

HIGH-LEVEL
EXPERT
FORUM

ROME, 13-14 SEPTEMBER 2012

Nutrition in protracted crises: a reason to act, and an entry point for effective response

Prepared by Charlotte Dufour and Florence Egal, FAO Nutrition and Consumer Protection Division

The designations employed and the presentation of material in this paper do not imply the expression of any opinion whatsoever on the part of the Rome-based agencies (FAO, IFAD, WFP) or their governing bodies, or the CFS and its governing bodies concerning the legal or development status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The views expressed in this document are those of the author(s) and do not necessarily reflect the views of FAO, IFAD, WFP the CFS their governing bodies.

Introduction

During protracted crises, individuals and households are exposed to a complex web of shocks and compelled to adopt costly coping strategies that may harm their physical and mental well-being. This pattern is ultimately reflected in unacceptably high levels of malnutrition and, in particular, high levels of stunting, which is caused by prolonged and/or repeated exposure to severe food insecurity, inadequate access to basic services such as health and water, and inadequate care. This paper describes levels of both acute and chronic malnutrition that prevail in countries in protracted crisis. Drawing upon field examples – in particular Afghanistan, Somalia and the Sahel – it illustrates the causes and consequences of malnutrition in protracted crises, demonstrating how populations can be locked in a self-perpetuating vicious cycle of conflict, destitution and malnutrition. The paper also describes challenges that currently limit the nutritional impact and sustainability of emergency and development interventions, and demonstrates how a **“nutrition lens” can add value** in designing and implementing resilience-building programmes. It highlights current opportunities related to food and nutrition security that can be harnessed to further progress on both nutrition and resilience-building in protracted crises. The paper concludes by recommending ways to better address malnutrition in protracted crises.

1. Levels and consequences malnutrition in protracted crises: a silent emergency

High levels of child malnutrition are a common feature of humanitarian crises, whether they are short-term or protracted. Many countries and regions affected by protracted crises are home to persistently high rates of acute malnutrition, also known as wasting,¹ with seasonal hikes and/or drastic increases during episodes when the crisis worsens. For example, countries such as the Niger, Chad, Somalia, and South Sudan (Table 1) regularly experience rates of acute malnutrition that exceed 15 percent – the World Health Organization (WHO) threshold for a **“critical”** crisis (WHO, 2003) – with occasional peaks above 20 percent. This occurred in certain parts of the Niger in 2005 and 2010 (MSF, 2007, and Demographic and Health Survey data cited in IFAD, 2011) and in Somalia, where global acute malnutrition (GAM) rates ranged from 19 percent to up to 58 percent in southern parts of the country during the famine of 2011 (FSNAU, 2011a, 2011b; Box 1). In general, an analysis of acute malnutrition rates at subnational level also demonstrates that regions most affected by crises are also areas where rates of acute malnutrition are highest. In Somalia, for example, rates of acute malnutrition are usually much higher in southern Somalia than in other parts of the country (FSNAU, 2011b, 2012). While there are various factors causing this, the state of insecurity is clearly an important cause as it not only has a direct impact on the social context, **people’s livelihoods** and living conditions, but also limits agencies’ **ability** to provide basic services and emergency assistance.

¹ Wasting is indicated by low weight-for-height – extreme thinness – and is usually caused by an acute lack of food, disease or a combination of the two. Acute malnutrition can also manifest itself as kwashiorkor, an acute form of childhood protein-energy malnutrition that is characterized by bilateral oedema which starts at the legs and can expand to the entire body.

Table 1. Rates of acute malnutrition and chronic malnutrition in countries categorized as being in protracted crisis in *The State of Food Insecurity in the World 2010: Addressing food insecurity in protracted crises* (FAO, 2010).

Country	Global acute malnutrition (wasting)	Chronic malnutrition (stunting)	Source
Afghanistan	9	59	National Micronutrient Survey MoPH (2004), Tables 5.1–5.3.
Angola	8	29	National Nutrition Survey 2007, Table 5
Burundi	11	35	DHS 2010, Preliminary report, Table 11, p. 18
Central African Republic	12	43	MICS 2006, reanalysed by UNICEF HQ, Nov 2007
Chad	16	39	MICS 2010, Preliminary report, Table NU.1
Congo	8	30	DHS 2005, reanalysed by UNICEF HQ Jul 2008
Côte d'Ivoire	8	40	MICS 2006, reanalysed by UNICEF HQ, Nov 2007
DR Korea	5	32	MICS 2009, Final report, Table NU.1
DR Congo	9	43	MICS 2010, Final report, Table NU.1
Eritrea	15	44	DHS 2002, reanalysed by WHO Nov 2007
Ethiopia	12	51	DHS 2005, Final Report, reanalysed by UNICEF HQ Jul 2008
Guinea	8	40	MEFP/DNS/UNICEF/PAM. 2008 Enquête Nationale sur l'état nutritionnel et le suivi des indicateurs de Survie de l'Enfant (ENENSE), Table 6.10a
Haiti	10	29	DHS 2006, reanalysed by UNICEF HQ Jul 2008
Iraq	6	26	MICS 2006, reanalysed by UNICEF HQ Nov 2007
Kenya	7	35	DHS 2008–2009, Final report, Table 11.1, p. 143
Liberia	3	42	Food Security and Nutrition Survey 2010, Table 5.1, p. 81
Niger	16	47	National Nutrition Survey 2010 October, Tables 4, 10, Annex 10, pp. 20, 27,
Sierra Leone	10	36	DHS 2008, Final report, Table 11.1, p. 145
Somalia	13	42	MICS 2006, reanalysed by UNICEF HQ Nov 2007
Sudan	16	40	Sudan Household Health Survey 2006, reanalysed by UNICEF HQ Jul 2008
Tajikistan	7	39	LSMS 2007, Table 2.1, p. 13
Uganda	6	38	DHS 2006, Final report, Table 12.1, p. 155
Zimbabwe	3	32	DHS 2010–2011, Preliminary report, Table 11, p. 18

Source: UNICEF nutrition database (http://www.childinfo.org/undernutrition_nutritional_status.php).

Grainne Moloney (Food Security Nutrition Analysis Unit – Somalia)

The world's attention was drawn to Somalia in July 2011, when a famine was declared. The levels of acute malnutrition were the highest reported in decades, reaching a shocking 58 percent in parts of the country (FSNAU, 2011). The major factors contributing to the crisis were a severe shortage of local cereals as a result of drought, which caused hyperinflation, and the political environment, which restricted humanitarian access and funding. However, the lack of resilience of the population was the reason why famine broke out in Somalia and not in neighbouring Kenya and Ethiopia, where similar food security shocks had occurred.

