Sharing Ready-to-Use Foods at Household and Community Levels

STRATEGIES FOR SUSTAINABLE BEHAVIOUR CHANGE

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IN THIS CAPSULE

The most commonly heard argument among western public opinions about aid and development efforts could be synthesized as: *"Aid is not given to those that are entitled to receive it; it is not effective and we don't have money to waste".* A study from the Institute of Development Studies about the UK's public's perception towards aid and development[1] corroborated this allegation, showing that 52% of the people interviewed during that study thought that UK's aid to developing countries was wasted. The problem with food aid diversion has been widely covered by media[2], often presented as a large scale and multi-facetted problem, which mainly finds its source in diversion by opponent armies, general corruption (Bailey, 2010; Migiro, 2012), or logistical gaps. While addressing food aid diversion effectively is important to preserve public opinions and donors' confidence in humanitarian action, it even represents, from an ethical and especially human rights viewpoint, a critical duty towards the beneficiaries.

Most widely used RUF products at the current time: Nutributter®, Plumpy'Nut®, Plumpy' Sup® and Plumpy'Doz® (source: Nutriset)

This document focuses on one particular and smaller scale aspect of food aid diversion, which is not so well documented, yet seriously affects nutrition programs' effectiveness and credibility as well: the sharing of food aid and particularly Ready-to-Use Food (RUF) - products that are given to specific target groups because of their extreme vulnerability- at household and community levels.

[1] In **What Does the Public Think, Know and Do about Aid and Development? Results and Analysis from the UK Public Opinion Monitor,** Johanna Lindstrom and Spencer Henson, October 2011. available at http://www.ids.ac.uk/idspublication/what-does-the-public-think-know-and-do-about-aid-and-development (last accessed: April 19, 2013)

[2] A quick web search on "humanitarian food aid diversion" with 3 different web search engine gave an average 700,000 results. One can also note that approximately 50% of the 10 first web-pages were dedicated to food diversion in 2 countries: Somalia and North Korea. Bailey (2010) also cites two articles from the NY Times among which one mentioned a UN report accusing WFP staff and partners of corruption. We can also cite Migiro's article (2012) on food aid diversion in Kenya last March from the Thompson Reuters foundation: http://www.trust.org/item/?map=food-aid-graft-worsened-kenya-drought-impact-report (last accessed: April 19, 2013).

List of acronyms

ACF	Action contre la faim
BBB (model)	"Beliefs, Break-down, Begin now"
BCC	Behaviour change communication
CHW	Community health worker
CMAM	Community-based management of acute malnutrition
CSB	Corn Soya Blend
CTC	Community-based therapeutic care
GFD	General Food distribution
MAM	Moderate acute malnutrition
MT	Metric ton
NICE	National institute for health and care excellence
OTP	Out-patient therapeutic centre
RUF	Ready-to-use food
RUSF	Ready-to-use supplementary food
RUTF	Ready-to-use therapeutic food
SAM	Severe acute malnutrition
SFP	Supplementary feeding program
TFP	Therapeutic feeding program
UNHCR	United Nations High Commissioner for the Refugees
UNICEF	United Nations Children (Emergency)* Fund
WFP	World Food Program
WHO	World Health Organization

* While remaining in the acronym, the term "Emergency" was removed

Box 1: Some concepts and definitions:

Community: Taylor and Seaman (2004) define a community as *"a group of households that are, to a greater or lesser extent, economically interdependent, e.g. a village. It would, for example, typically exclude a refugee camp, at least in the early stages of its existence."* Here however, because Chad eastern refugee camps have been existing since 2003 and are composed with ethnicities that share the same features in terms of feeding habits (Magen, 2012), we will consider them as a community as well.

Household: While there is no universal definition of a household, we will use Taylor and Seaman's operational definition (2004) that is, *"a group of individuals, usually related, who form an economic unit. At the extremes, a household might be a single individual or one hundred or more»* (Taylor, Seaman, 2004).

Inclusion error: "The proportion of individuals accessing the food who are not eligible to receive it" (Taylor, Seaman, 2004).

RUF (Ready-to-Use Food): "energy-dense, lipid-based pastes that do not require refrigeration or preparation, designed to treat and prevent malnutrition in the developing world" (Ickes, 2010).

RUSF (Ready-to-Use Supplementary Food): RUF initially used in the treatment of moderate acute malnutrition. RUSF are now being more and more used in prevention of malnutrition too. The three main RUSF currently in use are Plumpy 'Sup®, Plumpy' Doz® and Nutributter®.

RUTF (Ready-to-Use Therapeutic Food): RUF used in the treatment of severe acute malnutrition, like Plumpy' Nut®.

Why food aid and particularly Ready-to-Use Food?

If food aid costs are extremely high, those generated by the use of special nutrition products like and Ready-to-Use Food (RUF), given to specific target groups, are even higher *(cf. Table 1 and Figure 1)*. However, because these products are intended for more vulnerable groups, their availability and proper use are critical to restore these groups' nutritional and general health status that are in general, already affected and may be irreversible if they receive no treatment.

Cost category	Therapeutic Feeding Centre		Community-based Therapeutic	
	Mean cost per child ($)	Percent	Mean cost per child ($)	Percent
All personnel salaries	122.36	46.59	37.1	28.85
Capital depreciation and utilities*	50.47	19.22	17.92	13.94
Medicines	2.51	0.96	1.92	1.49
RUTF/Milk-based formula	42.93	16.35	55.53	43.19
Caretakers' food	11.64	4.43	0.15	0.12
Non-food item supplies	23.25	8.85	13.77	10.71
Other supplies	9.46	3.60	2.18	1.70
Total institutional costs	**262.62**	**100.00**	**128.58**	**100.00**

*Here utilities include vehicle fuel and operation, electricity, maintenance, etc.

Table 1: Institutional costs for an in-patient and community-based therapeutic program in Shebedino Woreda, Sidama Zone, Ethiopia, March 2007. (Source: Tekeste et al., 2012). *This table illustrates the costs generated for the treatment of one severely malnourished child. The in-patient therapeutic feeding centre uses a milk-based formula to treat children, while the community-based therapeutic facility uses a RUTF. Although the overall cost of a child's treatment in the in-patient therapeutic is more than twice higher than in the community based structure, the milk-based formula, which represents nearly 16% of the overall treatment cost, is cheaper than the RUTF used in the community-based centre, which represents approximately 43% of the treatment cost.*

Why sharing?

As mentioned previously, whilst large-scale food aid diversion aspects are often documented, even in the general media, this is not the case of sharing, which from personal and other field workers' observations, poses serious issues to consider in our general program strategy. The short literature review in p4 will show how information is still missing on this aspect of food diversion; indeed, we found only one work totally dedicated to the study of sharing (Mendalazi, Guerrero, 2008), and in the very specific context of Dinka society. In addition, from past field experience, sharing in general often appeared as a deep cultural identity trait in many communities, and while it may pose several issues in terms of nutrition programming, it is also a social value that strongly binds people from the same household or community together.

