven, using information from key informants, local reports and observation. For the purpose of sampling, two neighbouring troupes were combined to form one PSU. The combined troupes would therefore include approximately 15 children. This was done to make the field work easier - it is more straightforward to locate two neighbouring troupes than two independently sampled troupes. The approach of combining troupes is valid statistically as long as the number of sampled PSUs is not less than about 25.

An *organogram* was constructed with the relative size of each water point with respect to the number of troupes that were using the water point at the time of the survey. The organogram was used to produce a sampling frame of troupe-pairs by water point and a systematic sample was taken to achieve the target sample size (Figure 3).

The target sample size was read off the appropriate nomogram assuming 10% prevalence, PSU size of 15 and a required precision of 3% (Figure 2). This gives the target sample size of 42 troupe-pairs. A margin of error should be added to this of 10-15% to allow for overestimation of troupe size. In the Kidal survey our target sample size was only 40 troupes (this was lower than recommended due to an error in reading the nomogram and not adding the 10-15% for margin of error).

On each day of the field assessment, information was collected from a group of pastoralists at each water point. A simple map was drawn of all the troupes using the water point and their locations. The target number of troupe-pairs was selected randomly using this map to locate them (Figure 4). Each selected troupe was visited and all eligible children measured. MUAC case definition was used along with oedema assessment (Global Acute Malnutrition MUAC ≤ 125 mm or oedema and Severe Acute Malnutrition MUAC < 110 mm or oedema). This made the measurements on children very rapid. The amount of time spent at each troupe was not greatly increased by the number of eligible children within each troupe. Most time was spent in travelling.

Data were computerised using an excel spreadsheet and analysed using purpose-written software (Figure 5).

No children were found with bipedal pitting oedema. The prevalence of global acute malnutrition by MUAC was 1.64% (95% CI 0.21-4.26%) and severe acute malnutrition 0.43% (95% CI 0.01-1.12%). All cases of malnutrition were recorded in children height 65-85cm (a proxy for age less than 24 months).

Validation of the method

Qualitative data were validated by comparing information collected through qualitative methods at the central location (Kidal town), from informants at the water points and observations from the field. This resulted in the following observations:

- Troupes were found within daily reach of water points and in locations predicted by key informants (within approximately 25 km of water points).
- Locations corresponded to the 'zones of occupation' available through local food security maps (Figure 6).
- Relative size of the water points (in terms of the number of troupes using each) corresponded well (Cohen's kappa test showed 'moderate inter-observer agreement'). For this test we compared information given by key informants in town and key informants at the water point.
- The mean number of eligible children found in each troupe was similar to the number predicted by key informants (7 predicted, 5.4 observed)

Quantitative data were validated by comparing the precision of the estimates obtained in the field-trial to precision predicted by computer-based simulation. The prevalence of wasting was low at the time of the survey, so to test the method, we varied case-defining MUAC cut-points to produce a series of testable prevalences. This resulted in the following observations:

- Precision of the estimate of wasting from the field test was very similar to the precision predicted by computer-based simulations: 3.7% (actual) vs. 3.4% (predicted) using MUAC cut-point of 135mm and testable prevalence of 9.9% wasting.
- Using different cut-points of MUAC to simulate different prevalences of wasting, the predicted and observed precision were strongly related over the entire range of prevalences between 5% and 50% (Figure 7).

Figure 3: Example of the sampling frame used for Pastoralist Survey Method in Kidal, Mali

Water Point	Relative Size	Assigned PSUs [†]	Cumulative PSUs	PSUs chosen [‡]	No of PSUs
Inthagarene	Small	5	5		0
Inkoufé	Small	5	10	6	1
Sendimane	Medium	10	20	15	1
Ebelel	Large	25	45	24, 33, 42	3
Taghararat	Medium	10	55	51	1
Ighoras	Medium	10	65	60	1
Intadeini	Medium	10	75	69	1
Tanainait	Medium	10	85	78	1
Igouzar	Large	25	110	87, 96, 10	3
Tintersen	Small	5	115	114	1
Tadaït	Small	5	120		0
Aghilhek	Small	5	125	123	1
Djounhan	Large	25	150	132, 141, 150	3
Djenchéché	Large	25	175	159, 168	2
Tindamane	Small	5	180	177	1
Takalot	Large	25	205	186, 195, 204	3
Koniba	Medium	10	215	213	1
Tafiliante	Medium	10	225	222	1
Inféléféfé	Small	5	230		0
Tassik	Large	25	255	231, 240, 249	3
Aghabo	Medium	10	265	258	1
Tinsinanane	Medium	10	275	267	1
Agharous Alkit	Large	25	300	276, 285, 294	3
Tahadjante	Large	25	325	303, 312, 321	3
Kanaye	Medium	10	335	330	1
Amassine	Large	25	360	339, 348, 357	3
Intibzaz	Large	25	385	366, 375, 384	3
TOTAL			385		43