As a result of the civil war, which has been running since 1991, and the subsequent failure of a political solution, the availability of basic services such as education, basic health care and clean water and sanitation is extremely limited. What is available is provided only through non-governmental organizations and UN agencies, where access permits. This has led to a steady increase in the underlying levels of acute malnutrition to an average of 16 percent when food security conditions are favourable (2010) and 25 percent when they are not (2011). Stunting levels range from 18 percent in pastoralists to 25 percent among internally displaced people, who are known for their increased exposure to morbidity due to overcrowding and lack of access to sanitation. Micronutrient deficiencies are widespread, with half of women and children being anaemic and over a third vitamin A deficient in 2009. Poor care practices are endemic, with the population relying on tradition for direction. For example, babies are fed sugared water for the first three days after birth, as tradition states that colostrum is toxic and must be discarded. Practices also vary between groups; for example, in riverine populations pregnant women and young children avoid nutritious foods such as eggs and liver because they believe these foods may have detrimental effects on development. Malnutrition also affects adults; over 20 percent of women are underweight (2009), with a large proportion restricting food intake during pregnancy to reduce the size of the baby they are carrying and hence increase the likelihood of an easier delivery.

Not all countries affected by protracted crises, however, are home to very high levels of acute malnutrition. In Afghanistan, rates of acute malnutrition have rarely exceeded 10 percent (**the WHO threshold for a “serious” crisis**) despite very high levels of food insecurity (Box 2). Furthermore, a review of nutritional data carried out by FAO for FAO (2010) suggests that rates of acute malnutrition are not – on average – significantly higher in countries affected by protracted crisis. This can be explained by differences in the types and scale of crises, in causes of malnutrition and in the coping strategies households put in place (see section 2).

Box 2. Focus on Afghanistan

Charlotte Dufour

Considering the high levels of food insecurity in the country, rates of acute malnutrition in Afghanistan are relatively low at around 3 to 10 percent, depending on the season and region or population group. Rates of chronic malnutrition, however, are extremely high, ranging from 45 percent to 60 percent amongst some populations, and micronutrient deficiencies are widespread (MoPH/UNICEF, 2003; MoPH, 2004).

A major cause of malnutrition is household food insecurity, which manifests itself particularly in poor dietary diversity. Food insecurity is the consequence of strong seasonality in food production and access (roads are closed during the long winter in many parts of Afghanistan), erratic rainfall, deteriorated natural resources and, increasingly, by fluctuations in global food prices as a result of **the country's reliance on** imported wheat and imports.

Another important cause of malnutrition is poor sanitation, as indicated by the fact that acute malnutrition trends mirror seasonal incidence of diarrhoeal disease (Dufour and Borrel, 2007). Incidence of acute malnutrition is particularly high amongst infants less than 6 months old – a surprising finding as infants are usually protected by breastfeeding. An unusually large number of Afghan women report having low breastmilk production. This may be the result of **women's** low psychosocial well-being and the impact the war and restricted movement had on their mental health (Bizouerne, 2009).

Nutritionists have often wondered why low wasting rates could occur simultaneously with such high levels of food insecurity. Livelihoods studies showed that families put in place very costly coping strategies. For example, during the severe drought of 1999–2002, some fathers put up their daughters as collateral for their debts (Lautze et al., 2002). Years later, a local non-governmental organization was providing psychological support to fathers traumatized by guilt. Furthermore, the impact of that drought (and others that followed) has a political impact today: informants suggest that the resulting loss of livelihoods is one of factors that drive destitute youth to join the Taliban.

Regions affected by protracted crises are, however, characterized by particularly high rates of chronic malnutrition, also known as stunting.² Only 3 of 23 countries listed in Table 1 have stunting rates of less than 30 percent. The review of nutritional data carried out for FAO (2010) found that average rates of chronic malnutrition were significantly higher in countries affected by protracted crisis than in other countries (40.2 percent vs 35.1 percent).³ Afghanistan, for example, which has what can be considered relatively low rates of acute malnutrition given the prolonged state of conflict and repeated occurrence of natural shocks (droughts, floods, locusts etc.) has the highest average rate of stunting in the world (59 percent). Ethiopia and Niger follow with stunting rates at 51 percent and 47 percent, respectively. Furthermore, national averages cited in Table 1 mask strong variations at subnational level; rates of chronic malnutrition are often significantly higher in regions that are most exposed to protracted crises than in those that are not. For example, in Uganda stunting rates in the Karamajo region, the part of the country most affected by conflict, are estimated at 54 percent, compared with a national average of 38 percent (FANTA-2, 2010). These data are consistent with the literature on the impact of conflict on child nutrition, which consistently shows that children affected by conflict suffer long-term damage to their nutritional and health status situations (Justino, 2012).

A particular cause for concern are situations where rates of chronic malnutrition are regularly increasing, such as the Niger, where stunting rates have been on the rise in the

² Stunting is indicated by low height-for-age and is caused by low food intakes over a prolonged period of time and/or regular episodes of low food intake and/or disease, which affects child growth.

³ See FAO (2010), Table 3

last 20 years: 27 percent of children under five were stunted in 1992, 41 percent in 1998, 45 percent in 2006 and 51 percent in 2011 (DHS and National Statistics Institute data cited in IFAD, 2011). Such trends point to fundamental structural problems that trap populations in a state of constant precariousness (see section 2), and help explain why emergency situations that cause alarming increases in acute malnutrition regularly arise in those populations (e.g. the Niger and Somalia).

In many ways, stunting represents a silent emergency. It has received much less attention, in terms of programme response and funding allocations, than acute malnutrition, the management of which is a central part of most humanitarian responses. Stunting has severe consequences on the development of individuals, their children⁴ and entire societies. Stunting is associated with increased risk of mortality, increased vulnerability to disease (including non-communicable diseases, such as diabetes and heart disease, which are a growing scourge even in poor populations), lower ability to learn, lower productivity and increased workload caused by households having to care for sick family members. Several studies looking at the short- and long-term impacts of conflict and malnutrition found that children affected by conflicts are at higher risk of malnutrition and disease than those that are not, and that “adults that were affected by violence in their childhood (and are alive today) are likely to be shorter, less educated and earn less than comparable individuals that did not **experience violence in early ages**” (Justino, 2012).