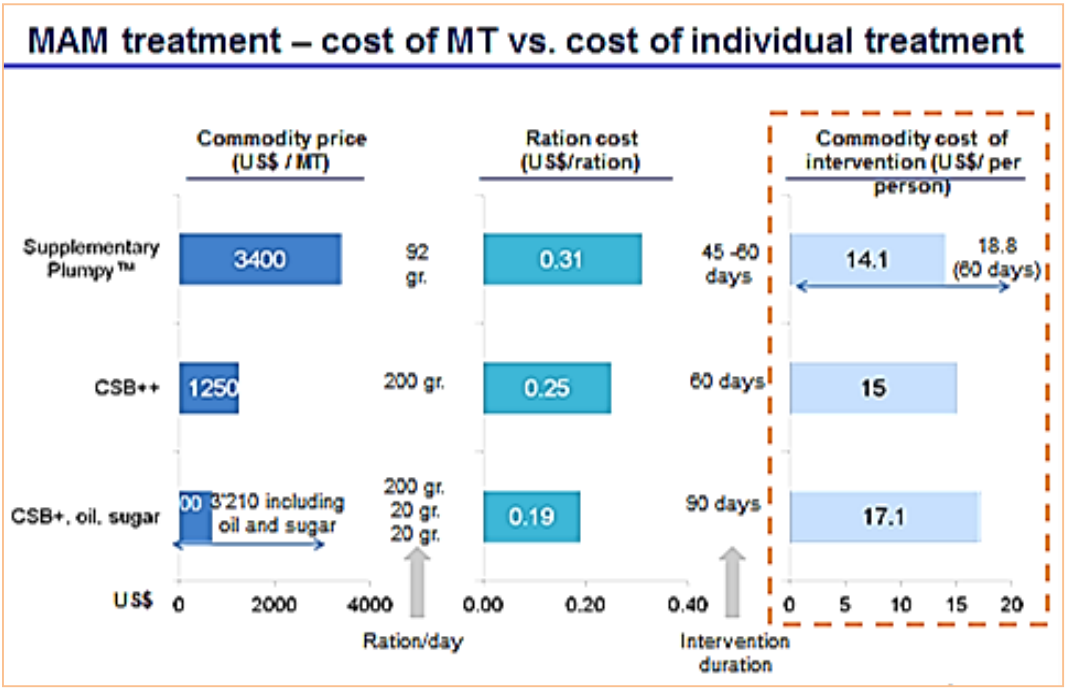


Figure 1: Comparison of moderate acute malnutrition nutritional treatment costs related to a RUSF vs. CSB++ and CSB+/sugar/oil rations. (Source: WFP presentation, Budapest, October 2012). *The diagram in the middle shows the cost of the ration needed to treat one individual. Here, a 92g ration of Supplementary Plumpy (now called Plumpy' Sup) costs $ 0.31USD, while a CSB+* ration to treat the same person costs $0.25USD, and a CSB+/oil/sugar* ration costs $0.19 USD. The diagram on the left presents the same information in metric tons (MT). It is interesting to note thanks to the third diagram that when calculated based on a number of average days of treatment needed for one person, the CSB ++ and CSB+/sugar/oil rations become slightly more expensive than the Supplementary Plumpy. However, given that these projections are very sensitive to the number of treatment days needed, the real cost effectiveness of a RUF treatment strongly relies on the child's adherence and his length of stay in the program.*

*CSB (Corn Soya Blend), CSB +, and CSB++: Family of fortified blended foods used in WFP food assistance operations. CSB, the original formula, was improved with a new vitamin and mineral premix in order to better match micronutrient requirements and called CSB+. Another formula, more adapted to young moderately malnourished children is also in use under the name of CSB++. More detail available in the joint WFP/UNHCR guidelines for selective feeding in emergencies (2011).

This work…

… is… say, a "thinking aloud capsule", an opportunity of sharing available knowledge on the topic and thinking together with the reader about several dimensions of RUF sharing practices. We will also try to open a way forward that could inspire other fieldworkers as well as those persons who may be in charge of programming and defining intervention strategies at a higher level. While this work will try as much as possible to use theoretical and empirical evidence, it does not have the ambition of being purely scientific. However, through a short literature review and the share of one

field experience, we will try to determine:

- *Where we stand in terms of knowledge on RUF sharing practices (Part 1: What do we know?)*
- *What a field experience can teach us (Part 2: The experience of Treguine refugee camp, Eastern Chad), and*
- *What could be the way forward (Part 3: What's next? The way forward)*

What do we know? A short literature review

Although we informally hear about it almost every day in the field, ***knowledge is missing*** about the factors involved in low consumption of RUF (Ickes et al., 2012), and by derivation, sharing.

> *"An obvious question in this area is "how much of the supplement has actually been consumed by those for whom it was intended?" In this regard the phenomena of sharing and substitution are now well-recognized. It is interesting to note how programs have addressed (or ignored) this issue." WHO, 1997*

In general, RUF sharing is quickly mentioned as a limitation of studies' findings on effectiveness (Manary et al., 2004; Flax et al. 2008, Huygbrets et al., 2012, among several others) or cost-effectiveness (Tekeste et al., 2012) of RUSF and RUTF. A possible reason is that exploring sharing in-depth poses many methodological challenges that will be explored further. Moreover, if the use of RUTF is now recommended by WHO in the treatment of severe acute malnutrition (WHO, 2007; Dewey, Arimond, 2012), research teams are currently very busy at learning and documenting the effectiveness of lipid-based nutrients used as RUSF (Dewey, Arimond, 2012). Thus, we suspect that priority is given to this critical aspect of acute malnutrition management.

Nevertheless, four studies (Cohuet et al., 2010; Phuka et al., 2011; Ickes et al., 2012; Wang et al., 2012), gave a substantial place to sharing patterns in broader investigations on use and acceptability of RUF and feeding practices. Ickes et al.'s article (2012) was based on a two years older dissertation on the assessment of supplemental feeding with a locally-produced RUF in Western Uganda. This dissertation provides further detail on the program, especially on the education strategy and the instruments used. Similarly, Cohuet et al. (2011) produced a full report on the intra-household use and acceptability of RUSF distributed in Niger before publishing their article two years later. This leads us to the idea that the study of sharing is seen, at least by these authors as part of a broader frame of investigation. Some less academic but still interesting research initiatives have been taken; for instance, Mendalazi and Guerrero's field article (2008) on food sharing practices in the Dinka that, although very specific and not limited to RUFs, is very helpful at understanding the relationships between a cultural value, its weigh in the overall way of functioning in a society, and its implications in terms of humanitarian programming.

An anthropological assessment on the causes of malnutrition in Chad refugee camps (Magen, 2012), was also very useful to understand the importance of beliefs and representations around RUF products in order to assess the risk of sharing (and selling, although this dimension will not be covered here).

We will try here to summarize the most useful findings of these works and others that despite not being specific to RUFs bring relevant issues, especially on targeting[3] to light. In parallel, because this capsule does not need to meet formal academic formatting requirements, we will take the opportunity to forge links between authors' investigations and the programmatic perspectives they can open.

Women in a food line, Eastern Chad (Source: Managan, A.)

[3] Targeting can be defined as *"directing a particular type or quantity of food, to a defined population group"* (Taylor, Seaman, 2004)

The extent of sharing

➲ *Has critical programmatic implications*

The key problem that arises because of sharing, is that RUF consumption taken below protocol compromises the child's nutrient intake (Maleta et al., 2004; Flax et al., 2010; Ickes et al., 2012). As a result, compromising this intake may have serious consequences in terms of recovery and/or prevention for the child.