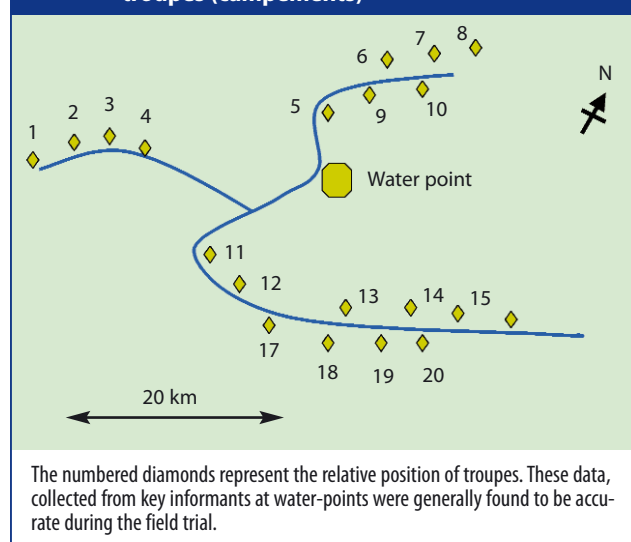
[†] Small water points were assigned 5 PSUs, medium water points were assigned 10 PSUs, large water points were assigned 25 PSUs based on information provided by key informants.

[‡] A sampling interval of 9 was used with an initial starting value taken at random from the range 1 to 9.

In this example the 'organising factor' was water-point and the 'troupe' was campement. 27 water points were identified and 385 campement-pairs (PSUs) assigned to the water points. Water points described as 'small' were assigned 5 pairs, 'medium' water points 10 and 'large' water points 25. These assignments were decided upon after qualitative data collection and were found to be reasonably accurate during the field trial.

The target sample size was 40 PSUs, hence the sampling interval 385/40, rounded down to 9. Random number chosen was 6. The systematic sampling method increased the sample to 43, and all 43 PSUs were included in the survey. The sample size of 40 was actually chosen in error. It should have been closer to 48 (see figure 2).

Figure 4: Example of a simple map drawn at each water point used to both enumerate and locate troupes (campements)



Discussion and Conclusions

The method is practical for use in pastoral populations; it is valid and is simple to apply. The quantitative data collection and data entry should present no difficulties for staff that are already familiar with cluster surveys. Many staff will be unfamiliar with collecting and analysing qualitative data and will require some training in the methods. Experienced staff may be needed during the early stages to advise on the choice of 'organising factor', for example. The delay between qualitative data and quantitative data collection needs to be as short as possible because seasonal changes and other movements of people affect the validity of the qualitative data.

The method could be used for any zone where population data are not well known in advance/ a population is moving, e.g. to escape conflict (although it may prove difficult to identify useful key informants to describe and locate 'communities' in such settings).

The method of sampling can be used for collecting information on many different variables in addition to malnutrition.

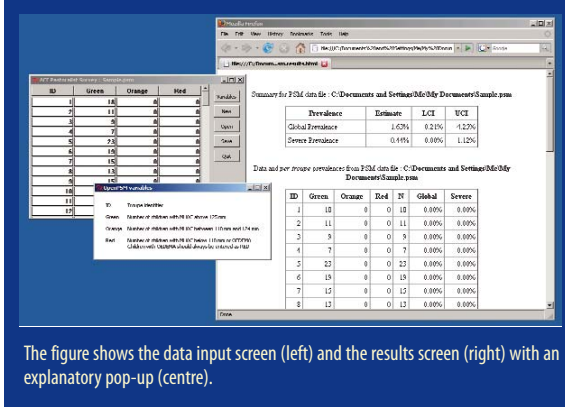
Good relations, both within the population and between the population and the agency carrying out the survey, are required because reliable information must be gathered from the people in the area to be surveyed. In situations of conflict or other social divisions, it may be difficult or impossible to get unbiased information. As a general principle, there should be no survey without the provision of services to the community.

The urban and rural areas both need to be included to allow for migrations between the two zones. Each requires different methods of sampling. During the harsh season, the children often move to urban areas where prevalence of malnutrition may be much higher than in the rural areas. This was shown in the previous survey in Kidal¹⁴.