At the societal level, malnutrition (in all its forms) results in significant costs to the local economy through its impact on health and productivity. Studies in developing countries show that malnutrition can cost between up to 11.4 percent **of a country's** gross domestic product (ECLAC/WFP, 2007; World Bank, 2006), but no studies have been identified that carried out similar analyses specifically for protracted crises. This is probably because such studies require extensive data on numerous variables, and this is seldom available in crisis situations.⁵ However, given the scale, severity and length of exposure to malnutrition in protracted crises, it is evident that poor nutrition fundamentally undermines individuals and households capacity to cope and their resilience to future shocks (Box 1). Furthermore, the direct consequences of malnutrition (ill health, low productivity) can exacerbate problems of income inequality and thus fuel social tensions and conflict. Populations affected by protracted crises are often locked in a vicious cycle of conflict, destitution and malnutrition. Thus, good nutrition should not only be a core objective of aid programmes designed to build resilience of crisis-affected populations, but it is also a necessary input for their success.

2. The causes of malnutrition in protracted crises: the story behind the statistics

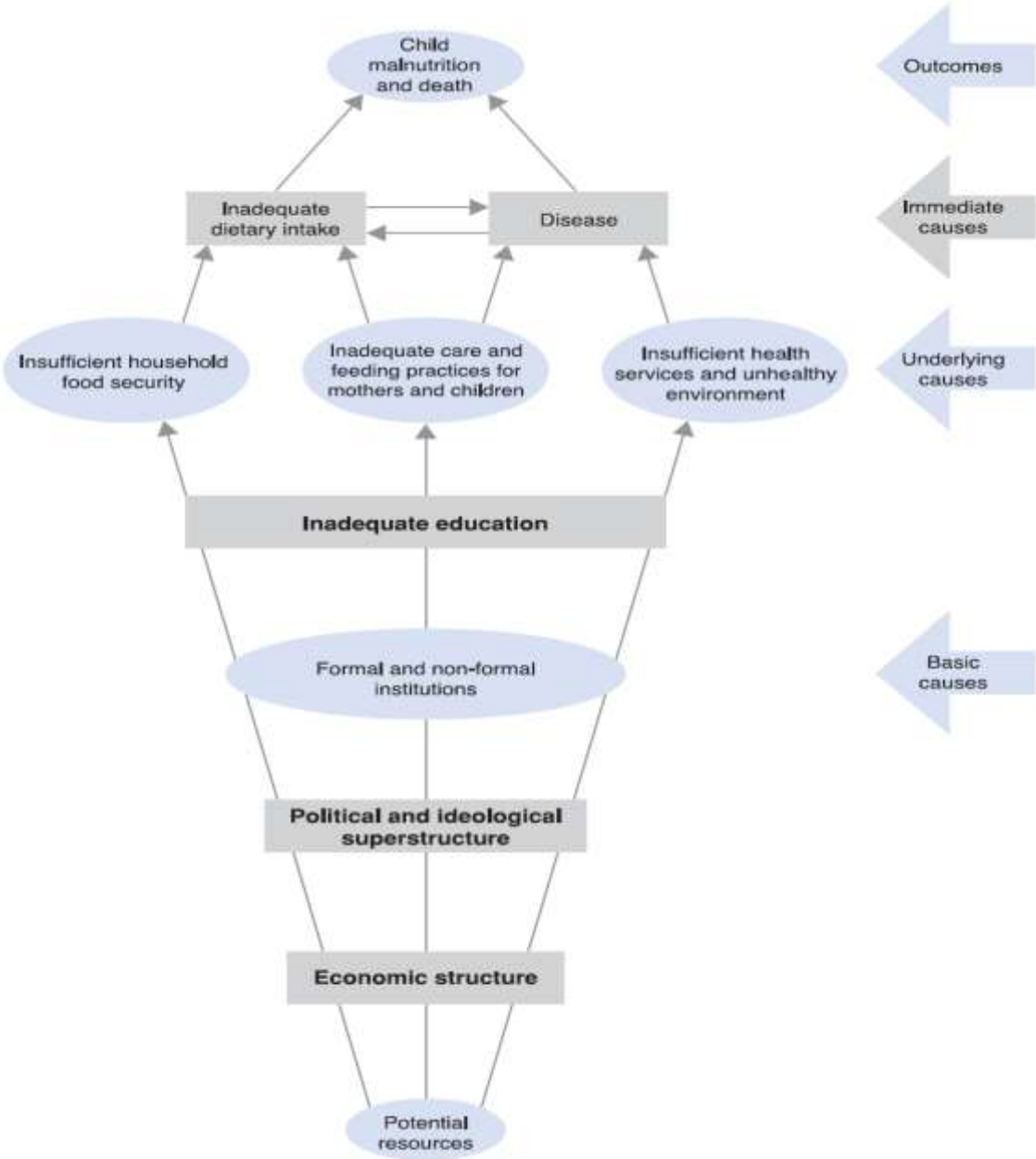
The persistence of high levels of both acute and chronic malnutrition makes it a requirement to tackle the causes, based on a clear understanding of the patterns and underlying factors that generate malnutrition.

⁴ Stunted, malnourished mothers are at greater risk to giving birth to low-birthweight babies who are in turn at greater risk of being stunted.

⁵ The African Union Commission and Economic Commission for Africa have recently launched a Cost of Hunger study, with the support of WFP. It will be conducted in 12 African countries (Botswana, Burkina Faso, Cameroon, Egypt, Ethiopia, Ghana, Kenya, Malawi, Mauritania, Rwanda, Swaziland and Uganda).

The generic causes of malnutrition in protracted crises are similar those in other contexts, and are typically categorized according to immediate causes (disease and inadequate dietary intake), underlying causes (household food insecurity, inadequate care and insufficient health services/unhealthy environment) and basic causes (education, political, economic and social institutions and structures and potential resources), as illustrated in Figure 1. This framework illustrates the multisectoral nature of malnutrition and highlights the features of malnutrition that make it useful indicator of whether there is a crisis and how severe it is. Malnutrition is a sign that something is wrong in that household and in the surrounding system, and an invitation to find out what is wrong. The answer will vary according to the context and therefore requires a local analysis of the various factors presented in Figure 1.

Figure 1. A conceptual framework of malnutrition.