In terms of programming, efficiency and effectiveness are also affected in that as showed in Table 1 and Figure 1 p2 and 3, program costs are very sensitive to the number of days of treatment or supplementation: the longer the treatment or supplementation, the heavier the burden. While the use of RUF in preventing/treating malnutrition aimed to decrease this burden, sharing, by affecting the average length of stay in programs among others, may not help to decrease costs but on the contrary, strongly contribute to increase pressure on treatment structures and overwhelm them.

Two main questions impose themselves when assessing the extent of sharing: *what amount of product is actually shared*, and *how spread is the practice of sharing in the community*? Answering the first question would help to assess the severity of the problem at the household scale and have an idea of the risk for the child not to recover from (or, in the case of preventive supplementation, fall into) malnutrition due to a lack of adherence (Box 2). Understanding this would be very useful to design therapeutic and preventive plans, decide when to provide the most vulnerable households extra-support like extra-counselling sessions, home visits, etc. The second question is critical to understand whether sharing is a practice that concerns only a few households within a community that for instance could be followed easily by a program team, or if it is a widespread practice that requires a more complex and large scale approach.

➲ *Is hard to measure*

Data collection on these two aspects is usually done through household interviews and direct observations s (Ickes, 2010; Ickes et al., 2012). However, these measurement tools are unable to ensure validity of results. For instance, studies that used weekly interviews indicated a small occurrence of sharing (Lin et al., 2008; Phuka et al. 2008, 2009; Matilski et al., 2009, cited by Ickes et al., 2012), while studies using dietary recall data mixed direct observation tools found that the amount of RUF consumed by the targeted child was low (Maleta et al., 2004, cited by Ickes et al., 2012). For Ickes (2010), the main challenge when assessing sharing [through interviews] in general is the respondent bias related to social desirability (Box 2), especially if the respondent thinks he/she is at risk of losing any advantage according to the answer provided.

➲ *Cannot be compared easily from one place to another*

It is important that programme staff are made aware that sharing is different dependant on context, and context specific information is necessary to ensure appropriate strategy and resource-allocationdecisions are made., However, it is also important to note that studies used different protocols and measurement tools to study sharing.Most importantly, they attributed different meanings to the concept of sharing and this lack of consensus on the definition adds to the difficulty of understanding what we are talking about. Cohuet et al. (2011, 2012) defined sharing as both sharing AND selling. Ickes (2010, 2012) did not provide a specific definition for sharing, but the way in which he worded his questions in his interview form ("*Does your child share the food with other siblings or children in the compound?*") leads us to think that he implicitely excluded selling in the definition.

Box 2: Some concepts and definitions:

Acceptability: "*The extent to which participants or caregivers of selected children liked the use, appearance and taste of the product"* (UNHCR, 2011)

Adherence: "*The extent to which product consumption conforms to the recommendations provided to the caregivers"* (UNHCR, 2011)

Social desirability: According to the reference.M.D, social desirability is "*A personality trait rendering the individual acceptable in social or interpersonal relations. It is related to social acceptance, social approval, popularity, social status, leadership qualities, or any quality making him a socially desirable companion*". This concept is used to explain why in many cases where some answers are considered to be more acceptable than others, respondents tend to give them instead of the true one.(URL: http://www.reference.md/files/D012/mD012928.html. Last visit: May 11, 2013).

Other main features of RUF sharing at household and community levels

➲ *The acceptability of RUF is generally high*

To assess the potential outcomes of implementing a RUF intervention in a community, humanitarian actors usually try to measure the acceptability (Box 2) of the product before or at the early stages of the intervention, either as a specific study, or as part of a broader monitoring

exercise. The four studies mentioned at the beginning of this capsule as well as an anthropological assessment of the causes of malnutrition in Chad refugee camps (Magen, 2012) found that the products tested in general were very popular. The two main reasons mentioned were the taste and the feeling of food insecurity (Cohuet et al., 2010, 2012; Magen, 2012), in the household. High acceptability is positive in that it means that the products are likely to be consumed; however, it can also mean that its probability of being shared or subject to other types of diversion, especially selling is high, as described in Magen's report on the use of Plumpy'Nut® (cf. Box 3 p 7).

➲ *There seem to be critical places and times for sharing*

Although this may not be true everywhere, it can be worth to keep in mind that some places and times are more favourable to sharing than others. In Niger for instance, Cohuet et al. (2011, 2012) found out that RUF sharing mainly occurred on the way back from the distribution site or while arriving in the compound. In terms of timing, mothers reported they shared the products with others while giving the food to targeted children. Similar patterns were identified in Chad (Magen, 2012).

"When I returned to the village, I opened a box of "koullou" [Hausa name given to Plumpy'Doz in the villages] and distributed some to the children who greeted. I kept the rest for my child"

A mother in Madarounfa district, Niger, cited by Cohuet et al. (2012)

➲ *Gender aspects and social roles*

Cohuet et al. also (2010) confirmed the general assumption that women play a key role in regulating the use of RUF rations, not only as they are often the main caregivers, but also because they are usually in charge of managing rations' stocks at home (2010). From one culture to another, this role may be more or less important and its influence over the quality of the household's food aid management quite limited. However, experience has shown that in many cases, stocks (whatever RUFs or other types of food aid) were better managed when women had control over them, and that chances for children to benefit from them were higher (Taylor and Seaman, talking about general food aid ration management, 2004). Based on this conclusion, some food aid programs took the bet, in cases where all community stakeholders' roles and responsibility were well-apprehended, to foster a re-negotiation of social roles, which among others consisted in giving women more control on the household's food basket. The authors (citing Acacia, 2002, Chapman, 1998 and WFP, 2001) also mentioned that interventions to reduce discrimination against women in the planning of targeting programs have been positive in many contexts. Meanwhile, Chapman (1998, 1999, cited by Taylor and Seaman, 2004) doing so empowered women to partake to decision-making and collaborating with men within the community. In other contexts though, this approach was pointed out as at risk of inducing division and conflicts between groups (Taylor and Seaman, 2004).

Two other important variables related to gender and social roles are age and transgenerational relationships. Indeed, women of different ages and generations may have more or less power over one another. For instance, in Chad, Sudanese refugee camps, grand-mothers seem to play an important role on how to feed children as found in this mother's testimony gathered by Magen (2012) in Amnabak refugee camp, Eastern Chad:

"It is true that it is very difficult to change the mentality of old women, especially grand-mothers and they are the one who influence the most what is given to the child. They force you to give all what you eat to the child too."


Mother and daughter, Treguine, Eastern Chad

➲ *People benefiting from sharing are not always the same*

Sharing may be directed towards other children of the same age range (Cohuet et al., 2010, 2012), towards older children, fathers and other adults from the household (Cohuet et al., 2010; Magen, 2012). It can also be directed towards neighbours, but to a lesser extent (Cohuet et al., 2010; Magen, 2012). Cohuet et al. also mention sick people or elderly as potential recipients of shared products (2010, 2012).