Further testing is necessary, especially in different pastoralist settings, and readers are invited to communicate with ACF about further trials. A field manual is being developed to assist the future development of the method.

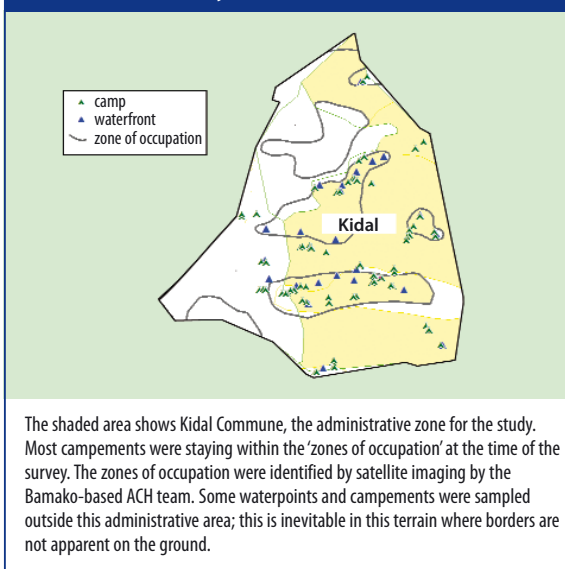
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 Myriam Ait Aissa,
 email: maitaissa@actioncontrelafaim.org

Figure 5: Custom built software for the Pastoral Survey Method (Open PSM)



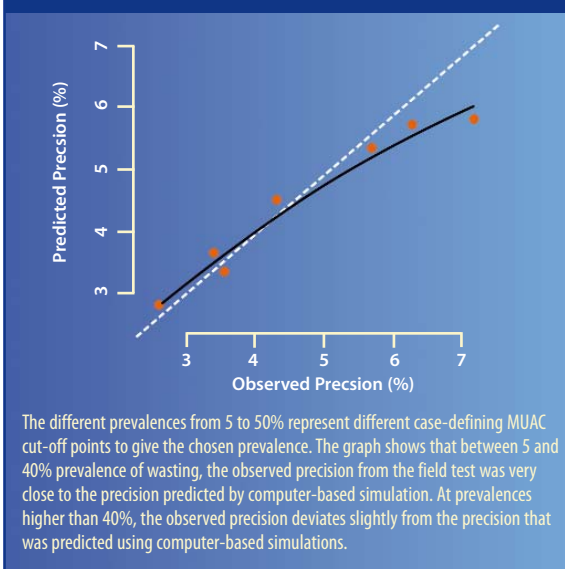
The figure shows the data input screen (left) and the results screen (right) with an explanatory pop-up (centre).

Figure 6: Waterpoints and campements selected for the survey in Kidal Commune, Kidal Cercle



The shaded area shows Kidal Commune, the administrative zone for the study. Most campements were staying within the 'zones of occupation' at the time of the survey. The zones of occupation were identified by satellite imaging by the Bamako-based ACH team. Some waterpoints and campements were sampled outside this administrative area; this is inevitable in this terrain where borders are not apparent on the ground.

Figure 7: Predicted and observed precisions of malnutrition from the initial simulation exercise (predicted) and the Kidal data (observed).



The different prevalences from 5 to 50% represent different case-defining MUAC cut-off points to give the chosen prevalence. The graph shows that between 5 and 40% prevalence of wasting, the observed precision from the field test was very close to the precision predicted by computer-based simulation. At prevalences higher than 40%, the observed precision deviates slightly from the precision that was predicted using computer-based simulations.



Seema Arora, Ethiopia, 2008

By Jeremy Shoham, ENN

After he left the White House, President Bill Clinton wanted the Clinton Foundation to focus on areas where he could make the most difference as a private citizen. President Clinton visited a number of national leaders from the developing world to ascertain views on priority areas for intervention that the Foundation might support. A prevailing view was that poverty alleviation strategies would be less effective for many countries without simultaneously addressing the supply and roll out of anti-retroviral (ARV) drugs for the treatment of HIV/AIDS. The Clinton Foundation therefore initially focused on strengthening the market for ARVs through working in parallel with both drug manufacturers and national treatment programmes. The Foundation's recent involvement in the procurement of Ready to Use Therapeutic Foods (RUTF) has since raised its profile with agencies working in the nutrition sector. The ENN therefore invited the Clinton Foundation to be the subject of this issue's agency profile slot.