Source: Adapted from UNICEF Framework of Underlying Causes of Malnutrition and Mortality

In protracted crises, the factors that cause malnutrition are exacerbated and accentuated (FAO, 1996; FAO, 2005;). Crises, especially when they involve conflict, negatively impact on **peoples' lives and livelihoods** in a variety of ways, including loss of household members, loss of assets, forced migration and changes in the local and national political and social institutions (social networks, markets, government services etc.) (Justino, 2012). Household food security is undermined: productive activities are disrupted, food stores are destroyed or looted, livestock are stolen, killed or die, people lose access to land (through natural degradation, landmines, asset depletion and/or migration), access to markets is reduced and prices increase, and better-off families are required to share scarce resources with displaced relatives and orphans. Reduced access to food, which can be combined with reduced access to water and fuel for cooking, results in changes in feeding practices, food preparation and food allocation within households. **Families' health is also put at risk**, as people may be forced to live in unhealthy surroundings and overcrowded shelters and/or health services may no longer be available or used. Caring practices are undermined, as families are separated and adults are traumatized or too busy trying to cope with the crisis to provide support to spouses or offspring (Egal, 2006)

Under both short-term and protracted crisis, households resort to coping strategies to mitigate and manage the impact of the crisis, and simply to survive. The most immediate coping strategy is usually to change the composition of meals (reducing intake of more expensive foods, such as meat, fruit and vegetables), to reduce the number of meals, and for some individuals within the household (often women) to reduce their intake to allow others to maintain their intakes. These strategies have a direct impact on individuals' nutritional status even before it can be detected by anthropometric measurements⁶. Other common strategies include migration of some members of the household in search of work, followed by the sale of assets. Some coping strategies lead to irreversible changes in **households' livelihoods (e.g. sale of land and migration to an urban area)**, while others put **individuals' safety and dignity at direct risk (e.g. sex trade, begging, sale of blood or organs)**. For these reasons, **some believe that "the term 'coping' may be inaccurate or imply an optimistic view. Even when coping strategies are effective in preserving vital assets, the costs of coping to those affected are great and can lead to a deterioration in people's health status and functional impairment" (FAO, 2005).**

In protracted crises, impaired nutritional status is thus not only a result of the repeated and/or prolonged exposure to shocks, but also of the impact of coping strategies that are put in place by households. For example, in the Sahel region of Chad a common coping strategy adopted by households as a reaction to the recurrence of drought and lack of income opportunities is for men to migrate to neighbouring countries in search of employment. Many women are left alone to raise children, tend to livestock, cultivate fields, collect firewood etc., which puts a severe strain on their own health and affects their capacity to care for their children (ACF/Valid, 2009). Also, coping strategies usually evolve over time : coping strategies adopted in the early stages of a crisis usually have less adverse effects and are more reversible. If crises are prolonged or become more severe, households may rely on increasingly costly and irreversible coping strategies, which can undermine their resilience and contribute to making a crisis protracted. For example, families who have depleted their productive assets commonly migrate to cities and

⁶ For example, a deterioration of micronutrient status or loss of weight that is insufficient to be classified below the cut-off point for moderate or severe acute malnutrition.

become reliant on petty jobs and purchased foods, becoming more vulnerable to increasing food prices and loss of diet quality (Groupe URD, 2011).

Gender issues, and in particular **women's workload** and mental health, play a central role in determining incidence and levels of malnutrition, but are often overlooked, especially in protracted crises. For example, women working in fields may not have the time to breastfeed as often as would be ideal or to prepare and present the small, energy dense and frequent meals young children need; if no child care facilities are available or no other arrangements are possible, children may end up staying in the fields with their mothers, exposed to heat and with insufficient food and water, or be left at home with young siblings (FAO, 2005; MSF, 2007, p. 14; **authors' observations in several countries**). The latter is one of the reasons why child malnutrition rates can be high in areas of good food production, and why some well-intended food security programmes targeted at women (e.g. cash for work, women's vegetable gardens) risk contributing to increased child under-nutrition **by reducing women's available time for care.**⁷ Finally, **gender roles and women's status** in societies also have a big impact on child care and nutrition (Box 2).

Another factor contributing to malnutrition that is often overlooked is the need for fuel to cook, boil water and heat homes. There are several impact pathways linking fuelwood and nutrition. First, the lack of fuelwood can make cooking impossible and thus affect the quantity and safety of foods consumed and the ability to boil water (for sterilization). Second, women often spend considerable time collecting fuelwood, which can impact on child care and increase exposure to gender-based violence (ACF/Valid International, 2009). Finally, the collection of fuelwood can contribute to the degradation of natural resources, which can affect local food production capacity such as through soil erosion and the deterioration of pastures (Gibert, 2009). The effects of these phenomena are particularly serious where there are high concentrations of people, such as around refugee camps, and are thus common in protracted crises.

It is apparent from the discussion above that the causes of malnutrition are multiple, complex (i.e. they often operate in synergy) and structural. The examples provided in Boxes 1, 2, and 3, illustrate how, while there are general similarities in the causes of malnutrition, the specific pattern in which these factors operate and interact varies according to the context, and in particular between livelihoods groups, making livelihoods assessments absolutely central to understanding who is malnourished and why. It is also important to analyse seasonal patterns, and identify correlations with other factors (e.g. relation between malnutrition rates and disease trends and/or food availability trends).

The combinations of factors described above explain the significantly higher prevalence of stunting that is observed in protracted crises. Furthermore, a vicious cycle links stunting with acute malnutrition, disease and death: a stunted child is more likely to become ill, which in turn puts him or her at risk of acute malnutrition, further illness and, ultimately, death. This explains why famine – such as that seen in the Horn of Africa in 2011 – and extreme food insecurity – as witnessed in the Sahel in 2011/12 – is much more likely to occur in countries affected by protracted crises than in those affected by only intermittent crises. Poor nutrition is thus both a consequence and an indirect cause of protracted crises.

⁷ No publications have been identified that document this phenomenon but the authors and several practitioners working on food security programmes have observed such cases occurring. Several scientific publications demonstrate **the impact of women's workload** on their nutritional status and that of their children, albeit not specifically in the case of protracted crises (e.g. Ilahi, 2000; Jones et al., 2012), which suggests that programmes that increase **women's workload** risk having a negative impact on maternal and child nutrition if no appropriate child-care facilities are available.

Box 3. Focus on the Sahel

Nanthilde Kamara (food and nutrition security expert)

During the last decade, the Sahelian countries have been facing extremely high rates of malnutrition: around 1.5 million children less than five years of age in these countries suffer from moderate or severe acute malnutrition (GAM) and 600,000 children under five die of acute malnutrition every year. The risk of malnutrition is highest during **the “hunger gap” between June and September** when people have exhausted their cereal stocks and market prices for food are high. However, recent nutritional surveys show that GAM prevalence are high even at harvest time.