➲ *Beliefs and representations play a key-role*

It is common to hear about beliefs, representations or rumours on RUFs, and depending on the context, they may trigger or alter the community's acceptance of a product. For example, a field worker presenting his RUSF program reported a serious lack of acceptance at the beginning of the intervention due to a packaging showing a child that, according to community members, looked like a dead body (UNHCR Operational Guidance presentation, Geneva, 2012). On the other hand, as mentioned previously, RUFs can also be victims of their success and the risk of sharing increased by some representations that almost make them appear as magical products. In Chad for example, key-informants and focus group discussion members reported to use Plumpy'Nut for various and sometimes unexpected reasons that are presented in Box 3.

Beyond representations[4] on RUFs themselves, a community's attachment to values of solidarity and equity among others, may strongly affect attempts of targeting. This is the case in the Dinka society of Southern Sudan that considers sharing as a step towards equity. (Mendalazi and Guerrero, 2008). This value is also shared by some fathers and neighbours in Niger (Cohuet et al., 2010, 2012).

Box 3: Popularity, beliefs and representations around Plumpy'Nut® in Eastern Chad: findings of an anthropological assessment*.

"Plumpy' Nut® is famous in the eastern region of Chad, and the region, famous in the rest of the country to have plenty of Plumpy'Nut. We were surprised that almost all our interlocutors from the East requested for "more Plumpy'Nut to be distributed" while no stock shortage was found in nutrition programs.

The popularity of this product meant for children suffering from severe acute malnutrition completely modified the perception of its properties.

For all it is much more a food than a medicine, but a food with very particular properties:

Men seek to consume it for its supposedly aphrodisiac properties, pregnant women to have healthy babies, young women to gain weight and increase their seductive power. More classically, it is impossible not to share the famous « biskit » with siblings**.

Plumpy' Nut brought in its wake similar representations of Plumpy'Doz and CSB. Plumpy Doz is consumed as sandwiches that can be offered to share to a guest. In N'djamena, a young girl asks her cousin travelling to Abéché to bring her only one thing: sachets of Plumpy'Nut, because we know there are plenty in the East. A former NGO staff even said that at the end of his contract, his employer distributed boxes of Plumpy'Nut as a premium and we even found an employee (…) consuming some in the car that was bringing her to her workplace."

In « Analyse causale de la malnutrition: enquête qualitative dans les camps de réfugiés à l'est et au sud du Tchad », Carine Magen for UNHCR, October 2012

** Personal translation*
***In bold in the text*

[4] A representation (or internal representation) is *"a presentation to the mind in the form of an idea or image"* (Visual Thesaurus: www.visualthesaurus.com)

➲ *The social pressure exerted on the caregiver to share RUF rations seems to be generally high and is related to established social norms*

The first pressure mentioned by mothers in Niger and Chad (Cohuet et al,, 2011, 2012; Magen, 2012) comes from other siblings, in front of whom mothers find it difficult not to share the product

"Now the child, and his young brother, is it possible to watch this child swallowing his saliva and prevent him, even if it's a very small quantity, and as soon as you give him, he will go away to play"

A mother of Mirriah region, Niger (cited by Cohuet et al., 2010)[5]

Administration of Plumpy Doz in a CMAM program, Bangladesh. All watching, one eating (Source: UNHCR Bangladesh)

Other adults from the household and immediate neighbours also exert pressure on the caregiver, who is compelled to share it with other children or even guests (Cohuet et al., 2010). As seen previously, the elderly, especially grand-mothers play an important role in some cultures and may impose the practice of sharing as a rule like is happening in Chad.

All these examples appear to be more or less spontaneous means of pressure. However, some cultures have more structured ways of exerting pressure on their members to impose sharing. Mendalazi and Guerrero (2008) describe three means to enforce the practice of sharing in the Dinka society: shaming and legal action. A short abstract on shaming in presented in Box 4 above.

On the other hand, sharing may also be limited by the development of an opposite social norm. In Niger for instance, Cohuet et al. noticed that awareness campaigns and/or the positioning of other household members also impacts not only the occurrence of sharing but also how much of the product can be shared as illustrated by this mother's testimony:

"During the second distribution they gave instructions that 'koullou' is not for all children, but only those who are less than two years of age – one spoon in the morning, one in the afternoon, and one in the evening. They also said that our children can grow, and be satisfied, even if we do not give them cereals. So we breastfed them and if they are feeling well, they sleep peacefully. Two weeks later, they returned to control us and told us to bring the rest of the "biskit". They found that we followed the instructions. If we had not only fed it to children less than two, they would have removed our village from the [distribution] list; even if just one woman didn't follow instructions, they would have deleted all of us from the list."

Box 4: The use of shaming to enforce general food sharing practices

"As Harrigan (1998) reports, the Dinkas use shaming as a mechanism to advocate for a fair distribution of resources amongst a larger majority of people - especially one's mac thok. People who do not share food with members of their mac thok (…) are often branded as kor (lit. 'lion'). This has elsewhere been attributed to the notion that like lions, people who eat alone give nothing to others, and should expect nothing from other members of the group. Sometimes if one refuses to share food with those in need it could lead to death - through spear masters who may invoke the wrath of the ancestral spirits. Whilst selfishness is socially shunned, sharing is socially rewarded. A wife who is generous to the children of her in-laws, for example, will be highly esteemed by the members of her husband's family.*

Shaming, traditional beliefs and appreciation are the socially constructed and powerful enforcement mechanisms that promote food sharing."

Mendalazi E. and Guerrero S., Field Exchange Issue 32, January 2008 available at http://fex.ennonline.net/32/socio

** Mac thok is the smallest family unit, generally composed of parents, siblings of a nuclear family. (Mendalazi and Guerrero, 2008)*

[5] Personal translation

Strategies implemented to reduce sharing and other limiting factors

The literature available did not really address strategies of reduction of sharing per se. Rather, some authors mentioned some steps that have been used in the field, or described contextual factors that could reduce the incidence of sharing.

➲ *Provision of protection rations for other household members*

Cohuet et al. (2011) found out that the way the product circulated within the household and the community was related to the presence or not of protection rations. The authors also mentioned that some people preferred sharing part of their protection rations with others instead of the RUSF.

➲ *Packaging as small sachets*

Mendalazi and Guerrero (2008) think that the presentation of Plumpy'Nut as small sachets makes it difficult to share (contrary to the CSB) in large amounts on a regular basis within the household; for example, adding it to a family meal as part of a sauce requires opening several sachets, which takes time and may have a prohibitive effect.

➲ *Sensitisation and Education*

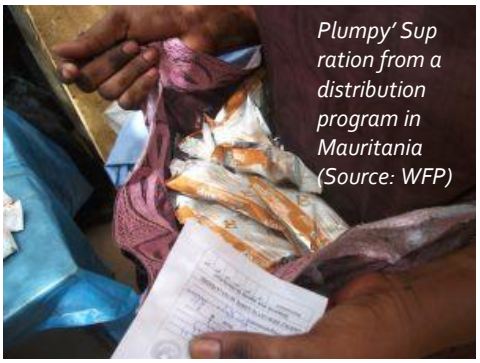
Awareness campaigns on the proper use of RUFs seemed to make a difference (Cohuet, 2011; Ickes, 2010; Zeleneh, 2011) on general adherence to RUFs. However, the contents and format of these awareness campaigns was not very well documented. That said, the last testimony quoted in p8 gives a general idea of what some women remembered from a campaign that took place in Niger during the 2010 intervention: the "Do not share" message was integrated into a broader frame on conditions of good adherence to the product. Sensitisation messages were also reinforced by home visits to monitor whether instructions were followed or not.