Phone interviews were conducted with Rebecca Egan – clinical programme manager for the 'Nutrition Access Team' and Seema Arora – the market development manager for the team. Rebecca has spent a year and a half working with the Clinton Foundation's country teams on CMAM (community management of acute malnutrition) roll out, providing technical assistance and liaising closely with partners. Seema initially started work with the Foundation in the Drug Access Team but has been working on the Nutrition Access Team for approximately one year, focused on the supply-side. There are two other team members – Erika Wagner, the director based in London and Sam Mayer, a senior analyst based in New York. In addition, there are a number of Clinton Foundation staff working in the nutrition sector in countries where the Foundation is active. For example, there is a group dedicated to nutrition and CMAM implementation in Malawi.

Although the Clinton Foundation initially began work in the HIV/AIDS sector, the Foundation swiftly grew to include other global initiatives in areas like climate change, as well as more domestic focused work in small business development, problems of poor nutrition and childhood obesity, and sustainable growth initiatives based domestically and abroad. The objective of the Clinton



Anne Marie Mayer, Mali, 2008



OTP centre located in a rural region several hours outside Addis Ababa, Ethiopia, supported by the Clinton Foundation.



Name:	Clinton Foundation
Address:	55 West 125th Street, New York, NY 10027
Email address:	sarora@clintonfoundation.org
Website:	www.clintonfoundation.org
Founded:	1970
Director:	Anil Soni, CEO
No. of HQ staff	4
No of staff world-wide (40 countries):	1,100 staff and volunteers

Foundation HIV/AIDS Initiative (CHAI) is to increase access for HIV/AIDS care and treatment in the developing world through lowering prices for drugs, diagnostics and other commodities. When CHAI began in 2003, the ARV market was fragmented and suppliers were unable to take advantage of economies of scale and therefore, unable to lower the price of drugs. To address this, CHAI has worked to increase coordination between the demand and supply sides of the AIDS treatment market in order to catalyze significant price reductions for ARVs.

Because ARV access for children has historically lagged far behind that of adults, CHAI began to focus on paediatric HIV treatment with the launch of its Paediatric Initiative in 2005. This was effectively the entry point for CHAI's work in nutrition, as the relationship between HIV and severe acute malnutrition (SAM) is so pronounced in many developing countries. The Foundation quickly came to realise that there are many strong linkages between SAM and HIV, and that in addressing SAM the quality of care for HIV treatment could be significantly improved. CHAI was subsequently chosen by UNITAID (a donor organisation supported by many national governments and seated within the World Health Organisation (WHO)) to be an implementing partner for a large scale donation of paediatric commodities. At CHAI's request, RUTF was included in this donation with 25 countries eligible to receive it. Since the inception of the UNITAID programme, CHAI has become the third largest purchaser of RUTF globally (behind UNICEF and Medecins sans Frontieres).

CHAI has established memoranda of understanding (MOUs) with a number of governments to provide RUTF. Programme implementation support is offered via national governments in select countries where local partners are strong. CHAI-procured RUTF is used to treat SAM-affected children whether HIV positive or not. In countries where CHAI is offering programmatic support in addition to the donation of the product, this can include assistance with development of treatment protocols, offering forecasting and supply chain management support, supporting trainings and seconding staff, or clinical mentors for paediatric and CMAM facilities.

The significant growth seen in the past year in RUTF production capacity has reduced the supply-side bottlenecks associated with the scale up of CMAM programmes. In CHAI's

experience, the stumbling block is now on the programmatic side, with a lack of capacity to implement CMAM. CHAI has been working closely with UNICEF and governments to identify implementing partners for CMAM and has been strongly advocating to get more funding for CMAM implementation and roll out.

Another focus of CHAI's work in RUTF has been in looking at whether price reductions for RUTF are possible. CHAI has conducted significant analyses of supplier cost structures to determine if there are areas where costs can be cut. These analyses have revealed that in general, RUTF suppliers are operating with slim margins and there is minimal potential for price reduction if the RUTF formulation remains unchanged. To address this, CHAI is working to generate funds for research into alternative formulations involving industry partners. Other supply side initiatives are centred on addressing concerns of new regional and local suppliers. CHAI have worked to form a consortium for purchasing milk powder, thereby cutting out intermediaries and extra costs, and has also mapped out solutions to other commonly faced barriers to market entry. CHAI is optimistic that as new products and new suppliers enter the market, prices will come down to a level that governments can eventually afford so that programmes become domestically sustainable.