The major causes of child malnutrition are multiple and primarily structural in nature. The main ones include low dietary diversity and inappropriate feeding practices in the first two years of life, poor maternal and childcare practices, particularly during pregnancy and lactation, lack of access to education for women and the low decision-making power of women. Feeding practices vary greatly across countries and regions, influenced by **people’s** beliefs, traditions and taboos. High morbidity levels resulting especially from diarrhoea and malaria, poor access to health services and lack of safe drinking water contribute strongly to malnutrition. Research in the Niger has shown that malnutrition is closely linked to poverty (Save the Children, 2009). Families lack the financial resources to afford nutrition-rich food items, and mothers lack time for child care due to other competing obligations (e.g. preparing meals, fetching water and collecting wood).

The combination of desertification, the steady erosion of natural resources, climate change and more-frequent drought cycles with the high fluctuation in staple food prices and regional market dynamics contribute to recurring nutritional crises in the Sahel. The local population is using more severe coping strategies such as rationing food, increasing household debt, migrating to urban areas or selling of livestock. Their livelihoods are thrown into jeopardy and their resilience to shocks has been sharply reduced. Pastoralists are particularly vulnerable to these cyclical crises and face high rates of livestock mortality, depleting their herds.

From a security perspective, some analysts see the recent events in Mali as exemplifying a link between chronic food insecurity and political instability, creating a perfect storm in this volatile region.

3. The challenges of addressing malnutrition in protracted crises

Despite decades of experience, lessons learnt and laudable improvements in the management of acute malnutrition, malnutrition rates (both chronic and acute) remain unacceptably high and organizations (both governmental and non-governmental) working in protracted crises still face considerable challenges in effectively reducing and preventing malnutrition. While this is largely because of the immense difficulty of dealing with large-scale natural disasters, climate change, and insecurity in contexts where local governance structures are profoundly disrupted, some challenges are inherent to the way the aid system is organized, in particular the lack of integration between health and food security responses.

Nutrition interventions in protracted crises have tended to focus on the treatment of acute malnutrition, with insufficient attention to prevention of malnutrition. Health-based emergency nutrition interventions usually concentrate on treating individuals, while limited attention is paid to the family and community context within which these individuals live. Children may be treated but once the treatment is finished they are once **more exposed to the consequences of their family’s food insecurity and poor sanitary conditions**. Conversely, food security interventions (food aid, food or cash for work,

agriculture support) tend to focus on the community and household levels, with limited attention to intrahousehold dynamics. The interventions may improve families' access to food, but if their young children are not breastfed and provided with the appropriate complementary food, or if they are sick, rates of child malnutrition will not go down. Clearly, programmes need to address symptoms and causes and meet the needs of communities, household and individuals. The result of this lack of integration is a loss of effectiveness and sustainability for the response as a whole. This state of affairs is common also in non-crisis situations also, but is exacerbated in protracted crises where most interventions are short term and implemented through sector-specific delivery channels, as opposed to a more holistic local development approach.

One set of challenges which contributes to parallel planning relates to how information systems are designed, and the fact that nutritional surveys are often conducted independently of food security and livelihoods studies. Several methodological issues explain this state of affairs:

- Different sampling frames and methods: samples for nutritional surveys tend to follow administrative borders to ease health service delivery planning, while sampling according to livelihoods or agro-ecological zones is more appropriate for food security assessments.
- Different timeframes: food security surveys may be timed to match the expected harvest time, for example, while it may make more sense to conduct a nutritional survey during the hunger gap or in line with seasonal disease patterns.
- Logistical difficulties of implementing comprehensive, multidisciplinary surveys.
- Difficulty of measuring household food access and dietary intakes, key elements that link livelihoods and food security analyses to nutritional outcomes (FAO, 2011a), and lack of consensus on the data collection methods to be used.

These factors make it difficult to analyse food and nutrition security problems holistically and encourages the continuation of the existing tendency to plan nutrition, food security and livelihoods programmes in isolation of each other. Organizations working in these fields undertake numerous efforts to improve the integration of nutrition and food security information systems through joint surveys (e.g. FSNAU joint food security and nutrition assessments), adjustments in sampling frames⁸ and the roll-out of the Integrated Food Security Phase Classification (IPC – a method for combining various sources of food and nutrition security data to determine the degree of severity of a crisis; see www.ipcinfo.org⁹), but progress is slow and further support is required.

Another challenge that limits the integration of food and nutrition security interventions concerns the structure of aid organizations and coordination mechanisms, which tend to emphasize separations between sectors. The establishment of the cluster system (see <http://oneresponse.info/Coordination/ClusterApproach/Pages/Cluster%20Approach.aspx>) has certainly facilitated greater coordination between agencies operating on similar interventions, but the separation between nutrition, food security, health and water and sanitation clusters has not facilitated dialogue between agencies that work on the management of acute malnutrition and those addressing underlying causes. These

⁸ For example, the WFP Vulnerability Assessment and Mapping unit is increasingly designing the methodology of Comprehensive Food Security and Vulnerability Assessments so as to allow analysis of food security indicators according to administrative borders and livelihoods areas, such as in Sierra Leone in 2010.

⁹ The IPC itself does not, however, resolve the issue of different sampling frames and surveys timings; the IPC analysis is made more difficult by the lack of harmonisation in sampling and timings of surveys.

distinctions even operate within organizations, and it is not unusual that nutritionists have limited interactions with their agronomist and economist colleagues. Efforts are underway to strengthen integration between the nutrition and food security clusters at both country and global levels;¹⁰ they need to be pursued and strengthened.

The aid architecture has also entrenched the **distinction between “emergency” and “development”** interventions. Despite years of discussions on Linking relief, rehabilitation and development (LRRD), and more recently on disaster risk management (DRM) (which addresses certain aspects of LRRD), there is still a tendency to prioritize quick impact interventions that address symptoms of acute malnutrition but neglect underlying causes in situations that are labelled as **“emergencies” by the international community**. It is common for agencies to consider that the prevention of stunting, for instance, is a **“development intervention”** and cannot be the objective of an emergency programme. Meanwhile, development programmes often neglect the management of food and nutrition security problems faced by chronically vulnerable populations¹¹ and pay insufficient attention to preventing crises and being prepared for them. These problems are compounded by the lack of evidence on how to prevent stunting in both development and emergency contexts, and the limited capacity to scale up interventions that are known to work.