➲ *Repression*

The same awareness campaign in Niger seems to have been combined a more repressive approach that consisted of warning beneficiaries that any lack of respect of the recommendations, including sharing would be followed by the exclusion of the whole village from the RUSF intervention. Although the report does not specify whether it was only the mother's understanding of what she was told, this repressive approach exists in many programs although it is not documented.

➲ *Strategy of gender inclusion*

Box 5 below presents an example of what Taylor and Seaman (2004) thought was a well-understood and appropriate context for encouraging gender inclusion in a food aid targeting (cf. paragraph on Gender aspects and social roles p 6).



Plumpy' Sup ration from a distribution program in Mauritania (Source: WFP)

Box 4: Gender inclusion in food aid targeting to improve effectiveness in Northern Bahr Al Gazal in Southern Sudan

"Prior to the introduction of Relief Committees, food was distributed through the chief structure and passed through chiefs, sub-chiefs, ghol leaders, headmen and women at household level. At the last level, food was distributed equally between households by the headman to avoid conflict. The quantities of food finally received were much less than originally intended and therefore nutritionally inadequate. The targeting system was revised and was founded on the development of relief committees, which had equal representation from men and women and were responsible for allocated geographical areas. In addition, women at village level elected a representative who was well known in the community. The representative publicly selected households that were most needy, and linked this information to information on geographic variation gathered by the RC. The distribution was supervised by RC members and the elected female representative at village level. The approach was considered successful as women claimed that more food reached household level. Additional benefits were noted, relating to the empowerment of women to participate in decision making and work alongside men for the betterment of the community.

Chapman, 1998a, 1999, cited by Taylor A. and Seaman J. in Targeting Food aid in Emergencies, ENN Special Supplement Series, July 2004

Recommendations from authors

➲ *Further investigate feeding habits and sharing practices*

Most of the authors presented here recommended to conduct further studies on feeding practices, including sharing (Manary et al., 2004; Mendalazi and Guerrero, 2008; Wang et al., 2012). Wang et al (2012) even specify that the clinical implications of sharing practices need to be further explored, which links with the difficulty mentioned by Yang et al. (2013) to measure the extent of sharing as mentioned in the first part of this literature review.

➲ *Dedicate more specific attention to sharing practices in terms of programming*

Mendalazi and Guerrero (2008) go further by strongly suggesting that to consider food sharing as *"an operational variable and a factor to be acknowledged and accounted for in order to maximise humanitarian programme performance"*, given that it is not an isolated trait among one of the many communities we work with. For them, *"doing so would ensure two of the most fundamental principles of humanitarian programming - minimising the negative impact on local support networks, and maximising the impact of proposed interventions*.

➲ *Encourage gender inclusion wherever appropriate*

As already mentioned, Taylor and Seaman (2004), although not talking specifically of RUFs and sharing, recommend gender inclusion wherever contexts are deeply understood and judged appropriate for such initiatives to happen in order to ensure better food resources management.

➲ *A 5 points conclusion for best practice in food aid targeting*

Although these recommendations do not specifically target RUFs, they remain relevant in that RUFs broadly pose the same challenges as other food aid products in terms of targeting, coverage and effectiveness. Box 6 summarizes these 5 points.

Distribution of Plumpy'Doz (source: WFP Chad)

Box 6: 5 recommendations for best practice in food aid targeting according to Taylor and Seaman (2004)

1. In order for a food distribution system to support targeting, it must be designed to maximise coverage and minimise inclusion errors. Once again, this involves trade-offs between inclusion and exclusion.
2. Maximising coverage requires consideration of the information needs required by the targeted beneficiaries to participate and the opportunity cost which they will ear as a result of participation, which is dependent on instance, cost of transportation and physical capacity to transport the food.
3. Minimising inclusion errors requires careful political analysis of the context and the points at which diversion could take place.
4. Strong and transparent information flow between the recipient community and the agency targeting the food aid is essential to promote effective targeting.
5. The most effective targeting systems are likely to be found in situations where agencies have been present for a long time, have been funded to invest in systems to support effective targeting, and have built up a relationship with the communities.

The case of Treguine, Eastern Chad Refugee Camp: "Children are our Future"

Context

Treguine is one of the twelve Sudanese refugee camps opened in 2003 in Eastern Chad to welcome civilians fleeing the Darfur conflict. In November 2012, its population was estimated at 20274 persons. The vast majority of the camp is Massalit like the host population in this region and cohabitates easily with it. Treguine's refugee community has been assessed as 100% food insecure (UNHCR 2011); the whole community is entitled to food aid under the form of monthly general food distribution (GFD) by WFP, and targeted nutrition programs address specific nutritional needs for more vulnerable groups by completing the normal ration. These programs, managed by UNHCR's health partner NGOs (IRC in Treguine), have been functioning for nearly 10 years; they use the community-based management of acute malnutrition (CMAM) approach (see box 7) endorsed by the Chad national nutrition protocol written in 2011. Treguine's nutrition program is composed of one supplementary feeding centre (SFP) targeting moderately malnourished children and pregnant and lactating mothers, one out-patient therapeutic program OTP treating severely malnourished children with no complications, and one therapeutic feeding program (TFP), which welcomes on-site those who suffer both from severe acute malnutrition and complications. In spite of these interventions, nutrition surveys from the last years still show high malnutrition levels[6] . To address this situation, all partners decided to investigate the potential of success and feasibility of a preventive RUSF intervention on children aged 6 to 36

Treguine camp, Eastern Chad (Source: Managan, A.)

Box 7: The CMAM approach

CMAM (community-based management of acute malnutrition) is an approach of the management of severe acute malnutrition at home allowed by the use of Ready-to-Use Therapeutic Food (like Plumpy' Nut®). This approach is an adaptation of its ancestor, the **CTC (Community-based Therapeutic care) approach**, created by Valid International and Concern Worldwide as an alternative to numerous challenges posed by the usual in-patient treatment approach, and fully piloted in Malawi in 2003 with positive results. In 2007, a WHO joint statement endorsed the use of the CMAM approach and RUTF. The approach kept evolving and nowadays, according to the CMAM forum*, CMAM (also referred as **IMAM** --Integrated Management of Acute Malnutrition-- or --still-- CTC) includes:

- "Community outreach for community involvement and early detection, referral of cases of acute malnutrition and follow up of problem cases,
- Management of Severe Acute Malnutrition (SAM) in outpatient care for children 6-59 months without medical complications,
- Management of SAM in inpatient care for children 6-59 months with medical complications and children under 6 months with acute malnutrition,
- Management of Moderate Acute Malnutrition (MAM) for children 6-59 months,

The comprehensive CMAM model links with maternal, newborn, and child health and nutrition, water, sanitation and hygiene, food security and livelihood, and other community outreach initiatives."

* Further information available at http://www.cmamforum.org/ (last visit, April 22, 2013)

[6] According to nutrition surveys conducted in 2008, 2010 and 2011, acute malnutrition prevalence levels were respectively 11.7%, 14,4%, and 9.4%, which are considered by WHO (2002) as signs of serious nutritional situation after triangulation with other data (i.e., presence of aggravating factors, trends and seasonality, context suggesting a potential aggravation, improvement or stabilization, etc.).