CHAI have endeavoured to strengthen government capacity to actually implement CMAM although with a growing evidence base of success in some countries, the political buy in is likely to increase demand and create sustainable resources and capacity for implementation. CHAI believe that decentralisation of CMAM to community level may be more challenging at this stage, but that with greater funding for HIV programming and home based care programmes, there is the potential for CMAM to piggy-back onto these existing programmes. This is already occurring in countries like Cameroon and Nigeria. Greater integration with Integrated Management of Childhood Illness (IMCI) will also help with decentralisation.

The Clinton Foundation obtains funds from a number of foundations, private donors, and governments. President Clinton is still very involved in fund-raising and is an excellent spokesperson for the Foundation. As UNITAD funding for RUTF winds down over the coming years, CHAI has been working with agencies like PEPFAR, the Global Fund and others to ensure a smooth transition of CHAI RUTF

procurements beyond the UNITAID programme. The Global Fund has begun to consider RUTF procurement in their grants, so funding for the commodity could become secure in the short-term. The Foundation is very aware of issues around RUTF supply sustainability and transition funding. For example, in Malawi where government is significantly decentralised and CMAM is being rolled out nationally, an agreement has been reached for each district to provide a certain percentage of resources for RUTF procurement. This percentage should increase each year by that percentage annually until most, if not all costs, are ultimately paid for by the districts.

Both Seema and Rebecca see CHAI as unique in that it works on both the demand and supply sides of commodity marketplaces. Although CHAI began its work in RUTF as a procurement body with little intention of being 'hands-on', it has had to roll up its sleeves and get involved in overseeing programme implementation in certain countries. This has necessitated forging strong relationships with government and often providing consultants and specialists seconded to government. CHAI has also supported government proposal writing to the Global Fund so that some programmes are now successfully funded.

When asked about major gaps and challenges in the nutrition sector from a Clinton Foundation perspective, Seema and Rebecca cited a number of areas. The lack of comprehensive care for SAM children leading to fractured programme implementation is a big worry. This is caused by lack of funding for key implementation components, with the problem most pronounced in development rather than emergency settings. They also expressed concern about high default rates in outpatient therapeutic programme and supplementary feeding centre facilities, especially in urban areas, as well as weak monitoring and evaluation of these phenomena. In connection with this they wondered about the appropriateness of SPHERE standards in some contexts and whether there may be a need to re-think these.

The Clinton Foundation has now grown into a global non-governmental organisation with 1,100 staff and volunteers in more than 40 countries. Its rapid expansion and diverse funding sources suggests that the Foundation will continue to grow in scope and engagement. It will be fascinating to see how the Foundation chooses to engage with the humanitarian community, as well as how big a player it becomes.



A child being weighed during the DRC survey.

D. Rizzi, DRC, 2008

GPS assisted coverage survey in DRC

By David Rizzi



David Rizzi graduated in Pharmacy and later took an MSc in Development at the Rome University La Sapienza, Italy. He holds a second MSc in Public Health Nutrition from the LSHTM in UK. He has been volunteering and working for NGOs in Tanzania, Palestine, Angola, Tchad, Burundi, Uganda and DRC, mainly focusing on nutrition survey and therapeutic feeding programmes in emergency contexts.

The author would like to thank Jean-Laurent Martin, GIS officer at OCHA in Goma for his valuable assistance with GPS and maps, and the ECHO office in Goma for their financial support. The author also acknowledges the COOPI field staff and the Binza's population for making this work possible.



A child being measured during a survey in DRC.

D. Rizzi, DRC, 2008

This article describes a modification of the centric systematic area sampling method using GPS, to overcome field constraints related to mapping and active case finding.

COOPI is an Italian non-governmental organisation (NGO) that has worked in the Democratic Republic of the Congo (DRC) since 1970. Its main sectors of intervention nowadays are health, nutrition, psychosocial care and water/sanitation. As a leading NGO in the nutrition sector in eastern DRC, COOPI was asked by the Ministry of Health and UNICEF to run a pilot phase of a Community-based Therapeutic Care (CTC) programme in Bunia (Ituri) and to provide technical assistance in the preparation of the national CTC protocol.

In late 2007, ECHO (European Commission Humanitarian Office) funded COOPI to provide nutritional care (or support) to Binza's population (over 100,000 people) in North Kivu province. The target population included many returnees who were subject to a high degree of insecurity, due to national army and rebel groups' dispute and conflict over the area. Displacements were frequent due to continuous attacks and pillaging by the warring factions. The intervention goals were to:

- Provide technical, logistic and financial assistance to a local NGO (BDOM¹) who was already running two therapeutic feeding centres (TFC) and ten SFC Supplementary Feeding Centres
- Set up a CTC programme to replace the classical centre-based approach. This would involve training of BDOM and provincial health personnel, rehabilitation of SFC tents, and establish Stabilisation Centres (SC) in two hospitals, transport of food and non-food items and supervision of activities until the programme was fully integrated into existing services.