Practitioners on the ground are aware of these limitations, especially since the number of masters programmes, diplomas and training courses on crisis situations has increased considerably in the last 10 years, thereby contributing to greater awareness and improved skill sets. But practitioners face numerous challenges in putting this knowledge in practice. **The separation between “emergency” and “development”** funding streams remains a major constraint. Appropriate planning and implementation requires both sound planning and rapid response. But funding for crisis situations is often limited to a maximum of 12 months. Teams on the ground are so busy preparing proposals and donor reports and rushing to purchase basic inputs that they have little time to work on sustainable approaches and improving the quality of programmes. Short funding terms also contribute to rapid staff turnover and limited resource allocation to capitalisation of experience, which leads to a loss of institutional memory. Aid agencies also need to adapt their organizational structures and build flexibility in their processes and programmes in a way that facilitates integration and enables staff to apply the training they have acquired. And finally, further investments in training are needed, especially in-service training, to **enable aid agencies to be “learning organisations” that adapt to dynamic and changing situations**.

There is a large body of research which addresses the challenges aid organisations face in crisis situations and new concepts and frameworks related to aid responses regularly emerge. While the production of new bodies of knowledge and concepts is essential to improve the quality of programmes, there is a need to communicate them more effectively to practitioners to facilitate their application by aid agencies. Concepts, frameworks and approaches such as LRRD, livelihoods, DRM and now resilience are all related, complementary and provide different ways of looking at protracted crises and tools for responding to them, but if the complementarities are not made clear there is a risk of

¹⁰ Discussions were held on this topic at the Global Nutrition Cluster meeting in Geneva in July 2012. A representative of the nutrition cluster attends the Global Food Security Cluster meetings and vice versa. Furthermore, various initiatives are undertaken at country level to ensure optimal communication between both clusters.

¹¹ For example, efforts have been underway for over a decade to integrate the management of acute malnutrition as part of regular health services, but acute malnutrition often still receives more attention **in crisis situations than in “development” situations**

creating confusion amongst field staff and losing efficiency in planning and training. For example, in the early 2000s significant investments were made in designing livelihoods programmes and developing manuals and implementing training on livelihoods approaches in the wake of growing interest in the LRRD. It took time for practitioners to adopt these concepts and find ways to operationalize them. Yet before genuine progress had been achieved, lessons learnt and capitalized upon and weaknesses corrected, a new paradigm emerged (DRM) leading to another wave of planning, design and implementation of training modules. **And in recent months, the term “resilience” has been** receiving growing attention. While the concepts are distinct, their operationalization requires very similar approaches at field level; if this is not made clear, there is a risk of confusion, double planning and ultimately inefficient use of resources. Some practitioners have expressed weariness with **changing “flavours of the month”** or what could be called **“concept turnover”**.¹² The current work on resilience is essential as it aims to improve the effectiveness and sustainability of responses in protracted crises, but genuine commitment from all stakeholders is required to ensure it is not a mere repackaging of existing concepts and that it leads to measurable improvements in the way programmes are designed and implemented.

Finally, there is still a lack of field practitioners with a broad understanding of food and nutrition security. Food and nutrition security is a broad topic, covering many disciplines (economics, agronomy, social sciences, public health, ecology etc.) and therefore requires multidisciplinary teams. Such teams can be strengthened by the presence of nutritionists who have a good understanding of both the health determinants of malnutrition and food security and social issues, thereby facilitating interdisciplinary linkages. Some institutions, such as Tufts University, have promoted the **“public nutrition approach” in complex** emergencies (Young et al., 2004), but few training institutions provide nutritionists with a multi-disciplinary set of skills, and it remains difficult to find nutritionists who have training and experience in holistic food and nutrition security programming.

4. Opportunities to better address nutrition in protracted crises

The description of the causes of malnutrition in protracted crises and challenges in addressing them may convey the message that effectively addressing nutrition in such situations is close to impossible. Though the issue is complex, it is not complicated, and a nutrition lens provides simple ways of addressing complexity, even in protracted crises. Furthermore, several opportunities can be seized to advocate for greater investments in both nutrition and responses to protracted crises.

Nutrition as an effective entry point for resilience planning and response analysis

As a multisectoral issue, nutrition is not a sector *per se*, but a common goal that can bridge **the various sectors, including health, agriculture, education, social affairs, women’s affairs** and rural development. A very practical way of developing an integrated food and nutrition security programme is to conduct a participatory causal analysis of malnutrition at the local level. One simple method entails organizing a participatory planning workshop, bringing together professionals from the various sectors working in a given area, and building malnutrition problem trees and solution trees for different livelihoods

¹² These remarks reflect the author’s opinion and observations gathered through over 12 years of working in protracted crises.

groups. As participants identify and organize causes of malnutrition, and then solutions, they identify how their respective interventions contribute to a common goal and where synergies can be enhanced; they identify gaps and agree on priorities. By the end of the exercise, participants share a common understanding of the food and nutrition security situation, the issue of nutrition is demystified and a common framework for action has been developed. It is a practical tool for livelihoods analysis that complements well the use of the sustainable livelihoods framework. This methodology has already been used successfully in a variety of contexts, including Afghanistan, Burundi, the Democratic Republic of the Congo, Rwanda and Somalia (FAO, 2011b).¹³

Understanding why people are malnourished also requires looking at seasonal and historical trends, and addressing malnutrition entails using locally-adapted sets of interventions and adapting/upscaling good practices that tackle both the symptoms and causes of malnutrition. This approach remains the same at all stage of the emergency cycle and nutrition can therefore bridge the artificial gap between emergencies and development (Egal, 2006). Participatory analysis of the causes of malnutrition, combined with a livelihoods approach and trends analyses, is a powerful tool for both response analysis and resilience planning, which are both receiving increased interest amongst aid organizations (including donors).

The growing interest in, and use of, the IPC represents a further opportunity for addressing malnutrition and resilience in protracted crises as it provides a framework for conducting better-integrated analyses of the food and nutrition security situation. This is particularly the case now that the IPC is also introducing a scale for chronic food insecurity. The combined analysis of chronic and acute food insecurity could be instrumental in facilitating joint analyses that support immediate- and longer-term planning. Since the IPC is a tool for compiling information, however, its use also requires strengthening local food and nutrition security information systems.