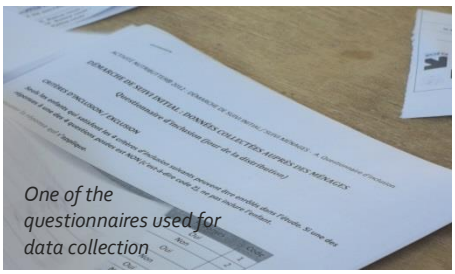
months. In 2011, UNICEF piloted a first RUSF (Plumpy'Doz) intervention that was very-well accepted according to key-informants. Around the same time, the NGO Action contre la faim (ACF) conducted a research in its program area (Huybregts et al., 2012), which was outside of refugee camps but located in the same region (Ouaddaï) and with similar features with the eastern Chad camps. Based on the positive outcomes of these activities, the nutrition community decided to scale-up the preventive RUSF intervention and adjust some parameters to increase the intervention's effectiveness. Among others, the use Nutributter® instead of Plumpy'Doz® was preferred to reduce the risk of mothers replacing breastfeeding by the product[7], and to narrow the target age group to 6-24 months-old in order to adjust to the current recommendations for use of Nutributter).

The initial follow-up activity

At the same time, with general implementation activities, an initial follow-up process was conducted. Its main goals were to assess the community's level of satisfaction and adherence to the product and help defining a customised communication strategy around the product.

Although this follow-up process was initiated for broader reasons than assessing the potential for sharing, this issue was considered with full attention because both RUSF distributed during the UNICEF pilot intervention and RUTF given to severely malnourished children were widely shared with everybody in the community, especially with fathers, who attributed them to having aphrodisiac properties. The process integrated a qualitative component[8] that consisted of:

- *Interviewing key-informants* from the community and camp staff (the Chief of community leaders, the Head of community health workers (refugee and national staffs in charge of sensitisation and education sessions as well as home visits, the camp's nutrition supervisor and health referent, and the reproductive health coordinator.
- *Facilitating 4 focus group discussions* (mothers, health and nutrition actors in the camp -- including traditional medicine actors[9], community leaders -- including imams, and fathers) before the beginning of the intervention and one global focus group discussion approximately 3 weeks later, and
- *Conducting individual interviews of 20 voluntary caregivers* during the first distribution and 2 weeks later as well as direct observations in between, preferably during meal times via home visits.



One of the questionnaires used for data collection

Findings related to the potential for RUF sharing

In brief, our findings corroborated Magen's. We will try here to present the most important.

- *Ready-to-use foods are very popular for many reasons*

The feeling of food insecurity[10] among others, despite WFP's provision of full GFD rations, was highly present. Some group members pointed out difficulties for them to access some foods that were strongly part of their feeding habits in Sudan, especially milk. In this context, the taste and texture of Plumpy'Nut®, Plumpy'Doz® and Nutributter® were felt as "very good" and not available in sufficient amount. In addition, these products being distributed for free, they did not require to spend money on them, contrary to other products like "Tahaniya" (a sesame paste available on camps markets). Another reason was the need for the community to feel that everyone was equal.

Specific groups provided other reasons. Fathers confirmed the belief in RUF's aphrodisiac properties during a focus group discussion (facilitated by a man to reduce respondent bias as much as possible). Mothers indeed find very difficult not to share the product with other children, especially when they cry or beg for it.

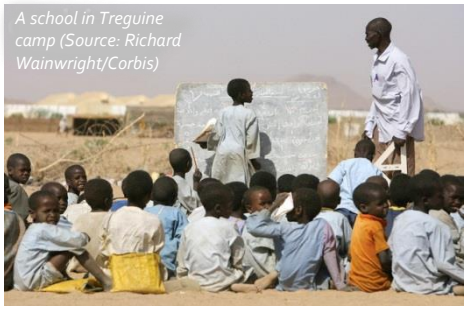
[7] The daily dosage of Nutributter is 20g while being of 46g for PlumpyDoz. The products are made by the same manufacturer, so there is no competition between them but just more or less indicated contexts.

[8] Because the quantitative part on sharing and the sample size were very small, we have several doubts on its validity and thus will not cover it here.

[9] « Dahias » that are, women in charge of pregnant women; unfortunately, we did not manage to approach other traditional health providers.

[10] According to the World Food Summit (1996), *"Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life"*. From this perspective we can say that the refugee's feeling of food insecurity becomes an objective fact to mandatorily integrate to food security strategies.

Listening to the caregivers also taught us that although some of them felt difficult to give the product to the targeted child only, many understood clearly why it was important for the targeted child to receive his full ration after being explained how the product works. Of course, we cannot ignore the risk of respondent bias, and this allegation's validity should be confronted to the occurrence --or not-- of a real behaviour change in practice. In addition, when asked what they could do to avoid sharing the RUF with others, some mothers mentioned that they could hide the stock of RUF, wait for older children to go away (many mentioned the time to leave to school), or even send them outside the house before giving the ration to the targeted child.



A school in Treguine camp (Source: Richard Wainwright/Corbis)

At the community level, a big part of the discomfort expressed about what they considered a too narrow targeting of RUF aid came from the lack of understanding (or explanation?) of the reasons why young children were given priority. After being explained that the product, although it is not a medicine, is meant for those children in particular because they are more fragile and thus, more at risk of falling into malnutrition and micronutrient deficiencies (concepts covered at the same time as an introduction), many group members, especially mothers and community leaders expressed their satisfaction and a better understanding of this targeting.

➲ *"We will sensitize our community"*

The community showed a lot of enthusiasm at all levels and spontaneously expressed their willingness to get involved in a sensitisation process on the importance giving targeted children their full ration. For instance, religious leaders offered to directly pass on the message that "the product is for the little child only because he needs it". National and refugee staffs also demonstrated a clear eagerness of commitment, which was key to strengthen the quality of the relationships with all categories of the community.

> *"For the project to succeed, we will support the community. We want some training and advice every month or every two months. We must assess what works and what does not. When we return to our country [Sudan], it will serve to support the healthcare to be given to 6-24 months."*
>
> *A Sudanese community health worker, Treguine.*

Local strategies used to reduce sharing

As part of the general implementation plan, and based on the initial follow-up assessment mixed with previous local experiences, all health and nutrition actors and a considerable number of people from the community worked on several aspects of prevention.

➲ *Sensitisation messages in the camp and on distribution sites*

Community health workers (CHW) started to deliver sensitisation messages long before the start of the intervention. The primary goal of early sensitisation was to ensure an as high intervention coverage as possible so caregivers could make arrangements to go to registration sessions. The second goal was to use this opportunity to present the product and the way to use it properly. As part of these recommendations, CHWs insisted on the need to give the child a full ration for the product to be reall y effective. This precaution was taken based on the serious concerns raised on the occurrence of sharing during a Plumpy'Doz® pilot activity that had happened one year before. Similarly, OTP staffs had also reported a strong tendency of household to share the Plumpy'Nut distributed for the home-based treatment of severely malnourished children. The second step consisted of using the initial follow-up findings to refine the sensitisation approach. For instance, it was noted during informal talks and discrete observations of some sensitisation sessions that the direct « Do not share » message was overused and could lead to serious arguments between some mothers and CHWs. After focus group discussions and work sessions with people from different horizons in the community, messages were refined and CHW given more guidance and tools to better transmit messages.