By January 2009, the traditional inpatient therapeutic programmes have progressively been replaced by CTC programmes throughout the country. In 2008, the national CTC protocol had been validated by health authorities, international organisations and NGOs, and was awaiting final approval and publication. The COOPI CTC programme in Binza started in January 2008 and included two SC and ten SFC/OTP (Outpatient Therapeutic Programmes). All the health centres in the zone hosted a SFC/OTP providing good geographical coverage of the zone. After seven months, 652 severely malnourished children had been admitted (averaging 93 per month); the cure rate was above 90% and mortality less than 2%. An anthropometric and coverage survey was undertaken at this point to monitor the progress of malnutrition rates and programme coverage. The anthropometric survey showed a significant fall in most indicators of malnutrition (see Table 1) compared to the previous survey conducted in November 2007. However, it was not possible to infer that this was due to the COOPI intervention or the new CTC approach: seasonality effect, improvement in security, food aid and better crops were likely to have been at least partly responsible for this positive trend.

There were no baseline data available on coverage of the therapeutic feeding programme so that the CTC programme coverage survey was, to the best of our knowledge, the first assessment of this type in the whole province.

Coverage survey methodology and constraints

The coverage survey was undertaken in July 2008. The CSAS methodology (centric systematic area sampling), which is based on active case-finding, was used². The first step in the implementation of this methodology consisted of drawing or overlaying a grid on a map of the area under investigation. The communities closest to the centre of each square were then the first to be surveyed.

Constraint 1: Lack of a detailed map of villages

No detailed map of the health zone was available for Binza and recent population movement had resulted in many villages being abandoned. When this problem occurred in previous surveys, a 'blank' map had been given to all the field teams so that on the day of data collection, they could locate the village closest to the centre of the square by means of a landmark shown on the map, e.g. river, hills, villages, etc. This method proved to be very time consuming, inaccurate and ultimately, prone to bias; the teams would hurry through this first phase in order to maximise time for the data collection itself. Moreover, where maps didn't show any physical landmarks or no landmarks were present, the task proved even more difficult.

Constraint 2: Absentees at the time of measurement

In previous coverage surveys, another problem was that many children were absent when the team visited the household. Children under 5 years of age are usually taken to the field with their mothers early in the morning and come back at sunset. Where this occurred, an appointment, whenever possible, would be made and a second visit arranged to measure the absent children at a later stage.

Moreover, the active case-finding approach needs the assistance of carers, key informants and local authorities to identify suspected malnourished children and those children enrolled in a programme. However, when those people were contacted on the day of data collection, many complained about not having had sufficient notice to think about the children to include in the survey (and to inform them). This process further reduced the time that COOPI field teams had for data collection.

A new strategy

A two-phase modified methodology was therefore designed to address these problems. In the first phase, Global Positioning System (GPS) receivers were used to select the target villages and key informants were informed about the survey and asked to assist in case finding. In the second phase, the teams focused solely on anthropometric data collection.

Phase 1: GPS aided village selection and preliminary actions

The best map available was kindly provided by the Office for Coordination of Humanitarian Affairs (OCHA) office in Goma. A physical map with a 1:50,000 scale showing the main

¹ BDOM (Bureau de Développement des Oeuvres Médicales) is part of the CARITAS association.

² Myatt M, Teshome F, et al. (2005). A field trial of a survey method for estimating the coverage of selective feeding programmes. WHO Bulletin 2005; 83(1): 20-26.

³ Although doable on the field through simple calculation, free online tools are available for such conversion: <http://www.fcc.gov/mb/audio/bickel/DDDMSS-decimal.html> (accessed on January, 5 2009)

Table 1: Comparison of malnutrition indicators from November 2007 and July 2008 surveys

	Nov 2007	July 2008	Difference in %	p value*
Global acute malnutrition (z score <-2)	10.5% [7.9-13.0]	4.9 % [3.2 – 6.7]	- 53.3%	<0.0001
Moderate acute malnutrition (-3≤ & <-2 z score)	6.1% [4.2-7.9]	4.7 % [2.9- 6.5]	-23.0%	0.01
Severe acute malnutrition (<-3 z score)	4.4% [2.3-5.5]	0.2 % [0.0 – 0.5]	-95.5%	<0.0001
MUAC** <125 & ≥110mm	6.85% [4.0-9.6]	6.5% [4.9-8.1]	-5.1%	0.6
MUAC < 110mm	0.46% [0.29-2.21]	0.3% [0.0-0.7]	-34.8%	0.0001

