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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Malnutrition in the Third World

SIR,—As an organisation much concerned recently in the famine relief operation in Africa we read with interest Professor A Stewart Truswell's article (24 August, p 525). We would like to share our observations and experiences.

The priority in ensuring that the population will not deteriorate further is to provide 2000-2100 kcal (8·4-8·8 MJ) daily per head as a basic ration. This calculation is an average based on the requirements of differing age groups: a child of 4 needs 17-1800 (7·1-7·5 MJ), a young man of 19 maybe 2900 (12·1 MJ). For ease of administration and to prevent envy the rations should be seen to be the same for all. They would consist of cereal, legumes (beans or peas), and oil. A few grams of salt or spice is recommended. The distribution of milk powder is discouraged because the conditions for safe reconstitution at home do not exist. Milk is used in therapeutic feeding for severely malnourished children based on the high energy milk recommended by Oxfam.[1]

A further supplement of the same types of basic food equalling 350 kcal/day (1·5 MJ) is given to those who are growing—that is, the under 5s, breastfeeding women, and those in the last trimester of pregnancy.

Multivitamins are not used but rather the specific vitamin for an identified nutritional problem. Borderline reserves of vitamin A are used up when malnourished children begin eating. Infectious diseases are often exacerbated as the child's nutritional status improves, further depleting stocks. Because the sequelae are so serious if there is any evidence of vitamin A deficiency in a community all the children receive prophylaxis. In the Sahel scurvy has been a problem owing to nomads losing their camels' milk, which is a good source of vitamin C. In our experience anaemia is a serious problem compounded by malaria and hookworm.

While appearing to address famine, the article actually deals with individuals, particularly children with severe malnutrition. More lives are likely to be saved with measles vaccination and adequate early treatment for diarrhoea. As both of these interventions also have considerable nutritional benefit we would direct our resources to this end.

Doctors concerned in famine relief operations should have a management/organisational role, determining and guiding a locally appropriate programme aimed at lowering the mortality and morbidity of the three or four most common conditions to the level usual for that country. This is after ensuring adequate food and water. Focusing on the treatment of a few individuals often means that the major, often preventable, health problems of the majority are ignored. Therapeutic feeding, which requires individual medical supervision, considerable time, and inpatient facilities, is not an effective use of resources, especially as the results are not encouraging. If it is done we would emphasise, however, that energy density is important along with an organisation which assures six to eight feeds per child in 24 hours. Potassium replacement is easily done by adding oral rehydration salts to the high energy milk mixture.

The mid-upper arm circumference is used for rapid screening only and the cut off point we use at present is 12 cm. This is under review and will be discussed with other agencies. The use of light 850 g hanging scales encourages the more accurate weight for height survey to be done. Weight for height surveys of children aged under 5 (or 115 cm) give an indication of the nutritional status of the community. But other information must also be obtained if the intervention is to suit the problem. For example, there must be an awareness of the normal loss of weight which occurs just before the harvest[2]—the hungry season—or knowledge of recent epidemics such as measles or recent migration due to civil unrest.

Food aid can have negative effects. Donations of food may depress local prices so much that the next year's harvest has no market value. In countries where the rainfall is always borderline communities have developed ways of coping with the lean years, and shortsighted "solutions" can destroy this balance. A central distribution, convenient from the relief agencies' point of view, may create a pull effect. This encourages people to leave the shelter of their villages and congregate in large numbers and thereby increases the transmission of infectious diseases due to overcrowding and pollution of the environment. The men may be so far from their villages that they miss the rains and so do not plant in time.

The five measures Professor Truswell mentions for preventing protein energy malnutrition are aimed at child health in general. Of these five, the early and adequate treatment of diarrhoea (rather more than the use of oral rehydration solution only), breast feeding and adequate weaning, and immunisation against measles are among the most critical of the interventions that may be made in famine relief operations.

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1 Oxfam. *Practical guide to selective feeding programmes*. Oxford: Oxfam, 1984.
2 Loutan L, Lamotte JM. Seasonal variations in nutrition among a group of nomadic pastoralists in Niger. *Lancet* 1984;i:945-7.

SIR,—Professor A Stewart Truswell (31 August, p 587) describes the problem of vitamin A deficiency endemic in east Asia and certain parts of Africa and Central and South America in association with protein malnutrition.

He states that the last reported case of xerophthalmia in Britain was in 1938. It is wrong to