➲ *"On the spot" education sessions*

During the initial follow-up process, extra time was systematically dedicated to answer the questions raised by focus group discussion participants. These planned sessions spontaneously turned into mini-education sessions on topics related to health and nutrition: groups of nutrients and their main functions, malnutrition, micronutrient deficiencies, especially anaemia, and nutrition advice. These

introductions/refreshers allowed addressing very specific questions at a time where people actively asked for it and could benefit from customised answers. These particularly fruitful times of receptivity were used to provide detail on the RUSF's composition and expected effects to indirectly reinforce the "*give the child his full ration*" message.


Our volunteer artist and a camp staff, busy creating, keen on discovering. Thanks to you both! ☺

➲ *Behaviour change communication (BCC) tools*

Based on key-informants and focus group discussions' inputs, four messages appeared as the most important to emphasize: *Keep breastfeeding, diversify food, preserve hygiene, and give the child his full-ration of Nutributter®.* Local actors also strongly recommended the use of visual tools to disseminate these messages. In order to make the intervention as visible as possible to all beneficiaries coming to the health centre, a large communication panel and posters presenting the product with a summary of the four messages were designed for strategic sites inside and in front of the most frequented structures. On demand of the CHWs, the team also created a culturally-sensitive image box that is, a visual tool made up with ordered pictures on one side turned towards audiences while the person conducting the education can see the main written messages he/she has to deliver. In order to be as relevant and useful as possible, pictures were designed by a volunteer artist who was very familiar with the community's traditions, and messages were translated into English, French, Arabic and Massalit, the four main languages spoken/read in the community.

The BCC strategy also included another tool based on the known strong influence of orality in the Massalit culture: role plays. The initial assumption based on previous experience was that role plays, by facilitating one's identification to some opinions and practices being played on stage, could help triggering the beginning of a behaviour change process according to the BBB Model (Box 8).


Colleagues busy thinking about what BCC tools they need and their format during a preparatory workshop, Abéché, Chad.

Box 8: Some concepts and definitions:

BBB Model of behaviour change
A theoretical approach widely used in BCC that broadly consists of declining the process of behaviour change into three main steps: *(1) **B**elieve benefits; (2) **B**reak down barriers; and (3) **B**egin now (goal-setting).*

Behaviour (human behaviour): A very clear definition is provided by the UK National Institute of health and Care Excellence in its Public Health guidance on behaviour change (2007): "human behaviour is defined as: 'the product of individual or collective human actions, seen within and influenced by their structural, social and economic context'. These actions produce observable social, cultural and economic patterns which limit – or enable – what individuals can do."

Behaviour change: Based on the NICE * definition of human behaviour, we can define a behaviour change as the modification of the product of individual or collective human actions that results in limiting -- or enabling -- what individuals can do from a social, cultural and economic viewpoint.

*National Institute for Healthcare Excellence, based in UK.

FOCUS: THEATRE, ORALITY AND PREVENTION

Theatre is a well-known medium in the field of health education, especially when approaching sensitive topics like HIV/AIDS prevention, for instance. Role plays, especially when improvised, also showed to be very effective and ludic when used to train surveyors on communication skills. Part of the rationale behind using theatre in behaviour change communication strategies is that orality is so strong in many cultures that the chances to effectively touch people, triggers a reflection and then, initiates a behaviour change are quite significant, even when addressing very "heavy" issues. Indeed, theatre allows both spectators and actors to exchange more or less implicitly many emotions, feelings, questionings, etc. by the means of fictive characters that are free of any limitations in expressing these affects. One of the most famous contemporary applications is the *forum-theatre*, a generic form its ancestor, the "Teatro Del Oprimido" (lit., "Theatre of the Oppressed"), founded by Augusto Boal, a Brazilian theatre director and writer. Boal developed the concept of "spec-actor" and staged situations of oppression that "spect-actors" could stop and ask actors to replay in the way they were suggesting*. His aim was to help people to empower themselves by taking control over situations that were very close to their real life and apply these changes in real situations. In 2009, a whole project based on these principles was adapted to nutrition issues in Burkina Faso by IRD (Institut de Recherche pour le Développement- lit., Research Institute for Development), a French NGO**.

In Treguine where orality usually takes the form of griots and storytellers performances, the bet was taken to succeed in strengthening CHWs' communication skills and initiate a different way of thinking about sharing both from CHWs and community members' perspectives. The idea was, by the means of improvised role plays very close to the format of the performances people were used with, to facilitate both CHWs and mother's self-identification to usual opinions and practices towards sharing and then, in an implicit and tactful manner, try to develop their receptivity "Do not share" messages. If this approach looked obvious when directed towards mothers, it was also necessary for the CHWs in that their vast majority had the same cultural background and did not feel so comfortable towards that message, especially when confronted to some arguments that sounded very meaningful to them. This first attempt lacked some refinement and would certainly benefit from a more structured approach. However, it was rich in lessons learnt as we will see further.

"A training that doesn't say its name"

A preparatory step consisted in facilitating a brainstorming with CHWs, not only on sharing practices, but also on the daily-life situations they experienced in their work. After a brief introduction on role plays and their relevance as a practice tool, the group was invited to quickly work on a short scenario to be improvised by a smaller group of voluntary CHWs. Two mothers were invited to watch the performance and share their impressions afterwards. The situation chosen by the group represented a family being visited by a pair of CHWs and providing arguments on why they "had to" share the RUF. The "family" was composed of a married couple, the targeted child an older children complaining that their parents only loved their younger sister because she was the only one to receive the product. This improvisation was very rich in that many other unexpected arguments were raised by the protagonists. Another unexpected result was that during the debriefing, CHWs reported to have felt very happy to be able to express what they were regularly experiencing in front of confronting situations like that one. In the eyes of the mothers present, watching the play was very "good" because "this is real life" and that "it is hard to say no to the siblings". Eventually, in order to integrate the feedback obtained from mothers and other spectators, the actors re-played the situation.

When asked their impressions about this first attempt of semi-directed improvisation, CHWs reported that not only this little exercise was pleasant and useful, but that it was a training that did not say its name because during the re-play , they realised how had made progress.

A similar experience of role plays in Haiti, 2008.

* Further information available at http://www.theatreoftheoppressed.org/en/index.php?useFlash=1 (last visit: May 16, 2013).

** Further information (in French only) available at http://www.ird.fr/la-mediatheque/videos-en-ligne-canal-ird/savante-comedie-en-pays-lobi/savante-comedie-en-pays-lobi (last visit: May 16, 2013).

What's next? The way forward

We need to fill some knowledge gaps

Reviewing the literature was an opportunity to realise once again how contexts can be very specific, or share some features and similar concerns. For instance, the need for "feeling equal" shown here is shared by communities in Niger, Chad and Southern Sudan and appears to be a strong traditional *value* that must be respected and taken into account when designing strategies to reduce sharing in these areas. Sharing lessons learnt from local attempts through forums and other communication means among the humanitarian community would probably make the work on sharing easier and more effective. As an example, UNHCR developed a website where many reports, measurement instruments (questionnaires, focus group discussion record sheets, etc.), and BCC materials used during the implementation of RUFs in different refugee settings are available to anybody for use and local adaptation[11]. That said, on top of the authors' suggestions presented at the end of the review, it may also be very useful to further explore the following issues:

- *Extra-economic burden generated by sharing*

Although it seems obvious that an extra-economic burden is added to program costs, developing/improving tools for measuring the extent of sharing and its financial weight would be very useful in helping determine the amount and nature of resources needed to reduce sharing and improve the program's effectiveness and efficiency.