*Calculated from the standard error of the differences **MUAC: Mid upper arm circumference

road and some large villages, it included longitude and latitude data also. An updated list of villages and populations of the intervention area was obtained at the Central Health Office of the Binza's Health Zone (*Bureau Central de la Zone de Santé*). The provincial doctor, nurses and community health workers were asked to position all the villages from the list onto the map. A provisional, partially hand-drawn, map was then available for the survey.

A grid was drawn on the map, and 23 out of 30 squares were selected on the basis of having at least 50% of their area in the health zone. The centre of each of these squares was found (tracing diagonals) and its latitude and longitude calculated from the data on the sidebars. This was subsequently recorded on four GPS receivers (again kindly provided by OCHA).



Any GPS receiver, including non-cartographic ones, can perform the tasks demanded for this survey. However, it is important to configure the devices so that they all have the same coordinate system as the map. Furthermore the longitude and latitude data from the map had to be converted from degrees/minutes/seconds into decimal degrees, as used by the GPS³.

At this point a first field visit with the following objectives was planned:

- Locating the waypoints recorded on the GPS (square's centre) and the closest village to that point.
- Inform the authorities and health workers of the villages about the survey.

Four teams (of two people each) were trained on GPS usage, people to contact and messages to convey. They were also given a list of villages within each square.

The GPS receivers were set on the 'go to' mode, which shows the direction and the distance to a given waypoint.

These activities largely ran smoothly. However there were some reported problems with estimating the GPS waypoint location when these were not reachable (due to thick

woods or being far from any road). In these cases, with the aid of local people, the team had to estimate the location and find the nearest village.

Once the village or community closest to the centre was identified, local authorities, health community workers and other key informants were met and informed about the objectives, sample and timetable of the survey. They were also asked to think about children to include, to establish a list with their names and to ask them to stay at home on the day of the data collection. These actions were repeated in the next nearest villages until five villages were visited within one square. Given the average size of the villages, the anticipated number of children to assess and the time available, we estimated that no more than five villages could be visited in one day. The time lag between the first visit to a village and the data collection was seven days, on average. Each team was able to work on two squares per day thereby visiting a maximum of ten villages.

The first-phase teams recorded the names of each village, their relative position within one square (1 being the nearest to the centre and 5 the last visited village) and the name of the most significant authority met. Coordinates of all visited villages were also recorded on GPS. It had been hoped that a more accurate map would be produced once the GPS coordinates of the villages had been handed over to OCHA and that a re-allocation of villages into the 23 squares based on the updated map would have been possible. However, due to technical problems with the large format printer, this was not possible and the provisional map was used until the end of the survey.

Phase 2: Data collection

In the second part of the fieldwork, the full survey team (20 people divided into five groups) visited the survey area. No GPS or maps were needed during this stage. Each team was handed the list of villages to visit in each square (until 3 p.m. or until the completion of the five villages) and the person to contact. The list of suspected malnourished or in-programme children was also given to them so that they could focus exclusively on data collection. As expected, the vast majority of the children's caretakers were aware of the survey and present.

Results

The coverage rates were worked out for both the OTPs and the SFPs. The results are set out in Table 2.

Given the relatively short duration of the CTC programme, and the upward trend in admissions at the OTP and SFP, we consider these results to be acceptable, although

Table 2: Point and period coverage

Programme	Coverage	%
OTP	Point	47%
	Period	72%
SFC	Point	36%
	Eriod	62%

improvement is possible. The rise in programme admission in spite of a lower prevalence of moderate and severe malnutrition (a 53% reduction since the last nutrition survey) is probably partly due to better coverage. Further investigation into programme coverage and anthropometric status of the population in 4-6 months time has been recommended, to achieve better understanding of programme performance and its evolution.

Conclusions

The two-phase coverage survey methodology, based on the CSAS procedure, was developed to get around the problem of lack of a detailed map of the area under investigation, as well as other constraints, e.g. lack of notice to key informants and population. This method facilitates identification of the villages to survey by means of GPS devices. Other advantages include less bias in village selection, a lower absentee rate, a reduced number of missed children (suspected malnourished children or in-programme who are not referred to the survey team), more time (and energy) available for the teams for the data collection. However, this methodology does require some additional resources, i.e. the first-phase necessitated eight people working for four days. A normal coverage survey on average involves 20 people working for 7-10 days for the entire data collection process. Other extra costs for the new method were only incurred for vehicles running costs, as GPS devices were borrowed from OCHA.