Finally, nutrition is a practical entry point for addressing gender issues, especially when they are culturally sensitive as is the case in many countries affected by protracted crises. This is because women play a key role in food production, preservation, preparation and utilization, as well as child care and family health. In Afghanistan, for example, community-level projects working on household food security and nutrition were an effective way of reaching women. Elders and husbands understood the benefits for their families if their wives and daughters received nutrition education and support to implement home gardens, raise poultry and process foods for home consumption and/or income generation, complemented by literacy courses. **These activities helped improve women's status within their households and strengthen their decision-making power, which in turn had benefits for the family's nutritional situation** (FAO, 2009). For example, some women participating in integrated local development projects reported that it was easier for them to introduce behavioural changes such as exclusive breastfeeding in their family since they were earning an income.¹⁴

¹³ FAO (2011b), *Joint planning for nutrition, food security and livelihoods*, provides a step by step methodology for running these workshops and examples of how the method was used in various countries.

¹⁴ **Observations from authors' field experience in Afghanistan.**

Growing investments in social protection in protracted crises

Over recent years there has been growing attention to the use of cash transfers as part of emergency responses, which has recently resulted in increased interest, and even commitment, to large-scale social protection programmes targeted to chronically-poor **populations, such as Ethiopia's Productive Safety Net** programme. The global food and financial crises, slow progress towards the achievement of Millennium Development Goal 1 and the persistence of protracted crises have underscored the need to protect the most vulnerable. Social protection systems are increasingly considered to be essential pillars for reconstruction, bridging the divide between humanitarian and development interventions by building human capital, alleviating market failures and fostering pro-poor growth, thereby addressing multiple dimensions of poverty. The introduction of social transfers as a way to combat malnutrition and other aspects of household poverty in protracted crises is relatively new and several impact studies are underway, but there is already a body of evidence from developing countries (Bangladesh, Brazil, Mexico and South Africa) showing that social transfers have positive impacts on child stunting and other nutritional outcomes (Save the Children, 2012). Increased investments in social protection schemes in protracted crises should be encouraged as they are likely to help families both prevent and manage malnutrition.

Unprecedented political momentum on nutrition: an opportunity to harness

Until recently, lack of political commitment was major constraint to addressing malnutrition in all contexts. But since the 2008 food crisis, political attention on food security, and now food and nutrition security, has greatly increased at global, regional and national levels, as illustrated by increased stakeholder engagement around the reformed Committee for Food Security, the G8 New Alliance for Food Security and Nutrition, the work of the New Partnership for Africa's Development on mainstreaming nutrition in the Comprehensive Africa Agriculture Development Programme (CAADP), and the growing number of countries that are joining the Scaling Up Nutrition (SUN) movement. Many of these countries are supported by the UN through the REACH (Renewed Efforts Against Child Hunger) partnership and UN joint programmes on food and nutrition security. Strengthening multisectoral coordination is indeed a core component of this momentum, and partners are increasingly focusing on joint planning at decentralized levels.

This political commitment and interest is not only present in development contexts, but also in countries categorized as being in "protracted crises". Ethiopia and Haiti are already members of the SUN movement, for example, and countries such as Afghanistan, Burundi and South Sudan are demonstrating commitment to nutrition and could join soon. Furthermore, advocacy for mainstreaming food and nutrition security in development programmes, such as CAADP, are very supportive of the resilience agenda. Indeed, **strengthening households' food and nutrition security is essential for them to be able to better face and manage crises.**

There is thus an opportunity to harness the political momentum on nutrition to advocate for greater attention to protracted crises, and vice versa. It is important to address these topics together as they go hand in hand at the field level, and addressing them separately could give a perception of overloading political agendas with a variety of issues, when they are actually closely related.

5. Conclusion: fighting malnutrition as a key to resilience-building in protracted crises

Fighting malnutrition is key to resilience-building because well-nourished individuals are healthier, can work harder, and have greater physical reserves, which enables them to better manage shocks as they arise. Furthermore, addressing malnutrition in a comprehensive way (addressing both symptoms and causes) entails working on the same factors of vulnerability that need to be addressed to strengthen crisis-affected populations' resilience.

The following recommendations are proposed as ways to better address malnutrition in **protracted crises and help strengthen populations' resilience** to shocks.

- Interventions addressing malnutrition in protracted crises should not be limited to the management of acute malnutrition, but be accompanied by greater investments in addressing underlying causes, in particular feeding of infants and young children, household food security and water and sanitation.
- Current efforts to strengthen the integration of emergency and development operations (particularly funding streams) between sectors and between assessments and response need to be continued and strengthened.
- Similarly, current efforts to implement better- integrated food and nutrition security assessments should be pursued and scaled up. Data on food consumption should be collected more systematically as part of assessment and monitoring and evaluation systems.
- Field workers, and in particular programme planners, need to be trained in basic concepts of food and nutrition security, including how to conduct participatory causal analyses of malnutrition at the local level. (This approach is key to bridging short-term and long-term approaches, bridging sectors and strengthening the link between assessments and planning.)
- The current work on resilience should clearly build on the body of knowledge and experience with livelihoods approaches, food and nutrition security analysis and DRM. It should be made clear that these approaches are complementary to avoid double planning and confusion at field level and amongst policy-makers.
- Investments should be increased in long-term social protection programmes in protracted crises, targeted at families vulnerable to food and nutrition insecurity.
- Greater attention should be paid to the prevention and preparation for crises in development planning, such as poverty reduction strategies and the CAADP. The current political momentum on food and nutrition security, illustrated by the growing adherence to the SUN movement, represents an opportunity to be harnessed.

In conclusion, protecting and improving nutrition in protracted crises is about helping vulnerable families fulfil their right to food, health and care in a sustainable way. It requires bringing together professionals from various sectors, and combining short-, medium- and long-term work. A focus on nutrition is an invitation to adopt a people-centred and pro-poor approach to response analysis and planning in protracted crises, and is essential to **support households' resilience to shocks**. Fighting malnutrition is key to breaking the cycle of protracted crises that have locked populations in destitution for decades.