A group work session with community members (Source: UNHCR)

- *Exploring the quality of communication and general relationships between humanitarians and the community*

The studies available did not examine the nature of communication and general relationships between communities and humanitarians, probably because it would be very difficult to design a technically sound model and would require a multi-disciplinary team to conduct a valid study, while other investigation may appear more important at the current time. However, exploring these critical aspects would very likely help humanitarians to better understand contexts in which they work in and cannot spontaneously understand. Sharing is a very good example to illustrate the need for us to try as much as possible to better understand why and how some beliefs and behaviours are so strong in some societies, what need they try to fulfil/compensate, to which extent they are successful or negative, and how it translates into daily life activities and rhythms within the household/community.

- *Investigate and document BCC strategies*

The rationale used to understand the general context, design sensitisation, education and BCC messages are not or very rarely documented (or disseminated?) when it comes to RUF intervention programming. This could help others to benefit from experiences and lessons learnt. In brief, the works examined in the review, gave us a hint that behaviour change strategies were used up to some point, but there is no information on the rationale, design and amount of resources mobilised for these strategies (i.e., initial assessments, community involvement, etc., except Ickes et al. (2010), mentioning the use of the "BBB" model of behaviour change. this would certainly constitute a whole new study and need a strong anthropological and psycho-social

[11] http://info.refugee-nutrition.net/operation-guidance-on-use-of-fsp (last accessed: April 22, 2013)

component. However, combined with nutrition data and economic analyses/projections it would considerably help building a more holistic and successful frame of intervention.

Lessons learnt from the Treguine experience

➲ *We need to maintain a continuous dialogue with the community*

The Nutributter intervention in Treguine refugee camp was designed to be as holistic and integrated as possible within other health and nutrition activities. Hence, the same actors could have a broader vision of the nutrition situation and issues and work from different angles on sharing. For instance, instead of focusing only on means to avoid the sharing of Nutributter®, many efforts were made by the team to manage this problem for all other products and from different points as well, like working on general BCC tools, strengthening the staff's communication skills, involving actors of reproductive health to address mens' beliefs on the aphrodisiac properties of Plumpy'nut, etc.

Efforts were also made to integrate other cross-sectional aspects of programming like gender or environment (i.e., by setting a "clean" circuit of disposal for empty sachets!). In other words, this field experience constituted a sound example of the importance of understanding the context and see activities in a holistic and integrated manner.

➲ *Surprises all along the road!*

The knowledge acquired or confirmed from the initial follow-up process and regular discussions with community members and camp staffs provided further evidence of how beliefs shape reactions and require full attention from us, which is in line with Mendalazi and Guerrero's recommendation to consider sharing practices as an operational variable for our programs.

But what to say about the reasons for sharing that were not foreseen at all? For instance we know mothers reported having troubles saying no to older children, but we did not expect them to suffer from them being accused of not loving them. Some more or less logical links like why is the general food distribution for everybody and not this product" was also identified and help to better tailor CHWs arguments and communication approach. this was possible thanks to role plays among others, and should definitely further developed.

➲ *Timing and planning are critical*

Indeed, due to logistical constraints and unexpected delays generated a considerable workload and confusion by forcing the team to manage several activities at the same time like in Chad. A balanced planning is key to maintain the staff's motivation and commitment, which luckily remained the case there despite challenges.

➲ *More documentation on the BCC strategy is needed*

Staff motivation and commitment are key-drivers of success. A community health worker playing with a child while is mother is busy with the registration staff, Treguine camp, Chad.

As current research give priority to other very important issues compared to feeding practices and behaviour change strategies , we favoured other criitical aspects of daily programming . However, it is necessary to better document these critical aspects from a field's viewpoint as soon as possible in order to keep improving the program and share lessons learnt with other actors worlwide.

➲ *From the field to the field*

- *Data collection and analysis in the field*

Gathering data data from the community and analysing it while still on the field allowed concerns/questions to be raised as early as possible; this helped building/reinforcing mutual trust, and working together on solutions. This back-and-forth process also brought the opportunity to let people know about the results of our data collection, which we know we should but rarely do.

- *Listening and asking the community first*

A close relationship with the community is critical to know what people think they can do to avoid sharing and what they need to reposition themselves towards sharing; this approach favours the empowerment of caregivers, leads them to feel supported by other group members that were experiencing similar difficulties. Moreover these opportunities of meeting each other in a non-judging atmosphere allowed caregivers to share their concerns, questions and solutions transparently with everybody. Developing communication messages and tools also became easier and more appropriate. Moreover, these exchanges led to spontaneous

propositions of full commitment to the sensitisation process. And last but not least, listening to the community opened (or maintained) a level of receptivity and interest that made nutrition education needs assessment very productive, leading for example to spontaneous requests for trainings and education sessions on very relevant issues.

➲ *Way forward in terms of decision-making and strategic planning*

- *The initial follow-up*

The initial follow-up process conducted in spite of all challenges brought many useful answers within a very short period of time (approximately one month) while the problem had been going on for so long. This positive outcome should support the decision of planning initial assessments that explore feeding practices and sharing patterns as well potential solutions more systematically. Indeed, though it is very tempting to skip this step given the lack of resources and time, its added value does not need to be demonstrated again. Going back to the Treguine experience, it is for now unfortunately too early to really measure the impact of the first communication activities undertaken, and the community's enthusiasm about getting involved in the process may fade away if not sustained. However, the first feedback from many staffs and community members encourage optimism.

Household interview in Treguine

- *Develop a better understanding of the local context thanks to a multi-disciplinary approach*

The pre-existence of an anthropological assessment allowed to confront the initial follow-up data and thus, assess their internal validity. Planning to conduct such concurrent approaches that at that time rather occurred by chance than really planned on purpose allowed to back many quick decisions made in the field. For example, being aware that some beliefs about the Plumpy'Nut were currently strong in the community and serious drivers of sharing allowed to take some precautions like strengthening the collabration with reproductive health professionals and thus think about better alternatives to solve specific problems.

Treguine's role play « spect-actors » after their performance

- *Opt for field-based solutions as much as possible*

Many field-based solutions, like using role plays and designing image boxes with the local resources available were very much cheaper and more culturally-sensitive than more sophisticated and expensive alternatives. Also, buying materials available on local markets like wood to make communication panels not only reduces costs, but injects cash into the local economy without distorting it given the small scale of theNutributter project in Treguine. By generating income-generating activities we not only reinforce other food security activities but also preserve people's dignity. Administrative and logistic procedures should facilitate such alternatives.

Treguine's market (Source : Managan, A.)

- *Monitoring and evaluation*

RUF implementation projects take time to become stable, and measuring their impact and efficiency may be tricky at the beginning. However, as recommended in the UNHCR Operational Guidance on the use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in Refugee Populations, a good monitoring framework (being designed currently) would not only help measuring effectiveness, in order to assess the relevance of the activities conducted, but also strengthen general transparency efforts.

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