Although not achieved in this case due to technical problems, the use of GPS to record village coordinates at the time of the visit should allow the production of more detailed maps for future use and a more accurate calculation of coverage in each square.

For more information, contact: David Rizzi, email: david.rizzi@gmail.com





Participants at the Nutrition in Emergencies Training Workshop held in Nairobi in November 2008 (see news piece).

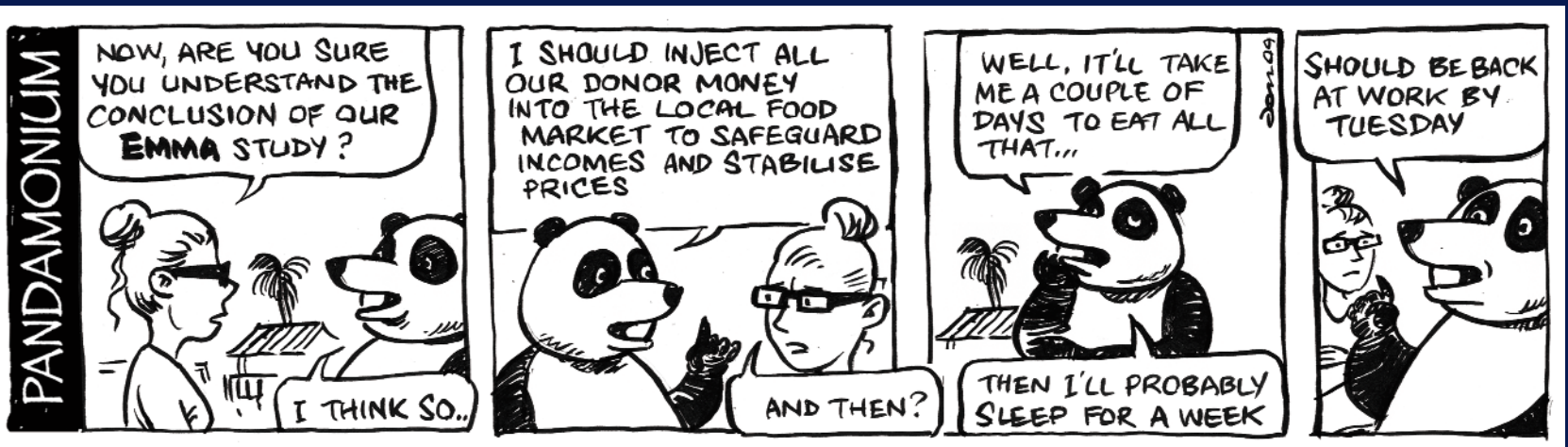
International Workshop on Improving Training in Nutrition in Emergencies

Organized by UN Inter-Agency Standing Committee Global Nutrition Cluster and NutritionWorks
6-7 November 2008, Safari Park Hotel
Nairobi, Kenya

People in aid



Two of the working groups at an IFE workshop in Sri Lanka (see news piece this issue).



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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.

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government staff and local NGOs who are under-represented in our coverage.

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 Paluku Bahwere
 Saskia de Pee
 Elizabeth Jordan-Bell
 Gwyneth Cotes
 Nutriset
 Susan Thurstans
 Anne Marie Mayer
 Feinstein Famine Centre

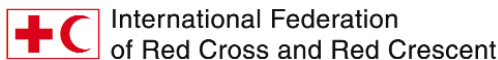
On the cover

Ethiopia's largest grain market, where some 300 traders rent stalls from the Addis Ababa city, WFP/Antonio Jaen, Ethiopia, 2008

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



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The Emergency Nutrition Network (ENN)

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

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

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

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

The Team



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



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



Diane Crocombe is Project and Finance Support Officer, based in Oxford.



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



Katherine Kaye has joined ENN as mailing administrator.



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



Phil Wilks (www.fruitysolutions.com) manages ENN's website.

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The Emergency Nutrition Network (ENN) is a registered charity in the UK (charity registration no: 1115156) and a company limited by guarantee and not having a share capital in the UK (company registration no: 4889844). Registered address: 32, Leopold Street, Oxford, OX4 1TW, UK. ENN Directors/Trustees: Marie McGrath, Jeremy Shoham, Bruce Laurence, Nigel Milway, Victoria Lack, Arabella Duffield



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