References

- ACF/Valid International. 2009. *Evaluation socio-anthropologique pour l'amélioration des programmes nutritionnels*.
- Bizouerne, C. 2009. *Insuffisance en lait maternel et souffrances psychologiques en Afghanistan*. Bordeaux, France, Université Victor Ségalen Bordeaux 2. (PhD thesis)
- Dufour, C. and Borrel, A. 2005. "Towards a public nutrition response in Afghanistan: evolutions in nutritional assessment and response", in Pain, A. and Sutton, J. *Reconstructing Agriculture in Afghanistan*.
- ECLAC/WFP, 2008. *The cost of hunger: Social and economic impact of child undernutrition in Central America and the Dominican Republic*. Santiago de Chile, Economic Commission for Latin America and the Caribbean.
- Egal, F. 2006. Nutrition in conflict situations. *British Journal of Nutrition*, 96(Suppl. 1): S17–S19.
- FANTA-2. 2010. *The analysis of the nutrition situation in Uganda*. Washington, DC, Food and Nutrition Technical Assistance II Project (FANTA-2). Available at: www.fantaproject.org/downloads/pdfs/Uganda_NSA_May2010.pdf. Accessed 28 August 2012.
- FAO. 1996. *Study on the impact of armed conflicts on the nutritional situation of children*. Rome. Available at: <http://www.fao.org/docrep/005/w2357e/W2357E00.htm>. Accessed 28 August 2012.
- FAO. 2005. *Protecting and promoting good nutrition in crisis and recovery*. Rome. Available at: <http://www.fao.org/docrep/008/y5815e/y5815e00.htm>. Accessed 28 August 2012.
- FAO. 2009. **Fact sheet on "Success stories on improved food security, nutrition and livelihoods in Afghanistan"**.
- FAO. 2010. *The State of Food Insecurity in the World 2010: Addressing food insecurity in protracted crises*. Rome.
- FAO. 2011a. *Guidelines for measuring dietary diversity*. Rome.
- FAO. 2011b. *Joint planning for nutrition, food security and livelihoods*. Rome. Available at: www.fao.org/fileadmin/user_upload/wa_workshop/docs/Joint_Planning_for_Nutrition_FAO_May2011.pdf. Accessed 28 August 2012.
- FSNAU, 2011a. *Nutrition analysis. Post Gu 2011*. Technical Series Report No VI. 41. Nairobi, Food Security and Nutrition Analysis Unit – Somalia. Available at: <http://www.fsnau.org/downloads/FSNAU-Nutrition-Technical-Series-Report-Post-Gu-2011-Analysis.pdf>. Accessed 27 August 2012.
- FSNAU. 2011b. *Nutrition update, May–June 2011*. Nairobi, Food Security and Nutrition Analysis Unit – Somalia. Available at: <http://www.fsnau.org/downloads/FSNAU-Nutrition-Update-May-June-2011.pdf>. Accessed 27 August 2012.
- FSNAU. 2012. *Nutrition update, May–June 2012*. Nairobi, Food Security and Nutrition Analysis Unit – Somalia. Available at: <http://www.fsnau.org/downloads/Nutrition-Update-May-June-2012.pdf>. Accessed 27 August 2012.
- Gibert, F. 2009. *Gestion des ressources naturelles et impacts environnementaux des programs humanitaires à l'Est du Tchad*. Rapport technique. Plaisians, France, Groupe URD. Available at: http://www.urd.org/IMG/pdf/Rapport_Gestion_des_RN_Tchad_2011.pdf. Accessed 28 August 2012.
- Groupe URD, 2011. *Gestion des crises en zone urbaine: sécurité alimentaire et nutritionnelle et liens urbains–ruraux* (web page). <http://www.urd.org/Gestion-des-crisis-en-zone-urbaine>.
- IFAD. 2011. **Document de travail sur l'amélioration de la sécurité alimentaire et nutritionnelle pour la mission de conception du Program d'Appui à la Sécurité Alimentaire et au Développement Economique et au Développement dans la région de Maradi (PASADEM)** (author : Adrienne Daudet)
- Ilahi, N. 2000. *The intra-household allocation of time and tasks: what have we learnt from the empirical literature? Policy Research Report on Gender and Development, Working Paper Series No. 13*. Washington, DC, World Bank. Available at: siteresources.worldbank.org/INTGENDER/Resources/wp13.pdf. Accessed 28 August 2012.
- Jones, A.D., Agudo, Y.C., Galway, L., Bentley, J. & Pinstup-Andersen, P. 2012. Heavy agricultural workloads and low crop diversity are strong barriers to improving child feeding practices in the Bolivian Andes. *Social Science & Medicine*. Available online 25 July 2012. DOI: <http://dx.doi.org/10.1016/j.socscimed.2012.06.025>.
- Justino, P. 2012. *Contribution to FAO High Level Expert Forum on Food Insecurity in Protracted Crises on the question "What can governments, aid agencies and donors learn from the steps taken by crisis-affected individuals, households, communities and institutions to cope and build their own resilience in the context of protracted crises?"*
- Lautze, S, Stites, E., Nojumi, N. & Najimi, F. 2002. *Qaht-e-Pool "A cash famine" – food insecurity in Afghanistan 1999–2002*. London, Overseas Development Institute. Available at: <http://reliefweb.int/sites/reliefweb.int/files/resources/04FA28AB5FDFCE5DC1256BE6004D79D1-odi-afg-21jun.pdf>. Accessed 28 August 2012.

- MEFP/DNS/UNICEF/PAM. 2008. *Enquête nationale sur l'état nutritionnel et le suivi des principaux indicateurs de survie de l'enfant, rapport provisoire*. Conakry, Ministère de l'Economie et du Plan (MEFP), Direction Nationale de la Statistique (DNS), UNICEF et Programme Alimentaire Mondial (PAM).
- MoPH/UNICEF, 2003. Database of nutritional surveys.
- MoPH. 2004. *National micronutrient survey*. Kabul, Ministry of Public Health.
- MSF España. 2007. *Le traitement de la malnutrition, et après ? Eléments de causalité, perception du traitement et insécurité alimentaire Bouza et Madaoua, région de Tahoua, Niger*. Barcelona, España, Médicos Sin Fronteras.
- Save the Children. 2009. *Understanding household economy in rural Niger*. London, Save the Children. Available at: http://www.savethechildren.org.uk/sites/default/files/docs/Understanding_HE_in_Rural_Niger_low_res_comp_1.pdf. Accessed 28 August 2012.
- Save the Children. 2012. *A chance to grow: how social protection can tackle child nutrition and promote economic opportunities*. London, Save the Children. Available at: <http://www.savethechildren.org.uk/resources/online-library/chance-grow>. Accessed 28 August 2012.
- WHO. 2003. *The management of nutrition in major emergencies*. Geneva, World Health Organization. Available at: <http://whqlibdoc.who.int/publications/2000/9241545208.pdf>. Accessed 28 August 2012.
- World Bank, 2006. *Repositioning nutrition as central to development. A strategy for large-scale action*. Washington, DC, World Bank. Available at: <http://siteresources.worldbank.org/NUTRITION/Resources/281846-1131636806329/NutritionStrategy.pdf>. Accessed 28 August 2012.
- Young, H., Borrel, A., Holland, D. & Salama, P. 2004. Public nutrition in complex emergencies., *The Lancet*, 364(Issue 9448): 1899–1909.